



What's in the Bill?

Nuffield Trust briefing on the
2026 Health Bill

What the Bill does

The Bill abolishes the arm's-length body NHS England, passing its powers to DHSC. This forms part of a wider reorganisation. The track record shows such restructures often disappoint. There are some real opportunities from abolishing NHSE, as unhelpful duplication existed. The 50% job cuts required, and the scale of reorganisation, will mean major disruption.

The Bill grants more powers to the Secretary of State and their Department to intervene in NHS trusts and boards. This includes directing the ICBs which purchase care, firing trust staff, and limiting spending. Political control by governments with varying agendas has been linked to problems in the past.

The Bill abolishes HealthWatch, which champions patient views. It merges HSSIB, which investigates patient safety issues, into the CQC regulator. The aim is to reduce the number of different voices in a cluttered patient safety landscape. An element of independence will be lost, and there is no clear case for reorganising HSSIB even as it carries on the same duties.

The Bill gives the Secretary of State a new power to compel all parts of the NHS, including GPs, to disclose data to combine in a single patient record. Better joined-up data would be a relief to patients and clinicians. Past experience shows there must be enough safeguards on data shared with public and private researchers, or public trust will be lost.

Key changes: structural reorganisation and abolishing NHS England

Clauses 1 & 2

Abolishes NHS England, the independent arm's-length body which previously held and allocated health service funding, produced most policy and guidance, oversaw data and IT, and ran medical education and training. Its powers and duties will pass to the Department of Health and Social Care (DHSC). The schedules set out how assets, legal duties, and restrictions will apply. Some restrictions are being dropped, as described below.

Clauses 21 and 23

Clause 21 **removes the duty for ICBs to have representatives** of GPs, local authorities, and NHS trusts on their boards. They will still need a mental health representative, and must now have representatives from any Mayoral Authorities in their areas. Clause 23 abolishes “partnerships” of staff, charity and community representatives which previously worked alongside ICBs, producing strategies to “integrate” care.

Clause 44

Removes the duty for ICBs to **work together try to keep the trusts in their local area financially healthy**: this will be replaced by spending objectives set by the Secretary of State.

Not in the Bill, but important to know...

The abolition of NHS England is **part of a wider wave of reorganisation** which also merges Integrated Care Boards (ICBs) at a regional level, creates a new National Quality Board, and creates new structures for neighbourhood health at a local level. There is a target for the combined NHS England and DHSC to cut their workforce by 50%, and also for ICBs to halve their running costs.

Our view: structural reorganisation

- Most NHS restructures fail to achieve their goals. Past abolitions and reorganisations we have studied and tracked show that disruption is inevitable, with NHS officials and planners busy reorganising themselves instead of improving services. This is likely to slow delivery of the government's priorities.
- There are opportunities from abolishing NHS England. Unhelpful duplication existed, and merging duties into the civil service might help coordination with other departments.
- It may now become easier to get a grip on the many undeliverable targets and priorities being piled onto the local NHS. To achieve this the Secretary of State will have to restrain their power to announce ever more initiatives, and to move towards really measuring whether the NHS saves or improves lives.
- 50% job cuts may be too ambitious. Nearly half of NHSE and DHSC staff are not duplicating health policy or analysis roles, but doing operational jobs such as running IT systems. It is not clear why a 50% target was chosen. It is not worth undermining important programmes to hit it exactly.

Key changes: new powers for the Secretary of State

Clauses 11

Clause 11 enables the Secretary of State to **issue directions to ICBs**, even if they are performing well.

Clause 33

Allows the Secretary of State to **cap the amount any NHS trust can spend on day-to-day costs**, something that previously Foundation Trusts were able to control.

Clause 35 and 29

Clause 35 means the **Secretary of State has a freer hand to strip away NHS foundation trust status** if a trust fails to comply with “any requirement imposed on it”. Clause 29 and Schedule 3 mean the Secretary of State will appoint the boards of foundation trusts, instead of governors from the local community doing this.

Clause 36

Allows the Secretary of State to **change the licence for any trust, to fire individual directors**, and to make other governance changes, if the trust is not reducing its risk of breaching licence requirements.

Clauses 40

Clause 40 removes the Secretary of State’s **obligation to publish accounts** setting out income and spending in NHS trusts. These will instead be merged into wider accounts also covering ICBs.

Other changes

5 Clause 10 enables provision to be shifted to the public or private sectors if this is seen to be in the interests of the NHS: clause 58 lets the Secretary of State set deadlines for implementing NICE decisions.

Our view: new powers for the Secretary of State over the NHS

- Overall, the Bill moves away from community engagement and from the idea of competing autonomous NHS trusts, towards Whitehall calling the shots.
- There are risks to greater reliance on direct central control. It enables bad behaviours highlighted by the government itself and past reviews, like announcing too many promises and targets, and firing competent managers for problems out of their control.
- The English NHS is already very centralised – most NHS-style systems run at a provincial or local level, not across 57 million people. National policies do not always fit the variety of buildings, workforces, and communities that exist across England.
- The DHSC plans to allow trusts and ICBs freedoms and lower reporting requirements if they perform well, preserving some devolution of power. However, these powers create an arsenal of powers for any future government, who may have a very different agenda, to intervene in NHS plans, decisions, and appointments.
- The end of NHS trust accounts will make it harder to see where health service funding is going, and whether budgets are balanced.

Key changes: abolishing HealthWatch and HSSIB

Clause 59

Abolishes the Health Service Safety Investigations Branch (HSSIB), transferring its role into the Care Quality Commission (CQC). HSSIB, modelled on the Air Accidents Investigation Branch, investigates patient safety problems. It issues recommendations but keeps evidence confidential and, unlike CQC, does not regulate or penalise NHS bodies. Nearly all its powers will be retained inside the CQC, with an “internal wall” to preserve confidentiality.

Clauses 64 and 65

These will respectively **abolish HealthWatch England, the national body which gathers and represents the views of patients**, and **abolish local HealthWatches, which receive and champion patient views** in over 150 areas across the country. The strategic functions of Healthwatch England will be transferred to the new directorate for patient experience at DHSC. Local Healthwatch functions will be transferred to trusts and ICBs – the details of this remain unclear.

Our view: abolishing HSSIB and HealthWatch

- Officials inside the DHSC and NHS may be able to replicate most of HealthWatch's functions, and might have more influence. This will reduce the number of different voices in the system. However, the large job reductions planned will make it hard to secure enough skilled staff, and the element of independent scrutiny will be lost.
- It is not clear what the point is of merging HSSIB into CQC. This will be a complicated and bureaucratic process because of their different roles and the confidentiality principle. CQC has been repeatedly identified as a struggling organisation by the government.
- Because most of HSSIB's duties and powers will stay the same, the merger will not reduce the amount of demands made on NHS trusts - unless HSSIB is directed to act differently. This would again raise questions about a loss of independence.

Key changes: taking GP data into a Single Patient Record

Clause 47

Transfers NHS data, the systems and staff that collect and analyse it, and the power to create such systems **from NHS England to the Secretary of State and their Department**. These powers and assets can be transferred to other public sector bodies.

The clause allows the Secretary of State to **compel all parts of health and social care**, including GP partnerships, care homes, and agencies providing social care at home, to disclose their data for the new system, with the power to set fines if they refuse set out in new section 250F. The government intends to use this to **create a “Single Patient Record”, unifying GP data with other parts of the NHS**. This would be visible to patients and clinicians providing care, and like other NHS data, could be approved for sharing with public and private researchers.

Schedule 7

Means that NHS England’s **duty to report to parliament will not pass over to the Secretary of State**, and that **the statutory guidance on data which bound NHS England will not be replicated**. This mostly contains general principles of security and transparency, requiring NHSE to minimise conflicts of interest, have rigorous processes for accessing the data it held, and consult advisory groups.

Not in the Bill, but important to know...

Many **other protections for use of patient data** will remain in place. These include GDPR; the common law requirement of “confidentiality”; approval for research uses by the Health Research Authority; and the non-statutory policy of a “national opt-out” where patients can choose for their data not to be used in research.

Our view: taking GP data into a Single Patient Record

- A Single Patient Record including GP data would be transformative for patients. The present lack of joined-up information creates real and sometimes dangerous problems for patients and clinicians.
- International evidence shows that public trust is very important for health data systems. Past experience with NHS initiatives suggests people will want reassurance about how their data is shared for research and analysis, especially when it is shared with private firms.
- MPs could consider new safeguards, such as a public interest test for sharing data, or bringing back requirements to report to parliament.
- Past national NHS IT initiatives have often failed simply by poor execution. The government must show it has learnt the lessons, and explain why this is a better option than individual NHS regions combining data in their areas, as some have.



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