healthwatch

Local Healthwatch funding 2022–23

February 2023

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Executive summary

Listening to the public and involving them in health and care decisions is vital to building public trust because it enables the government, commissioners and providers to be responsive to the needs of communities and be held accountable for delivering improved care[1].

The government recognise this right to participate in decisions about health care in the NHS constitution[2]:

"You have the right to be involved, directly or through representatives, in the planning of healthcare services commissioned by NHS bodies, the development and consideration of proposals for changes in the way those services are provided, and in decisions to be made affecting the operation of those services"

One way the government aims to promote this right is by commissioning a statutory local Healthwatch in every area, which finds out what people want from health and care and shares these views with the people commissioning or running services to help improve them.

The Department of Health and Social Care (DHSC) funds the commissioning of local Healthwatch both via the Department for Levelling Up, Housing and Communities (DLUHC) and directly to local councils.

To enable DHSC to track what is happening to its investment, each year, we're asked to analyse the funding received by local Healthwatch. This report sets out the findings for 2022-2023.

Despite a slowing down in the extent to which Local Authorities are cutting funding for local Healthwatch, rising inflation means that in real terms, overall **funding has fallen by £3.7 million this year**.

We are now in a position where Healthwatch only receives the equivalent of **49% of the funding allocated when Healthwatch began in 2013**.

We know from research carried out by Kings College that Healthwatch funding levels directly correlate with the extent to which Healthwatch can gather people's feedback on health and care services. For example, one of their conclusions was: [3]

[1] Fredriksson, M., & Tritter, J. Q. (2017). Disentangling patient and public involvement in healthcare decisions: why the difference matters. Sociology of Health & Illness, 39(1), 95–111. https://doi.org/10.1111/1467-9566.12483

[2] The NHS Constitution for England - GOV.UK (www.gov.uk)

[3] Zoccatelli G, Desai A, Robert G, Martin G & Brearley S. Exploring the work and organisation of local Healthwatch in England: a mixed-methods ethnographic study. *Health Soc Care Deliv Res* 2022;10(32). https://doi.org/10.3310/YUTI9128

"The greater the number of FTE staff, the larger the number of types of local impact"

Based on the information provided by local Healthwatch, if a local authority provides funding of £100,000 or less, they can expect 30% fewer people to be engaged by their local Healthwatch compared to services with over £100,000. Diminished funding for a service reduces staff, volunteers, and the extent to which local people are engaged to share their experience of health and care services.

In some areas, funding has fallen to such a small amount (e.g. with a staff team of only two) that local Healthwatch can't deliver the statutory functions that safeguard against poor health and care services originally envisaged by DHSC.

Commissioners are increasingly allocating only year-on-year funding rather than multi-year contracts, compounding limited resourcing with staffing uncertainty as they divert the finite resources of Healthwatch providers into annual contract negotiations or procurement processes.

In the face of a changing health and care landscape and the establishment of Integrated Care Systems (ICSs), the Healthwatch network continues to be valued by system actors for their insight into local people's concerns and their expertise in engagement. For example, 45% of Integrated Care Boards (ICBs) have a participant seat for local Healthwatch, requiring their involvement in strategic discussions.

Whilst some ICBs provide funding for the role their Healthwatch play in supporting public voice and accountability, this funding is often short-term and does not cover the additional costs incurred by local Healthwatch for carrying out these functions.

As demand for local Healthwatch insight and expertise grows, the funding for the function is in decline.

This year Local Authorities faced uncertainty about the DHSC LRCV grant allocation for Healthwatch and have been required to contract for almost a whole financial year without confirmation of the amount available.[4]

This delay, a transformed health and care system and diminished resourcing indicate that the decade-old funding model for Healthwatch is no longer fit for purpose. This requires action to address the challenges of:

- The complexity of dual funding streams for Local Authorities
- The lack of ring-fenced funding, which is leading to Local Authorities under pressure to divert funds meant for local Healthwatch
- The requirement to undergo competitive tendering processes, which drives down limited funding even further

[4] DHSC usually writes to Local Authorities to inform them of their allocated grant. AThe announcement was not made until 16th February, meaning Local Authorities have proceeded to fund at 'risk' for 11 of the 12 months of this financial year.

- Short-term contracting by local authorities, which leads to high provider and staff turnover limiting the impact
- Limited action to hold local authorities to account who do not pass on designated funds.

Inaction on the funding model means the capacity of Healthwatch and, indeed, the power of citizens' voices is becoming increasingly diluted.

Next steps

- Local Authorities should commission Healthwatch based on multi-year contracts and following expectations that DHSC set out when deciding on funding levels.
- We have discussed with DHSC creating a process for formally referring funding concerns over individual Healthwatch contracts to Ministers. This would happen when we identify Local Authorities providing worryingly low levels of funding for local Healthwatch or where principles of good commissioning are not being followed. We request that the DHSC embeds such a process.
- DHSC should complete the current review of guidance given to systems and Local Authorities on the funding of local Healthwatch to deliver the additional responsibilities brought about by the system transformation.
- We request that DHSC systematically review the current funding and commissioning model for local Healthwatch. The model needs to be modernised to reflect the current health and care system and enable local Healthwatch to carry out their statutory function fully.

Introduction

Healthwatch is the independent champion for people who use health and social care. Across England, there are 152 local Healthwatch services (153 from April 2023).

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

In 2021-22, we supported over 2,000,000 people with information and to have their say on care.

Nationally

- 414,000 people used our service for clear information and advice.
- 9,600 people shared their experiences of care.

Locally

- 1,400,000 people used our service for clear information and advice.
- 407,400 people shared their experiences of care[5].
- 71% of stakeholders report valuing the contribution Healthwatch makes[6]

The Department of Health and Social Care (DHSC) funds local 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 by legislation to commission local Healthwatch for their area to:

"exercise its functions under this Part so as to secure that the arrangements— (a)operate effectively, and (b)represent value for money."[7]

[5] Local Healthwatch data return 2022-23

[6] Healthwatch England stakeholder perceptions survey 2022

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

Funding

Historical changes

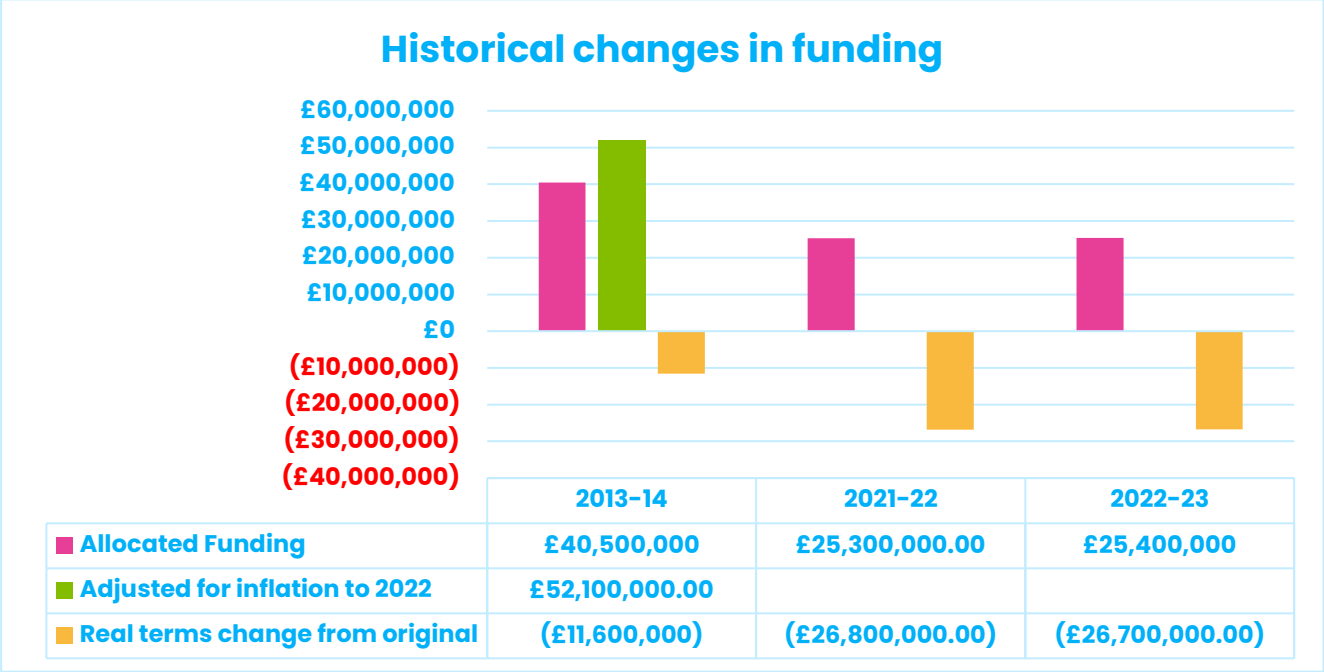
Since Healthwatch began in 2013, there has been a significant downward trend in funding for local Healthwatch provided by Local Authorities.

Commissioners and policymakers must also view the reduction in real terms from the perspective of inflationary rises. Real terms figures give a clearer indication of available resources and their impact on Healthwatch's ability to fulfil their statutory functions effectively.

The following table shows what the original funding for local Healthwatch in 2013 would be in the present day if inflation was taken into account.

Cost in 2013	Cost in 2022 accounting for inflation[8]
£40,500,000	£52,081,573

When adjusted for inflation **the real term funding for local Healthwatch is now only 49% of what was originally allocated** when Healthwatch was established.



[8] Calculated using the Bank of England inflation calculator in November 2022. The inflation rate is 14%.

Latest funding

We gather self-reported data from Healthwatch providers annually about the funding received from Local Authorities.

Appendix one shows the funding provided by 152 Local Authorities.[9]

Our analysis of the latest figures reported by local Healthwatch indicate that very few local authorities are increasing funding in line with inflation.

	Funding increase	Funding reduction
Headlines	7 local authorities increased core funding in line with inflation	16 local authorities reduced core funding
Impact of inflation	29 local authority funding increases were not in line with or above the 2022-23 inflation rate.	143 local Healthwatch received an in-year real terms funding reduction when accounting for inflation.
Average	+£11,430	-£15,116
Range	+£9 to £42,000	-£400 to -56,103
Median	+£8,082	-£12,229

This downward trajectory of local authority funding for local Healthwatch and 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.

Alignment with DHSC funding expectations

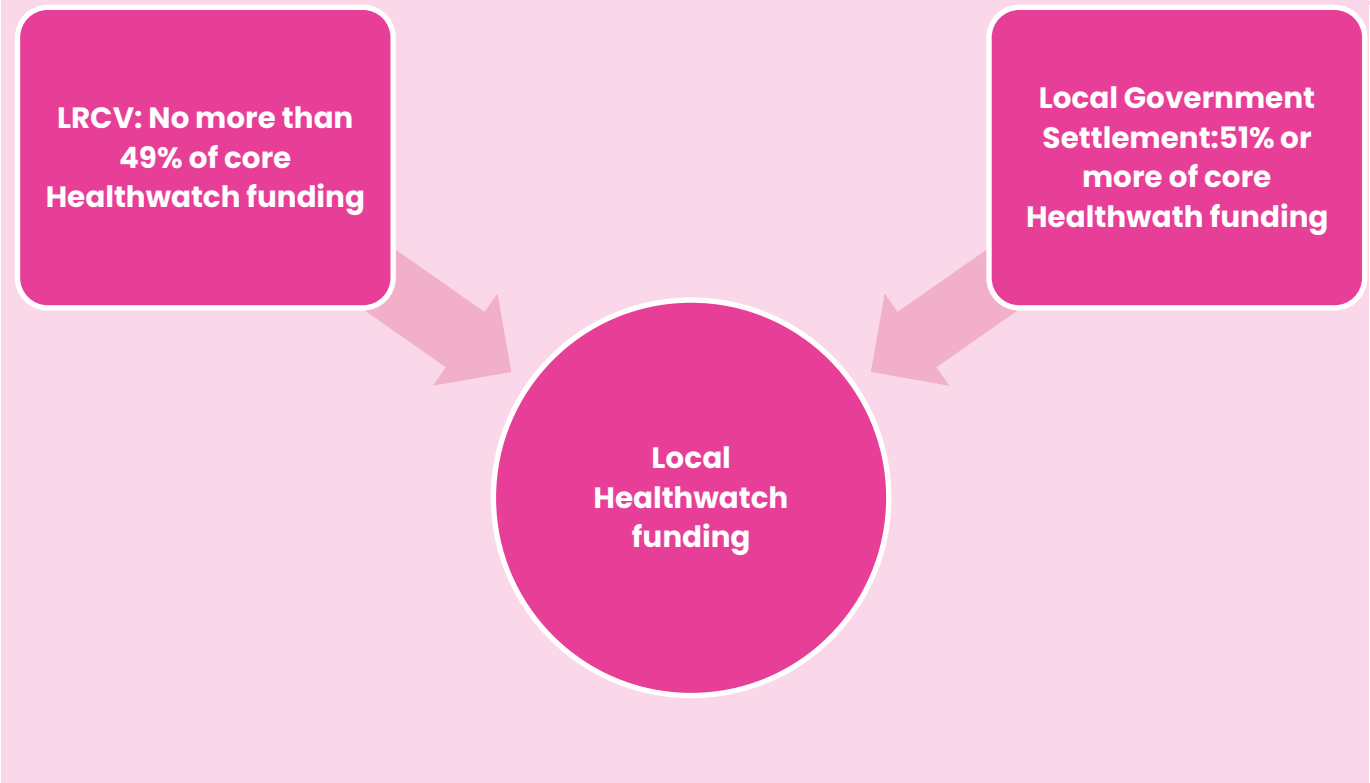
"The Local Reform and Community Voices grant provides one element of the non-ringfenced funding provided for local Healthwatch, with the larger proportion having been rolled into the local government settlement".[10]

Local Healthwatch funding is made up of two pots of DHSC funding. The first and largest is rolled into the Local Government Settlement. The smaller part comes from the Local Reform and Community Voices Grant (LRCV), the allocation of

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

[10] Local authority social services letter 2022 - GOV.UK (www.gov.uk)

which should be announced annually by DHSC before the end of the calendar year.



Each year DHSC sends the Local Authorities a letter confirming the LRCV grant funding available to Local Authorities for commissioning Healthwatch.[11] This letter has been known as the local authority social services letter (LASSL).

The letter setting out LRCV allocations for the 2022-23 financial year was not released by DHSC until 16th February 2023. This is a significant issue meaning a eleven-month delay in disbursement to Local Authorities. Commissioners have been contacting Healthwatch England to request information about the LRCV allocation and to raise concerns about the knock-on impact of the delay in announcing their funding decisions. One local authority commissioner said:

"Not having this figure (which after all is backward looking for the year we are in and not a projection for 2023/24), makes it difficult for commissioners to understand the overall trend (reduced/standstill/increased) for this particular funding stream. This in turn means we are estimating budgets for the future based on imperfect information".

[11] Local authority social services letter 2022 - GOV.UK (www.gov.uk)

Delays to announcement of the LRCV grant allocations may inadvertently force further decline in funding available for Healthwatch to deliver their statutory functions.

The expectation from DHSC is that the LRCV constitutes the smaller part of the overall funding allocated to local Healthwatch. As a minimum, local authorities should be spending at least twice the amount provided through the LRCV.

To assess compliance, we have analysed the contractual amounts given to Local Authorities against the expectations stipulated by DHSC in the previous financial year.

Local authority numbers	Compliance with DHSC expectations
77	Funding is in line with expectations
66	Funding local Healthwatch using mostly LRCV grant
6	Funding local Healthwatch only using LRCV grant
3	Funding local Healthwatch at less than the LRCV grant

In summary, 77 Local Authorities are funding their Healthwatch in alignment with DHSC expectation (of LRCV plus majority funding from Local Government settlement).

While, 75 Local Authorities are not passing on the totality of funding they receive from DHSC to local Healthwatch by an average of £72,434 (median £43,427). The largest divergence of Local Authority funding is £326,000 less than expectations.

Of these 75, six local authorities do not utilise any of the funds which were rolled into the local government settlement to fund Healthwatch. They rely solely on the LRCV grant allocations.

While three local authorities fail to pass on the full LRCV grant, with a median shortfall of £16,637.

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.

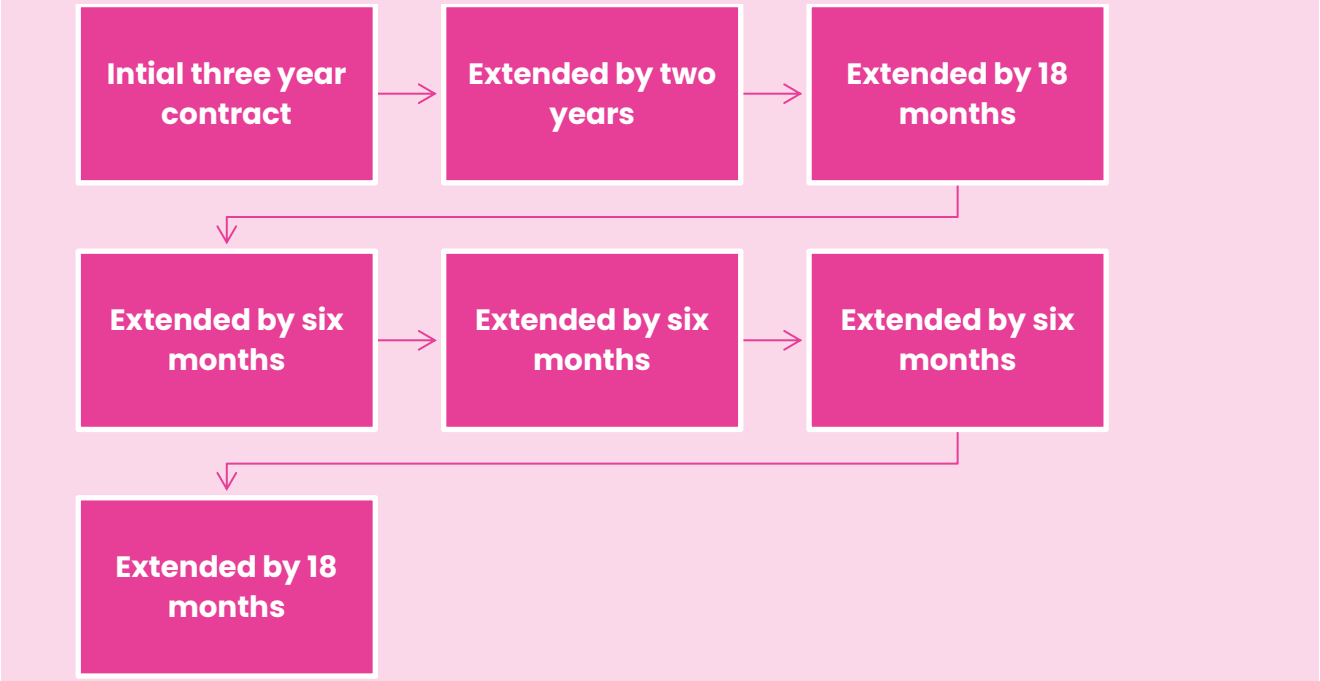
Compliance with principles of good commissioning

The National Audit Office Principles of Good Commissioning include "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. We found that:

73 local authorities have awarded a contract extension for 12 months or less during the last financial year.

The example below demonstrates the contract length that a local Healthwatch provider has been given since the contract began. Whilst the local authority demonstrated it was committed to multi-year contracts initially, it has since made multiple awards of less than a year. In this scenario, it is possible that the provider staff would have been issued with redundancy notices six times over nine years.



When local Healthwatch contracts are renewed every 12 months or less, 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.

In just under 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 based on multi-year funding.

With this funding model, 76 Local Authority contracts with local Healthwatch providers are due to end in the coming financial year. This means that commissioners and providers across half of England will have to invest human resources in contract negotiations and procurement processes, diverting limited resources away from local Government and local Healthwatch activities.

The impact of funding on statutory functions

The statutory functions of local Healthwatch are broad, reaching across the whole population and a wide spectrum of health and care services. Yet the funding to carry out this work is limited and unevenly distributed.

To illustrate the extent to which this funding varies across local authorities, the table below categorises the contracts into income banding.

Income	Local authority numbers
£100,000 or less	27
£100,000 - £250,000	105
£250,000 - £500,000	17
£500,000 - £1,000,000	2

This demonstrates that:

- The majority of Healthwatch are funded between £100,000- £250,000.
- 18% are funded less than £100,000 and 8 contracts are below £60,000.
- Only 19 local Healthwatch receive £250,000 and over.

Research by Kings College[12] into the effectiveness of local Healthwatch states that:

"larger contract value enables such Healthwatch organisations to hire greater numbers of staff specialised in a greater range of disciplines and skills, and therefore to offer additional (and qualitatively different) services".

This year's funding figures and activity reporting affirm their findings that the extent to which local Healthwatch has the necessary human resources (including paid staff and volunteers) to deliver on its statutory functions is directly linked to its income levels. Any reduction in funding will significantly impact its ability to engage members of the public.

As demonstrated by the graph below, the smaller the income of a Healthwatch, the fewer staff and volunteers they will have to engage with the public and to help them have a say in health and care services.

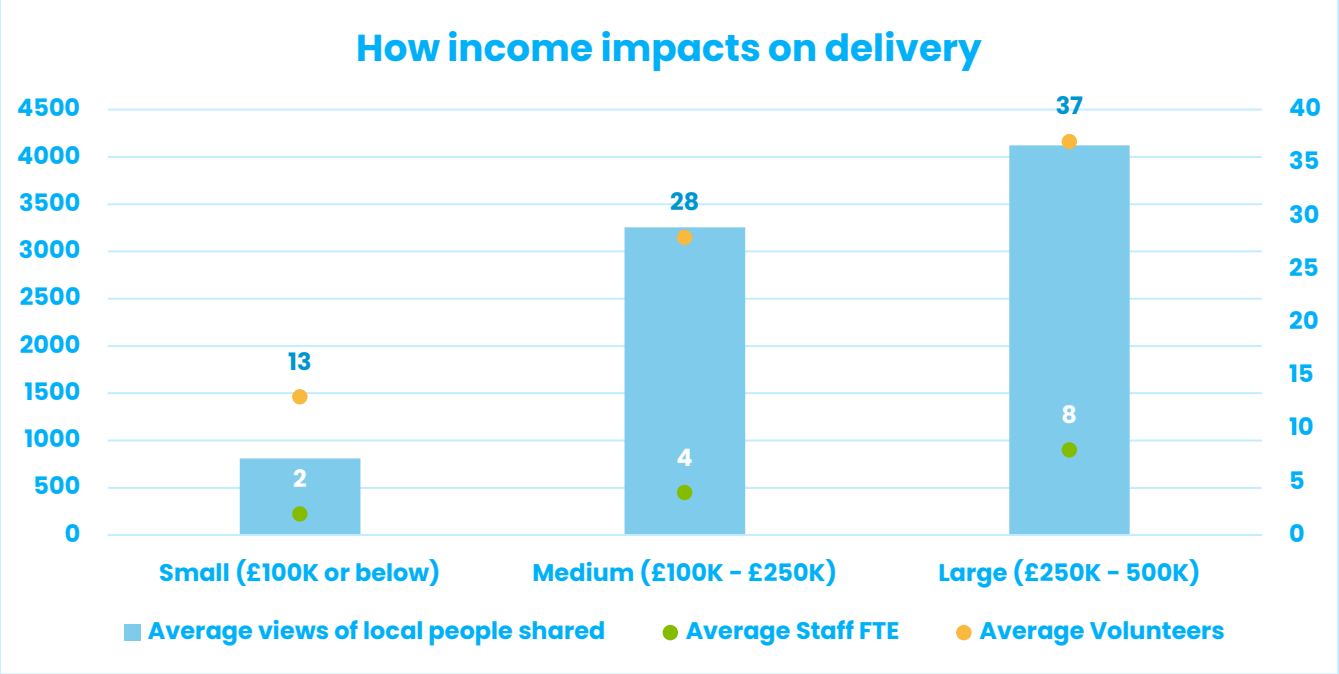
The return on investment for a local Healthwatch significantly reduces in the lowest income band. For example, a Healthwatch in the £100,000-£250,000

[12] Exploring the work and organisation of local Healthwatch in England: a mixed-methods ethnographic study Crossref DOI link: https://doi.org/10.3310/YUTI9128

income band reports on average four times the engagement levels of Healthwatch that gets under £100,000 of funding.

This is because all Healthwatch (regardless of size) have similar fixed operating costs (e.g. rent, insurance IT support, admin and finance costs). Therefore, for the Healthwatch who get under £100,000 in funding, the remaining capacity for carrying out engagement activity is disproportionately low.

Local authorities investing less than £100,000 are arguably not investing at a level where the provider can be expected to meaningfully deliver the statutory functions of a local Healthwatch.



A definition of a small Charity is one which has an income of £1,000,000 or less.[13]

45% of Healthwatch are stand-alone organisations, and a considerable proportion of the network are 'small charities' and face the challenge of balancing the requirement to operate a legally compliant organisation on small incomes for their statutory functions.

[13] www.smallcharitiesdata.org

Funding work with Integrated Care Systems

Changes brought about by the Health and Care Act 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 additional burdens set out in the Act and accompanying guidance are not a change to the statutory functions of Healthwatch, there is an expectation that Healthwatch will respond to, and play an active part in, the new health and care landscape. These new responsibilities draw on the already much-reduced resources of local Healthwatch.

New responsibilities 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 and partnership meetings.
- Local Healthwatch sharing system-wide 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 to work with neighbouring Healthwatch to develop and deliver a system-wide strategy for engaging with people and communities.

However, the lack of government direction on funding local Healthwatch participation at the system level means local Healthwatch are not adequately funded for the role they are expected to play.

There is also a considerable disparity in the funding available to local Healthwatch in different ICS areas. For example, in North East and North Cumbria ICS the **average local Healthwatch funding is 47% less than the average** for a local Healthwatch in the West Yorkshire and Harrogate ICS.

Currently, 22 Integrated Care Systems still need to fund local Healthwatch for the additional work of collaborating with their ICS despite 45% of Integrated Care Boards involving local Healthwatch in their governance.

While 15 ICSs have invested a reported total of £993,449 to fund the work of 30 local Healthwatch.[14] The reported funding received by local Healthwatch ranges from £1,000 to £204,712.

Most of this funding is for the delivery of engagement activity in line with ICS priorities or to fund a coordinator who works across the local Healthwatch in an ICS area. Other funding is set out in the table below. Funding is provided for the following functions and activities:

Activity	Number of ICSs funding local Healthwatch
Engagement of the population within an ICS	10

[14] Please note that not all Healthwatch reporting that their ICS has resourced them have shared the funding figure.

Funding of a coordinator or Director at ICS level	6
Funding for ICS Healthwatch coordination	4
Dedicated Engagement Worker for ICS work	1
Collating insight across the ICS	2
Development work to get ready for ICS	2
Coordination of VCSE relationship	1

Next steps

Healthwatch England calls on the Department of Health and Social Care and local authorities to take the following action

- Local Authorities should commission Healthwatch based on multi-year contracts and following expectations that DHSC set out when deciding on funding levels.
- We have discussed with DHSC creating a process for formally referring funding concerns over individual Healthwatch contracts to Ministers. This would happen when we identify Local Authorities providing worryingly low levels of funding for local Healthwatch or where principles of good commissioning are not being followed. We request that the DHSC embeds such a process.
- DHSC should complete the current review of guidance given to systems and Local Authorities on the funding of local Healthwatch to deliver the additional responsibilities brought about by the system transformation.
- We request that DHSC systematically review the current funding and commissioning model for local Healthwatch. The model needs to be modernised to reflect the current health and care system and enable local Healthwatch to carry out their statutory function fully.

Appendices

1 - Local Healthwatch funding by local authority

Below are the funding figures provided to Healthwatch England by local Healthwatch. These figures are self-reported and, as such, may be subject to inaccuracy. If your reported figure needs to be corrected, please contact: enquiries@healthwatch.co.uk.

Local Authority	Funding provided in 2021-2022	Funding provided in 2022-2023
Barking and Dagenham	£115,677	£115,088
Barnet*	£123,845	£121,478
Barnsley	£150,000	£150,000
Bath and North East Somerset*	£83,622	£83,622
Bedford Borough	£94,760	£95,840
Bexley	£100,000	£100,000
Birmingham	£407,207	£407,207
Blackburn with Darwen	£133,650	£133,650
Blackpool	£58,000	£61,550
Bolton	£125,000	£153,000
Bracknell Forest	£64,439	£64,439
Bradford and District	£180,000	£180,000
Brent	£135,000	£127,861
Brighton & Hove	£178,600	£178,600
Bristol*	£119,155	£119,155
Bromley	£74,000	£74,000
Buckinghamshire	£175,317	£184,320
Bury	£122,000	£122,000

Calderdale	£112,000	£152,000
Cambridgeshire	£287,602	£287,602
Camden	£187,000	£187,000
Central Bedfordshire	£151,410	£161,252
Cheshire East	£151,051	£151,126
Cheshire West	£150,449	£151,126
City of London, City of	£66,722	£92,722
Cornwall	300,000	300,000
County Durham	£180,600	£180,600
Coventry	£201,000	£201,000
Croydon*	£154,000	£152,000
Cumbria	£267,174	£267,174
Darlington	£74,950	£76,709
Derby	£235,000	£235,000
Derbyshire	£321,114	£321,114
Devon	£350,000	£350,000
Doncaster	£176,360	£176,360
Dorset* (BCP and Dorset are reported combined)	£201,928	£200,532
Dudley	£206,000	£206,000
Ealing	£140,000	£120,000
East Riding of Yorkshire	£202,697	£172,697
East Sussex	£376,000	£376,000
Enfield*	£120,822	£144,973
Essex	£420,000	£420,000
Gateshead	£140,250	£84,147
Gloucestershire	£209,908	£212,252
Greenwich	£135,000	£140,000

Hackney	£150,000	£150,000
Halton	£121,715	£121,715
Hammersmith & Fulham	£122,000	£122,000
Hampshire	£249,518	£249,518
Haringey	£152,000	£152,000
Harrow	£65,000	£65,000
Hartlepool	£116,150	£116,150
Havering	£117,359	£117,359
Herefordshire	£140,000	£140,000
Hertfordshire	£384,125	£401,603
Hillingdon	£158,000	£158,000
Hounslow	£81,000	£84,667
Isle of Wight	£153,000	£153,000
Isles of Scilly	£44,600	£45,480
Islington	£156,100	£156,100
Kensington & Chelsea	£150,000	£153,685
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	£242,115
Lancashire*	£324,995	£322,000
Leeds	£374,000	£374,000
Leicester	£142,705	£142,705
Leicestershire	£157,285	£157,285
Lewisham	£105,000	£105,000

Lincolnshire	£299,600	£299,600
Liverpool	£553,825	£553,825
Luton	£119,325	£122,000
Manchester	£140,000	£140,000
Medway	£121,550	£121,550
Merton	£125,000	£125,000
Middlesbrough	£92,500	£92,500
Milton Keynes	£158,644	£158,644
Newcastle*	£209,008	£209,179
Newham	£125,000	£124,000
Norfolk	£348,140	£355,300
North East Lincolnshire	£112,340	£112,340
North Lincolnshire	£115,640	£115,640
North Northamptonshire North	£97,500	£97,500
North Somerset*	£54,284	£54,284
North Tyneside	£141,259	£151,970
North Yorkshire	£167,460	£167,460
Northumberland	£200,000	£200,000
Nottingham	£108,000	£108,000
Nottinghamshire	£198,000	£198,000
Oldham	£135,000	£135,000
Oxfordshire	252,866	290,833
Peterborough	£187,500	£187,500
Plymouth	£114,200	£114,200
Portsmouth	£106,032	£116,432
Reading	£100,000	£100,000
Redbridge	£116,309	£116,309

Redcar & Cleveland	£92,500	£92,500
Richmond upon Thames	£146,000	£146,000
Rochdale	£136,066	£136,066
Rotherham	£90,000	£90,000
Rutland	£72,600	£72,600
Salford	£166,520	£166,520
Sandwell	£180,250	£180,250
Sefton	£143,281	£143,281
Sheffield	£209,952	£209,952
Shropshire	£144,198	£144,198
Slough	£64,439	£64,439
Solihull	£155,322	£155,322
Somerset	£190,000	£191,912
South Gloucestershire*	£54,936	£54,936
South Tyneside	£103,409	£114,995
Southampton	£133,251	£133,260
Southend	£88,000	£119,995
Southwark	£140,000	£155,000
St Helens	£145,427	£145,427
Staffordshire	£205,338	£215,000
Stockport	£108,000	£150,000
Stockton-on-Tees	£130,000	£130,000
Stoke-on-Trent	£153,508	£128,000
Suffolk	£436,500	£436,500
Sunderland	£155,250	£155,250
Surrey	£470,060	£477,143
Sutton	£109,962	£89,962

Swindon	£107,400	£107,000
Tameside	£115,600	£115,600
Telford & Wrekin	£100,000	£100,000
Thurrock	£125,186	£125,186
Torbay	£95,800	£95,800
Tower Hamlets	£179,716	£149,965
Trafford	£124,500	£124,500
Wakefield	£211,295	£211,295
Walsall	£190,450	£190,450
Waltham Forest	£101,000	£111,690
Wandsworth	£185,810	£185,810
Warrington	£146,000	£146,000
Warwickshire	£217,000	£227,427
West Berkshire	£98,000	£98,000
West Northamptonshire West	£97,500	£97,500
West Sussex	£230,899	£230,899
Westminster	£150,000	£153,685
Wigan and Leigh	£200,000	£200,000
Wiltshire	£179,619	£179,619
Windsor, Ascot & Maidenhead	£64,439	£64,439
Wirral	£170,000	£170,000
Wokingham	£103,982	£108,141
Wolverhampton	£194,289	£169,000
Worcestershire	£265,000	£265,000
York	£122,898	£105,580

* Local Authority funding figures for 2021-2022 adjusted to correct errors reported to Healthwatch England in last year's funding report.

2 -Compliance with DHSC expectations

Three local authorities who are funding less than the LRCV Grant amount:

Hampshire

Manchester

Nottinghamshire

Six local authorities using only LRCV Grant to fund their local Healthwatch

Bristol

Dorset (Bournemouth, Christchurch and Poole and Dorset combined)

Lancashire

North Somerset

South Gloucestershire

Local authorities who use some local government settlement funding but not in line with expectations

Barnet

Bath and North East Somerset

Bexley

Birmingham

Blackpool

Bolton

Bradford and District

Brent

Bromley

Buckinghamshire

Cheshire East

Cheshire West

Cornwall

County Durham

Croydon

Cumbria

Derbyshire

Devon

Doncaster

Ealing

Enfield

Essex

Gateshead

Gloucestershire

Greenwich

Hackney

Harrow

Havering

Hertfordshire

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Nottingham

Plymouth

Redbridge

Rotherham

Sandwell

Sefton

Sheffield

Shropshire

Somerset

Southwark

Staffordshire

Stockport

Stoke-on-Trent

Sunderland

Tameside

Torbay

Tower Hamlets

Waltham Forest

Warwickshire

West Sussex

Wiltshire

Wirral

Worcestershire

Local Authorities that fund within the expectations of DHSC

Barking and Dagenham
Barnsley
Bedford Borough
Blackburn with Darwen
Bracknell Forest
Brighton & Hove
Bury
Calderdale

Cambridgeshire
Camden
Central Bedfordshire

Coventry
Darlington
Derby
Dudley
East Riding of Yorkshire
East Sussex
Halton
Hammersmith & Fulham
Haringey
Hartlepool
Herefordshire
Hillingdon
Isle of Wight
Isles of Scilly
Islington
Kensington & Chelsea
Kingston upon Thames
Knowsley
Lambeth
Liverpool
London, City of
Luton
Medway
Merton
Middlesbrough
Milton Keynes
Newcastle
North East Lincolnshire
North Lincolnshire
North Tyneside
Northumberland
Oldham
Oxfordshire
Peterborough
Portsmouth

Reading
Redcar & Cleveland
Richmond upon Thames
Rochdale
Rutland
Salford
Slough
Solihull
South Tyneside
Southampton
Southend
St Helens
Stockton-on-Tees
Suffolk
Surrey
Sutton
Swindon
Telford & Wrekin
Thurrock
Trafford
Wakefield
Walsall
Wandsworth
Warrington
West Berkshire
Westminster
Wigan and Leigh
Windsor, Ascot & Maidenhead
Wokingham
Wolverhampton
York

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