From Community Health Councils to Healthwatch and beyond

A reflection on the legacy of independent patient voice in England since 1974

Executive summary

In light of the decision to abolish Healthwatch England and its 153 local branches, as announced as part of the government's 2025 Ten Year Plan for Health, we reflect on the legacy of patient voice organisations in the NHS in England. These have taken different formats over the past 50 years, but have been a consistent feature of the health service during this time.

Reviewing the different formats that patient voice organisations have taken over this period, we conclude that to be successful, organisations need to be **independent**, have **appropriate statutory rights and powers**, be **well-resourced**, and **work at both a national and local level**.

Strong foundations alone are not the only route to success, however. Delivering a truly person centred health service requires the above conditions, coupled with **strong leadership to model and drive cultural change**. Person centred care and improving patient experience must be **embedded at all levels** to prevent it becoming an afterthought when operational and financial challenges arise.

As the decision to abolish the Commission for Patient and Public Involvement in Health (CPPIH) and Patient and Public Involvement (PPI) Forums shows, there are **significant risks to scrapping a model without a clear vision of what will follow**.

With the Health Bill progressing through parliament, there is a need for clarity on what model will replace Healthwatch – and particularly on how independence will be safeguarded. Clarity is also needed on the Directorate of Patient Experience within the Department of Health and Social Care, including its role, remit and governance structure.

On 3 July 2025 the Department of Health and Social Care (DHSC) published the Ten Year Plan for Health. The plan confirmed the government's intention to abolish Healthwatch England and its 153 local branches, with their functions to be transferred to the new National Director of Patient Experience (NDPE) within the Department and to providers, commissioners and local authorities respectively. Dr Penny Dash's review of the patient-safety landscape followed, finding that the landscape of oversight bodies had become fragmented, with overlapping responsibilities, and an 'overwhelming' number of recommendations from national reviews and inquiries with limited impact. Dash suggests this is largely because most of these bodies sit outside the commissioners and providers responsible for delivering care and improving quality.

This would not be the first time a body like Healthwatch has been abolished. Since the National Health Service Reorganisation Act 1973 created Community Health Councils (CHCs), England has repeatedly revised its approach to the question of how patient voice should be formally integrated into the NHS. Over the following 50 years, this question has been answered through different

means as changes to governments and health policy led to largescale legislative changes in the arms-length bodies intended to safeguard patient voice and public accountability within the service. CHCs were succeeded by a national Commission of Patient and Public Involvement in Health (CPPIH) and local Patient and Public Involvement Forums (PPI Forums), which were in turn succeeded by Local Involvement Networks (LINks), subsequently followed by Healthwatch, now itself scheduled for abolition. Each new approach was introduced to address the limitations of the last, yet many were scaled back or replaced before there was enough evidence to evaluate their success.

Reflecting on the various models, we see three themes as central to understanding their effectiveness and implementation:

1. **Independence:** The extent to which each body could operate, investigate, and comment without being controlled by the organisations it was intended to scrutinise.
2. **Statutory rights:** The legal powers available to each body, including rights of entry and rights to a formal response, which determined whether patient voice carried enforceable weight or functioned primarily as consultation.
3. **Budget:** The consistency and adequacy of funding and resources relative to the responsibilities each body was expected to carry out.

Picker has a long-standing commitment to patient voice and person centred care, as our briefing on the Health Bill sets out. With the abolition of Healthwatch England tabled as part of the Bill, this review reflects on the legacy of public involvement in the NHS in England over the last 50 years. The NHS is at an inflection point – not just on patient voice, but in relation to increased digitisation and the rise of Artificial Intelligence (AI), which are both reshaping how people interact with services. At this crossroads, there is an opportunity to truly give power to patients, but there is also a risk if we do not learn from the past while adapting for the future. Below we look at each model in turn, before discussing what considerations are needed for what comes next.

Community Health Councils (1974 – 2003)

Community Health Councils (CHCs) were established under the Nation Health Reorganisation Act 1973 and began operating in 1974. They were created to give patients and the public a voice within a newly reorganised NHS, following a number of scandals in long stay hospitals and while recognising that Health Authorities could not manage hospitals and represent patients without creating a conflict of interest[1]. CHCs aimed to be a direct link between national services and the communities they served. 204 councils were established across England and Wales, organised by locality and composed of 16-30 volunteer members, of whom approximately one third were nominated by local voluntary organisations, alongside employed permanent paid staff.

A distinguishing feature of CHCs, relative to their successors, was the combination of operational independence and statutory powers. They employed their own staff and controlled their own budgets, rather than being hosted by, or directly financially dependent on, the organisations they were scrutinising; this combination has been identified in subsequent analysis as an important precondition for effective independence[2]

Table 1: Overview of the patient voice organisations in the NHS in England between 1974 and today

Organisation	Dates	Statutory rights and powers	Funding Structure	Locality
Community Health Councils (CHCs)	1974 - 2003	Rights to information and visits to NHS premises Observer status on Health Authority Boards Must be consulted on major changes and right to appeal the Secretary of State	Funded via regional health authorities	204 councils across England and Wales
Commission for Patient and Public Involvement in Health (CPPIH) and Patient and Public Involvement (PPI) Forums	2003 - 2008	Right to visit NHS premises and to information	CPPIH directly sponsored by Department of Health PPI Forums funded by CPPIH	Started as 572 PPI Forums in December 2003, reduced to 397 by March 2007
Local Involvement Networks (LINks)	2008 - 2013	Power to request information and to visit NHS premises but they had to negotiate when the visit will take place Could refer matters to the Overview and Scrutiny Committee (OSC) and would receive a response but not a binding outcome	Department of Health funded local authorities to commission LINks	151 networks
Healthwatch	2013 to present	Local Healthwatch can enter and view health and social care services and make formal recommendations to providers Providers are legally obligated to reply within 20 working days Healthwatch England can give advice to CQC, Secretary of State for Health and Social Care and NHS England, who are legally obligated to respond in writing	Funded by the DHSC which gives money to local authorities to commission local Healthwatch	153 local branches

CHCs also held defined legal powers, including observer status on NHS Trust boards, a statutory right to be consulted on substantial service changes, a right of entry to inspect NHS premises, and the right to refer a disputed local decision to the Secretary of State. These powers gave CHCs a formal mechanism for holding local NHS bodies to account, rather than a purely advisory role. For example, CHCs led to the implementation of Casualty Watch[3], the first co-ordinated data collection and analysis of service delivery to assess waiting times in A&E. Casualty Watch started as a local initiative in 1990 at King's College Hospital London and grew to include many hospitals nationwide until the closure of CHCs in 2003. It served as a campaign tool for more resources, beds, and better treatment, and aided the re-development of casualty departments.

Yet, CHCs struggled in consistency across councils, disputes with management, and adapting to broader changes to the NHS, such as the purchaser-provider split in 1990[4]. Performance varied between individual councils, reflecting differences in staff capacity and resourcing[5]. CHCs' dual role as both a patient representative and a quasi-managerial body created some ambiguity regarding lines of accountability. By the late 1990s, CHCs themselves had begun to call for reform of the model, requesting increased funding and an enhanced statutory role as patient advocates and watchdogs[6].

Proposals to abolish CHCs and replace them with Patient and Public Involvement Forums (PPI Forums) were included in the 2000 Health and Social Care Bill. Alan Milburn, the then Health Secretary, claimed that legislative changes introducing Forums would increase patient choice and involvement[7]. This was met with widespread opposition from charities, patient groups, MPs and CHCs[8]. Picker's then Chief Executive, Angela Coulter, declared the abolition of CHCs a "major mistake"[9]. In response to the uproar, the proposed abolition was set aside to allow the Bill to proceed.

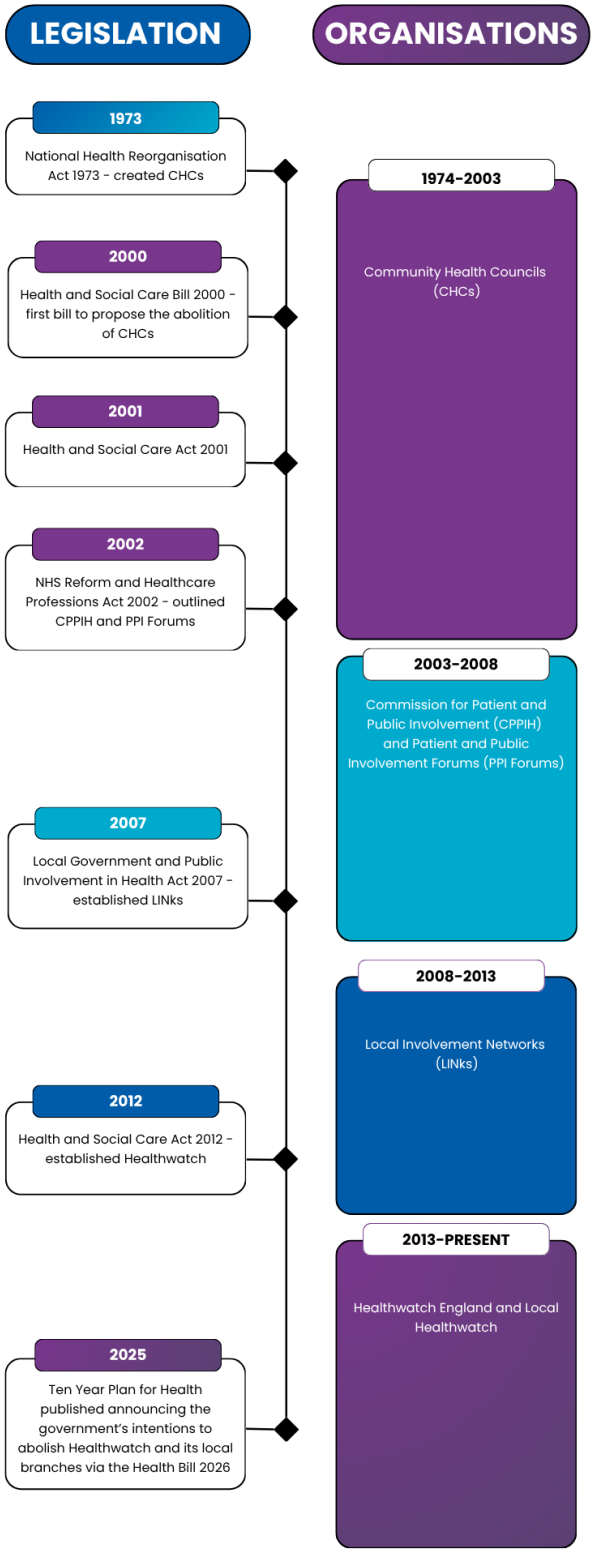
When the proposal to abolish CHCs was reintroduced in 2002, however, there was limited consultation with CHCs and the public and Milburn described them as "dinosaurs without relevance" to a modern health service[10]. CHCs were subsequently abolished in 2003, after 29 years of operation, and were not replaced by a single successor body. Their functions were instead distributed across several new organisations, including the Patient Advice and Liaison Service (PALS), the Commission for Patient and Public Involvement in Health (CPPIH), Patient and Public Involvement Forums (PPI Forums), Overview and Scrutiny Committees (OSCs), and the Independent Complaints Advocacy Service (ICAS).

Patient Advice and Liaison Service (PALS): Proposed by the NHS Plan in 2000, their main function is to resolve concerns and queries and provide confidential information and advice to patients[11].

Overview and Scrutiny Committees (OSCs): Introduced in 2000, Committees are formed by local authorities to independently review, monitor and scrutinise decisions and actions that affect local communities, including decisions related to health services.

Independent Complaints Advocacy Service (ICAS): A service which helps patients who wish to make a complaint about the NHS.

Figure 1: Overview of the patient voice organisations in the NHS in England between 1974 and today and the relevant legislation



Commission for Patient and Public Involvement in Health and Patient and Public Involvement Forums (2003 – 2008)

The direct successor to CHCs combined a national arms-length body, the Commission for Patient and Public Involvement in Health (CPPIH), with a network of 572 local Patient and Public Involvement Forums (PPI Forums) – more than three times the CHCs they replaced. Unlike CHCs, each forum was attached to an individual NHS Trust or Primary Care Trust rather than to a locality. The basis for this model was Section 11 of the 2001 Health and Social Care Act, which introduced a duty to involve patients and the public, partly in response to an NHS increasingly organised around patient choice and joint commissioning across health and social care. However, pressure from the Department of Health on the CPPIH to get the Forums up and running over a short timeframe led to rushed appointments, poor training and inadequate guidance within the Forums[12].

PPI Forums retained some of the statutory rights held by CHCs, including the right to enter and view NHS premises. However, both CPPIH and PPI Forums encountered structural difficulties at an early stage. CPPIH and the Department of Health held differing views of the Commission's remit: the Commission favouring a broader public health and democratisation focus, and the Department a narrower emphasis on improving user involvement. This was compounded by reported disagreement between the Commission's Chief Executive and its Chair. Forums experienced difficulty recruiting members of the public, partly reflecting an intention to broaden participation beyond those with prior involvement experience, which had the effect of reducing access to relevant expertise[13]. It was also reported that due to a lack of consultation in the transition between CHCs and Forums, many experienced and knowledgeable CHC members were not encouraged to become Forum members[14]. Forum performance was reported to be more variable than that of CHCs, which has been attributed in part to Forums relying on staff provided by a host organisation rather than employing their own[15].

18 months after their establishment in 2005, the government announced the abolition of the CPPIH and PPI Forums as the model was seen to be overly centralised and prescriptive, therefore failing to allow Forums to represent local communities effectively[16]. Local Involvement Networks (LINks) which succeeded them did not come into existence until 2008, meaning that motivation stalled within Forums and the CPPIH in the interim[17]. The 2007 Health Select Committee report on ‘Patient and Public Involvement in the NHS’ was more measured regarding local Forums than the government's subsequent response: it proposed that PPI Forums be retained and reformed rather than replaced, and noted that the government had given insufficient consideration to the financial and operational cost of further reorganisation. The government’s formal response did not adopt this recommendation, arguing instead that Forums were too rigid and heavily regulated to support the more flexible model envisaged for their successor, Local Involvement Networks (LINks). The government’s response also addressed concerns that LINks were being developed ahead of the evaluation of early-adopter pilot projects, stating that full trials of the new model were “not necessary, nor desirable” on the basis that a networked approach was already familiar to many Forum members.

CPPIH and PPI Forums were abolished in 2008, five years after their establishment, and no single national body succeeded CPPIH during the subsequent transition period to LINks. In many ways, the abolition of PPI Forums and the CPPIH echoes elements of the proposal to abolish

Healthwatch and its local branches. The abolition of Healthwatch was announced in summer 2025, but will not be enacted until at least spring 2027, assuming the Health Bill passes. This, alongside the announced abolition of NHS England and changes to the structures and staffing levels within integrated care boards (ICBs), has resulted in a 'centre' that is in a prolonged period of transition. This is, of course, unsettling for affected staff, but it also affects the wider sector, patients, and the public. We have noted how the draft Health Bill presently contains limited detail on what will replace Healthwatch, which presents a significant risk.

Local Involvement Networks (2008 – 2013)

Local Involvement Networks (LINks) were established under the Local Government and Public Involvement in Health Act 2007, following the 2006 consultation A Stronger Local Voice. Similar to PPI Forums, LINks were organised around localities but their geographical boundaries were aligned directly with local authorities rather than individual NHS Trusts and Primary Care Trusts. The remit of LINks covered both NHS and social care, reflecting the desire for greater integration. The model was designed to allow more informal participation: individuals could contribute through a single meeting or by submitting views online, rather than through sustained membership[18]. 'Open membership' meant that any local residents, volunteers, and voluntary or community groups could become members.

However, LINks also saw a significant reduction in statutory standing. Unlike CHCs and PPI Forums, LINks did not have an independent right of entry to NHS or social care premises and could be refused access without prior written permission[19]. Their formal powers were limited to writing reports and making recommendations, requesting information, and referring matters to local Overview and Scrutiny Committees (OSCs), in each case with an entitlement only to a response within a specified period rather than a binding outcome. LINks were also structurally dependent: each was established and led by a commissioned "host" organisation funded by the local authority, which created a potential conflict of interest, given that the host was expected both to support the Network and, in practice, to originate proposals for it to consider[20].

Prior to implementation, a 2007 Health Select Committee report raised concerns that the LINks model had not been evaluated, noting that departmental guidance was being developed before the early-adopter pilot projects had been assessed, and that funding for both the pilots and LINks more broadly was inconsistent. LINks were subsequently given a broader remit than PPI Forums, covering both health and social care, without a corresponding increase in resourcing. Many LINks operated with limited capacity as a result[21].

An assessment of the LINks model was later included in the Francis Inquiry into failings at Mid Staffordshire NHS Foundation Trust. This identified weaknesses in local patient voice structures, including LINks, as one contributing factor within a wider system that did not identify serious deficiencies in patient care. The inquiry described LINks as comprising small, largely self-selected volunteer groups without an obligation to gather or represent wider public views; noted a structural tension between hosts required to support the network and those required to lead with proposals; and observed that members with limited prior experience were often occupied with procedural rather than substantive matters. This assessment indicates that, in this instance, the statutory rights and resourcing available to LINks did not correspond to the scrutiny function they were

expected to perform. LINks were abolished in 2013, five years after their establishment, and were replaced under the 2012 Health and Social Care Act by local Healthwatch branches and a national Healthwatch England.

Healthwatch (2013 to present)

The Mid Staffordshire NHS Foundation Trust Public Inquiry heavily influenced the creation and duties of Healthwatch England and its local branches, particularly the need to strengthen collective patient voice and the independence of local Healthwatch from the NHS. The role of the 153 local Healthwatch branches is to provide advice about health and care services, collect and analyse data about people's experiences of health and care, and use this data effectively[22]. Healthwatch England is a national body – a subcommittee of the Care Quality Commission (CQC) – which provides leadership to the network of local Healthwatch and uses the data they collect to improve health and care at a national level. This is a 'hub and spoke model'. Local Healthwatch primarily differs from the previous organisations in its role in providing advice and aiding patient and service user navigation as well as having a stronger brand identity and engagement with local communities[23]. In contrast to LINks, the national body of Healthwatch England which advises the Secretary of State for Health and Social care and NHS England, provides patient voice with a collective body which can escalate concerns. Local Healthwatch branches are not accountable to Healthwatch England.

A 2026 report from the King's Fund praised the Healthwatch model on its credible independence, successful 'hub and spoke' structure which allowed for effective insights at both national and local levels, local Healthwatch's successful community engagement, and the amount of qualitative and quantitative data Healthwatch has collected.

However, local Healthwatch, like many of its predecessors, has been critiqued for the variability in performance between local Healthwatch branches[24]. This has been linked to substantial budget cuts to local Healthwatch which have occurred in an unequal manner. A 2026 Healthwatch England report highlighted a 43% reduction in budget from 2024-2025 to 2013-2014 in real terms. Yet the variability across local Healthwatch was also connected to differences in capabilities[25]. The commissioning model also led to unhelpful competition between local branches and likely increased variability. Healthwatch also struggled to adapt to the abolition of Clinical Commissioning Groups (CCGs), which were followed by Integrated Care Systems (ICSs). While Healthwatch has more power to enhance and amplify patient voice than some of the previous organisations, with the focus on providing recommendations and advice, it does not have the teeth or powerful rights to force service providers, commissioners, the CQC, or NHS England to act on their recommendations.

What's next?

Following the proposed abolition of Healthwatch and its local branches, and the distribution of its responsibilities between commissioners, providers, and the soon-to-be created Directorate of Patient Experience within DHSC, history tells us that any model's foundations must be strong for changes to be successful.

Previous efforts to embed the patient voice in the NHS give us the benefit of hindsight – but strong foundations alone are not the only route to success. Delivering a truly person centred health service requires appropriate resource, capacity and capability, coupled with strong leadership to model and drive cultural change. Person centred care and improving patient experience must be embedded at all levels to prevent it becoming an afterthought when operational and financial challenges arise.

The legacy of patient voice in the NHS in England over the last 50 years shows that DHSC and the Director of Patient Experience need to consider how patient voice will be amplified independently from the health and care services provided. Patients and the public may not feel comfortable giving feedback or making complaints directly to their care provider or commissioner. To mitigate against this, in our NDPE To Do list we suggest that the Secretary of State works with an independent external advisory group. This requirement could be written into the Health Bill currently progressing through parliament.

Additionally, funding and resources for patient voice should be ringfenced and maintained over time. This does not only mean financially, but that capabilities and institutional memory should be safeguarded where possible[24]. Where legislative changes are proposed, attention should be paid to how these changes will affect patient voice and what measures should be taken to mitigate any risks as a result. History shows that on too many occasions statutory patient voice organisations have struggled to adapt because they were not considered as part of legislative changes which reorganised parts of the health service. Agreeing sufficient budgets, and ensuring people well experienced in the sector are involved from an early stage, would go some way to showing that patient voice is not just a tick-box exercise, but instead an aspect of healthcare which is truly valued and deeply embedded.

In order to be effective, the new patient voice advocacy model must also carry statutory rights and have real power. Given the fact that many patient advocacy groups are largely funded by pharmaceutical companies, which can lead to conflicts of interest[26,27], it is imperative that patient voice is amplified through an effective statutory organisation. Our NDPE To Do list recommends that a provision should be added to the Health Bill for the Secretary of State to provide annual reports to parliament and the public on patient voice and experience – and, most importantly, evidence that this feedback has led to change. While recommendations for improvement are useful, there also needs to be power to track, monitor and report on them, as was done by CHCs as part of their Casualty Watch initiative.

Finally, previous models show that connections between the multiple levels and scales at which patient voice operates should be maintained. Local community engagement was key to Healthwatch's success, and the lack of a national body played a large role in the failure of LINks. Patient voice must be heard at both a national and local level. Research suggests that ICBs are the least equipped bodies to take over the duties of local Healthwatch[28], raising concern that without sufficient engagement with the local community, local patient voice will be lost as a result of the Health Bill's proposed changes. This is especially important in the context of health inequalities and digital exclusion. As Chris Graham, Picker's Chief Executive, and Angela Coulter, Picker's Chair, write "it will be essential to develop ways for people who lack the knowledge, skills, and confidence to advocate for themselves to feel engaged and listened to."[29] Local community

engagement is essential to achieving this, and closely aligns with the new Prime Minister's agenda to prioritise local communities and devolution.

Ultimately, ensuring that healthcare is person centred requires more than a commitment to listening to patients. The history of patient voice in England demonstrates that effective advocacy depends on adequate funding, genuine independence, meaningful statutory powers, and strong links between local and national decision making. If these foundations are embedded within the new arrangements, patient voice can continue to shape and improve health and care services. If not, there is a risk that the lessons of the past will be repeated.

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