healthwatch

# Healthwatch resourcing in the new health and care landscape

A briefing on local Healthwatch resources and the impact of system transformation

February 2022

# Foreword

Over the last 12 months, the Government has put forward several key reforms to support the levelling up of health and social care services across the country.

As Chair of Healthwatch England, it has been particularly encouraging for me to see Government put community engagement at the heart of the thinking on these changes.

In a white paper last February, the Department of Health and Social Care (DHSC) set out its plans for new legislation to underpin the creation of Integrated Care Systems (ICS). It stated that this would create a "real chance to strengthen and assess patient voice at place and system levels, not just as a commentary on services but as a source of genuine co-production."

Indeed, we can now see the Health and Care Bill sets out a clear expectation that Healthwatch, as the statutory champion for service users and the public, will play a key role in supporting both the Integrated Care Boards and the Integrated Care Partnerships in delivering their statutory duties to engage communities.

In the Integration white paper, published just a few weeks ago, we also saw Government reiterate the importance of 'place' level decision making. One of the major strands of this document focuses on "shared outcomes which prioritise people and populations". To deliver this, it will be vital that Healthwatch, with its already established roots at place level, continues to do what it has always done to ensure local leaders have access to the insights they need to deliver what their communities want and need.

Lastly, it is clear Government more widely is looking to empower communities, wanting to work with them to support the broader Levelling Up agenda. It was really good to see the white paper issued by the Department for Levelling Up, Housing and Communities (DLUHC) set out four guiding principles on developing community power, listening more to people and ensuring every community matters. Healthwatch clearly has an important part to play in supporting this policy. These are strong commitments from Ministers on the value of insights and ideas generated by people.

However, there is a very real risk of this approach being compromised if it is not properly resourced.

The most straightforward way to mitigate against this risk is to get the investment in the Healthwatch network right. This is not just about investing the right amount of money but also about using the right mechanisms to get these funds to where there are needed most.

I look forward to using the evidence presented in this report to help the DHSC and Government as a whole level-up listening and ensure we deliver a world-beating health and care service for all, reflecting what people tell us they need.

Sir Robert Francis QC, Healthwatch England Chair

# Executive Summary

The DHSC funds Healthwatch by making money available to local councils to commission an effective local Healthwatch. To enable DHSC to track what is happening to its investment, each year, we're asked to analyse the funding received by local Healthwatch.

Alongside this year's review, we have also provided our opinion of how current resourcing will impact the ability of the network to operate in the new health and care landscape in 2022/23 and beyond.

## Healthwatch Funding

Since Healthwatch was established, the funding provided by local authorities has been reduced in real terms by £24 million.[1]

We believe that this downward trajectory of funding for local Healthwatch, and thus investment in listening to people and communities to shape health and care at 'place', will have broader implications for systems and nationally.

### Compliance with funding directions of DHSC

Only 74 of 152 local authorities comply with the direction of DHSC that the majority of the funding for local Healthwatch should come from the local government settlement (as opposed to Local Reform and Community Voices [LRCV] grant).

We believe that this lack of compliance with the DHSC-stipulated funding levels impedes the ability of the health and care systems to consider the views of people and communities in improving care and will continue to do so.

### Compliance with principles of good commissioning

Despite National Audit Office principles of good commissioning stating that authorities should commit to multi-year funding, 85 local authorities have historically commissioned their Healthwatch with a commitment of one year or less.

Where local Healthwatch contracts are renewed annually (or for less than a year), this impacts their effectiveness, including their ability to forward plan work, procure essential services with good value (e.g. office lets, insurance) and retain staff. Therefore, we think that in over half of local authorities, there is a risk of non-compliance with the duty to commission an effective local Healthwatch.

### Impact of funding reductions on staff

Based on our analysis of the costs of running local Healthwatch, it is clear that funding reductions mainly impact staffing. Currently, 81 local Healthwatch are

[1] Accounting for inflation.

funded below the level that we would consider viable to run a legally compliant organisation and deliver effective local Healthwatch services.

We believe that commissioning in a way that does not account for full cost recovery and staffing of the organisation to be sufficient for delivery of the statutory functions is not consistent with the duty to commission effective local Healthwatch.

## Future of Healthwatch funding

The health and care system is in the process of major reform. Later this year, we expect ICSs to become statutory organisations, which will have implications for how these ICSs need to engage with their communities. Therefore, this will significantly impact the expectations placed on local Healthwatch and their role in giving communities a voice.

Many ICSs have yet to confirm funding for additional requirements for Healthwatch at a system-level brought about by the health and care bill. This juxtaposed with the dwindling local authority resources for Healthwatch at place-level is extremely concerning.

We believe that without additional resourcing for local Healthwatch at system level, many will be unable to support the ICS meaningfully. This places systems' ability to deliver on the core principle set out in NHS England's ICS implementation guidance for working with people and communities at risk.

> "Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS".[2]

There are considerable disparities in Healthwatch funding across ICS footprints, translating into inequity in the engagement and insight shared between Healthwatch and the ICS. In 18 ICSs, a single Healthwatch holds more than 50% of the overall funding for Healthwatch across the footprint.

We believe that without the following actions, some local Healthwatch will have inadequate resources to amplify the voices of their communities within the ICS effectively:

- Level-up funding allocations for local Healthwatch.
- Ensure decisions are taken on place-based resourcing with an understanding of systemwide implications.
- Identify resources for Healthwatch to coordinate, represent each other, and collate and present the views of people to the ICS.

Further reading: Positive examples of where systems have funded their Healthwatch

[2] NHS England and NHS Improvement, Building strong integrated care systems everywhere, September 2021: Report template - NHSI website (england.nhs.uk)

## Next steps

1. We will continue to fulfil our statutory function to support local authorities in their role of commissioning effective local Healthwatch and, in doing so, will update our commissioning guidance in light of upcoming changes brought about by the Health and Care bill.
2. We will review how we escalate issues to the DHSC when we identify local authorities providing worryingly low levels of funding for Healthwatch or where principles of good commissioning are not being followed. We then request that the DHSC reviews the actions it takes in these cases.
3. We will provide local Healthwatch with support to raise their resourcing requirements with their Integrated Care Board (ICB) to help systems understand the challenges of disparity and lack of overall resourcing.
4. We request that the DHSC reviews the guidance given to systems and local authorities on the funding of Healthwatch to deliver the additional burdens brought about by the system transformation.
5. We request that DHSC carries out an Equality Impact Assessment on the disparate funding of local Healthwatch and share this with the Healthwatch England committee with proposed mitigations.

# Introduction

Healthwatch is the independent champion for people who use health and social care. Across England, there are 152 local Healthwatch services.

Their statutory role is to find out what people want from health and care and share these views with those running services to help make them better. Local Healthwatch also provides people with information and advice about local services.

Over the last 12 months, local Healthwatch across England have delivered their statutory activities, including:

- Engaging with 750k local people about their experiences of health and care.
- Supporting two million people to find the right help and support through their health and care signposting services.
- Increasing the number of times partners in health and care drew on the insight they gather to inform decision making (36% increase on the year before).
- As a result, 71% of stakeholders report valuing the contribution Healthwatch makes.[3]

[3] From independent stakeholder perceptions analysis conducted for Healthwatch England by Savanta Comres.

The DHSC funds Healthwatch by making money available to local councils to commission an effective local Healthwatch. To enable DHSC to track what is happening to its investment, each year, we're asked to analyse the funding received by local Healthwatch.

A Local Authority is required to commission local Healthwatch for their area:
"exercise its functions under this Part so as to secure that the arrangements—
(a)operate effectively, and
(b)represent value for money."[4]

This year, we have reviewed local Healthwatch funding to enable us to give notice of our opinion on local Healthwatch resourcing to "operate effectively" in the context of a shifting health and social care environment.

# Healthwatch Funding

## Historical changes in funding

Since Healthwatch began in 2013, there has been a downward trend in funding for local Healthwatch provided by local authorities.

The reduction in real terms must also be viewed from the perspective of inflationary rises. This gives a clearer indication of available resources and its impact on Healthwatch's ability to effectively fulfil their statutory functions.


Figure i – Inflationary rise based on Bank of England calculator

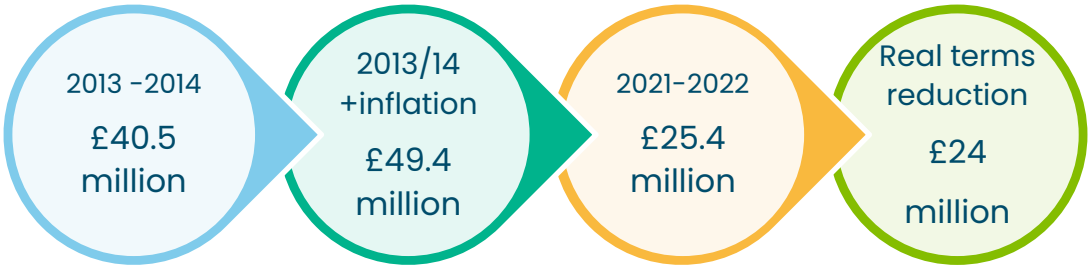



Figure ii – Historical change in funding for local Healthwatch

[4] Local Government and Public Involvement in Health Act 2007 (legislation.gov.uk)

We gather self-reported data from Healthwatch providers annually about the funding received from local authorities. A table setting out the funding provided by 152 local authorities is in Appendix one.[5]

During 2021-2022, we found that 23 local Healthwatch have received reduced funding, and 24 local Healthwatch have had their funding increased.

However, accounting for inflation, 123 local Healthwatch received an in-year real terms reduction in their resourcing due to lack of increases in line with inflation.[6]

We believe that this downward trajectory of local authority funding for local Healthwatch and, therefore, investment in an independent service designed to listen to people and communities to shape health and care locally will have broader implications for systems and nationally.

## Compliance with funding Directions of DHSC

Each year DHSC sends local Government a letter confirming part of the funding available to local authorities for commissioning Healthwatch.[7] In the letter, the DHSC stipulates that:

"The Local Reform and Community Voices grant provides one element of the non-ringfenced funding provided for local Healthwatch, with the larger proportion having been rolled into the local government settlement".

Therefore, the expectation from DHSC is the local Healthwatch should be funded by local authorities in excess of twice the amount of the LRCV grant stated amount.

We have analysed the contractual amounts given to local authorities against the expectations stipulated by DHSC to assess compliance.

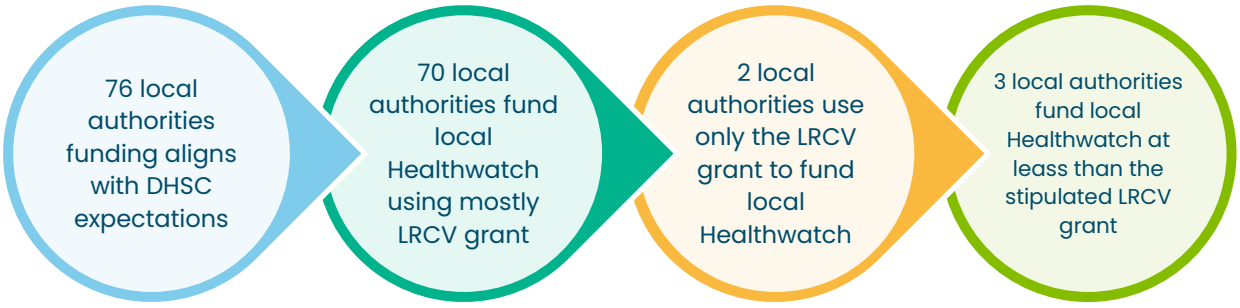



Figure iii- Local authority compliance with the DHSC expectations on funding

[5] This funding does not include funding provided by the Local Authority or other state actors for projects outside of the statutory activity or a one-off basis (e.g. for COVID support activity). As this information is self-reported, we acknowledge that there may be some inaccuracies.

[6] Accounting for inflation of 2.6% using Bank of England calculator.

[7] Adult personal social services: specific revenue funding and grant allocations for 2021 to 2022 - GOV.UK (www.gov.uk)

We believe that the lack of compliance by local authorities with the DHSC outlined funding levels will impede the ability of the health and care systems to consider the views of people and communities in improving care.

# Compliance with principles of good commissioning

## Commitment to multi-year funding

Government standards on commissioning services from the Voluntary, Community and Social Enterprise sector set out in the Compact that they should "Commit to multi-year funding where appropriate and where it adds value for money."[8]

The National Audit Office Principles of Good Commissioning includes, "Ensuring long-term contracts and risk sharing, wherever appropriate, as ways of achieving efficiency and effectiveness."

We have analysed the local authority contract terms against these principles and their impact on the effectiveness of Healthwatch.

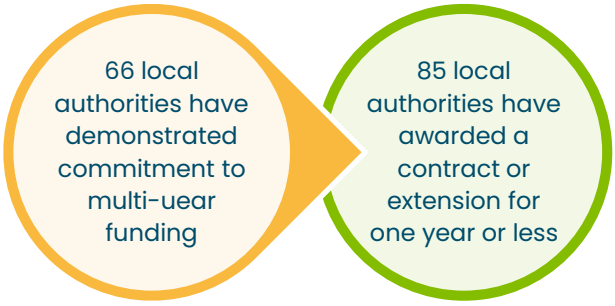



Figure iv- Compliance with principles of good commissioning

Where local Healthwatch contracts are renewed annually (or less than a year), this impacts their effectiveness, including the ability to forward plan work, procure essential services with good value (e.g. office lets, insurance), and retain staff.

We believe that in over half of local authorities, there is a risk of non-compliance with the duty to commission effective local Healthwatch due to a failure to contract on the basis of multi-year funding.

[8] The Compact: The_20Compact.pdf (publishing.service.gov.uk)

## Commitment to Full Cost Recovery

The National Audit Office Guidance on Full Cost Recovery states:

"Funders and commissioners have an interest in meeting their fair share of a provider's central administrative costs because that will help to ensure that the provider can manage its activities and finances properly, and will contribute to the organisation's sustainability".

Healthwatch analysed the available data of the fixed organisational costs and the staffing costs for a cross-section of 25 local Healthwatch to understand commissioning practices and their impact on the organisation's value for money, effectiveness and sustainability.

We found that the fixed costs of running Healthwatch do not necessarily correlate to the size of the provider's contract. There are some costs that all organisations require to be legally compliant, e.g. professional support, audit, insurance, which mean the fixed costs of running Healthwatch will not reduce when funding is reduced.

Local Healthwatch funding reductions, therefore, result mainly in overall reductions to staffing costs meaning less full-time equivalent staff available to support the delivery of statutory functions.

Based on our analysis of fixed versus staffing costs, we consider 81 local Healthwatch to be currently funded at a level where they cannot achieve full cost recovery and have enough suitably qualified staff to deliver their statutory functions. We believe that this is not compliant with the duty to commission effective local Healthwatch.

# The future of local Healthwatch funding

## Additional requirements on local Healthwatch

So far, this briefing sets out a historical picture of funding from local authorities for the delivery of Healthwatch statutory functions at 'place,' i.e. within their local authority boundaries.

However, changes brought about by the Health and Care Bill, which will be enacted in July 2022, require locally funded Healthwatch to collaborate with counterparts in other areas to ensure that their statutory functions are delivered effectively across integrated care systems. Although, if enacted, additional burdens set out in the bill and accompanying NHSE guidance are not a change to the statutory functions of Healthwatch, there will be an expectation that Healthwatch will respond to, and play an active part in, the new health and care landscape. These new burdens will draw on the much-reduced resources of local Healthwatch.

New burdens placed on the Healthwatch network include:

- Requirement for Integrated Care Partnerships to involve local Healthwatch and local people in the development of the integrated care strategy.
- Requirement for local Healthwatch to share relevant reports and recommendations, including annual reports, with the Integrated Care Boards (in addition to sharing this insight with any 'place' forums and care providers.
- Requirement with Healthwatch to develop and deliver a system wide strategy for engaging with people and communities.

The pivotal role that Healthwatch will play with their ICSs was re-affirmed in the recent House of Lords debate by Earl Howe: *"we would expect Healthwatch to be closely involved with ICBs in carrying out their engagement and involvement duties*".[9]

Our research is encouraging in demonstrating the perceived effectiveness and value that ICSs place on the role of local Healthwatch:[10]

- 83% of ICS respondents scored eight or above out of ten when asked how highly they value the role of Healthwatch.
- Over 90% of ICS respondents said that Healthwatch would be involved in the forthcoming refresh of the ICS engagement strategy.
- A third of ICSs intended to involve Healthwatch in their ICB
- 100% of ICSs intend to involve Healthwatch in their ICP
- Almost 60% of ICS respondents said that the constructive challenge provided by local Healthwatch along with insight and engagement work they undertake could add the most value to the ICS

Further reading: Positive examples of where systems have funded their Healthwatch

However, the lack of government direction on funding local Healthwatch participation at the system level does not suggest that Healthwatch will be adequately funded for the roles they are expected to play in all systems. Only 5% of ICSs told us they intend to fund Healthwatch for their involvement with the ICP, 29% told us they do not intend to fund Healthwatch, and the remainder were unsure.

This lack of confirmed funding for additional requirements for Healthwatch at a system level, juxtaposed with the dwindling local authority resources for Healthwatch at place set out above, is extremely concerning.

We believe that without additional resourcing for local Healthwatch functions at system level, many will be in a position where they are unable to support the ICS meaningfully. This places at risk systems' ability to deliver on the core principle

[9] Health and Care Bill - Hansard - UK Parliament

[10] Healthwatch England, Executive Summary: Mapping the relationships between local Healthwatch and Integrated Care Systems, October 2021: 20211007 - Executive summary of local Healthwatch and ICS survey findings - Final.pdf

set out in NHS England's ICS implementation guidance for working with people and communities:

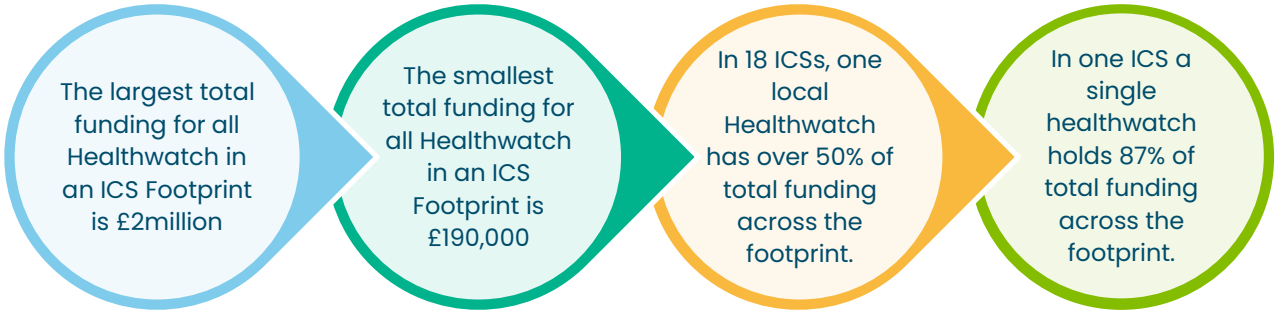
"Put the voices of people and communities at the centre of decision-making and governance, at every level of the ICS".[11]

## Healthwatch funding across integrated care systems

To support national and local Government and ICSs to understand the resourcing implications for local Healthwatch, we analysed local authority funding data for local Healthwatch within Integrated Care Systems' footprints. The detailed findings are in Appendix two.

## Inequity in funding for Healthwatch

As local authorities make decisions about local Healthwatch funding independently of a system-wide perspective, the distribution of Healthwatch funding is far from equitable within ICSs.




The vast disparity that exists in funding for local Healthwatch within and across ICS areas carries the risk that there will be inequality in the engagement of and listening to people and communities based on geographical bias.

In the areas where the local Healthwatch have a higher proportion of total resources spent on Healthwatch across the ICS, local people's views will be better represented at system level. This has implications for ensuring diversity and inclusion of people from all communities equally and carries a risk of decisions being taken by a system that could exacerbate health inequalities.

We believe that without action, some Healthwatch will have more resources to amplify the voices of their communities with the ICS than others. This is contrary to the ICS's duties to tackle health inequality and involve people and communities and ambitions for 'Levelling Up' to be community driven. We, therefore, recommend the following action:

- balance funding allocations for local Healthwatch,

[11] NHS England and NHS Improvement, Building strong integrated care systems everywhere, September 2021: Report template - NHSI website (england.nhs.uk)

- ensure decisions are taken on place-based resourcing with an understanding of systemwide implications and
- identify resources for Healthwatch to coordinate, represent each other and collate and present their insight on the views of people to the ICS

# Next steps

1. We will continue to fulfil our statutory function to support local authorities in their role of commissioning effective local Healthwatch and, in doing so, will update our commissioning guidance in light of upcoming changes brought about by the Health and Care bill.
2. We will review how we escalate issues to the DHSC when we identify local authorities providing worryingly low levels of funding for Healthwatch or where principles of good commissioning are not being followed. We then request that the DHSC reviews the actions it takes in these cases.
3. We will provide local Healthwatch with support to raise their resourcing requirements with their ICB to help systems understand the challenges of disparity and lack of overall resourcing.
4. We request that the DHSC reviews the guidance given to systems and local authorities on the funding of Healthwatch to deliver the additional burdens brought about by the system transformation.
5. We request that DHSC carries out an Equality Impact Assessment on the disparate funding of local Healthwatch and share this with the Healthwatch England committee with proposed mitigations.

# Appendices

## 1. Local authority local Healthwatch funding

| Local Healthwatch | Funding 20/21 | Budget 21/22 |
|---|---|---|
| Barking and Dagenham | 115,677 | 115,677 |
| Barnet | 123,853 | 121,478 |
| Barnsley | 150,000 | 150,000 |
| Bath and North East Somerset | 80,000 | 80,000 |
| Bedford Borough | 94,760 | 94,760 |
| Bexley | 100,000 | 100,000 |
| Birmingham | 407,207 | 407,207 |
| Blackburn with Darwen | 133,650 | 133,650 |
| Blackpool | 58,000 | 58,000 |
| Bolton | 150,000 | 125,000 |
| Bracknell Forest (part of East Berkshire grouping) | 64,860 | 64,439 |
| Bradford and District | 180,000 | 180,000 |
| Brent | 149,000 | 135,000 |
| Brighton & Hove | 178,600 | 178,600 |
| Bristol (part of BNSSG grouping) | 112,524 | 119,516 |
| Bromley | 78,000 | 74,000 |
| Buckinghamshire | 214,680 | 175,317 |
| Bury | 122,000 | 122,000 |
| Calderdale | 78,000 | 112,000 |
| Cambridgeshire (working as Cambridgeshire & Peterborough) | 287,602 | 287,602 |

| | | |
|---|---|---|
| Camden | 187,000 | 187,000 |
| Central Bedfordshire | 151,410 | 151,410 |
| Central West London (counts as two local Healthwatch – Kensington and Chelsea/Westminster) | 300,000 | 300,000 |
| Cheshire East (working as Healthwatch Cheshire) | 168,003 | 151,051 |
| Cheshire West (working as Healthwatch Cheshire) | 166,987 | 150,449 |
| City of London | 66,722 | 66,722 |
| Cornwall | 300,000 | 300,000 |
| County Durham | 180,600 | 180,600 |
| Coventry | 199,205 | 249,716 |
| Croydon | 175,896 | 177,301 |
| Cumbria | 253,483 | 237,174 |
| Darlington | 73,000 | 74,950 |
| Derby | 235,000 | 235,000 |
| Derbyshire | 320,000 | 321,114 |
| Devon (part of Devon/Plymouth/Torbay grouping) | 350,000 | 350,000 |
| Doncaster | 176,360 | 176,360 |
| Dorset (always counts as 2 LHW) | 198,940 | 201,928 |
| Dudley | 206,000 | 206,000 |
| Ealing | 140,000 | 140,000 |
| East Riding of Yorkshire | 172,697 | 202,697 |
| East Sussex | 376,000 | 376,000 |
| Enfield | 180,000 | 145,000 |
| Essex | 420,000 | 420,000 |
| Gateshead | 140,075 | 140,250 |

| | | |
|---|---|---|
| Gloucestershire | 209,907 | 209,908 |
| Greenwich | 129,000 | 135,000 |
| Hackney | 150,000 | 150,000 |
| Halton | 121,715 | 121,715 |
| Hammersmith & Fulham | 122,000 | 122,000 |
| Hampshire | 249,518 | 249,518 |
| Haringey | 156,250 | 152,000 |
| Harrow | 65,000 | 65,000 |
| Hartlepool | 116,150 | 116,150 |
| Havering | 117,359 | 117,359 |
| Herefordshire | 140,000 | 140,000 |
| Hertfordshire | 376,593 | 384,125 |
| Hillingdon | 158,000 | 158,000 |
| Hounslow | 85,000 | 81,000 |
| Isle of Wight | 147,000 | 153,000 |
| Isles of Scilly | 44,600 | 44,600 |
| Islington | 156,100 | 156,100 |
| Kent | 511,000 | 511,000 |
| Kingston Upon Hull | 135,817 | 135,817 |
| Kingston upon Thames | 122,000 | 122,000 |
| Kirklees | 185,000 | 185,000 |
| Knowsley | 171,000 | 171,000 |
| Lambeth | 225,115 | 225,115 |
| Lancashire | 326,772 | 326,772 |
| Leeds | 374,000 | 374,000 |
| Leicester | 142,773 | 142,705 |
| Leicestershire | 156,884 | 157,285 |

| | | |
|---|---|---|
| Lewisham | 107,428 | 105,000 |
| Lincolnshire | 299,600 | 299,600 |
| Liverpool | 553,825 | 553,825 |
| Luton | 119,325 | 119,325 |
| Manchester | 140,000 | 140,000 |
| Medway | 121,550 | 121,550 |
| Merton | 125,000 | 125,000 |
| Middlesbrough (working as South Tees) | 92,500 | 92,500 |
| Milton Keynes | 158,644 | 158,644 |
| Newcastle | 204,003 | 209,008 |
| Newham | 125,000 | 125,000 |
| Norfolk | 348,140 | 348,140 |
| North East Lincolnshire | 112,340 | 112,340 |
| North Lincolnshire | 115,640 | 115,640 |
| North Somerset (part of BNSSG grouping) | 56,262 | 54,437 |
| North Tyneside | 138,490 | 141,259 |
| North Yorkshire | 167,460 | 167,460 |
| Northamptonshire North | | 97,500 |
| Northamptonshire West | 195,000 | 97,500 |
| Northumberland | 199,666 | 200,000 |
| Nottingham | 108,000 | 108,000 |
| Nottinghamshire | 198,000 | 198,000 |
| Oldham | 135,000 | 135,000 |
| Oxfordshire | 247,908 | 252,866 |
| Peterborough (working as Cambridgeshire & Peterborough) | 187,500 | 187,500 |
| Plymouth (part of Devon/Plymouth/Torbay grouping) | 114,200 | 114,200 |

| | | |
|---|---|---|
| Portsmouth | 70,522 | 106,032 |
| Reading | 100,000 | 100,000 |
| Redbridge | 116,309 | 116,309 |
| Redcar & Cleveland (working as South Tees) | 92,500 | 92,500 |
| Richmond upon Thames | 146,000 | 146,000 |
| Rochdale | 136,066 | 136,066 |
| Rotherham | 90,000 | 90,000 |
| Rutland | 66,600 | 72,600 |
| Salford | 166,520 | 166,520 |
| Sandwell | 180,250 | 180,250 |
| Sefton | 143,280 | 143,281 |
| Sheffield | 209,960 | 209,952 |
| Shropshire | 144,198 | 144,198 |
| Slough (part of East Berkshire grouping) | 80,610 | 64,439 |
| Solihull | 155,909 | 155,322 |
| Somerset | 190,000 | 190,000 |
| South Gloucestershire (part of BNSSG grouping) | 56,262 | 55,096 |
| South Tyneside | 103,409 | 103,409 |
| Southampton | 133,251 | 133,251 |
| Southend | 119,095 | 88,000 |
| Southwark | 120,000 | 140,000 |
| St Helens | 145,427 | 145,427 |
| Staffordshire | 205,338 | 205,338 |
| Stockport | 108,000 | 108,000 |
| Stockton-on-Tees | 130,000 | 130,000 |
| Stoke-on-Trent | 153,508 | 153,508 |
| Suffolk | 436,500 | 436,500 |

| | | |
|---|---|---|
| Sunderland | 150,000 | 155,250 |
| Surrey | 496,284 | 470,060 |
| Sutton | 110,000 | 109,962 |
| Swindon | 116,939 | 107,400 |
| Tameside | 115,600 | 115,600 |
| Telford & Wrekin | 100,000 | 100,000 |
| Thurrock | 126,844 | 125,186 |
| Torbay (part of Devon/Plymouth/Torbay grouping) | 95,800 | 95,800 |
| Tower Hamlets | 179,716 | 179,716 |
| Trafford | 124,500 | 124,500 |
| Wakefield | 211,295 | 211,295 |
| Walsall | 190,450 | 190,450 |
| Waltham Forest | 101,000 | 101,000 |
| Wandsworth | 185,810 | 185,810 |
| Warrington | 146,000 | 146,000 |
| Warwickshire | 215,000 | 217,000 |
| West Berkshire | 98,000 | 98,000 |
| West Sussex | 232,877 | 230,899 |
| Wigan and Leigh | 200,000 | 200,000 |
| Wiltshire | 179,617 | 179,619 |
| Windsor, Ascot & Maidenhead (part of East Berkshire grouping) | 64,860 | 64,439 |
| Wirral | 170,000 | 170,000 |
| Wokingham | 100,953 | 103,982 |
| Wolverhampton | 194,289 | 194,289 |
| Worcestershire | 260,820 | 265,000 |
| York | 122,898 | 122,898 |

## 2. Local authority local Healthwatch funding distribution at ICS level

| Integrated Care System | Total local Healthwatch resources | Number of local Healthwatch | Average local Healthwatch |
|---|---|---|---|
| Bath Swindon and Wiltshire | 367,019 | 3 | 122,340 |
| Bedfordshire, Luton and Milton Keynes | 524,139 | 4 | 131,035 |
| Birmingham and Solihull | 358,926 | 2 | 179,463 |
| Bristol, North Somerset and South Gloucestershire | 229,049 | 3 | 76,350 |
| Buckinghamshire, Oxfordshire and Berkshire West | 730,165 | 5 | 146,033 |
| Cambridgeshire and Peterborough | 475,102 | 2 | 237,551 |
| Cheshire and Merseyside | 1,752,748 | 9 | 194,750 |
| Cornwall and the Isles of Scilly | 344,600 | 2 | 172,300 |
| Coventry and Warwickshire | 466,716 | 2 | 233,358 |
| Cumbria and the North East | 1,853,193 | 14 | 132,371 |
| Derbyshire | 556,114 | 2 | 278,057 |
| Devon | 560,000 | 3 | 186,667 |
| Dorset | 201,928 | 2 | 100,964 |
| Frimley Health and Care | 553,106 | 5 | 110,621 |
| Gloucestershire | 209,908 | 1 | 209,908 |
| Greater Manchester | 1,372,686 | 10 | 137,269 |
| Hampshire and Isle of Wight | 517,042 | 4 | 129,261 |
| Herefordshire and Worcestershire | 405,000 | 2 | 202,500 |
| Hertfordshire and West Essex | 524,125 | 2 | 262,063 |
| Humber, Coast and Vale | 773,122 | 6 | 128,854 |

| | | | |
|---|---|---|---|
| Kent and Medway | 632,550 | 2 | 316,275 |
| Lancashire and South Cumbria | 667,237 | 4 | 166,809 |
| Leicester, Leicestershire and Rutland | 372,590 | 3 | 124,197 |
| Lincolnshire | 299,600 | 1 | 299,600 |
| Mid and South Essex | 353,186 | 3 | 117,729 |
| Norfolk and Waveney | 566,390 | 2 | 283,195 |
| North Central London | 761,578 | 5 | 152,316 |
| North East London | 971,783 | 8 | 121,473 |
| North West London | 1,001,000 | 6 | 166,833 |
| Northamptonshire | 195,000 | 2 | 97,500 |
| Nottinghamshire | 306,000 | 2 | 153,000 |
| Shropshire and Telford and Wrekin | 244,198 | 2 | 122,099 |
| Somerset | 190,000 | 1 | 190,000 |
| South East London | 779,115 | 6 | 129,853 |
| South West London | 866,073 | 6 | 144,346 |
| South Yorkshire | 626,312 | 4 | 156,578 |
| Staffordshire and Stoke on Trent | 358,846 | 2 | 179,423 |
| Suffolk and North East Essex | 358,250 | 2 | 179,125 |
| Surrey Heartlands | 235,030 | 1 | 235,030 |
| Sussex | 785,499 | 3 | 261,833 |
| The Black Country | 974,593 | 5 | 194,919 |
| West Yorkshire | 1,062,295 | 5 | 212,459 |

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