Nuffield Trust Briefing: September 2026

Health Bill: Report Stage

The Nuffield Trust is an independent think tank which aims to improve the quality of health and social care in the UK by providing evidence-based research and policy analysis.

The Health Bill involves historic changes in how patient data is used at the front line, and the largest restructure of the English NHS since 2012. MPs should scrutinise these changes closely: health service reorganisations have often failed to deliver in the past. This briefing presents our understanding of the Bill and suggests questions and amendments we hope MPs will draw upon.

Key points

- The Single Patient Record is a laudable ambition. Patients and clinicians are let down by the lack of shared data across general practice, trusts, and other parts of the system. Shared data would also make research more accurate, showing which NHS initiatives really work and which do not.
- Public trust is critical to making this work. Many safeguards exist and will not change, but it would be helpful to have further details as to how the SPR will work, which bodies will be the data controller, and how it will relate to the separate Federated Data Platform initiative.
- MPs could increase the level of safeguards over patient data for the future by setting in law the general principle of patients being able to opt out of their data being shared for research, planning or other purposes outside direct patient care.
- The Bill creates new powers for the Secretary of State to intervene in NHS trusts and integrated care boards, well beyond what NHS England can currently do. These intensify the unusual centralisation of power in the English NHS, and would limit the scope for any real devolution.
- MPs should consider at least barring the Secretary of State from directing the relocation, opening, and closure of specific services, and providing for an independent commission to oversee the appointment of local NHS executives – or for combined authorities to play a role in doing so.
- The abolition of NHS England brings some opportunities, because unhelpful dysfunction and duplication did exist. It has not been handled smoothly, and disruption is inevitable. Ministers should give more clarity on how they will deliver the potential benefit of getting a grip on excessive, badly coordinated targets.

- The planned 50% DHSC job cut appears to require removing the large majority of central policy and analytical staff, or cutting operational staff. This risks having to rehire staff again or undermining new initiatives such as the Single Patient Record.
- The abolition of HSSIB and its merger into the CQC does not have a clear case behind it. It risks causing disruption and will certainly reduce independence, while not in itself reducing the number of different ways trusts are held accountable. Comparable bodies in other sectors and countries do not try to combine safety investigators with regulators.
- The abolition of local and national Healthwatches means an end to independent patient voice in the NHS. This may lose credibility, links to the community, and the ability to hold services to account. Local HealthWatches could be retained, or replaced by a new duty for independent patient voice bodies to be established by ICBs or combined authorities. It does not replace independent voice to have a function inside the ICBs.
- Several amendments proposed at Report Stage aim to broaden the scope of the Bill. The need to identify unpaid carers better, and the lack of transparency around trade agreements impacting the NHS, are pressing issues. However, statutory targets for general practice waiting times would be unhelpful.

The Single Patient Record

The Bill sets out the powers to create a single patient record. Achieving this would be a relief for patients and staff, but it must come with strong enough safeguards to maintain public trust.

What would the Bill change about patient data?

Clause 47 of the Bill transfers the data NHS England holds, the national systems and staff that collect and analyse it, and the power to create such systems to the Secretary of State and DHSC. It 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, as set out in new section 250F.

The government intends to use this to create a 'Single Patient Record', unifying GP data with data elsewhere in the NHS. This would be visible to patients and clinicians providing care and, as is the case for NHS data in general, could be approved for sharing with public and private researchers.

This is a good and necessary goal – though government claims of precise reductions in A&E attendance should be viewed with scepticism without supporting evidence, given how unclear the planned system is. The lack of connected data today, in particular between GPs and other parts of the system, is often infuriating and dangerous for patients. The ability to see patient information across settings exists in other countries, such as in Sweden's tax-funded system.

Cleaning and combining the data will be a major task at a time of sweeping cuts to DHSC staff. The government should set out what the priority is – patient access, clinical use, or research – and address this first. Unconfirmed briefings suggest that DHSC may take the "controller" role under GDPR, making them ultimately accountable for personal data. This would be another major new central commitment. However, if GPs keep this duty the chair of the Royal College of General Practitioners has expressed concern that they could be held liable for how the data is used across the entire NHS.

Above all, there is the need to maintain public trust. It was public concerns about how data would be shared, not any technical problem, which dealt the fatal blow a decade ago to care.data, the previous initiative to extract GP record data. Failing to build trust is a major factor in why the UK has fallen behind the leading European countries in using health data.

How does this relate to the Federated Data Platform?

The Federated Data Platform is an existing NHS project joining up data held by trusts and ICBs. For example, trusts can use it to analyse what is going on in their own A&E department, and how it compares to others. The Science and Technology Committee has suggested that the contract holder since 2024, Palantir, may challenge NHS values by providing software for weapons targeting and US immigration enforcement, and warns that the UK state might be becoming over-reliant on it.

Palantir staff are only allowed to use and access data as instructed by the NHS. The National Data Guardian has raised concerns that they have access to data identifiable to individual patients when this was not envisaged in the initial data protection impact assessment for the project.

The FDP is quite different to the aim for the Single Patient Record. It is designed for planning and analysing care, not delivering it; it does not move data between organisations in identifiable form; it is not visible to patients; and does not include GP records. Whether data in the SPR would be accessible to the FDP is unclear.

However it relates to the SPR, the FDP holds two important lessons to consider. It struggled to deliver value to all trusts as some already had better systems, something again likely with the SPR, and it raised deep concerns about over-reliance on one vendor.

What safeguards exist on patient data, and how are they changing?

The Bill generally does not change the level of safeguards on patient data. However, it does significantly change the scale of that data, and how policies regarding it are set out.

The UK GDPR and 2018 Data Protection Act categorise health data as meriting a high level of protection, and a duty of confidentiality applies under English and Welsh common law. The sharing of care data for 'secondary' purposes – such as public or private research or planning – is limited to use for a specific legal basis.

The abolition of NHS England will mean that the Secretary of State now has a crucial role in whether disclosure is allowed, while also potentially being the data controller for amalgamated patient data. It will also remove two ways in which policy and principle is currently set out: the statutory guidance DHSC currently issues to NHS England, and the responsibility of the latter to report to Parliament.

Using patient data is necessary for medical science, and to understand whether NHS programmes and interventions are improving or worsening care. However, these changes create a more important role for strong and clear safeguards, to offer protection and improve trust through future governments who may have very different policies and priorities.

The national opt-out allows patients to block in most cases the 'secondary' use of health data – for research, or anything other than direct care. Widespread opt-outs would be a worrying sign, but this exists as a fallback option to protect patient autonomy, and a safeguard if government policies on using data caused a sharp loss of trust. Currently, there is no legislative requirement for it to exist. This is increasingly an anomaly. The European Health Data Space Regulation mandates opt-outs in Britain's EU neighbours.

Since commercial research has recently been defined as able to benefit from easier access to patient data under the 2025 Data Use and Access Act, new wording could require that the Secretary of State's regulations under subsection (1) should aim to ensure that the NHS gains a proportionate share of commercial value generated. This could be done by strengthening the definition of "public benefit" in Section 251 of the 2006 NHS Act, which grants the underlying legal basis for secondary care disclosure. It might help to alleviate concerns that patient data is used for commercial products which are then sold back to the NHS at a profit, delivering no net value to the public.

Suggested clarifications, questions and amendments

- Can DHSC confirm that they will be the data controller for the Single Patient Record? What liability implications will there be for GPs, and are the national staff to deliver this being protected from ongoing job cuts?

- What is the relationship between the FDP and the SPR?
- Consider an amendment to clause 47 which requires the Secretary of State to provide for an accessible system whereby people can choose to opt out from the processing of their personal electronic health data for purposes other than direct patient care. This would ensure the continuation of an opt-out system.
- Consider an amendment strengthening the definition of “public benefit” in Section 251 of the 2006 NHS Act, adding a new section stating that where this is relied on to share data, there is a duty to ensure that the NHS gains a proportionate share of commercial value.

Abolition of NHS England

Clauses 1-3 of the Bill would abolish NHS England as a separate arm’s-length body, merging its functions into the DHSC. This forms part of a wider ongoing reorganisation at multiple levels, alongside sizeable job cuts.

What are the opportunities and risks of this abolition?

Our research with the Institute for Government identified several possible advantages of abolishing NHS England. Unhelpful and costly duplication exists across DHSC and NHS England, with teams providing scrutiny of others doing the same job and frictions over sharing information. This contributes to the NHS’s excess of targets and priorities, impossible to deliver in full. Having a single command centre would allow a grip on this, as the Secretary of State could oversee all commitments in the round. It could also help the NHS and DHSC to work more closely with public services like transport and housing.

However, the restructure track record is worrying. The NHS in England has been through six statutory reorganisations in the previous thirty years. None have shown clear evidence of causing improvement. Cutting back targets and focusing on the true drivers of health is not dependent on the shape of the organisational structure.

To limit the of orders sent out to the NHS, Ministers could commit to using the merged structure to have a system similar to what was in place from 2006, a period when the NHS model was quite similar to the model set out in the Bill. During this period, the Secretary of State formed a 'Gateway' with other key officials to create limits on NHS orders and targets.

Where are we in the process? What are the options at this stage?

Evidence from Institute for Government and Nuffield Trust studies of past public sector abolitions identifies several factors linked to success, most of which were not in place for the end of NHS England. The abolition was announced without plans to explain its goals to staff,

and without redundancy funding being in place, leading to months of delay. Preparation ahead of time was limited, with detailed planning for the shape of the new department beginning only in early 2026, almost a year after the merger was announced.

Earlier cuts in tiers of management have at times been followed by costs re-emerging later, or elsewhere. Following the 2013 reforms removing many managers from commissioning bodies, health department consultancy spend peaked at over £600 million a year, more than double its level today. The number of managers rose back above its 2013 level again in 2018.

Given that directorates-general have already been merged, trying to reverse the abolition would still cause extensive disruption. However, the planned 50% cut appears to sit close to the level at which nearly all policy staff would be removed unless some operational roles were lost It would be worth examining whether a somewhat less ambitious target might avoid some of the more difficult and potentially costly consequences.

How does it fit with a wider reorganisation of the NHS?

Other levels of the service are also being reorganised. Local integrated care boards (ICBs) are being merged to reduce their number from 42 to 26. They are losing roles in planning workforce and managing performance, and will no longer have duties to jointly plan and analyse or seek financial balance across their area. Clause 23 removes the 'integrated care partnerships' which used to contain a wider range of charities and health and care representatives to draw up strategies.

Taken together, this means ICBs will look more like purchasers in an internal market than joint committees coordinating care with local trusts and GPs. ICBs are also under a requirement to shed 50% of staff, originally by December 2025, though this too was delayed by the redundancy funding issue.

Meanwhile, new 'neighbourhood provider' structures will be created, at a local level covering around 50,000 people and a larger level covering around 250,000 people, and new 'Integrated Health Organisations', often NHS trusts, will hold contracts for care across the whole population.

This reorganisation stands alongside 2012 as one of the only two times in the past thirty years that every level of the NHS has been reorganised at once. Without exception, past abolitions and reorganisations we studied across government caused those overseeing them to believe they were disrupting normal work. Within healthcare, the Darzi review commissioned by the current Government in 2024 concluded that “a top-down reorganisation of NHS England and

Integrated Care Boards is neither necessary nor desirable… constant reorganisations are costly and distracting."

Suggested clarifications, questions and amendments

- Does DHSC recognise that the process of abolition has been handled poorly, and are lessons being learnt from this?
- How will the Government ensure that the number of targets and priorities is better controlled within a merged centre?
- Will the centre of the NHS lose operational staff in areas such as IT due to the ongoing job losses? Is there an understanding of which policy teams will be removed or reduced to a small fraction of their previous size? Is the scale of the job cuts too large?
- Is the Government confident that spending on management consultants will not rise again due to the removal of public sector staff?

New powers for the Secretary of State

The English NHS is already highly centralised by international standards, with other similar tax-based systems having much more local accountability and control. The Bill as drafted intensifies this, granting the Secretary of State extra powers to intervene in the running of NHS trusts, NHS foundation trusts, and Integrated Care Boards, beyond those NHS England holds today. In the case of powers over NHS foundation trusts, they exceed the powers that the Department held even before NHS England was created.

These added powers would make it more difficult to meaningfully devolve decisions to the level of combined authorities. However, by building on the small role it creates for combined authorities, an amended Bill could sit more naturally with the wider stated aims of the government.

Does the power to direct ICBs create too much space to micro-manage or politicise decisions?

Clause 11 of the Bill will give the Secretary of State power to issue directions to ICBs, even when they are performing well. NHS England's powers only applied when an ICB was failing or at risk of failing to discharge its legal functions.

The Bill sets the course to devolve commissioning powers for highly specialist services to ICBs – formalising a process already well underway for these often expensive, rare and scientifically advanced forms of care. Clause 11's new powers are an effective answer to the concerns raised by several MPs at Second Reading that this could lead to unacceptable

variation. But the clause as drafted goes much broader, creating an open-ended power across the day-to-day activities of the NHS.

While some exceptions are provided to protect against political interference in individual clinical decisions and NICE guidance, they do not protect ICB decisions about which services to provide, how to allocate budgets across a population, whether to reconfigure services, and broader commissioning decisions.

This smooths the path for Secretaries of State to succumb to the temptations to announce specific configurations of buildings and staff for everyday care in a way that does not work for all areas, and to roll out too many new targets for the health service, resulting in the problems discussed above. In principle, a government could exercise political favouritism in opening, relocating and closing health services.

An option to limit these risks would be to restrict this power to specialised services. At the very least, individual commissioning decisions about specific sites and providers of care should not be subject to national political direction.

Currently, the seven NHS regions which will manage performance are intended to function as outposts of Whitehall, without independent boards, and with chairs appointed by the Secretary of State. They could be made more representative of leaders in their area if combined authorities were given a role in appointments, or if representatives of mayors sat on boards overseeing their activities.

Does the Bill increase the risk that political pressures distort the functions of NHS foundation trusts?

Nuffield Trust's work with the Institute for Government highlighted problems with NHS culture. These include threats to fire competent leaders for problems that are beyond their control or poorly understood by ministers, contributing to secrecy and a loss of concern for patient safety against what Robert Francis called "the system's business". As drafted, the Bill could facilitate this tendency. Greater direct control of NHS trusts by Whitehall would also limit the possibilities of meaningfully devolving healthcare powers to combined authorities.

The Bill transfers to the Secretary of State the power to appoint the chairs and non-executive directors of foundation trusts – a role currently held by an elected Council of Governors drawn from the community, which the Bill abolishes.

The Bill further allows for a Secretary of State to revoke a foundation trust's licence (Clause 35), remove individual directors (Clause 36), and make other governance changes when there is concern that a trust is failing to act in compliance with its license, or even when they believe it is not taking steps to reduce the risk of breaching requirements. Clause 45 adds a wider power to modify licence conditions, to promote or secure compliance with regulations.

The effects of these changes would be to further centralise an already unusually highly centralised system. While these powers are intended to be used only when there are concerns that a trust is failing, or at risk of failing, to meet the conditions of its license, determinations of whether those circumstances exist would rest largely with the Secretary of State and lack independent scrutiny.

In the past, an NHS Appointments Commission was created to remove any questions of political bias in the appointments of chairs and non-executive directors to all local NHS boards. This could return, or Combined Authorities could be given an expanded role in appointing or approving trust executives.

How could the Bill affect the balance between public and private sectors?

Clause 10 adds more scope for the Secretary of State to increase the proportion of public sector or private sector provision. It changes section 12E of the 2006 Act to state that this can be done if the "Secretary of State considers that to do so is in the interests of the health service" – a broad and permissive exception.

While the previous section covered only the Secretary of State's function with regards to specific, albeit still broad, matters (NHSE function, procurement, and mandate to NHSE), the new clause refers to "any functions". This means it is more comprehensive, but much weaker as a restriction.

The purpose of this change, and any intention to increase nationalisation or privatisation into it, remain unclear.

How does the Bill change financial transparency?

Clause 40 removes the obligation to publish accounts setting out income and spending in NHS trusts. These will instead be merged into wider accounts also covering ICBs. Given that ICBs will now be clearly separate commissioners, it is unclear why this is being done: NHS trust accounts are important to understand financial performance and make it easier to see in which sectors money is being spent.

Suggested clarifications, questions and amendments

- Consider tabling an amendment which prohibits the Secretary of State from directing ICBs to commission a specific site or provider. This could be added to the list of exemptions in proposed new section 14Z62 under Clause 11 of the Bill.
- Consider tabling an amendment to limit the general power to direct ICBs to specialised services. These would be a set of services defined by the Secretary of State set out based on the criteria in Section 15 of the 2012 Health and Social Care Act, which originally delineated the national commissioning of these services.
- Consider whether combined authorities ought to have a role in oversight or appointments for the NHS regions which will manage performance.
- Consider tabling an amendment requiring the Secretary of State to establish, and to have regard to, an independent NHS appointments commission with responsibility for making appointments of trust boards, or to confer an appointments role on Combined Authorities.
- The Secretary of State could also be required to have regard to an appointments body or to combined authorities when exercising the power to remove directors under Clause 36, with a remit to ensure that any director could be removed only where they were culpable of poor performance.
- Why does Clause 40 bring an end to published accounts for NHS trusts, and what information will no longer be available as a result?
- What is the purpose of Clause 10 of the Bill, and under what circumstances does DHSC anticipate using it to change the balance of public and private provision?

Abolition of HSSIB and Healthwatch

In the context of the Bill bringing so many other powers into DHSC, abolishing HSSIB and Healthwatch carries a risk of important sources for scrutiny of the NHS and power outside of Whitehall being reduced.

Transfer of HSSIB's functions to CQC

Clause 59 abolishes the Health Service Safety Investigations Branch (HSSIB), transferring its role into the Care Quality Commission (CQC). HSSIB issues recommendations but keeps evidence confidential and, unlike CQC, does not regulate or penalise NHS bodies. Nearly all its powers would be retained inside the CQC, with an 'internal wall' to preserve confidentiality.

What are the risks of HSSIB's abolition?

The purpose of merging HSSIB with CQC is unclear. This will be a complicated and bureaucratic process, in large part because of the confidentiality principle which protects patient and staff information disclosed during HSSIB investigations. The CQC is a struggling organisation , adding further difficulties for a complex organisational change.

There is no clear evidence that putting regulation and safety investigation together would help safety recommendations to be implemented in the NHS. If the government wants to change the remit of HSSIB, such as to make its safety investigations more specific, this is a management and direction issue, not a structural one.

A merged structure is not typical in other industries or other countries' health systems. While confidentiality powers would remain strong on paper it may not be clear to staff that it is safe to speak up when problems arise if they are facing employees from a regulatory body.

Because most of HSSIB's duties will stay the same, the merger will not obviously reduce the demands made on NHS trusts. The change raises the risk that the burden and costs of HSSIB will remain, while the independence that makes it worthwhile is lost.

Abolition of Healthwatch England

Clauses 64 and 65 would abolish Healthwatch England, the national body which gathers and represents the views of patients, and local Healthwatches, which receive and champion patient views in over 150 local areas. DHSC have said the functions of Healthwatch England would be transferred to a new directorate for patient experience at DHSC. Schedule 10 sets out new requirements for ICBs to cover parts of the role of local Healthwatches.

What are the opportunities and risks of abolishing Healthwatch?

DHSC and ICBs may be able to replicate most of Healthwatch's functions. However, significant staff time would be needed, and the sizeable job reductions and budget cuts planned for the DHSC and ICBs would make it hard for them to take on these responsibilities. Whether the NHS listens to patient voices is deeply rooted in culture, and its capacity to do anything other than respond to existing targets and goals.

DHSC and ICBs won't be able to replicate the independence of Healthwatch, which raises several issues.

Firstly, patients may have less trust in the credibility of a function which sits within the NHS itself. .

Secondly, local Healthwatches have been effective as an 'independent chair' which helps to connect NHS, social care, and other local services. Splitting local Healthwatch functions between ICBs (for health) and local authorities (for social care) could be a backward step that ignores the reality that the worst patient experiences often happen in the gaps between these services.

Lastly, Healthwatch organisations can hold local services to account, from a specific patient perspective. ICBs are focused on planning and purchasing, stepping back from managing

performance. Other parts of the Health Bill will also lead to ICBs focusing more on executing national standards, which would distract them from properly delivering a new patient voice function.

Suggested clarifications, questions and amendments

- Consider removing Clause 59 from the Bill so that HSSIB is not abolished.
- Consider removing clauses 64 and 65 to retain the independent existence of Healthwatch.
- If Healthwatch is abolished, Schedule 10 should be strengthened to require ICBs to commission an independent body/bodies to obtain the views of patients, giving them the option to retain a Healthwatch for their area or to commission a charity which patients can still trust to act autonomously. Decisions about what should be covered should be made at a local level and could be thematic based on the issues affecting the local population.
- As an alternative, if combined authority mayoralties are to be granted more power over ICBs and the running of local NHS services as part of the government's devolution plans, the Bill could require mayoralties to establish their own patient voice function given they are more independent of the NHS than ICBs. This should also cover social care.

Proposed amendments broadening the scope of the Bill

Identifying unpaid carers

Proposed new clause 54 at Report Stage would create a duty on ICBs to identify unpaid carers, and to create systems enabling this. Our work comparing GP data to the 2021 Census suggests that only one in five carers is identified currently, with those in the most deprived areas most likely to be overlooked, and Black people more likely to be overlooked than White people. This is a serious problem, and the Bill presents an important opportunity to address this. MPs should be vocal in supporting this change.

Statutory commitments to GP access

Proposed new clause 53 at Report Stage would require the Secretary of State to introduce a scheme to ensure patients have the right to see a GP within seven days, and to add this to the NHS Constitution.

Seven days is not a relevant timeframe for patients: those with an urgent need should be seen faster, whereas people booking a routine or review appointment may not mind at all whether they wait seven or twelve days. Formalised targets on paper detached from delivery and resources have not been a successful mechanism to improve the NHS, and most targets in the NHS Constitution have been missed for many years.

Transparency in trade agreements

Proposed new clause 8 at Report Stage would require trade agreements likely to cost the NHS more than £100 million to be put to Parliament under the affirmative procedure, with their impact assessments published.

Scrutiny of treaties in the UK is relatively weak, and there is a good case for strengthening it. The recent US-UK medicines agreement, which lowers cost-effectiveness standards for new NHS drugs, is likely to divert significant sums of money from more efficient care. The Nuffield Trust has tried to obtain impact assessments under the Freedom of Information Act, but this request was initially denied. We have served a Notice of Appeal asking the Information Rights Tribunal to review this decision.

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Nuffield Trust is an independent health and social care think tank. We aim to improve the quality of health and social care in the UK by providing evidence-based research and policy analysis and informing and generating debate.

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