

2 July 2026

The NHS Alliance: Written evidence to the Health Bill Public Bill Committee

About us

We are the independent membership body that represents and supports the health and care system in England, Wales and Northern Ireland.

We represent, strengthen and support providers and commissioners of NHS care so that the NHS performs at its best and improves patient care across the UK – representing frontline reality to government, shaping policy and building capability. We work across the whole NHS as well as within its individual sectors.

In England, our members include NHS trusts, integrated care boards, community interest companies, voluntary and independent providers, and primary care providers. We:

- Provide a strong, influential voice
- Build leadership capability and accelerate improvement
- Convene leaders
- Cultivate relationships beyond the NHS
- Deliver insights that inform better decisions

When passed as an Act, the Health Bill will change the way that local and national health structures work and will impact on all aspects of the delivery of healthcare in England. **We have consulted with our members working in commissioning, primary and acute care and in mental health to provide the broadest possible evidence base for this submission.**

Executive summary

1. The NHS Alliance is broadly supportive of the Bill's stated aims of improving patient safety and experience through a new single patient record (SPR), empowering patients by enabling joined-up, proactive care, and stripping back national bureaucracy to devolve power and resources to front line organisations.
2. However, we would like to see greater detail in the Bill on a number of key issues outlined below:
 - Abolishing NHS England and establishing the 'new centre'
 - Empowering NHS providers
 - Empowering NHS commissioners

- Prioritising patient safety
 - Supporting integration and system working
 - Enabling the SPR
3. The NHS Alliance fully supports the 10-Year Health Plan's vision for more locally determined and appropriate care. However, we believe that the Bill does not go far enough to promote local autonomy for either ICBs, NHS trusts or Foundation Trusts (FTs).
 4. Our members have expressed concerns over the proposed changes to the oversight of healthcare functions and patient safety, given the abolition of local and national Healthwatch and the Health Services Safety and Investigations Body (HSSIB). In particular, our members leading ICBs are concerned about their ability to absorb the functions of local Healthwatch, in the context of ongoing cuts to their operational budgets. There are also questions over whether ICBs could truly independently oversee services that they themselves commission.
 5. Our members recognise the crucial role that the SPR has to play in delivering more joined up care and promoting patient engagement. However, a lack of clarity in the Bill around data controllership may leave GPs liable for incorrect information and data breaches for which they are not at fault. The NHS Alliance's members feel strongly that data controllership should be outlined in the legislation, and an indemnity scheme developed to safeguard primary care providers.
 6. The Bill places extensive powers in the hands of the Secretary of State, some of which were previously held at arm's length (such as regulation of NHS organisations) for good reason. We would like to see reasonable independence from the Secretary of State in the exercise of these functions, reasonable checks and balances put in place to ensure those powers are only exercised in the public interest, and that the Secretary of State remains accountable to Parliament for their proper use.

Abolishing NHS England and establishing the 'new centre' (Clauses 1, 11 and 29)

7. Clause 1 of the Bill seeks to abolish NHS England and transfer its functions to the Secretary of State (SoS) and DHSC or to the wider system. The NHS Alliance supports the move to abolish NHS England in order to reduce bureaucracy and duplication, streamline decision-making and clarify accountability for the health service.
8. The functions to be transferred to the SoS/DHSC include powers of direction over ICBs (Clause 11), control of board composition and making non-executive appointments for FTs (Clause 29), the power to set revenue limits for FTs and the SoS will regulate providers and ICBs. The government maintains that this will streamline bureaucracy and reinforce democratic ministerial accountability in national decision making, however there is a risk that increased direction by ministers could hamper the ability of local NHS organisations and their partners to respond to the needs of their communities.
9. The delivery of NHS services and regulatory functions have been at arm's length from government since the early 2000s. This was intended to protect their ability to operate in the best interests of patients and the public by providing appropriate separation from political considerations. **We do not believe that the risks that these arm's length**

arrangements sought to mitigate through arm's length institutions are addressed in this Bill.

10. One ICB Chair member said: *"Taken as a whole, I am concerned that the ICB measures risk turning ICBs into local delivery arms of DHSC rather than empowered strategic integrators of local health and care. The Bill says it wants to empower local leaders, but the combined effect of ... wider powers of direction, delegated liabilities, and potential intervention in ICB leadership would centralise decision-making and make local leaders more risk averse. That would be directly at odds with the aim of redesigning services around population need, prevention and integrated neighbourhood care"*
11. We are also concerned that this may unintentionally give a signal to local leaders that they should wait to be directed, or that their decisions could be overridden at any time. This would be at odds with the stated intention to devolve power and risks delaying or inhibiting local leaders from redesigning services around patient outcomes and value for money.
12. **The NHS Alliance is keen to go further by seeking qualifications to the use of powers, such as the requirement for the Secretary of State to provide written statements on their use.**
13. Returning regulatory functions to the SoS – so that the person who commissions services, allocates the budget, makes policy, makes non-executive appointments, and can direct NHS organisations in the exercise of their functions, is also the regulator – risks the SoS marking their own homework. In a system that gives the SoS such extensive powers, an independent regulatory function is essential to maintain trust, and to undertake objective scrutiny of the service. The NHS Alliance will be proposing at minimum a ringfenced regulatory function within DHSC to address these concerns.
14. As recently reported in the Health Service Journal, there is growing concern that Ministers may seek to remove the role of the separate national NHS CEO.¹ **The NHS Alliance takes the view that it would be desirable to maintain a Chief Executive for the NHS, to oversee its day-to-day management and maintain some operational separation from the SoS.**

Empowering NHS providers (Clauses 29 and 33, Schedule 3)

15. The government's 10 Year Health Plan praises the FT model for its ability to harness the benefits of reasonable autonomy to make decisions in the best interests of local populations. It is also the model of NHS provider organisation which all providers will move to by 2035, according to the 10 Year Health Plan. However, the transfer of certain powers to the SoS, such as FT board appointments, compromises that autonomy.
16. The Bill proposes to abolish the requirement for FTs to have councils of governors (CoGs) and remove their statutory functions (Clause 29). This is intended to give providers more freedom to design services around local need. However, a consequence of this change is to transfer several powers to the SoS, including the appointment and

¹ Caitlin Tilley for the Health Service Journal, 'Minister to consider scrapping separate national NHS CEO', June 2026

removal of FT chairs and non-executive directors (NEDs) (Schedule 3), and approval of changes to an FT's constitution (Schedule 3).

17. The constitution of an FT sets out the rules that establish the internal governance of the organisation. Each constitution must in any case comply with the law, but their use was intended to leave FTs flexibility to make other such local arrangements as would best enable them to be effective. Giving power of approval or veto to the SoS risks undermining that local flexibility.
18. The Bill also grants the SoS the authority to set limits on FT's annual revenue expenditure (Clause 33), extending beyond NHS England's current capital-only powers. Revenue limits are qualitatively different from capital controls as they can directly affect staffing, activity, beds, community capacity, diagnostics and the ability of FTs to hit financial targets and invest in service redesign.
19. The power to set revenue limits risks undermining the stated aim of empowering local leaders and enabling them to take decisions in the best interests of local populations, including spending decisions, and for these reasons we would like to see the extension of the power removed.
20. Our members have concerns about some implications for FT governance once CoGs are removed and we question how the extension of ministerial powers over FTs to match those over NHS trusts aids the government's stated aim of empower FTs. The changes to the legal form of FTs will result in negligible differences in the statutory forms between FTs and NHS trusts.
21. **We are seeking realistic checks and balances, with the Bill requiring the SoS to make written statements when exercising powers to veto legally compliant changes to FT constitutions.**
22. **Our members would also like to see the creation of an independent appointments process for FT chairs and NEDs to protect good governance (ie NED independence and the ability to act in the interests of local communities without fear or favour) and reasonable autonomy for trusts.**
23. One mental health FT chair said: *"Councils of governors are a form of local accountability, for better or worse, and I see nothing here about replacing the links they potentially provide, let alone the governance consequences in terms of chair and NED appointments (which will pass to the DHSC, it appears)".*

Empowering commissioners (Schedule 11)

24. The NHS Alliance does not believe the stated intention to empower ICBs as commissioners is well reflected in the government's proposals in the Bill.
25. The development of strategic authorities with devolved powers and integrated funding settlements presents an opportunity to integrate NHS and non-NHS public services in new and promising ways, to strengthen democratic accountability, align with the wider determinants of health, and lead to more coherent place-based prevention strategies.
26. The former SoS recently announced that two strategic authority mayors will be trialling an approach in the South Yorkshire and Greater Manchester mayoral combined authorities which sees ICB chairs 'in effect, become like deputy mayors for health',

accountable to both the SoS and the mayor.² This development builds on the new ability, established in the English Devolution and Community Empowerment Act 2026, for mayors to appoint commissioners in their formal areas of competence, one of which is health, wellbeing and public service reform. The Act also conferred a health duty on strategic authority mayors.

27. ICB leaders have some concerns about the apparent lack of acknowledgement of the potential conflict of interest in having a politically appointed representative who is also expected to be an independent chair. There are also risks in making ICBs accountable to both the SoS and the strategic authority that should be worked through, including the potential for politicisation of decision-making and creating potentially contradictory of lines of accountability for ICBs.
28. **In order to place the relationship between ICBs and local government on a footing that would support integration, the Bill could seek to introduce a statutory duty to collaborate on ICBs and local government bodies.** There should also be an expectation that ICBs, as strategic commissioners, should be involved in local government decisions that impact them and local health provision.
29. The Bill retains broad powers for the SoS to ‘call-in’ (and subsequently take over, modify or block) any proposed change to how an ICB arranges NHS services (Schedule 11), powers that were only introduced in the Health and Care Act 2022. Service change is often politically difficult, but is necessary to improve safety, outcomes and value for money. Now strategic authorities and their mayors have an explicit health duty, we believe it would make sense to revert to the system that was in place until 2022. This was where local authorities (via their health overview and scrutiny committee) could refer a proposal to the SoS if it believed consultation was inadequate or the proposal was not in the interests of the local health service. In combined and strategic authorities this duty might fall to joint health scrutiny committees or their equivalent. This would better serve the principle of subsidiarity and support integrated local decision-making.

Prioritising patient safety (Clauses 64 and 65)

30. The bill seeks to abolish Healthwatch England (Clause 64) and local Healthwatch (Clause 65) by transferring its functions to the SoS and ICBs (for healthcare) and local authorities (for social care) respectively. The government maintains that this will enhance local patient voice and ensure that community input more directly informs the design and delivery of services.
31. Our members have some serious concerns about the practicability of transferring the local Healthwatch functions outlined in Clause 65 into ICBs and local authorities.
32. One member, who is a primary care provider Chair, said: *“I have huge concerns about transferring Local Healthwatch to ICBs. They are immensely useful in not only raising themes for systems to improve but also are a powerful tool for explaining changes to the population. I think their independence gives them credibility and therefore increases effectiveness. Within the ICB they would be much less trusted.”*

² Department for Health and Social Care, ‘Health devolution in Greater Manchester and South Yorkshire’, March 2026.

33. ICBs would be required to gather and consider views from patients, carers, and their representatives when planning services or considering changes for service delivery. The NHS Alliance has raised two urgent issues with DHSC:

- Given Healthwatch currently provides assurance and challenge to health and social care commissioners, clarity is needed on how potential conflicts of interest will be managed to keep patients safe. Embedding this function within the very bodies it is meant to inform and hold to account may otherwise undermine its effectiveness.
- Outside the legislation, ICBs must receive the appropriate resourcing to effectively deliver the patient engagement and oversight functions previously held by local Healthwatch, in the context of the recent 50% cuts to ICB budgets and the commensurate reduction in workforce.

Supporting integration and system working (Schedule 1)

34. Aside from the long-planned delegation of commissioning responsibilities for pharmaceutical, general ophthalmic and dental (POD) services to ICBs outlined in Schedule 1, the Bill does not propose any legislative changes related to primary care. **However, given the changes envisaged in the 10 Year Health Plan, the NHS Alliance believes that there is a need to enable primary care to be a more effective partner and to take on a fuller leadership role at place level (250,000-500,000 population).**

35. Primary care providers are funded and contracted separately from statutory NHS bodies and are therefore not subject to the same statutory duties. This misalignment continues to hinder effective integration, which is essential for shifting to a more prevention-focused model of care. NHS England has signalled its intention to consider ways for non-NHS organisations to hold integrated health organisation (IHO) contracts in its Towards Population Health Delivery Models blueprint.³ It seeks to either partner with NHS organisations or form new NHS organisations. IHO contracts present a potential major shift in how care is organised, moving from activity-based contracting to population-based models. This would give providers responsibility for outcomes and resource use across whole populations.

36. **The NHS Alliance is keen to see a route created for mature at scale primary care organisations such as GP federations to become NHS organisations to enable them to access section 75 funding pots to drive integration and more locally focussed provision.** Currently, non-statutory organisations are excluded from this to protect public accountability, financial propriety, and democratic control.

37. Our members are keen to see the SoS use existing powers so mature primary care organisations such as GP federations and primary care collaboratives can become statutory NHS bodies, with equivalent duties and accountabilities. This would enable them to participate fully in system governance and enter pooled budget arrangements with other NHS bodies and local authorities under section 75 of the NHS Act 2006, and unlock closer collaboration to address local health challenges.

³ NHS England, 'Fit for the future: towards population health delivery models', March 2026

Enabling the Single Patient Record (Clause 47)

38. The SPR, introduced in Clause 47, is a landmark development which our members feel holds the potential to support safer, joined up care by ensuring access to the right information at the right time. To establish the SPR, the legislation requires that patient data is processed and made available to patients and those involved in the delivery of their care.
39. **The NHS Alliance believes that the right model is national standards with federated implementation: the centre should set interoperability, cyber, privacy and transparency standards to ensure consistency and patient safety. But local NHS systems should retain clear responsibility for stewardship, implementation and use in direct care where accountability is clearest.**
40. **We also believe the Bill should state clearly who is the data controller for each function, who carries liability for what, what indemnities apply, which uses are permitted for what, and what transparency obligations are owed to patients.** Without that clarity, the SPR risks creating uncertainty for providers and undermining trust in patients.
41. The transfer of data controllership for the SPR to the SoS raises key governance and accountability questions. Without robust and clear safeguards, it risks creating some distance between the individuals to whom the data relates and organisations and actors who need to use it. With decisions about data use resting with the SoS as data controller, this decision-making authority over personal data risks weakening local accountability, reducing NHS organisational responsiveness and undermining public trust in the SPR overall.
42. One ICB Chair member said: *“The Bill should state clearly who is controller for what, who carries liability for what, what indemnities apply, what uses are permitted, and what transparency duties are owed to patients. Without that clarity, the SPR will generate distrust rather than confidence.”*
43. There is also a significant risk of placing GPs in an untenable position where they would be concerned about personal liability for data that is used, transformed or linked for purposes outside of their direct control. GPs already report concerns about liability when information coded into their records by other providers are coded incorrectly, sometimes leading to missed health checks or clinical errors. The absence of explicit, statutory clarity on data controllership also heightens risk for them.
44. Our GP members have told us that this could inhibit the creation of rapid data-sharing agreements without some form of indemnity cover and clear local roles and responsibilities for the SPR. They have also raised concerns about the risk of unintended workload transfer if the SPR is not implemented and managed with local input from primary care, commissioners and NHS trusts and FTs, alongside clear rules and principles regarding how data is used within shared care arrangements across the NHS and between the NHS and the independent sector.