

Five things to know about the Health Bill

The Health Bill¹ that's currently passing through Parliament puts many of the proposals in the NHS Ten Year Health Plan² on a legal footing and facilitates "the three shifts" called for by the Plan.³ The Bill represents the most significant restructuring of the NHS for over a decade, not least by bringing it under direct ministerial control. –

As the Bill stands, there are at least five areas of concern:

1. New powers for the Secretary of State and DHSC

One of the Bill's main purposes is to abolish NHS England (NHSE), the independent body that currently holds and allocates health service funding, develops policy and guidance, and oversees commissioning, data and IT. NHSE's responsibilities are to be transferred either to Integrated Care Boards (ICBs) or to the Department of Health and Social Care (DHSC). Alarmingly, 50% of jobs across NHSE and DHSC are being cut, with the potential loss of operational experience and up to a £1 billion in redundancy payments with no extra cash to pay for this.

Despite the scale of restructuring it proposes, the Bill provides little prescriptive detail: instead, many of the Government's intentions are expected to be realised through additional secondary legislation, policy and guidance. If passed, the Bill would grant the Secretary of State for Health and Social Care (SoS) more extensive powers than those currently held by NHSE, for example, the ability to direct ICBs to provide any health service functions that the SoS specifies without laying such directions before Parliament for scrutiny.

In addition, the Bill broadens the SoS's ability to delegate to, or jointly exercise health service-related functions with NHS bodies, local government and prescribed public bodies, allowing, for example, joint committees and the pooling of funds (ostensibly to facilitate collaboration). The Bill would allow such delegation to be extended to "other persons prescribed in regulations" (our italics), which could mean anyone, including a private company. Significantly, this would mean the SoS would escape legal liability for any failings, as liability would rest with the company.

Further, instead of system-wide targets, the SoS would be able to set financial objectives for individual Integrated Care Boards (ICBs), set capital and revenue resource limits and issue expenditure directions for ICBs and Foundation Trusts (FTs). At the same time, the Bill would reduce scrutiny by removing the SoS's obligation to publish accounts that document income and spending in NHS Trusts. The SoS would also be able to 'de-authorise' FTs and return them to NHS Trust status, making FT status dependent on the SoS's approval of an FT's performance. Concern has been raised that these powers will mean less accountability and could lead to political interference in the management of the NHS, and enable political bias in appointing local leaders.

Finally, the Bill allows the SoS to adjust the balance of services provided by public and private sectors, if this is considered to be in the interests of the health service. This could be a positive or negative measure, depending on the nature of the government in office.

2. Powers for ICBs

For the first time, each ICB would include a mayor (or their delegate) from each of the mayoral authorities within, or overlapping, an Integrated Care System's boundary and (following a U-turn), possibly only one member nominated from the local authorities across the System. Meanwhile Board representation from primary and hospital care services would no longer be a statutory requirement.

¹ Referred to as the NHS Modernisation Bill in the King's Speech of May 2026.

² <https://www.gov.uk/government/publications/10-year-health-plan-for-england-fit-for-the-future> 2025

³ The 10 Year Health Plan was based on the Health and Care Act 2022, which legalised changes NHSE made under Simon Stevens without parliamentary basis from 2014 onwards.

In addition, the Bill would remove FTs' statutory requirement to have a council of governors, reducing FTs' accountability. Strangely, this measure is deemed necessary to allow "more [flexibility](#) to design and deliver healthcare around local needs". It's proposed that the Council of Governors' existing powers – such as to appoint and remove FT Chairs, non-executive directors and auditors; to hold the Board of Directors to account; to approve 'significant transactions'; and to represent the interests of the public - should be conferred on the SoS. An FT might decide to retain its Council of Governors, but it would have no legal status or powers.

3. Commissioning

ICBs would become responsible for over 90% of the NHS commissioning budget, including for primary care, dentistry, ophthalmology, and pharmacy. However, the Bill cements central control of local commissioners, raising concerns about whether ICBs would have sufficient autonomy to be effective.

Additional concerns include that the huge shift in commissioning structure would take place as ICBs are responding to the government's demand that they reduce their running costs by 50%. On top of which, and increasing the risk of de-stabilising the NHS, the Bill proposes that Integrated Care Systems (ICSs) should be consolidated from the present 42 to approximately 26, with each covering a huge geographical area, inevitably reducing accountability and transparency.

Further, Clause 13 of the Bill proposes that when the SoS or ICBs are commissioning a service from a provider, "the arrangements may allow that *person to exercise their discretion* in how services are provided" (our italics), as long as the outcomes achieved meet the terms of the contract. This could mean, for example that a private provider contracted to review and redesign how services are provided for a population, would have the freedom to design how those services would be delivered as long as they remained within the parameters set by the commissioner.

Clause 23 removes the requirement for the ICB to carry out joint forward planning and capital resource use plans with partners, and for consultation on forward plans.

Advanced FT status (set out within the NHS 10 Year Health Plan as the first step towards an FT becoming an Integrated Health Organisation) is not mentioned in the Bill, although it might appear in secondary legislation. Advanced FTs have been promised strategic and operational autonomy and greater financial flexibility, which sits at odds with the Bill's aims to roll back some existing freedoms for FTs.

4. The single patient record

The Bill enables the SoS to compel all NHS providers, including GPs, social care workers and private providers involved in patient care, to share data that will then be combined in a single patient record (SPR). The SPR would be available, subject to data safeguards, to patients and those involved in providing their care as well as for secondary purposes, such as planning or research, including research by the commercial sector. The Bill also includes provisions for enforcing compliance with future regulations on data sharing and narrows the scope of the national Data Opt-Out.

During the second reading of the Bill in the House of Commons, MPs acknowledged that, if 'done well', the SPR might end the fragmentation of patient information and care, but many also found that the Bill lacks clarity about data security, privacy and control. It is unclear, for example, whether the Bill would change GPs' responsibility as data controllers for patients' GP records (and potentially their liability for data errors by other providers). It is also unclear how the SPR might interact with the Federated Data Platform,⁴ currently supplied by Palantir, and whether the SPR would be better than individual regions combining data (as with Local Shared Care Records). The Bill makes no mention of data sovereignty, perhaps because the Government lacks a coherent position on this issue.

Further concerns include whether the SoS, in some circumstances, could make secondary regulations that set aside the common law duty of confidentiality.

⁴ According to [medConfidential](#), inside NHSE the FDP and SPR have been run as a single project.

The greater involvement of the SoS risks undermining public trust in the sharing of their health data: a [Health Foundation](#) survey (2024) has found that about two-thirds of the public trust the NHS's handling of their data, compared to around one third who would trust their data with local or national governments.

5. Loss of independent scrutiny

Despite widespread opposition from MPs, the Bill proposes that a new arm of the Care Quality Commission (well known for struggling to properly regulate and inspect health and social care providers) will take on the statutory investigative responsibilities of the currently independent Health Services Safety Investigations Body (HSSIB).⁵ The approaches of these two organisations appear incompatible: the CQC focuses on assurance and compliance (and, arguably, blame). In contrast, the HSSIB (in line, for example, with international approaches to aviation and rail safety) aims to identify risk and generate learning through investigations based on creating a safe space for individuals to raise concerns.⁶

The Bill also intends to abolish Healthwatch England and local Healthwatch organisations charged with championing the views of patients. Despite Government claims that the Bill's measures will ensure services are driven by patient experience, it proposes that the responsibilities of Healthwatch England will be transferred to the DHSC, so allowing it to mark its own homework. The functions of local Healthwatch organisations, (already seen as pretty toothless), would be transferred to ICBs, meaning any semblance of independence would disappear.

Opportunities for scrutiny will be further reduced as members of the public would be excluded from attending some DHSC Board meetings, while they have not been from NHSE.

Comment

The Government [claims](#) that abolishing NHSE and transferring its functions to the DHSC will reduce duplication, bureaucracy and costs, allowing power and resources to be given to frontline organisations. In effect, the Bill appears to do the reverse, actually increasing central control, with little indication of checks and balances on the powers of the SoS.

We are concerned that the Bill will introduce significant structural change, resulting in weakened accountability and transparency and, like previous [re-organisations](#), may do little to improve care or patient experience. The Bill will mean a weaker voice for patients. It will do nothing to abolish the market and it raises concerns about data security, privacy and control.

On this basis we call for this Bill to be stopped in its tracks unless it is sufficiently amended to address these concerns.

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⁵ The incoming CQC Chair told the Health Service Journal that she “would not have abolished HSSIB”.

⁶ The 10 Year Health Plan does not mention a ‘no-blame’ NHS culture. According to the [Thirlwall Inquiry](#) into events at Countess of Chester Hospital and subsequent convictions of neonatal nurse Lucy Letby, the notion of ‘no blame’ “seems to have been, quietly, dropped”, which the Inquiry’s Chair sees as a positive development.