Richmond Group of Charities
Evidence submission to Health Bill Committee
June 2026

We are submitting evidence and perspectives on three themes within the Health Bill that are of particular significance for the Richmond Group of Charities, as a coalition of 15 leading national health and care charities. Collectively our members advocate for over 15 million people living with long-term conditions by understanding what patients, carers and communities say they want and need. Our members have considerable reach across the health sector, run national helplines, deliver locally commissioned services and have enduring partnerships with NHSE and local health systems.

1. Changes to governance and oversight of health services

The Bill proposes the abolishment of NHS England and transfer of its responsibilities between the Department of Health and Social Care (DHSC) and Integrated Care Boards (ICBs). This is happening at a time of considerable challenge for the health system in terms of cuts to ICB and NHS regional budgets and workforce, organisational mergers and high demand for health services. Embedding these changes will be challenging while the system is in a state of upheaval, and government must ensure that focus and resource remain on transformation and improvement for patients.

At a national level the Bill may risk shifting too much responsibility towards the Secretary of State. It could result in politically driven decision making and reduce the potential for local empowerment. The added responsibilities for could slow down of the pace of decision making and require the introduction of greater checks and balances on the additional decision-making power conferred by this Bill. It is important that the Bill ensures there is neutrality in reporting and ensuring insights don't inadvertently become politicised.

The merger of NHSE into DHSC risks losing crucial central clinical expertise. Our member charities have developed enduring and constructive relationships with clinical leaders across both organisations to improve the quality of services and achieve better outcomes for patients and have a wealth of practical examples of how these have delivered. The Bill needs to ensure that DHSC has sufficient clinical expertise and capacity, to undertake its enhanced responsibilities. We strongly recommend that programmes that have the knowledge and capacity to improve care for people who use the health and care system the most – people living with long-term and multiple long-term conditions – are retained and should extend beyond the initial National Priority Programmes.

At a local level, given the loss of staff within ICBs due to the 50% cut to budgets, there is a risk that many areas will lack the expertise and capacity to commission high quality services, particularly where health data is patchy or poor. Commitments to addressing health inequalities will not be possible if commissioners do not have the time and resource to commission appropriate services. The Bill will need to ensure that national oversight of service performance remains, to reduce the risks associated with the increasingly localised, under-resourced and fragmented commissioning of services and to overcome existing postcode lotteries (or inconsistencies in quality and provision of services).

The Bill proposes removal of the mandatory requirement for ICBs to have local authority representation and removes the mandatory requirement to establish and maintain Integrated Care Partnerships. This, taken alongside the removal of local authority representatives, could weaken integration at a local level, and weaken the prominence of social care in decision making. Overall there could be numerous unintended consequences, particularly given the ongoing changes to local authority structures also taking place in parallel.

2. Changes to patient voice

The Health Bill proposes to abolish the current Healthwatch functions, with the national Healthwatch England functions transferring to the DHSC, and Local Healthwatch functions being taken on by ICBs for health and local authorities for social care respectively.

While arguments have been made that this brings patient voice closer to decision making, there is a risk that we lose capacity for patient advocacy, independent voice, and the patients most mistrustful of services will be least likely to be heard. There are numerous recent examples where health services have not listened to patients and their families, resulting in significant and adverse patient outcomes.

We need to ensure that there is transparency, accountability and equity in any changes to patient voice engagement, and this must be underpinned by adequate resource to deliver. Any new patient experience functions replacing Healthwatch must go beyond collecting individual views and routine feedback, with robust mechanisms to co-produce services.

3. Introduction of a Single Patient Record

The Health Bill would create the legal foundation for a Single Patient Record (SPR), bringing health and social care information together through national technical infrastructure. While there are existing laws which allow sharing of patient information for direct care, approved research and emergencies, this Bill would move the NHS towards a more standardised, nationally coordinated approach. The Bill will also seek to resolve ongoing difficulties around national access to GP held records. There remain considerable concerns amongst the GP community, who needed to be reassured that the proposed model of data sharing is both lawful and workable in clinical practice.

We believe that the proposed SPR has the potential to support joined up and safer clinical care if well implemented. It would be a positive step forward in allowing patients greater access and control to their own information while also giving health professionals access to information they need. This could be particularly transformative for people living with multiple health conditions, both in terms of better joined up clinical decision making and also relieving the current burden on patients to repeat their health history to every individual health professional or service they encounter.

From a voluntary and charitable sector perspective, there is a growing role for non-clinical roles, such as valued members of neighbourhood teams or multi-disciplinary teams. This will include seeing, sharing and contributing to patient records as appropriate. Therefore, the SPR model must support safe and appropriate data sharing that extends beyond NHS teams.

Parliament needs to ensure that the model being proposed for the SPR is robust enough to reassure both clinicians and the public. This includes ensuring that the information being used to create the single patient record is accurate. Our members across many health conditions are aware of inconsistencies across primary and secondary care records due to differences in medical coding practice. There is a risk these inaccuracies and inconsistencies could be carried across to the SPR depending on how it is developed and implemented.

About the Richmond Group of Charities

The Richmond Group is a coalition of 15 leading national health and care charities, collectively representing over 15 million people living with long-term conditions. We deliver support services, fund research, and have sector-leading capability to support problem solving, policy development, service design and delivery. We work together to ensure that people living with long-term, multiple, or complex health needs have the support they need to live well and thrive.

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Contact: RichmondGroup@macmillan.org.uk