Written Evidence Submitted by the Royal College of Nursing (RCN) – Health Bill 2026 – Public Bill Committee

About the Royal College of Nursing

With a membership of over half a million registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations.

Contents

1. Introduction

1.1. The RCN welcomes the opportunity to submit evidence to the Public Bill Committee. As the largest profession across health and care, nursing must be central to policymaking, with nursing expertise reflected in decisions that recognise the vital role nursing staff play in delivering care to patients, residents and communities every day.

1.2. The Health Bill marks a pivotal shift in how health and care will be governed in England. While it proposes major structural changes, including the abolition of NHS England and the transfer of its functions to the Department of Health and Social Care, its significance goes beyond reorganisation.

1.3. The Bill introduces wide-ranging changes to NHS governance, including expanded ministerial powers, reforms to integrated care boards, commissioning, health inequalities, digital records, foundation trust governance, patient safety investigations and patient voice.

1.4. It also moves away from aspects of the framework established by the Health and Social Care Act 2012. The RCN welcomes steps in this Bill which restore clearer public accountability for the health service, and the opportunity it presents to address longstanding challenges across health and care.

1.5. However, greater ministerial control must be matched by greater ministerial accountability. Local leaders need the flexibility to respond to the needs of their communities, but many of the most serious pressures facing the system cannot be solved locally. Workforce supply, retention, safe staffing, health inequalities and variation in service quality all require national action, clear standards and proper accountability from Ministers.

1.6. The RCN believes the Bill should be guided by three core principles.

1.6.1. **Accountability must follow power, with clear national safeguards.** The Bill gives Ministers greater control over NHS structures, commissioning and performance. That must come with clearer national accountability for the problems local leaders cannot solve alone, including workforce supply, safe staffing, health inequalities and unacceptable variation in care.

1.6.2. **Nursing leadership must be protected wherever decisions are made about care.** Nursing is the largest safety-critical profession in health and care. Decisions about services, staffing, safety and quality should not be made without senior nursing expertise. The Bill should strengthen nursing leadership, not leave it vulnerable to local discretion or future erosion.

1.6.3. **Care closer to home must be planned across NHS, palliative and social care.** The government's ambition to move more care closer to home will not be delivered unless community, primary care, palliative and social care services have the nursing workforce and support needed to make it safe. Neighbourhood healthcare cannot succeed if NHS and social care planning continue to functionally operate as separate systems.

1.7. Below, these points are expanded on to assist the Committee in its line-by-line scrutiny of the Bill.

2. Clauses 1 and 2: abolition of NHS England and transfer schemes

2.1. Clauses 1 and 2 abolish NHS England and make provision for transfer schemes connected to that abolition.

2.2. Clause 2 gives the Secretary of State broad powers to make one or more schemes for the transfer of property, rights and liabilities from NHS England to a range of public bodies. This includes provision which is the same as or similar to the Transfer of Undertakings (Protection of Employment) Regulations 2006, and references to rights and liabilities include rights and liabilities relating to a contract of employment.

2.3. The abolition or restructuring of national bodies under the Bill will involve the transfer of staff, functions and expertise across the system. Given that these changes are being facilitated by legislation, it is reasonable for Parliament to seek ongoing assurances that affected staff will be treated fairly, kept informed and properly consulted, and that workforce stability, patient safety and nursing expertise will be protected throughout the transition.

3. Clause 4: reducing inequalities

3.1. Clause 4 substitutes section 1C of the National Health Service Act 2006. It would require the Secretary of State, when exercising functions in relation to the health service, to have regard to the need to reduce inequalities in access to health services and inequalities in outcomes achieved by the provision of health services.

3.2. The RCN supports the Bill's intention to reduce health inequalities. However, the duty must be meaningful in practice. Health inequalities are worsened when services are under-resourced, understaffed or inaccessible.

3.3. The equalities implications of the Bill go beyond clause 4. Digital reform, changes to patient voice, local planning arrangements and the transfer of functions could all affect people and communities who already face barriers to care.

3.4. Older people, disabled people, people living in poverty, migrants, people with low digital literacy and people facing language or accessibility barriers must not be excluded from care as services change.

3.5. The Bill should require Ministers to show how major decisions under it will affect inequalities in practice. This should include the impact of workforce shortages on access, safety and outcomes.

3.6. The RCN welcomes the revised duty, but its practical effect will depend on how Ministers apply it. As drafted, it remains a "have regard" duty and does not require the Secretary of State to publish an assessment of how significant decisions may affect inequalities in access, outcomes or workforce capacity.

3.7. The Committee should therefore consider amending section 1C so that, when making significant decisions about the health service in England, the Secretary of State must assess and publish the likely impact of those decisions on inequalities in access to health services and outcomes. Such an assessment should include consideration of workforce capacity, staffing levels and access to services in underserved communities.

4. Clause 7: education, training, and safe staffing

4.1. Clause 7 amends section 1F of the National Health Service Act 2006 so that the Secretary of State must exercise functions under the relevant enactments with a view to ensuring that there are sufficient people with appropriate education and training to meet the workforce needs of the health

service, and that there is an effective system in place for the planning and delivery of education and training to meet those needs.

4.2. The RCN welcomes the provisions related to education and training. However, the duty remains high-level and lacks sufficient mechanisms for delivery.

4.3. The longstanding nursing workforce crisis is a direct result of historic ambiguity in accountability for the supply and retention of a sustainable domestically educated workforce.[1] The Bill should make clear that the Secretary of State is accountable for workforce planning and supply alongside service and financial planning. Workforce planning cannot be separate from decisions about how services are configured, funded and delivered.

4.4. Clause 7 should be strengthened, or a new clause inserted to require transparent workforce projections, nursing-specific workforce modelling, assessment of the graduate and newly registered nurse pipeline, action to support recruitment and retention, proper consideration of the wider health and care labour market, and workforce planning linked to service and finance planning.

4.5. The duty should also include clear routes for nursing staff to raise concerns about unsafe staffing without fear of detriment. Safe staffing is not only a workforce issue; it is a patient safety issue.

4.6. Our intention is to make explicit the responsibility for delivering workforce supply and plans which meet patient needs. Clause 7 should be amended, or a new clause added, to insert new subsections into section 1F of the National Health Service Act 2006, requiring the Secretary of State to publish, fund and maintain a sustainable health and care workforce strategy for England. This would turn the new duty from a broad statement of intent into a clearer mechanism for accountability, planning and delivery. This would complement the existing duty to make clear the roles and responsibilities for workforce planning, by providing assurance to Parliament that the outcomes and outputs of these plans are sufficient to meet needs.

4.6.1. The strategy should assess current and projected workforce demand and sustainable supply, including nursing-specific workforce modelling, vacancy levels, retention, skill mix, the graduate and newly registered nurse pipeline, and whether education and training supply is sufficient to meet projected need.

4.6.2. It should also set out how workforce planning will be aligned with service planning and finance planning. Workforce planning cannot be treated as a separate exercise from decisions about how services are configured, funded and delivered.

4.6.3. The strategy should address access to continuing professional development, protected learning time, workforce wellbeing, equality impacts, and clear routes for staff to raise concerns about unsafe staffing or unsafe systems without fear of detriment.

4.6.4. In preparing and reviewing the strategy, the Secretary of State should be required to consult relevant bodies, including ICBs, providers, organisations representing nursing staff, recognised trade unions, Royal Colleges, professional bodies, education providers, the Chief Nursing Officer for England, the Nursing and Midwifery Council and the Care Quality Commission.

[1] Royal College of Nursing, *Our work to fix the nursing workforce crisis*, available at: https://www.rcn.org.uk/employment-and-pay/Safe-staffing/England-Staffing-for-safe-and-effective-care [accessed 3 June 2026].

4.7. The Bill should also provide a route to introduce safety-critical registered nurse-to-patient ratios, potentially through regulations. This is crucial for patient safety and draws on best practice from around the world.[2] The RCN does not suggest that a single blunt ratio should be placed on the face of the Bill, as these will change with developing evidence. However, the Bill should create a mechanism for safe nursing requirements for all healthcare settings to be developed, consulted on and implemented properly.

4.8. Any such mechanism should allow ratios and safe staffing requirements to be tailored to services, settings, acuity, dependency and skill mix, while ensuring minimum safety standards across England. This would provide a proportionate route for developing evidence-based safe staffing requirements, rather than requiring all of the detail to be set out in primary legislation.

4.9. Continuing professional development (CPD) is also integral to safe care. While nursing staff do have access to CPD, provision remains insufficient and is not supported at the same level as medical professional development. Nursing staff need access to funded, protected CPD to maintain safe and effective practice, develop specialist skills and support retention. CPD should not depend on local budgets, staffing shortages, or whether a service can release staff from the rota.[3]

4.10. Clause 7 should therefore also be amended to ensure workforce planning includes assessment and reporting on CPD access, protected learning time and funding, including nursing-specific CPD needs.

4.11. Furthermore, the Bill should include provisions to provide legal protections for people who raise concerns about unsafe staffing levels or other systemic risks to the delivery of health and care services. Currently, when staffing levels are insufficient, staff are still held to the same level of accountability under their professional registration. However, incidents are more likely to occur. If an incident was to occur whilst staffing levels are insufficient, the staff member should not be held accountable for failings outside their scope of control. The Bill should provide protections in these situations.

5. Clause 10: variation in public and private provision of health services

5.1. Clause 10 replaces section 12E of the National Health Service Act 2006. It provides that the Secretary of State must not exercise functions in relation to the health service for the purpose of causing a variation in the proportion of health services provided by the public or private sector, or by different kinds of legal entity, unless the Secretary of State considers that doing so is in the interests of the health service.

5.2. The RCN welcomes the fact that clause 10 moves away from the rigid market neutrality associated with the Health and Social Care Act 2012.

5.3. The Bill should go further, however, and move towards a presumption in favour of public provision and insourcing.

[2] Royal College of Nursing, *Safe Staffing: Evaluating the evidence for mandatory nurse-to-patient ratios* (RCN, 2025), https://www.rcn.org.uk/Professional-Development/publications/rcn-safe-staffing-uk-pub-012-306

[3] Royal College of Nursing, *RCN response to the Health and Social Care Committee Expert Panel evaluation: planning for the health and social care workforce* (RCN, 2024), https://www.rcn.org.uk/-/media/Royal-College-Of-Nursing/Documents/Policies-and-briefings/Consultation-responses/2024/CONR-5024.pdf

5.4. The Bill must not entrench an artificial neutrality between public and private providers in a way that restricts the government's ability to strengthen public accountability, support service integration and rebuild capacity within the NHS.

5.5. The RCN has longstanding policy, endorsed through its democratic and constitutional structures, opposing the privatisation of NHS services.[4]

5.6. Where private provision exists, providers should be held to the same standards of data reporting and transparency as NHS Trusts and Foundation Trusts, to allow for robust monitoring and public assurance.

5.7. The Committee should therefore consider whether clause 10 could be strengthened to make explicit that the Secretary of State may act with a clear preference for public provision, including through a statutory presumption that increasing the proportion of services delivered by public bodies, and reducing reliance on private providers, is in the public interest and in the interests of the health service.

6. Clauses 11, 12 and 16: Secretary of State powers, commissioning and palliative care

6.1. Clause 11 gives the Secretary of State broad powers to direct integrated care boards as to the exercise of their functions. Clause 12 makes changes to commissioning responsibility under sections 3, 3A and 3B of the National Health Service Act 2006, including by replacing references to NHS England with the Secretary of State. Clause 16 creates regulation-making powers around commissioning by integrated care boards.

6.2. Taken together, these clauses strengthen the role of the Secretary of State in relation to commissioning and ICB functions. The RCN believes that greater national power must be matched by clearer national accountability, particularly where access to services is inconsistent.

6.3. Palliative and end-of-life care is an important example. Access to high-quality palliative care remains inconsistent. Section 21 of the Health and Care Act 2022 amended section 3 of the NHS Act 2006, placing a duty on ICBs to commission palliative care services. However, there is no equivalent direct duty on the Secretary of State to ensure universal access, quality or consistency.

6.4. If the Bill gives Ministers greater control over structures, commissioning and ICB performance, and creates an opportunity to strengthen accountability for workforce planning, it should also be clear how these powers will improve access to services where provision is currently inconsistent.

6.5. The RCN believes the Committee should consider amendments to strengthen national accountability for palliative and end-of-life care.[5] This should include a duty on the Secretary of State to report on access, quality, workforce planning and inequalities in palliative and end-of-life care, or to publish a national palliative and end-of-life care strategy.

[4] Royal College of Nursing, *Council's report to members on Congress 2013* (RCN, 2014), https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2014/june/pub-004617.pdf
[5] Royal College of Nursing, *The commission on Palliative and End-of-Life Care* (RCN, 2025), https://www.rcn.org.uk/About-us/Our-Influencing-work/Policy-briefings/conr-0925

6.6. The debate on the Terminally Ill Adults (End of Life) Bill revealed clear cross-party consensus that end of life and palliative care need urgent, systematic improvement.[6] This is the first major government health bill before Parliament since that debate. To let that moment pass without action would be to squander an opportunity for progress.

6.7. More broadly, where the Secretary of State exercises direction-making powers over ICBs, the Committee should seek safeguards to ensure that the workforce impact, patient safety impact and equality impact of those directions are properly considered.

7. Clause 20: performance assessments of integrated care boards

7.1. Clause 20 substitutes section 14Z59 of the National Health Service Act 2006 and creates an annual performance assessment process for ICBs. The RCN believes this is an important opportunity to ensure ICBs are held accountable for whether the services they commission can be delivered safely.

7.2. Safe and effective care depends on having the right number of staff, with the right skills, at the right time and in the right place. A service cannot be safely commissioned if the appropriate workforce does not exist to deliver it.

7.3. Clause 20 should therefore be amended so that ICB performance assessments include consideration of workforce capacity, nursing staffing levels, skill mix, vacancy rates and whether commissioned services are deliverable with the available workforce.

7.4. Performance assessments should also consider the impact of staffing shortages on access, patient safety, quality of care and health inequalities.

7.5. This would support the wider purpose of the Bill by ensuring that greater national accountability for ICB performance includes scrutiny of the workforce conditions needed to deliver safe services.

8. Clause 21: membership of integrated care boards

8.1. Clause 21 amends Schedule 1B to the National Health Service Act 2006 in relation to ICB membership. Although the clause itself concerns mayoral strategic authority nominations, it reopens the statutory framework for ICB membership.

8.2. The Committee should therefore consider whether the Bill should also address the continuing ambiguity around how nursing leadership is represented in ICB decision-making.

8.3. ICBs are responsible for planning and commissioning services. Nursing expertise must therefore be embedded in their decision-making. At present, this is not guaranteed, and this needs to change.

8.4. The move from CCGs to ICBs has created ambiguity and gaps across the system about how nursing leadership is secured. This is particularly important as the Bill gives the Secretary of State greater powers over commissioning, ICB performance and service planning.

[6] HC Deb 29 November 2024, vol 757, *Terminally Ill Adults (End of Life) Bill*, https://hansard.parliament.uk/commons/2024-11-29/debates/796D6D96-3FCB-4B39-BD89-67B2B61086E6/TerminallyIllAdults%28EndOfLife%29Bill ; HC Deb 13 January 2025, vol 760, *Hospice and Palliative Care*, https://hansard.parliament.uk/commons/2025-01-13/debates/9E924211-FFE3-4377-95FD-00168281766E/HospiceAndPalliativeCare

8.5. Clinical leadership must mean nursing leadership as well as medical leadership. Nursing leaders bring direct expertise in safe staffing, patient safety, community services, discharge, health inequalities, public health, prevention and care closer to home. As the largest part of the health and care workforce, nursing staff deliver much of the care on which these priorities depend, particularly in community and social care settings.

8.6. The Bill should be amended to ensure nursing expertise is embedded in ICB decision-making, particularly in relation to commissioning, workforce planning, service planning, patient safety and health inequalities.

9. Clauses 22 to 24: integration, planning and neighbourhood health plans

9.1. Clauses 22 to 24 make significant changes to local planning arrangements. Clause 22 removes joint forward plans and capital resource use plans for ICBs and their partners. Clause 23 abolishes integrated care partnerships and integrated care strategies. Clause 24 amends the Local Government and Public Involvement in Health Act 2007, replacing joint local health and wellbeing strategies with neighbourhood health plans.

9.2. The RCN supports the ambition to move more care closer to home, but this cannot be delivered without investment in the nursing workforces that provide care in communities, including in primary care, mental health, learning disability, public health and social care settings.

9.3. Neighbourhood care cannot succeed without social care. Too often, problems in hospitals are caused or worsened by lack of capacity in community and care settings.

9.4. Neighbourhood health planning must be informed by nursing expertise and underpinned by proper workforce assessment. It must also connect meaningfully with social care, rather than treating NHS and social care planning as separate.

9.5. Clause 24 should be amended so that neighbourhood health plans include an assessment of the nursing workforce needed to deliver care closer to home. This should include community, primary care, mental health, learning disability, public health and social care nursing.

9.6. Neighbourhood health plans should also address the relationship between NHS services and social care, and should involve nursing leaders, staff-side representatives and relevant professional bodies in their development.

10. Clause 28: Special Health Authorities and staff transfers

10.1. Clause 28 amends provisions relating to Special Health Authorities, including arrangements for staff transfers and placing staff at the disposal of other bodies. The RCN has members and recognition agreements in many of these workplaces.

10.2. The RCN recognises that structural change can require the transfer of staff and expertise across the system. However, transfer powers should be accompanied by proper safeguards.

10.3. The Committee should seek assurances that the use of clause 28 powers will not weaken workforce stability, patient safety or professional expertise, and that affected staff will have clear information about how they may be affected.

11. Clause 29 and Schedule 3: constitution of NHS foundation trusts

11.1. Clause 29 and Schedule 3 make changes to the constitution of NHS foundation trusts. The RCN was concerned that, as introduced, the Bill would remove the existing statutory requirement in Schedule 7 to the National Health Service Act 2006 for foundation trust boards to include, as one of the executive directors, a registered nurse or midwife.

11.2. The RCN welcomes Government amendment Gov 19, tabled by Karin Smyth MP, which would require NHS foundation trusts to have at least one executive director who is a registered medical practitioner or registered dentist, and another who is a registered nurse or registered midwife. This follows positive and constructive dialogue between the Government and the RCN on the importance of protecting nursing representation in NHS governance.

11.3. This is an important safeguard. Nursing is the largest safety-critical profession in health and care, and senior nursing leadership at board level brings essential expertise on safe staffing, patient safety, quality of care, discharge, workforce planning and the practical impact of service decisions on patients and staff.

11.4. The Committee should therefore agree to Government amendment Gov 19.

11.5. The RCN would also welcome assurance that any regulation-making power to create exceptions will be used only where genuinely necessary and will not weaken the principle that executive nursing representation must be protected in all NHS foundation trust governance structures.

11.6. This also points to a wider question about the status of the nursing profession. Parliament has recognised the particular public service contribution of some workforces through statutory covenants, including for the armed forces and police. Nursing is also a profession of national importance, predominantly made up of women, whose members make significant sacrifices in public service across health and care, including those working outside the NHS in general practice and independent health and social care.

11.7. Further, the RCN also supports exploring whether this Bill provides an appropriate opportunity to strengthen the recognition of nursing leadership in national decision-making. This could include considering parity of esteem for the Chief Nursing Officer for England with the Chief Medical Officer, where relevant to the exercise of national health functions, so that senior nursing advice is properly reflected alongside senior medical advice.

12. Clause 33: limits on expenditure of NHS foundation trusts

12.1. Clause 33 substitutes sections 42B and 42C of the National Health Service Act 2006, giving the Secretary of State power to impose limits on the expenditure that may be incurred by an NHS foundation trust in respect of a single financial year, and requiring the Secretary of State to publish guidance about the exercise of that power.

12.2. The RCN recognises the need for financial accountability. However, financial controls must not be exercised in a way that compromises patient safety, staffing levels, clinical leadership or quality of care.

12.3. The guidance required under substituted section 42C should include how the Secretary of State will assess the patient safety and workforce impact of any proposed expenditure limit.

12.4. The Committee should consider whether clause 33 should be amended to require the Secretary of State, before imposing an expenditure limit, to consider its likely impact on staffing, skill mix, patient safety and quality of care.

13. Clauses 47, 50 and Schedule 7: single patient record and information systems

13.1. Clause 47 introduces the single patient record provisions by inserting new sections 250E and 250F into the National Health Service Act 2006. Separately, clause 50 gives effect to Schedule 7, which amends Chapter 2 of Part 9 of the Health and Social Care Act 2012 in relation to health and social care information systems. Taken together, these provisions raise important questions about data sharing, governance, safeguards, staff involvement and patient confidence.

13.2. The RCN recognises that better information sharing and a single patient record could support safer, more joined-up care. If done well, it could reduce duplication, improve patient experience and help nursing staff access the information they need to provide safe care.

13.3. However, digital reform must reduce administrative burden, not add to it. Nursing staff must be involved in the design and implementation of systems they will be expected to use.

13.4. While the proposed single patient record is distinct from the Federated Data Platform and other national data programmes, many of the same ethical considerations remain relevant. Any new system for patient data must have robust safeguards around data privacy, safeguarding, transparency, access, procurement and secondary uses of data.

13.5. The single patient record will only work if it has the confidence of patients and staff. Nursing staff should be involved in its design, implementation and governance.

13.6. The same principle applies to wider digital tools, including AI where relevant. The Bill must ensure these technologies support clinical decision-making, professional judgement and patient safety, not replace the judgement of nursing staff or create unsafe assumptions about staffing, workload or productivity.

13.7. The Bill should require meaningful engagement with nursing staff, professional bodies, patient groups and other relevant stakeholders before regulations establishing the single patient record are made.

13.8. The Bill should also require appropriate safeguards around data privacy, transparency, access, procurement, secondary uses of data, digital exclusion, staff workload and patient safety.

14. Clauses 50 and 62: information, transparency and oversight

14.1. Clause 50 and Schedule 7 deal with health and social care information systems. Clause 62 gives the Care Quality Commission (CQC) functions in relation to reviews and investigations of commissioning. Together, these provisions provide possible routes to improve transparency about patient safety risks, workforce pressures and unsafe care environments.

14.2. The RCN believes the Bill should improve transparency about the pressures facing services, not obscure them. There is a strong case for better reporting on sustainable workforce modelling and supply, staffing levels, staff access to continuing professional development, unsafe care environments and variation in access to services.

14.3. These issues directly affect patient safety and whether nursing staff can do their jobs safely and professionally.

14.4. Corridor care is one of the clearest examples of unsafe care environments. Patients should not be treated in corridors, waiting rooms or other inappropriate temporary spaces. The RCN believes corridor care must be eradicated.[7]

14.5. An immediately workable route may be to require reporting on care delivered in inappropriate temporary escalation spaces, including corridors, waiting rooms or other non-clinical areas, or to require CQC reviews of commissioning to consider whether system pressures are leading to care being delivered in unsafe or inappropriate environments.

14.6. The Bill's provisions on information systems and CQC oversight provide an opportunity to ensure that patient safety risks and workforce pressures are visible, measurable and subject to clear national accountability.

14.7. The same principle applies to staff access to CPD. Ministers should be able to demonstrate whether nursing staff are receiving the training and development they need.

14.8. The Committee should consider whether the Bill should require reporting on care delivered in inappropriate temporary spaces, staff access to CPD, protected learning time and workforce pressures. The Committee should also consider whether CQC reviews and investigations of commissioning should explicitly consider workforce capacity, nursing staffing, skill mix, patient safety, unsafe care environments and health inequalities.

15. Clauses 59 and 60 and Schedule 8: transfer of HSSIB functions to the Care Quality Commission (CQC)

15.1. Clause 59 gives effect to Schedule 8, which makes provision transferring HSSIB's functions to the CQC. Clause 60 provides for transfer schemes in connection with the abolition of HSSIB. Schedule 8 amends the Health and Social Care Act 2008 and related legislation, including provisions on protected material and exceptions to the prohibition on disclosure.

15.2. The RCN is concerned about the impact this could have on independent, learning-focused safety investigation. Safety investigation must focus on learning and prevention. Bringing HSSIB functions into the CQC risks blurring the line between learning-focused investigation and regulatory enforcement. Both are important, but they are fundamentally distinct.

15.3. Nursing staff need confidence that they can speak openly about unsafe systems, risks and mistakes. Any weakening of safe space principles risks reducing openness and undermining learning.

15.4. The Bill should preserve the independence of safety investigations, protect safe space principles and support a just culture.

15.5. The Committee should consider amendments to ensure the transfer of HSSIB functions to the CQC does not weaken the independence of safety investigations, safe space principles,

[7] Royal College of Nursing, *On the frontline of the UK's corridor care crisis* (RCN, 2025), https://www.rcn.org.uk/Professional-Development/publications/rcn-frontline-of-the-uk-corridor-care-crisis-uk-pub-011-944

confidentiality protections, or the ability of staff to participate openly in investigations. This is sometimes described as a 'firewall' approach.

15.6. The Committee should also consider whether the Bill should maintain a clear operational distinction between learning-focused safety investigation and CQC enforcement or regulatory functions. The RCN believes that amendments are likely to be necessary to provide adequate reassurance.

16. Clauses 64 and 65 and Schedules 9 and 10: Healthwatch England and Local Healthwatch organisations

16.1. Clauses 64 and 65 abolish Healthwatch England and Local Healthwatch arrangements. Schedules 9 and 10 make the related amendments.

16.2. The RCN is concerned by the potential loss of independent patient voice. If ICBs are responsible for gathering patient views about services they plan or commission, that is not the same as independent scrutiny. This points to a clear conflict between commissioning and oversight.

16.3. This is particularly important for people and communities who already face barriers to care, whose voices are least likely to be heard without independent advocacy.

16.4. The issue is not whether the current system is perfect, but whether the replacement arrangements preserve independent, accessible and properly resourced patient voice.

16.5. The Bill should ensure that independent patient voice and scrutiny are not lost through these reforms.

16.6. Any replacement arrangements should be independent, accessible, properly resourced and able to represent the views of people and communities who face barriers to care.

17. Clause 66: civil contingencies and category 1 responders

17.1. Clause 66 amends Schedule 1 to the Civil Contingencies Act 2004 to add an NHS trust as a Category 1 responder if, and in so far as, it has the function of providing ambulance services or hospital accommodation and services in relation to accidents and emergencies.

17.2. The RCN recognises the importance of robust civil contingencies arrangements. Emergency preparedness in health and care depends not only on organisational responsibilities, but on the nursing staff and wider workforce required to deliver services during periods of extreme pressure, disruption or emergency.

17.3. The Covid-19 pandemic demonstrated the central role of nursing staff in responding to a national health emergency.[8] It also showed that emergency planning must take proper account of workforce capacity, staff safety, access to protective equipment, infection prevention and control, psychological support and the need to maintain safe staffing levels during sustained periods of pressure.

[8] Royal College of Nursing, *Module 3 of the UK COVID-19 Public Inquiry: Opening statement on behalf of the Royal College of Nursing* (RCN, 2024), https://www.rcn.org.uk/-/media/Royal-College-Of-Nursing/Documents/Policies-and-briefings/UK-Wide/Policies/2024/Module-3-of-the-UK-COVID-19-Public-Inquiry-RCN-opening-statement.pdf

17.4. The Committee should seek assurances that any changes to civil contingencies arrangements are accompanied by proper workforce planning, staff protection and engagement with nursing leaders and recognised trade unions. Staff should be treated as partners in preparedness and resilience planning, with their professional expertise informing decisions before a crisis occurs, not simply relied upon to absorb risk when services come under pressure.

17.5. Emergency preparedness should not be treated as a purely organisational duty detached from the staff needed to deliver it. Where NHS bodies are given or clarified as having civil contingencies responsibilities, there should be corresponding consideration of the workforce capacity, training, equipment and support needed to discharge those responsibilities safely.

Should you have any questions, or for further information, please contact Dom Trendall, Senior Public Affairs Adviser at dominic.trendall@RCN.org.uk or publicaffairs@rcn.org.uk