Health Bill: structural measures to ICBs and foundation trusts - impact assessments

This document contains the following impact assessments:

1. Title: Reform to the integrated care board (ICB) model - IA number: DHSCIA9713
2. Title: Removing the requirement to set up integrated care partnerships - IA number: DHSCIA9714
3. Title: Reform to the foundation trust model - IA number: DHSCIA9715
4. Title: Financial accountability reform - IA number: DHSCIA9716

Final stage impact assessment

Title: Reform to the integrated care board (ICB) model

Type of measure: Primary Legislation

Stage: Final

Source of intervention: Domestic

Department or agency: DHSC

Other departments or agencies: wider engagement with MHCLG

IA number: DHSCIA9713

RPC reference number: N/A

Contact for enquiries: healthlegislation@dhsc.gov.uk

Date: 28/08/2026

Summary: Intervention and Options

Cost of preferred (or more likely) option (base year = 2026)

Total net present social value (in £m): N/A

Business net present value (in £m): N/A

Net cost to business per year (in £m): N/A

What is the problem under consideration? Why is government action or intervention necessary?

- The 10 Year Health Plan sets out the government's ambition to create a new NHS operating model where ICBs will strengthen their partnership working, particularly with strategic authorities (being introduced as part of the English Devolution and Community Empowerment Act 2026 (the Devolution Act)). The 10 Year Health Plan also sets out a new NHS operating model where ICBs will be the strategic commissioners of local healthcare services.
- The current legislative requirements for ICB membership can be burdensome for ICBs and create challenges with conflicts of interest. The current set-up also doesn't create close working relationships with strategic authorities.
- The strategic planning landscape is also complex and can involve duplication across plans.

What are the policy objectives of the action or intervention and the intended effects?

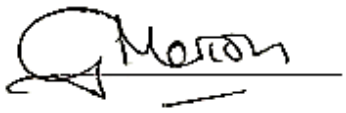
- Changes to ICB membership aim to enable greater strategic alignment across the health, wellbeing and economic priorities of local areas.
- These measures aim to support ICBs to perform their new strategic commissioner role by clarifying roles in the system, lessening the administrative burden and providing more flexibility for strategic, long-term planning.
- These changes and reforms to strategic planning will also support wider government ambitions such as the 10 Year Health Plan, wider ICB changes and the Devolution Act

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

- **Option 1 (business as usual)**: this option retains the existing membership structures of including local authorities and provider organisations. It also maintains the current planning structures of ICBs.
- **Option 2 (preferred option)**: this option removes the requirement for providers to be nominated as members of ICBs and allows strategic authority mayors to nominate themselves or a representative to the ICB board. The preferred option has been updated so that the requirement for local authorities to be nominated as members of ICBs is retained. This option also reforms the strategic planning landscape.

Will the policy be reviewed? It will be reviewed. If applicable, set review date: TBC				
Is this measure likely to impact on international trade and investment?		No		
Are any of these organisations in scope?	Micro No	Small No	Medium No	Large No
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)		Traded: N/A	Non-traded: N/A	

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Minister:  Date: 8-9-2026

Summary: Analysis & Evidence — Policy Option 1

Description: Reform to ICB model

Full economic assessment

Price Base Year N/A	**PV Base Year** N/A	**Time Period Years** N/A	Net Benefit (Present Value (PV)) (£m)		
			Low: N/A	**High:** N/A	**Best Estimate:** N/A

COSTS (£m)	Total Transition (Constant Price) Years		Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low				
High				
Best Estimate	N/A		N/A	N/A

Description and scale of key monetised costs by 'main affected groups'

N/A

Other key non-monetised costs by 'main affected groups'

- Familiarisation costs for strategic authorities to understand the requirements of ICB membership and set up admin processes
- Familiarisation costs for ICBs and partner organisations will need to understand the new planning requirements
- Opportunity cost for strategic authorities being members of ICBs

BENEFITS (£m)	Total Transition (Constant Price) Years		Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low				
High				
Best Estimate	N/A		N/A	N/A

Description and scale of key monetised benefits by 'main affected groups'

N/A

Other key non-monetised benefits by 'main affected groups'

- Integrated working between ICBs and strategic authorities
- Administrative cost savings for previous ICB members
- Streamlined decision making for ICBs by having fewer members
- Alignment with wider government priorities
- Reduced admin costs associated with developing strategic plans
- Opportunity to tailor planning to local populations

Distributional impacts

N/A

Key assumptions/sensitivities/risks	Discount rate	N/A

- Risk of managing the consequences of more complex geographies, such as where ICB and strategic authority boundaries do not align. Mitigated by the long-term ambition for strategic authorities to cover the whole of England and to be co-terminus with ICBs, where feasible, as well as guidance and support to ICBs affected in the interim.
- Risk of less effective working created by adding a requirement for strategic authorities to be nominated as ICB members, as well as existing local authority requirements.
- Risk of current strategic planning content being lost in the reformed planning landscape, mitigated by factoring in current requirement to the content of future plans.

Business assessment (Option 1)

Direct impact on business (Equivalent Annual) £m:		
Costs: N/A	Benefits: N/A	Net: N/A

Evidence Base

Problem under consideration and rationale for intervention

Integrated care boards (ICBs) are statutory NHS bodies established under the Health and Care Act 2022. They are responsible for planning NHS services, managing NHS budgets and resources, and delivering NHS functions across a defined geographic area[1].

The 10 Year Health Plan for England sets out the government's ambition to create a new NHS operating model where ICBs will be the strategic commissioners of local healthcare services. To do so, ICBs must ensure that local care systems are using funds efficiently to improve population health, reduce health inequalities and improve access to high-quality services. ICBs will need to evolve new capabilities to be successful in their role, for example they will need a strong strategy function and capability in partnership working[2].

ICB membership

How ICB membership currently operates

Membership of ICBs is currently determined by a combination of primary, secondary legislation and guidance. Legislation determines an ICB's constitution[3] must provide for the ICB to consist of a chair, a chief executive and at least 3 other members. Of the other ICBs members, at least one member must be:

- nominated by the NHS trusts and NHS foundation trusts (providers) that provide services in the area
- jointly nominated by any primary medical care provider in the ICB area
- jointly nominated by local authorities whose areas coincide with the ICB area

All these nominees are put forward for membership of the board, but it is ultimately the chair who makes the final decision and formally appoints members to the ICB.

The approach to ICB membership varies significantly across ICBs so it is difficult to draw general conclusions about the effectiveness of current membership arrangements. While research indicates some aspects are positive, for example facilitating broad and diverse memberships of ICBs has been presented as an advantage[4], other insights from the research has found that, while prescribed ICB membership creates the conditions and structures for closer collaboration, this was often lacking in practice within systems[5].

Local authorities as ICB members

The geographical footprint of larger ICBs will cover more local authorities, meaning their boards could have more local authority representatives as members. These local authorities will often have divergent populations, priorities and views. Therefore, the ability of a single local authority representative to cover the totality and diversity of local authority perspectives becomes more

[1] Legislation.gov.uk (2022), Health and Care Act 2022 - PART 1 - Establishment of Integrated Care Boards (Section 19) (viewed October 2025)
[2] NHS England (2025), NHS England » Working together in 2025/26 to lay the foundations for reform (viewed November 2025)
[3] NHS England (2024), NHS England » Guidance on integrated care board constitutions and governance (viewed November 2025)
[4] Sanderson, M., Hammond, J. and others. (2022), Post Implementation Review of the Health and Care Act 2022 Phase 1: Interim Report (Working Paper), page 47 (viewed October 2025)
[5] Sanderson, M., Hammond, J. and others. (2022), Post Implementation Review of the Health and Care Act 2022 Phase 1: Interim Report (Working Paper), page 154 (viewed October 2025)

challenging in this context. For example, the ICB merger that created West and North London ICB means this new ICB covers 13 London Boroughs (equivalent to local authorities).

A qualitative study of the development of integrated care systems noted examples of 'double-layer set-ups' being created between ICB-level and local authority level, leading to a 'systems within systems within systems' approach that led to unclear accountabilities.

Providers as ICB members

Maintaining providers as ICB members creates potential conflicts of interest**Error! Bookmark not defined.**. These conflicts should be managed by ICBs where they arise, in favour of patients and value for money. However, in smaller ICBs, a single provider can potentially have more influence over decision making, making their involvement in ICBs more challenging.

Further, the 10 Year Health Plan and wider ICB policy aims for ICBs to become strategic commissioners. This means ensuring that the money available to each local care system is put to the best possible use. Therefore, there is less of a need for provider representation on the board following these changes, as the role of the ICB is more focussed than previously. Large boards, such as those with multiple provider members, may also make timely decision-making more difficult, which could impact on the ability of ICBs to work effectively in their role as strategic commissioners.

Introduction of strategic authorities

Separately to this bill, the Devolution Act introduced the category of 'strategic authorities'. These are organisations designated by Government which have responsibility for strategy development and programme delivery over larger functional economic areas. This role will be fulfilled by:

- (mayoral) combined authorities, such as Greater Manchester Combined Authority
- (mayoral) combined county authorities, such as East Midlands Combined County Authority
- the Greater London Authority, and
- in some cases, single local authorities

Strategic authorities will play a vital role in shaping population health through employment, housing, skills, and economic policy[6]. They will have a mandate over regional economic strategies and over some of the determinants of population health, such as environmental and housing planning.

Strategic authorities will, in most cases, be much larger than local authorities. However, strategic authority mayors (or their delegated representatives) are not currently nominated to be members of ICBs, which risks creating misalignment on strategic planning between the NHS and local government. The 10 Year Health Plan therefore committed to making strategic authority mayors (or their delegated representative) board members of their ICBs. This was to align the opportunities for strategic planning between the NHS and strategic authorities.

Strategic planning

The 10 Year Health Plan announced intentions for a simpler and more joined up NHS system, as well as greater flexibility through having fewer planning requirements in primary legislation. The 10 Year Health Plan also proposed simplifying the planning structures within the NHS,

[6] The Health Foundation (2025), Not just a duty: unlocking the full potential of strategic authorities to tackle the wider determinants of health (viewed October 2025)

reducing them in number and making them more locally relevant and understandable (to those developing them and those implementing them).

Current strategic planning landscape

This is because the current health strategic planning landscape is complex and has multiple requirements on different organisations. Table 1 below sets out a summary of these plans. Some of these planning documents are statutory requirements (legally required) whereas others are guidance (not legally required). The details of these plans, and who is responsible for each, is set out in more detail in the Annex.

Table 1: Summary of planning requirements by organisation

Body responsible	Plan(s)
Health and wellbeing boards (HWBs) – all plans are *statutory requirements*	Joint Strategic Needs Assessment Pharmaceutical Needs Assessment Joint Local Health and Wellbeing Strategy
ICBs	Joint Forward Plan – *statutory requirement* Joint Capital Plan - *statutory requirement* Better Care Fund plan – *guidance*
Integrated care partnerships (ICPs)	Integrated Care Strategy

As set out in the table above, ICBs are required by law to produce the Joint Forward Plan which covers how local NHS organisations and partners plan to improve health outcomes, reduce inequalities, and deliver national NHS priorities over a 5-year period. They are also legally required to produce the Joint Capital Plan, which sets out their planning for capital resource use. In addition, there are several strategic planning documents which ICBs and partner organisations must produce, or have regard for, which cover similar areas.

Given the range of plans that ICBs are required to produce, there is some duplication across planning documents. For example, the Joint Forward Plan covered the integration of services, which the Better Care Fund plan also considers, as does the Joint Local Health and Wellbeing Strategy. This duplication of planning documents generates an administrative burden on ICBs as additional staff time and resources are required to complete parallel planning returns and fulfil competing data requests. There is therefore a case to reduce these burdens by rationalising the range of statutory planning requirements.

Description of options considered

Option 1: business as usual

This option retains the existing membership structures (which includes local authorities and provider organisations, but not strategic authorities). It also maintains the current planning structures of ICBs.

This was not considered the preferred option as these approaches to membership and planning do not help enable the ambitions of the 10 Year Health Plan.

Option 2 (preferred option): including LA members and strategic authority mayors or their representatives in ICBs and reforming strategic planning

The preferred option is amending primary legislation so the statutory requirements for ICB membership will no longer include nominations from provider organisations (both primary

medical providers, and NHS trusts and NHS foundation trusts). Further, strategic authority mayors will be able to nominate members.

The preferred option has been updated so the statutory requirements for ICB membership will continue to include nominations from local authorities, as is currently the case. This will support ICBs to maintain collaborative working with local authorities, alongside their close working via health and wellbeing boards (HWBs).

The preferred option will also reform the planning responsibilities of ICBs, HWBs, and local authorities to streamline the planning system.

Policy objective

Mayors of strategic authorities (or a deputy nominated by them) will have the right to be nominated as ICB members as part of this bill. At the same time, the requirement for provider organisations (including primary care providers) to be nominated as members will be removed.

These changes enable greater strategic alignment across the health, wellbeing and economic priorities of local areas. Facilitating more integrated working between mayors and ICBs may also support local people to benefit from healthier lives, greater independence, and more opportunities for economic participation. For example, strategic authorities will have a strategic responsibility to deliver local energy and environmental plans, so integration between these and health strategies would be beneficial to allow each to support the other. Ensuring these organisations sit on ICBs helps enable this type of integrated working.

Membership changes also help to reduce the administrative burden on ICBs in managing potential conflicts of interests with provider members in taking commissioning decisions.

Reducing ICB membership requirements and streamlining the strategic planning landscape support wider government ambitions such as:

- **The 10 Year Health Plan**: ambitions for a new NHS operating model where larger ICBs will be the strategic commissioners of local healthcare services.
- **Wider ICB changes**: reducing ICB headcounts and delivering operating cost savings.
- **English Devolution and Community Empowerment Act 2026:** combined authorities and combined county authorities have been given a health improvement and health inequalities duty.

Summary and preferred option with description of implementation plan

The 10 Year Health Plan sets out the government’s ambition to create a new NHS operating model where ICBs will be the strategic commissioners of local healthcare services. There is also an ambition to align strategic planning between the NHS and local government. This bill proposes 2 ICB reforms covered in this impact assessment.

The statutory requirements for ICB membership will no longer include nominations from provider organisations (both primary medical providers, and NHS trusts and NHS foundation trusts). Further, strategic authority mayors will be able to nominate members. Local authorities will also continue to be able to nominate members, as is currently the case.

ICB membership

Following these changes, ICBs will include at least one member nominated by the mayor of each mayoral strategic authority whose area coincides with, or includes the whole or any part

of, the integrated care board's area (if any). The nominated members are not automatically appointed as the nomination remains subject to tests. These include the fit and proper person test, conflicts of interest and rules around involvement in the private sector prohibiting appointment, which is overseen by the chair before they are appointed.

The long-term ambition is for strategic authorities to cover the whole of England and to be co-terminus with ICBs, where feasible. However, this will take time to implement, and the government has committed to universal strategic authority coverage by the end of 2028. Current strategic authority boundaries do not cover all of England and they are not all aligned with ICB boundaries. This means that there could be some cases where some ICBs:

- **do not include a strategic authority**, for example Herefordshire and Worcestershire, while others are only partially covered by a strategic authority. Therefore, some ICBs will not (at least initially) include mayoral representation.
- **have several strategic authorities within its boundary**, such as the ICB "North East and North Cumbria", which includes 3 strategic authorities (Tees Valley, North East, and part of the new Cumbria region). In these cases, an ICB could have representation from several mayors.
- **cover only part of a strategic authority areas**, so mayors may need to make nominations to multiple ICBs.

In the interim period where these cases occur, further guidance will be provided to ICBs to support them in finding the most appropriate arrangement for their local area. This aims to be flexible to acknowledge the unique geographies and situations that ICBs will be operating within.

Strategic Planning

At present, ICBs work with their partner local authorities through a body called the Integrated Care Partnership (ICP). The ICP is a statutory joint committee made up of the ICB, upper-tier local authorities (and other members as appointed by the same ICP) in the same geographical area. In the current system, the ICP is required to develop an Integrated Care Strategy, and ICBs must also develop a Joint Forward Plan and a Joint Capital Plan.

In parallel, planning also takes place at individual local authority level through HWBs. These are statutory committees of local authorities and are responsible for producing two key documents: the Joint Strategic Needs Assessment, which assesses the health and care needs of the local population, and the Joint Local Health and Wellbeing Strategy, which sets out how those needs will be addressed. Separately, HWBs also produce statutory Pharmaceutical Needs Assessments.

The NHS 10 Year Plan committed to simplifying this planning system and this bill realises this ambition. Wider bill changes remove the legal requirement to establish and maintain ICPs, and the associated Integrated Care Strategy. This impact assessment covers the removal of the Joint Forward Plan, and the Joint Capital Plan. Whereas previously the Integrated Care Strategy triggered the development of a Joint Local Health and Wellbeing Strategy, all planning will now start with the publication of the Joint Strategic Needs Assessment, which will continue to be developed by the HWB. The development of a Joint Strategic Needs Assessment will encourage the local authority and ICBs to assess the needs set out in that plan and decide how to meet it using the Neighbourhood Health Plan (unless they consider their current plan to be sufficient).

The Neighbourhood Health Plan should consider how the NHS, local government and partners can improve the health and wellbeing of the people in its area.

In parallel, as set out in guidance, the ICB will produce a PHIP covering how it will commission services for the needs of its population. As ICBs are significantly larger than local authorities, this will require the ICB to consider multiple Joint Strategic Needs Assessments and Neighbourhood Health Plans. It will also mean working with multiple HWBs to ensure alignment between a Population Health Improvement Plan and the Neighbourhood Health Plans in its footprint. This Population Health Improvement Plan will aim to translate national and local strategic priorities and will be underpinned by guidance, allowing flexibility to the planning system to evolve as needed.

The Annex provides a more detailed overview of the new planning structures being proposed as part of the 10 Year Health Plan ambitions.

Wider changes to ICBs

Separately to the changes being made as part of this bill, there are wider non-legislative ICB changes. ICBs are delivering operating cost savings (reducing running costs by an average of 50%) to become leaner and cutting the duplication of functions with other parts of the system. Therefore, keeping the current statutory planning requirements and membership structures uses more ICB resources than necessary.

Further changes to ICB boundaries are expected so that the number of ICBs will reduce over time. This will create bigger ICBs with a changed focus to delivering priorities, such as improving population health, and will help drive efficiencies and give ICBs the skills they need to deliver strategic commissioning effectively.

These changes are related to wider changes happening as part of this bill. For example, this bill will also remove the requirement for ICPs. ICPs are a committee where ICBs work with local authorities and wider partners to unite around a single, shared strategy and hold each other mutually accountable for delivery.

Monetised and non-monetised costs and benefits of each option

The costs or benefits haven't been quantified in absolute terms as this section focusses on the differences between the business-as-usual option and the preferred option.

This impact assessment provides a proportionate assessment of costs and benefits based on the best available evidence and in line with HMT Green Book guidance. However, these proposals depend on future policy decisions regarding the application of the powers and therefore, as those policy decisions have not yet been made, it is not possible to quantify costs and benefits at this stage.

Costs – ICB membership

Familiarisation costs

There would be one-off familiarisation costs for strategic authorities to understand the requirements of being an ICB member and to set up the administrative process for attending board meetings.

Opportunity cost to strategic authorities

There would be ongoing opportunity costs for strategic authorities by being represented on ICBs. This is because membership would require resources to attend meetings and be involved in decision making with ICBs. In some cases, single local authorities may be the strategic authority for that area. In those cases, there may not be additional costs on the local authority because they may have already been a member of the ICB and they would continue to be one.

Costs – Strategic planning

Familiarisation costs

Changing the strategic planning landscape for ICBs and partner organisations will involve some one-off familiarisation costs to understand the new planning requirements. This will largely involve staff time required in each ICB to review the new requirements and set up appropriate structures to deliver these new plans.

The 10 Year Health Plan impact statement notes that the new Population Health Improvement Plan may require extra resources. However, removing the requirement for ICBs to produce the Joint Forward Plan and Joint Capital Plan should offset the new plan. As a result, only one-off familiarisation costs are anticipated.

Benefits – ICB membership

Integrated working with strategic authorities

Requiring strategic authority mayors (or delegated representatives) to be nominated to be members of ICB boards is designed to enhance the ability of ICBs as strategic commissioners to align with wider agendas relevant to health. It also ensures the NHS and the wider public sector (and others) are able to work together to generate public value they cannot generate alone. This would be done, for example, through addressing the wider determinants of health including housing, transportation and economic development. The ambition of the 10 Year Health Plan is for ICBs to closely collaborate with local government partners, in particular with mayors and strategic authorities. This allows citizens to benefit from a "seamless work, health and skills offer in their area".

Furthermore, ICBs collaborating with strategic authority mayors may improve prevention in healthcare; an ambition of the 10 Year Health Plan. Where devolution and a focus on population health outcomes are most advanced, the government will work with strategic authorities as "prevention demonstrators".

Savings for previous ICB members

Providers (NHS trusts and foundation trusts) and primary care medical providers will no longer be required to nominate members to the ICB. ICB members require resources for the administrative work required to participate in the ICB, which represents an opportunity cost for these organisations. Removing the requirement for these organisations to be members of the ICB may result in administrative savings where they are no longer board members. However, these savings will likely be absorbed by other statutory responsibilities of the organisations, as well as continued close working with ICBs. Therefore, the scale of this benefit is uncertain.

The administrative savings for these organisations will vary across integrated care systems (ICSs). Research by NIHR Policy Research Unit in Health and Social Care Systems and Commissioning (PRU HSSC) gives an indication of the scale of activities taken on by ICB members[7]. The different ICSs explored in the case studies had several committees and sub-committees within the ICB. These included Place Boards, the ICS Executive Committee, and a Quality and Performance Assurance Committee.

[7] Allen, P. and others (2024), The Architecture of System Management (2022-2023), page 57 (viewed October 2025)

One case study ICB from this research had 16 designated voting members, of which ten of those were representatives for NHS providers and primary care providers in that area. However, the scale of members involved will vary as it is largely driven by the geographical footprint of the ICB. This contrasts with a single or a few strategic authority representative board members, depending on boundary alignment.

Streamlined decision-making

Removing some of the previous requirements for ICB membership could lower the number of board members on each ICB, where that is determined to be the best arrangement for an individual ICB. Having fewer members may make it easier to align priorities. If this reduces the time taken to reach decisions, there could be increased opportunity for ICBs to focus on delivering priorities, such as achieving 10 Year Health Plan ambitions.

Removing the requirement for provider organisations to be ICB members removes the risk of conflicts of interest that can occur through providers of services being involved in commissioning decisions about services. The post implementation review of the Health and Care Act 2022 found concerns were raised by some ICB directors regarding the conflicts of interest which arise during procurement and contracting activities, given ICBs currently have substantial provider representation[8].

Alignment with wider government priorities

Reducing the risk of conflicts of interest supports wider changes happening as part of this bill to confer commissioning functions on ICBs, as they will be responsible for more commissioning following the abolition of NHS England. Please see the Impact Assessments Summary Document for further information on the *Abolition of NHS England* impact assessment.

Also, including strategic authority mayors (or their delegated representative) on ICBs will support mayoral strategic authorities in delivering their specific duties in relation to health inequalities[9].

Benefits – Strategic planning

Reduced administrative costs

ICBs and other organisations allocate resource to developing strategic plans, which presents an opportunity cost. Currently, there is some overlap in the plans ICBs are required to produce, such as between the Joint Forward Plan and the Better Care Fund plans. By streamlining the number of plans ICBs are responsible for, this will reduce the resource required for ICBs to develop these plans and, subsequently, reduce the opportunity costs of planning.

While there is no evidence on the scale of work required to develop these plans, it will involve senior officials across each ICB, as well as the members currently sitting on those boards, to agree the ambitions set out within them.

Opportunity to tailor planning to local population

ICBs operate in diverse contexts, with differing demographics, levels of deprivation, and service challenges. This new planning approach, with its focus on neighbourhood health and reduced primary legislative requirements, helps support ICBs to focus on local priorities.

[8] Sanderson, M., Hammond, J. and others. (2025), Post Implementation Review of the Health and Care Act 2022 Phase 1: Interim Report (Working Paper), page 148 (viewed October 2025)

[9] MHCLG (2024), English Devolution White Paper, section 3.8, page 60 (viewed September 2025)

Furthermore, simplifying the planning landscape to have a clearer purpose will support the planning process to be more transparent. This means partner organisations and wider stakeholders (like local communities, HWBs and regulators) can better understand how decisions are being made, and funding is being spent. This may then enable strengthened local accountability and trust.

Alignment with wider ICB changes

Streamlining strategic planning requirements supports ICBs to free up resources to deliver wider changes (like reducing running costs and refocussing on strategic commissioning). Fewer statutory planning requirements, for example, could enable ICBs to become leaner and run with lower costs, which can then be redirected to frontline services.

Direct costs and benefits to business calculations and impact on small and micro businesses

There are no direct costs and benefits to businesses as a result of this measure.

Risks and mitigations

ICB Membership

Managing the consequences of more complex geographies

In cases where ICB and strategic authority boundaries are not coterminous; there will be support and guidance provided to manage these situations. This includes both the risks of balanced decision-making on the part of the ICB and the proportionate use of mayoral and strategic authority time.

There is also a risk that health decisions could become subject to the divergent political views of mayoral authorities. This would be mitigated through a combination of guidance, dialogue and support and development for ICB chairs in guiding the ICB towards effective decisions.

Risk of less effective working

As this bill proposes to include strategic authorities on ICBs, as well as maintaining the existing requirements for local authorities to be nominated as members, that boards become larger and more complex. Large boards could make timely decision-making more difficult, which may affect ICB's ability to work effectively in their role as strategic commissioners. This risk could be mitigated by guidance to ICBs on the role of local authorities and strategic authorities.

Strategic planning

Risk of reducing the content of plans

Removing the Joint Forward Plan and Joint Capital Plan from primary legislation risks some of their content not being captured by other plans. The detail of the Population Health Improvement Plan (the non-statutory plan replacing the Joint Forward Plan) is in development and will take account of the current requirements that need to be covered in these plans to mitigate this risk.

Monitoring and Evaluation

Monitoring and evaluation for this proposal will be considered as part of the wider approach covering all the Health Bill proposals, please see the Impact Assessments Summary Document for more details.

Annex

Figure 1: Overview of an ICS and involvement with wider committees

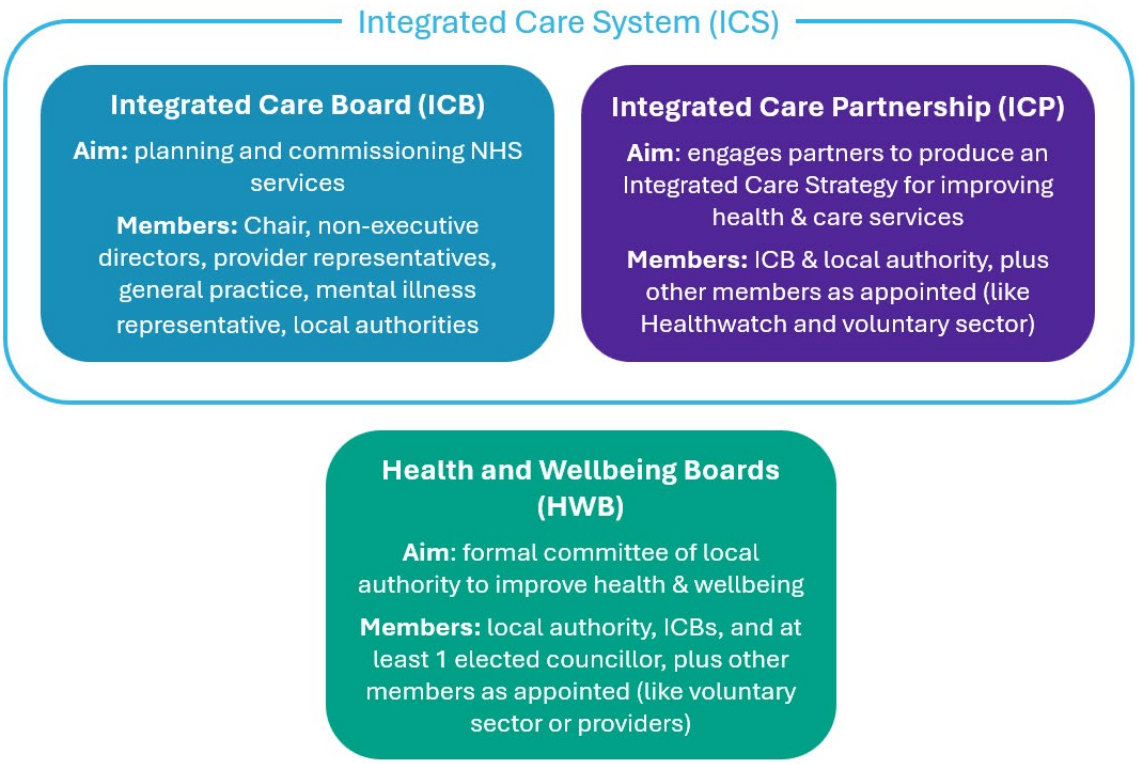


Table 2: Overview of the changes to the planning landscape

Plan	Organisational lead and purpose	Changes required
Joint Strategic Needs Assessment (JSNA)	**HWB: Statutory requirement.** A JSNA looks at the current and future health and care needs of local populations to inform and guide the planning and commissioning of health, well-being and social care services within a local authority area.	Keep with no changes Will be used to inform the Neighbourhood Health Plan.
Pharmaceutical Needs Assessment	**HWB: Statutory requirement**. This is a published assessment of the need for pharmaceutical services in a HWB area.	Keep with no changes

Plan	Organisational lead and purpose	Changes required
Joint Local Health and Wellbeing Strategy (JLHWS)	**HWB: Statutory requirement.** JLHWSs are strategies that detail how the needs identified in the JSNA will be met in the HWB area. JLHWS must currently have regard to the Integrated Care Strategy and the Mandate to NHS England (both of which are being abolished as part of this Bill).	Abolish (see NbHP)
Neighbourhood Health Plan (NbHP)	**HWB: Statutory requirement.** New approach to planning introduced by 10 Year Health Plan will be considered in the development of this framework.	New plan incorporating the content of the abolished JLHWS
Individual provider business plans	**Providers: Guidance**. Details the provider strategy and operational delivery for the upcoming financial year and beyond (required for provider management).	Keep with no changes
Integrated Care Strategy	**Integrated Care Partnerships (ICPs): Statutory requirement**. Long-term plan developed by ICPs, local government, and voluntary organizations, to improve health outcomes and reduce health inequalities for a specific population The requirement for ICPs is being removed as part of this bill, so the Integrated Care Strategy will also be removed.	Abolish
Joint Forward Plan (JFP)	**ICB *with* partner NHS providers: Statutory requirement.** This is a duty to prepare a plan setting out how they propose to exercise their functions in the next 5 years.	Abolish Guidance will be used for ICB planning instead (see PHIP).

Plan	Organisational lead and purpose	Changes required
Joint Capital Plan (JCP)	**ICB *with* partner NHS providers: Statutory requirement.** Linked to the JFP, the JCP describes how capital spend is contributing to delivering ICB priorities for patients.	Abolish Guidance will be used for ICB planning instead (see PHIP).
Better Care Fund (BCF)	**ICBs and local authorities jointly produce: Guidance** Requirement to produce a plan on ICB and local authority use of the BCF.	Review This will largely continue but will need to reflect 10 Year Health Plan approach. Additional guidance on how BCF funds will be used in neighbourhood health plans.
Population Health Improvement plan (PHIP)	**ICBs: Guidance** A new approach to planning introduced by the 10 YHP to set out ICB's commissioning intentions. The approach to developing a PHIP is ongoing but will take account of existing duties. This will merge the planning functions of the JFP and JCP.	New guidance Will replace JFP and JCP

Final stage impact assessment

Title: Removing the requirement to set up integrated care partnerships

Type of measure: Primary Legislation

Stage: Final

Source of intervention: Domestic

Department or agency: DHSC

Other departments or agencies: wider engagement with MHCLG

IA number: DHSCIA9714

RPC reference number: N/A

Contact for enquiries: healthlegislation@dhsc.gov.uk

Date: 28/08/2026

Summary: Intervention and Options

Cost of preferred (or more likely) option (base year = 2026)

Total net present social value (in £m): N/A

Business net present value (in £m): N/A

Net cost to business per year (in £m): N/A

What is the problem under consideration? Why is government action or intervention necessary?

- Integrated care partnerships (ICPs) are joint committees between integrated care boards (ICBs) and local partner authorities, and they have a statutory duty to produce an Integrated Care Strategy.
- ICPs can be seen as duplicative of health and wellbeing boards (HWBs) in some areas and there is a lack of clarity regarding their role beyond strategic planning.
- Ambitions of the 10 Year Health Plan are to simplify the strategic planning landscape.

What are the policy objectives of the action or intervention and the intended effects?

- The intended outcome of the intervention is to reduce the complexity and create a more streamlined system.
- Removing the requirement for ICPs establishes a clearer role for HWBs in neighbourhood health and planning.
- These changes also support other measures in this bill, such as strategic planning changes for ICBs and local government.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

- **Option 1(business as usual)** – under this option, the statutory requirement to form ICPs and develop an Integrated Care Strategy would be retained.
- **Option 2 (preferred option)** – remove the requirement for ICPs and their respective strategies.

Will the policy be reviewed? It will be reviewed. If applicable, set review date: TBC				
Is this measure likely to impact on international trade and investment?		No		
Are any of these organisations in scope?	Micro No	Small No	Medium No	Large No
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)		Traded:	Non-traded:	

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Minister: Date: 8-9-2026

Summary: Analysis & Evidence

Policy Option 2

Description: Removal of the requirement for integrated care partnerships (ICPs)

Full economic assessment

Price Base Year N/A	**PV Base Year** N/A	**Time Period Years** N/A	Net Benefit (Present Value (PV)) (£m)		
			Low: N/A	**High:** N/A	**Best Estimate:** N/A

COSTS (£m)	Total Transition (Constant Price) Years		Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low				
High				
Best Estimate	N/A		N/A	N/A

Description and scale of key monetised costs by 'main affected groups'

N/A

Other key non-monetised costs by 'main affected groups'

- Removing a formal mechanism for collaborating between ICBs and local partners
- Transitional costs, such as communicating changes
- Inconsistent approaches to collaboration

BENEFITS (£m)	Total Transition (Constant Price) Years		Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional		Optional	Optional
High	Optional		Optional	Optional
Best Estimate				

Description and scale of key monetised benefits by 'main affected groups'

N/A

Other key non-monetised benefits by 'main affected groups'

- Time and resource savings to ICP members, such as not running the secretariat function
- Autonomy in ICB's approach to collaborating with wider system partners
- Streamlined planning landscape

Distributional impacts N/A	
Key assumptions/sensitivities/risks	Discount rate N/A
• Risk of reduced focus on the wider determinants of health at system level, mitigated by wider ICB membership and planning changes, as well as the role of HWBs. • Risk of less direction from the removal of the Integrated Care Strategy, mitigated by the new strategic planning landscape. • Risk of reduced opportunity for private provider inputs to ICBs, expected to be mitigated by continued close working between ICBs and all types of providers (given their role as strategic commissioners).	

Business assessment (Option 2)

Direct impact on business (Equivalent Annual) £m:		
Costs: N/A	Benefits: N/A	Net: N/A

Evidence Base

Problem under consideration and rationale for intervention

The role of ICPs

The Local Government and Public Involvement in Health Act 2007 (as amended by the Health and Care Act 2022) requires integrated care boards (ICBs) to form joint committees with their partner local authorities. These joint committees are called integrated care partnerships (ICPs) and must include one representative from the ICB and each of its partner local authorities. The ICP can appoint other members as appropriate. The statutory function of the ICP is to produce an Integrated Care Strategy, setting out how the local population's assessed needs are to be met by the ICB, its partner local authorities and NHS England.

ICPs are intended to function as system convenors, acting as the vehicle for system partners to coalesce around a single, shared strategy and hold each other mutually accountable for delivery. However, ICPs operate in a complex landscape of other committees and strategies (see Figure 1 in Annex).

10 Year Health Plan for England ambitions

The 10 Year Health Plan for England recognised that the complexity at the system-level has resulted in "…confusion, siloed working and inaction". The 10 Year Health Plan aims to overcome this challenge by streamlining the system and reforming the current strategic planning landscape.

To support these 10 Year Health Plan ambitions, wider changes proposed as part of this bill will also reform the strategic planning landscape. This will mean ICBs will be responsible for developing new (non-statutory) Population Health Improvement Plans. These Plans will build on place-level planning and consider the Neighbourhood Health Plans (addressing the health and care needs of the local population) developed by Health and Wellbeing Boards (HWBs). HWBs are statutory committees of local authorities that include local government, ICBs and partners. Retaining ICPs and their integrated care strategies is a barrier to adopting this more streamlined way of working. These wider strategic planning changes are covered in a separate impact assessment (see ICB reforms in the Impact Assessments Summary Document).

Challenges of the ICP approach

The Phase 1 (Interim Report) of the Post Implementation Review of the Health and Care Act 2022[1] found ICPs to be an important structure that supported bringing together a wider range of partners. However, challenges were also noted, such as a recurring theme in interviews with system leaders that ICPs, despite their role as system convenors and setting the strategic direction for systems through the Integrated Care Strategy, have struggled to unleash their potential.

Furthermore, financial pressures within the system make it harder for ICPs to drive change on long-term goals (for example, tackling the wider determinants of health) and the perception that ICPs lack authority [over ICBs] were reasons why it was felt ICPs could not unleash their potential. There was also confusion over their role and some respondents felt they acted merely as discussion forums with limited opportunity to effect change.

The research also highlights other issues, such as confusion over how ICPs relate to HWBs with one interviewee regarding them as 'duplicative' and there was a lack of clarity on the role of an ICP beyond publishing an Integrated Care Strategy. In some areas, the ICP and the HWBs

[1] Sanderson, M., Hammond, J. and others (2025), Post Implementation Review of the Health and Care Act 2022 Phase 1: Interim Report (Working Paper), page 47 (viewed August 2025)

cover the same geographical area. For example, Somerset ICB works with Somerset County Council on the same geographical footprint, so the ICP has been brought together with the Somerset HWB to meet with a common agenda[2]. This has the potential to cause confusion between what the Joint Health and Wellbeing Strategy (produced by the HWB) and the Integrated Care Strategy (produced by the ICP) should each cover.

Description of options considered

Option 1: business as usual

This option retains the statutory requirement to form ICPs and develop integrated care strategies. This was not the preferred option due to the challenges with the current system and it also does not support wider 10 Year Health Plan ambitions.

Option 2 (preferred option): amend primary legislation to remove the requirement to set up ICPs and the Integrated Care Strategy

Under this option, the requirement to set up ICPs would be removed, along with their respective integrated care strategies, to enable delivery of the ambitions of the 10 Year Health Plan.

Policy objective

The 10 Year Health Plan sets out ambitions to streamline the current system and reduce complexity. Within the planning landscape, the 10 Year Health Plan aims to best align opportunities for strategic planning between ICBs (the NHS) and strategic authorities (local government) and streamline the wider requirements for strategic planning.

Overall, these 10 Year Health Plan ambitions aim to reduce complexity and the administrative burden within the system, to enable more funds to be directed to patient care.

Removing the requirement for ICPs, which subsequently establishes a clearer role for HWBs in neighbourhood health, seeks to create the clarity required in the system. It also removes the requirement for integrated care strategies, which supports wider strategic planning changes happening as part of this bill.

Removing the legislative requirement to have an ICP doesn't prevent areas from adopting this approach on a non-statutory basis. Therefore, these changes also give ICBs the flexibility to determine the most effective collaborative working approach for their area.

Without intervention, there is a risk that confusion regarding the role of ICPs continues, along with the more complex strategic planning landscape. This limits the opportunity for effective system functioning to support the government's 10 Year Health Plan ambitions.

Summary and preferred option with description of implementation plan

Removing the requirement for ICPs

This bill proposes there would no longer be a statutory requirement on ICBs and partner local authorities to form an ICP. Following the removal of this requirement, ICB and local authority

[2] Somerset Council (2025), Our Somerset - integrated care system - NHS Somerset ICB (viewed September 2025)

partnership meetings could be maintained on a non-statutory basis where it is agreed on a voluntary basis by existing members.

A recent NHS Confederation report indicated some local areas were considering keeping their ICP arrangements (in the form of non-statutory ICB and local authority partnership meetings) to maintain joint working between the NHS, local government and wider partners[3]. Qualitative research with integrated care system (ICS) leaders (such as ICB chief executives & chairs, and ICP chairs) covered over 80% of ICSs (34 out of 42) with 53 responses[4]. It found 26% of respondents were expecting to retain non-statutory ICB and local authority partnership meetings, while other respondents indicated moving to other ways of working, such as utilising HWBs, or working with strategic authorities.

Therefore, removing the requirement for ICPs from legislation gives local areas the autonomy to decide the most effective way of joint working with local government.

Planning alignment

ICPs are responsible for developing and delivering the Integrated Care Strategy. They also have a non-statutory role of actively promoting integration across the system. Therefore, they focus on public health and the wider determinants of health, which may include employment, access to transport and opportunities and the local environment (such as access to green space, leisure facilities).

Local authorities and NHS bodies need to consider wider determinants of health when developing plans for neighbourhood health. Currently, the model ICB blueprint (a framework for ICBs to follow with regards to commissioning) encourages areas to take a whole system approach to prevention, where ICBs as strategic commissioners should be collaborating with local providers, local government partners and the VCSE sector, to address the wider determinants of health in line with the government's health mission (which includes reducing health inequalities).

Continuing the requirement for ICPs risks creating unnecessary complexity that may prevent wider planning reforms as part of this bill, which move towards a new approach to neighbourhood health planning. Therefore, this change enables future policy development work to more clearly define the role for HWBs in neighbourhood health.

Alignment with wider ICB reforms

These changes are also being made in the context of wider changes to ICBs, such as reducing their running costs by 50% and refocussing their role as strategic commissioners[5]. Removing the requirement for ICPs enables ICBs to operate under leaner structures and allow the money saved through these changes to flow into frontline services instead.

Therefore, removing the requirement for ICPs supports ICBs to maintain their focus on strategic commissioning while undergoing these changes to create leaner organisations. Further, removing the requirement of the Integrated Care Strategy streamlines the ICBs strategic planning role.

Monetised and non-monetised costs and benefits of each option

The costs or benefits haven't been quantified in absolute terms as this section focusses on the differences between the business-as-usual option and the preferred option.

[3] NHS Confederation (2025), The state of integrated care systems 2024/25 | NHS Confederation, page 36 (viewed November 2025)
[4] NHS Confederation (2025), The state of integrated care systems 2024/25 | NHS Confederation, page 9 (viewed March 2025)
[5] NHS England (2025), NHS England » Working together in 2025/26 to lay the foundations for reform (viewed November 2025)

This impact assessment provides a proportionate assessment of costs and benefits based on the best available evidence and in line with HMT Green Book guidance. However, these proposals depend on future decisions by ICBs in their approach to collaboration and therefore, it is not possible to quantify costs and benefits at this stage.

Costs

Removing a route to collaborate

Removing the requirement for ICPs will potentially remove a route for collaboration between ICBs and local partners, such as local authorities and voluntary sector organisations. However, this is largely considered a risk in the following section, due to the dependency on future decisions by ICBs in how they will work collaboratively following the removal of the ICP requirement.

Transition costs

Removing the requirement for ICPs will generate some transitional costs, such as to communicate these changes to the system and stopping the existing arrangements (like cancelling meetings). These costs are expected to be minimal and overlap with the transition costs of wider bill proposals, like ICB reforms (see Impact Assessments Summary Document).

Inconsistent approaches to collaboration

Some local areas may choose to keep the ICP approach in a non-statutory format, where others may utilise the HWBs or adopt other approaches. This means the approach to collaboration will likely differ across England, which may increase complexity within the system. Ultimately, this is dependent on the approaches taken by each area so is included as a cost and benefit (of increased flexibility) by increasing autonomy in the system.

Benefits

Savings for ICP members

There may be some financial savings from removing the requirement for ICPs. The ICB and local authorities are required in law to set up and run the ICP[6] in equal partnership, which entails administrative costs. Removing this requirement will generate savings for both the ICB and local authority who set up and run the ICP, and ICP members who attend the ICP meetings, such as voluntary, community; and social enterprise (VCSE) members.

The cost of staff time to set up and run the ICP is uncertain. The responsibilities of ICPs are all opportunity costs in terms of staff time at these organisations. In terms of secretariat time, the removal of the requirements for ICPs would likely entail a saving for the ICB and local authorities. However, any time and resource savings from not running the secretariat are assumed to be absorbed by other statutory responsibilities and the need to collaborate with these organisations through other forums.

ICP members, such as local authorities, dedicate resources (like administrative resources) to participate in the ICP, therefore by removing the requirement for ICPs there are potential administrative cost savings for ICP members. These administrative savings for ICP members will vary across ICSs. The statutory members of the ICP are one representative from the ICB, and one from each partner local authority. Other members can then be appointed in addition to this and will vary across ICPs.

[6] DHSC (2021), Frequently asked questions (FAQs) on the integrated care partnership engagement document - GOV.UK (viewed August 2025)

There is also no set frequency for how often ICPs meet, so the impact of removing the requirement for ICPs on reducing admin time will vary. Some examples are South Yorkshire ICP met 5 times during 2025[7], while Norfolk and Waveney ICP met 4 times in 2025[8].

Research by the NIHR Policy Research Unit in Health and Social Care Systems and Commissioning (PRU HSSC) gives an indication of the scale of activities taken on by ICPs[9]. The researchers interviewed leaders in a case study ICS and found the ICP committee met quarterly and had a variety of subgroups and workstreams to achieve more meaningful engagement with the variety of different stakeholders. The subgroups focused on, for example, children and families, workforce and education, mental health and wellbeing, social care, housing, and met at different frequencies according to need. In addition, 5 further networks such as the prevention network met every 2 months. However, this research only reviewed 3 ICSs (of 42), so these approaches may not be generalisable across ICPs. The topics discussed in these networks are expected to be covered in the neighbourhood health plan and led by HWBs.

Autonomy in approach to collaboration

As HWBs also aim to bring the local authorities and ICBs together, removing the requirement for ICPs removes any potential duplication in collaboration and provide clarity on the role of HWBs. Where the ICP and HWB approach has been useful, local areas may continue to use an approach similar to this on a non-statutory basis. However, where these roles have been considered duplicative, removing this requirement provides ICBs the flexibility to determine the most effective collaborative working approach for their area.

Streamlined planning landscape

As the system moves towards new approaches for strategic planning set out by the 10 Year Health Plan, the Integrated Care Strategy may ultimately become redundant. Therefore, removing the requirement for the Integrated Care Strategy is an enabler of the ambitions of the 10 Year Health Plan to better align strategic planning with local government. Reducing the potential overlap with other plans and clarifying strategic planning roles, also enables the system to function more effectively and with a clearer focus.

Direct costs and benefits to business calculations and impact on small and micro businesses

There are no direct costs and benefits to businesses as a result of this measure.

Risks and mitigations

Risk of reduced focus on the wider determinants of health at system level

The single statutory purpose of ICPs is to provide the Integrated Care Strategy, however the arrangements also promote partnership arrangements and collaboration, bringing together a wide range of strategic partners. Removing the requirement for ICPs will remove a direct line of communication between ICBs and ICP members, which may impose a risk to collaboration between organisations within the ICPs.

For example, local authorities play a significant role in environment, housing, transport, the local economy so by local authorities being member of ICPs, supporting consideration of the wider determinants of health. Removing the requirement for ICPs, may risk this focus being lost.

[7] South Yorkshire ICS (2024), Integrated Care Partnership meetings and minutes :: South Yorkshire I.C.S. (viewed September 2025)
[8] Norfolk and Waveney ICS, (2024), Norfolk and Waveney ICP - Meetings and Papers (viewed September 2025)
[9] Allen, P. and others (2024), The Architecture of System Management (2022-2023), page 45 (viewed September 2025)

However, this risk is mitigated by the requirements for ICBs and local authorities to work closely as part of HWBs, as well as through wider legislative changes. For example, this bill includes nominating mayors of strategic authorities (or their delegated representatives) to be members of ICBs, which aims to support bringing more attention to health inequalities and the wider determinants of health. Also, wider strategic planning changes ensure the wider determinants of health continue to be considered.

This risk also applies to collaboration with voluntary organisations. NHS Confederation published an in-depth look at the role of ICPs based on conversations with ICP leaders across England. They identified that ICPs have a role in enabling participation from the VCSE sector[10]. However, it has also been noted that the VCSE sector have sometimes found it difficult to engage with ICSs because of lack of capacity[11].

The existence of HWBs may mitigate this risk, as HWBs can appoint additional members, which may include those from the VCSE sector.

Risks of less direction from the removal of the Integrated Care Strategy

Furthermore, removing the requirement for ICPs will also remove their statutory duty to develop an Integrated Care Strategy, which aims to set the direction on addressing the health, social care and public health needs of the system. Each ICB and local authority must have regard for this plan, as set out in the Health and Care Act 2022. Some interviewees in the post implementation review of the 2022 act identified ICPs as being crucial in delivering holistic objectives, with the Integrated Care Strategy being a helpful requirement in pursuit of improving population health[12].

Without the Integrated Care Strategy, organisations may no longer be pulled in the same direction, and partners may collaborate less. This imposes a risk of losing strategic direction for the whole system, and if the wider focus is lost then this may impact on prevention, a focus of the 10 Year Health Plan.

This risk will be mitigated by ensuring any bespoke parts of the ICP's strategy are captured elsewhere, for example, in the Population Health Improvement Plans that ICBs will lead, or the Neighbourhood Health Plans developed by the HWBs. The future policy development of these plans will take account of these existing duties to ensure they are comprehensive.

Risk of reduced opportunity for private provider input to ICBs

The impact assessment for the Health and Care Act 2022[13] sets out that while private providers are not allowed to sit on ICBs, due to the potential conflicts of interest, they are allowed to sit on ICPs. There was a risk with the 2022 act that the views of private providers would not be considered when decisions are made on ICBs, which would reduce the quality of commissioning.

As ICBs develop their roles as strategic commissioners, it is expected that they will work closely with all types of providers to ensure they are able to secure optimal care for patients alongside good value for money.

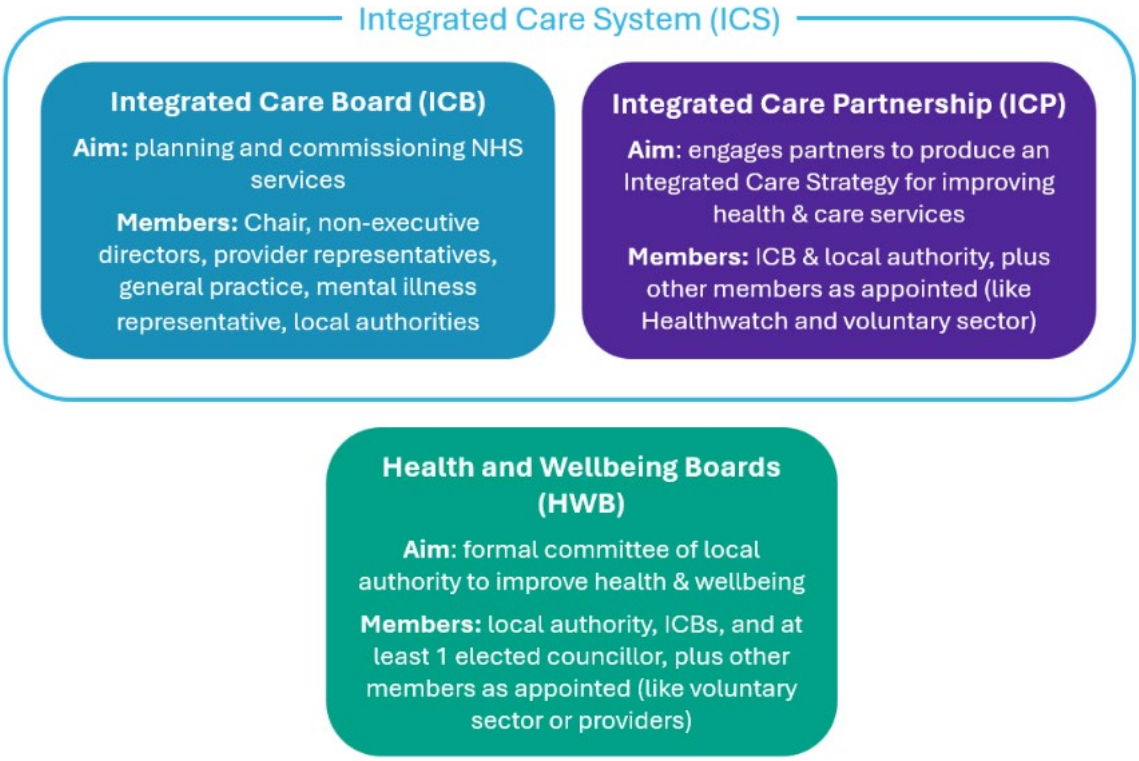
[10] NHS Confederation (2023), Integrated care partnerships: driving the future vision for health and care, page 13 (viewed September 2025)
[11] Phillips, C. (2025), Rhetoric Versus Reality – Embedding a New Relationship Within Integrated Care Systems for Third Sector Organisations | International Journal of Integrated Care, page 6 (viewed November 2025)
[12] Sanderson, M., Hammond, J. and others (2025), Post Implementation Review of the Health and Care Act 2022 Phase 1: Interim Report (Working Paper), page 47 (viewed August 2025)
[13] DHSC (2022), Health and Care Act 2022 Core Measures Impact Assessment, page 18 (viewed September 2025)

Monitoring and Evaluation

Monitoring and evaluation for this proposal will be considered as part of the wider approach covering all the Health Bill proposals, please see the Impact Assessments Summary Document for more details.

Annex

Figure 1: Overview of the current integrated care system approach and wider committees



Final stage impact assessment

Title: Reform to the foundation trust model

Type of measure: Primary Legislation

Stage: Final

Source of intervention: Domestic

Department or agency: DHSC

Other departments or agencies: wider engagement with MHCLG

IA number: DHSCIA9715

RPC reference number: N/A

Contact for enquiries: healthlegislation@dhsc.gov.uk

Date: 28/08/2026

Summary: Intervention and Options

Cost of preferred (or more likely) option (base year = 2026)

Total net present social value (in £m): N/A

Business net present value (in £m): N/A

Net cost to business per year (in £m): N/A

What is the problem under consideration? Why is government action or intervention necessary?

- There can be challenges with the current approach to the Council of Governors (CoGs) of NHS foundation trusts (FTs), such as lacking the capability to hold non-executive directors to account or not always being representative of the populations they serve.
- Also, NHS England (NHSE) and Secretary of State for health and social care (SoS) can direct failing or challenged NHS trusts but do not have the same general power of direction over FTs. This prevents SoS intervening to the fullest possible extent in cases of serious FT failure.
- Separately, wider 10 Year Health Plan ambitions aim to reinvent the FT model and aims to restore greater freedoms of FTs through earned autonomy.

What are the policy objectives of the action or intervention and the intended effects?

- The objective of removing the requirement for CoGs is to enable FTs to have a more tailored approach to patient and community engagement.
- Where CoG functions will be conferred on SoS, this aims to create a more consistent and national approach to specific functions, like appointing chairs and non-executive directors.
- The objective of introducing powers of de-authorisation is to have an operating model which drives improvement based on clearer incentives for FTs.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

- **Option 1 (business as usual)** – this option would retain the current FT model which maintains the requirements for FTs to have CoGs and does not enable de-authorisation of FTs back to NHS trusts.
- **Option 2 (preferred option)** – the preferred option is amending legislation to remove the requirement for FTs to have CoGs and members. The changes also introduce a new SoS power to de-authorise FTs back to NHS trusts in cases of serious failure.

Will the policy be reviewed? It will be reviewed. If applicable, set review date: TBC				
Is this measure likely to impact on international trade and investment?		No		
Are any of these organisations in scope?	Micro No	Small No	Medium No	Large No
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)		Traded:	Non-traded:	

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Minister:  Date: 8-9-2026

Summary: Analysis & Evidence

Policy Option 3

Description: Reform to the foundation trust model

Full economic assessment

Price Base Year N/A	**PV Base Year** N/A	**Time Period Years** N/A	Net Benefit (Present Value (PV)) (£m)		
			Low: N/A	**High:** N/A	**Best Estimate:** N/A

COSTS (£m)	Total Transition (Constant Price) Years		Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low				
High				
Best Estimate	N/A		N/A	N/A

Description and scale of key monetised costs by 'main affected groups'

N/A

Other key non-monetised costs by 'main affected groups'

For removing the requirement for CoGs, the following costs are considered:

- Opportunity costs to SoS to deliver new functions being conferred on them following the removal of the requirement for CoGs.
- Less tailored approach to CoG functions that will be delivered at a national level following their removal

For the new FT de-authorisation powers, the following costs are considered:

- Transitonal costs for de-authorised FTs to return to being an NHS trust

BENEFITS (£m)	Total Transition (Constant Price) Years		Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low	Optional		Optional	Optional
High	Optional		Optional	Optional
Best Estimate				

Description and scale of key monetised benefits by 'main affected groups'

N/A

Other key non-monetised benefits by 'main affected groups'

For removing the requirement for CoGs, the following benefits are considered:

- Flexibility for FTs to tailor their approach to patient, staff and stakeholder engagement
- Admin savings, such as staff time of the secretariat function
- Reducing regional variation of CoG functions

For the new FT de-authorisation powers, the following benefits are considered:

- Ability for SoS to intervene in cases of serious failure
- Incentivising challenged FTs to improve performance

Distributional impacts N/A		
Key assumptions/sensitivities/risks	Discount rate	N/A
For removing the requirement for CoGs, the following risks are considered: • Loss of local accountability from removing CoGs For the new FT de-authorisation powers, the following risks are considered: • Staff morale within an FT that is de-authorised • SoS using powers of de-authorisation beyond the intended purpose		

Business assessment (Option 3)

Direct impact on business (Equivalent Annual) £m:		
Costs: N/A	Benefits: N/A	Net: N/A

Evidence Base

Problem under consideration and rationale for intervention

NHS trusts are authorised as NHS foundation trusts (FTs) when they demonstrate consistently high performance. FT status provides them with more flexibility and autonomy in the day-to-day running of their organisations than operating as an NHS trust. While NHS England (NHSE) and the Secretary of State for Health and Social Care (SoS) have oversight of NHS trusts through a power to direct them about the exercise of their functions, FTs are not subject to equivalent powers.

The 10 Year Health Plan sets out plans for a new operating model to deliver a devolved and diverse NHS, which includes reinvigorating and reinventing the FT model. These changes aim to restore the greater freedoms and earned autonomy of FTs. FTs will also, as part of the 10 Year Health Plan changes which remove the requirement to have a Council of Governors, be expected to put in place their own arrangements for considering local patient, staff and stakeholder interests.

The limitations of the FT Council of Governors approach

The role of the Council of Governors

One of the differences in the governance models of FTs and NHS trusts is that FTs must have a Council of Governors (CoG). A CoG represents members, staff and other stakeholders of the FT, with membership open to anyone living within areas defined in the FT's constitution. Most governors are elected to their role.

The intended purpose of a CoG is to make the FT accountable to the public they serve and under this model[1] the CoG has 2 general duties which are:

1. To hold the non-executive directors (NEDs) to account for the performance of the board of directors (note the FT board remains responsible for the performance of the FT and accountable to regulators).
2. To represent the interests of the members of the FT and the interests of the public.

They also have specific governance functions set out in primary legislation, for example the appointment of the FT Chair and NEDs and approving applications for statutory transactions. The full list of functions is set out in Table 1 (see costs and benefits section). The CoG should be factoring in their general duties listed above when making all decisions regarding their specific functions.

Evidence on the role of the Council of Governors

While CoGs have been valuable in some cases, they can also create governance challenges. For example, NHSE engagement with FTs has noted challenges when governors lack the capability to hold nonexecutives to account, constrain boards from taking difficult systemwide decisions, or fail to reflect the priorities of the diverse communities they serve. Although this is not true of all FTs, these experiences highlight the limitations of the current rigid CoG requirement.
Some research has found the governor role to be valued, with governors able to raise questions of hospital performance and influence decisions (based on 4 case studies)[2]. However,

[1] Legislation.gov.uk (2025), National Health Service Act 2006 - schedule 7 - section 10a (viewed November 2025)

[2] Millar, R., T. Freeman, R. Mannion and H. T. Davies (2019), Journal of Social Policy 48(3): 595-613, Meta-regulation meets Deliberation: Situating the Governor within NHS Foundation Trust Hospitals - Cambridge University Press (viewed November 2025)

observation of governors' meetings as part of that research suggested that in some cases governor involvement in decision-making was more symbolic than real, with meetings used by executives to legitimise their decisions rather than as opportunities for real participation.

The research also found board members welcomed the 'soft intelligence' that they can obtain from governors but struggled to prioritise this above the 'hard' performance metrics by which they are held to account by national regulators. Furthermore, the summary of the paper notes concerns about the representativeness of governors, as they are generally older than the populations they represent and are more likely to be retired[2]. This may impact on the CoG's ability to represent the diverse views of the population they are expected to serve to ensure health services meet population needs.

Other studies have found CoGs struggle to hold FTs to account, as well as improve engagement with local communities. One study on all FT hospitals and NHS trust hospitals found that there was limited local accountability with many governors lacking access to information[3]. This finding is supported by another study from 2012 which found that based on case studies with 52 senior clinicians and managers, FT status did not significantly improve engagement with local communities and stakeholders[4].

Evidence suggests the potential benefits of governors being elected may not be being fully realised. An international evidence review[5] highlights the conflict between the aspiration for governors to make the trust more accountable to local populations against the strong hierarchical accountability to national authorities for performance and finance. As the elected members do not have direct decision-making power, decisions may be over-ruled by executives with formal decision-making responsibilities.

In summary, although there are some reported benefits of CoGs, research suggests the approach to accountability and decision-making processes could be simplified by removing the statutory requirement for CoGs. Furthermore, engaging the local community could be made more flexible to allow FTs to operate in a way that is suited to their local population.

Lack of ability for SoS to intervene in cases of serious FT failure

The benefits of NHS trusts becoming FTs

The Health and Social Care Act 2003 created FTs, with the first established in 2004. It allowed high performing NHS trusts to become public benefit corporations, accountable to regulators, commissioners and to the communities and stakeholders they serve.

NHS trusts can become legally authorised as FTs via an assessment against specific criteria. The most recent NHS trust to be converted to an FT was in 2016. FTs are given more operational autonomy and statutory freedoms than NHS trusts, such as ability to retain surpluses and reinvest them, borrowing for capital investment and freedom to control their board composition.

The 10 Year Health Plan ambitions

[3] Allen P, Keen J, Wright J, Dempster P, Townsend J, Hutchings A, Street A, Verzulli R. (2012), Journal of Health Services and research vol 17(2): 94-100, Investigating the governance of autonomous public hospitals in England: multi-site case study of NHS foundation trusts - PubMed (viewed June 2025)

[4] Anand P, Exworthy M, Frosini F, Jones L (2012), Public Money & Management vol 32(3): 209-216, Autonomy and improved performance: lessons from an NHS policy reform (viewed June 2025)

[5] Stewart, E. A., S. L. Greer, I. Wilson and P. D. Donnelly (2016), The International journal of health planning and management 31(2): e69-e85 Power to the people? An international review of the democratizing effects of direct elections to healthcare organizations - Wiley Online Library (viewed November 2025)

The 10 Year Health Plan has ambitions to reinvent the FT model for a modern age. This includes the ambition for all NHS providers to be an FT by 2035, with the freedoms mentioned above. The 10 Year Health Plan also sets out that NHS trusts applying for FT status (or those seeking re-authorisation), will need to have demonstrated excellent delivery on areas like waiting times, access, quality of care and financial management. FTs can then use these freedoms and flexibilities to improve population health, not just increase activity.

Rationale for intervention

While NHSE and SoS can direct failing or challenged NHS trusts on the exercise of their functions[6], they do not have the same general power of direction over FTs, due to their different statutory status. This power of direction may, in certain situations, be required to deliver an organisational turnaround in the event of significant failure. NHSE and SoS can currently require FTs to take steps to address a breach of the Provider Licence (like addressing issues on financial performance, quality of care or governance), however these powers do not enable SoS to intervene to the fullest possible extent in cases of serious failure.

Although NHSE has never had the power to de-authorise FTs back to NHS trusts (or convert FTs to NHS trusts), these powers have existed in the past. In the Health Act 2009, the Independent Regulator of FTs (Monitor, at the time) was given the powers to require SoS to de-authorise FTs by means of order in cases of serious failure. These powers were never used, and the provisions were repealed in the Health and Social Care Act 2012. However, the lack of such powers going forward would prevent SoS intervening to the fullest possible extent in cases of serious failure in FTs, which does not align with the re-invigorated FT model as part of the 10 Year Health Plan.

While other regulatory levers to manage poor performance are available (such as via the Provider Licence), there are 2 core arguments for the introduction of de-authorisation:

- **SoS power to intervene:** de-authorising an FT to an NHS trust will enable the necessary powers of direction over NHS trusts to be used by SoS out of patient and public interest. The Department of Health and Social Care (DHSC) considers making these necessary interventions in cases of serious failure is more important than the preservation of a provider's statutory freedoms.

- **Incentives**: the possibility of deauthorisation in cases of serious failure (and the subsequent loss of statutory autonomy) could incentivise challenged FTs to improve. These powers are meant for cases of serious failure, so this proposal would be intended to incentivise FT leaders to tackle serious failure. De-authorisation powers are not designed to promote minor performance improvements among all providers.

Having a legal power to de-authorise will not hinder or dilute the ability to use any of the other powers granted by Parliament in the past to address issues at FTs; it would be an option available in the case of serious failure.

Description of options considered

Option 1: business as usual

This option would retain the current FT model which maintains the requirements for FTs to have CoGs and does not enable de-authorisation of FTs back to NHS trusts. The costs or benefits

[6] Legislation.gov.uk (2025), National Health Service Act 2006 - PART 1 - Secretary of State's directions to certain health service bodies (Section 8) (viewed November 2025)

have not been quantified in absolute terms as this section focusses on the differences between the business-as-usual option and the preferred option.

Option 2 (preferred option): NHS foundation trust reforms

The preferred option is amending legislation to remove the requirement for FTs to have CoGs and members. To enable this, CoG's existing functions will be conferred on SoS (or alternative organisations) or repealed. The changes also introduce a new SoS power to de-authorise FTs back to NHS trusts in cases of serious failure.

Policy objective

Removing the requirement for the FT Council of Governors and members

The objective is for FTs to have a more tailored approach to patient and community engagement, which meets the ambitions of the 10 Year Health Plan. Greater community engagement may provide FTs with the information required to, for example, improve patient experience of their services.

By removing the formal legal role and duties of FT CoGs and members, FTs will have flexibility to design alternative approaches to listen to staff, patient and public voices as part of their ongoing engagement. This would help them meet existing responsibilities to consider patient views under the public sector equality duty.

Following the removal of the CoG requirement, some of its functions will be conferred on SoS, or they will cease to exist. For example, this includes the power to appoint the Chair and NEDs of the FT. This aims to create a more consistent, national approach to appointing the Chair and NEDs across FTs, which would then also be consistent with NHS trusts.

Introducing foundation trust de-authorisation

As set out in the 10 Year Health Plan, the objective is to have an operating model which drives improvement based on clearer incentives for high-performing providers.

Introducing a power in primary legislation for SoS to de-authorise an FT back to an NHS trust (in cases of serious failure), allows SoS to intervene in the event of serious poor performance. This would happen when other powers have been exhausted (such as via the NHS Provider Licence). Once the poor-performing FT becomes an NHS trust, SoS will be able to direct the trust (using existing powers of direction applicable to NHS trusts), to allow SoS to intervene to the fullest possible extent.

Summary and preferred option with description of implementation plan

The changes set out in this impact assessment align with, and may interact with, other changes being made as part of the Health Bill, see the Impact Assessments Summary Document for further information. This includes the *financial accountability reforms* impact assessment introduces a 'backstop' power to impose a revenue limit on FTs, which is a separate change applicable to FTs to support 10 Year Health Plan ambitions.

Removal of FT Council of Governors and members

The 10 Year Health Plan sets out that more tailored arrangements will be put in place for FTs to take account of patient, staff and stakeholder insights. This will be carried out by removing the requirement for FTs to have CoGs and members. The legal status of the CoGs and members

will be removed and the current functions of the CoGs, which are set out in primary legislation, will either be repealed or conferred on SoS or an alternative organisation; the details of which are outlined in Table 1 (see costs and benefits section).

FTs will remain under the public sector equality duty and need to continue to comply with the expectations set out in the statutory guidance on working in partnership with people and communities[7].

Also, as set out in the quality of care and NHS workforce chapters of the 10 Year Health Plan, FTs and NHS trusts will, going forward, need to place more importance on:

- Patient Reported Outcome Measures (PROMs, such as patient outcomes of hip and knee replacements), and
- Patient Reported Experience Measures (PREMs, such as patient experience surveys)
- the collection of informed feedback from patients and carers, and
- a new set of 'staff standards' setting minimum standards for modern employment.

In addition, the 10 Year Health Plan plans to trial new ‘patient power payments’, which are an innovative new funding flow in which patients are contacted after care and given a say on whether the full payment for the costs of their care should be released to the provider.

Also, as part of this bill, Healthwatch England and Local Healthwatch will be abolished. Integrated care boards (ICBs) and local authorities will be required to incorporate the views of patients and users directly into their commissioning of services for health and social care. Following the abolition of NHSE (see Impact Assessments Summary Document for more information), there will also be a new central function within the restructured DHSC (the patient experience directorate) which will bring a greater role for patient voice in policy making.

Therefore, there will be new approaches for FTs (and wider health bodies) to engage with patient feedback following the proposed changes in this bill, which forms part of the more tailored approach to replacing the role of CoGs.

As part of these changes a further clarification will be made to the legislation setting out that the executive directors must include:

- at least one person who is a registered medical practitioner or a registered dentist, and
- at least one other person who is a registered nurse or a registered midwife

This change makes clear in legislation that the policy position for these requirements has not changed as part of these wider changes to FTs.

Introducing foundation trust de-authorisation

The 10 Year Health Plan aims for a new approach in which providers are treated differently depending on their performance and capability.

This includes the proposed new 2-way system where NHS trusts can be authorised to become FTs but also be de-authorised (converting them back to being NHS trusts) in case of serious failure. In this situation the FT, in becoming an NHS trust again, would lose those freedoms exclusively conferred on FTs and would be subject to SoS’ general power of direction over NHS trusts on the exercise of their functions.

The de-authorisation power would be one of a suite of intervention powers that SoS will have over FTs but is intended to be used as a last resort power. This legislation sets out a list of

[7] NHS England (2023), NHS England » Working in partnership with people and communities: statutory guidance (viewed January 2026)

factors that the SoS must consider when deciding whether to make an order to convert an FT to an NHS trust. These are:

- the seriousness of the failure
- the health and safety of patients
- quality of services provided by the FT
- the FT's financial position, and
- its governance

Statutory guidance on these and other factors that SoS may consider (criteria for de-authorisation) will also be produced and consulted upon. This guidance will then provide clarity to FTs over the criteria which will trigger de-authorisation.

The test (or basis) for making a de-authorisation order will be a failure to comply with one or more conditions of its provider licence or any statutory requirement. Alongside consideration of the factors and tests, SoS will also be required to consult before making an order to de-authorise an FT.

The policy intention is for de-authorisation to only be used in extreme cases where it is in the public interest to de-authorise the FT to NHS trust. De-authorisation will allow SoS to use existing powers of direction (those already in place for NHS trusts) to support the organisation's turnaround and address the clear public need for improvement.

Advanced foundation trusts

The introduction of Advanced FTs is a separate policy (not part of this bill) being introduced to the FT model to introduce further earned autonomy. Advanced FTs will gain additional freedoms, beyond those an FT has, and is a process open to both FTs and NHS trusts (if they meet the performance criteria to become one). NHS trusts would also be required to meet the conditions to be authorised as an FT via legislation, in order to enable them to go on to having Advanced FT status.

De-authorisation will not apply to removing Advanced FT status back to an FT, because this status is a policy designation, not a statutory process. Any FT could be de-authorised back to an NHS trust, regardless of Advanced FT status.

Monetised and non-monetised costs and benefits of each option

The costs or benefits haven't been quantified in absolute terms as this section focusses on the differences between the business-as-usual option and the preferred option. This impact assessment provides a proportionate assessment of costs and benefits based on the best available evidence and in line with HMT Green Book guidance.

Costs

Removal of FT Council of Governors and members

Opportunity costs

The statutory functions of CoGs will either be repealed or conferred on SoS or an alternative organisation (see Table 1). The functions being conferred on SoS will create an opportunity cost to SoS as resource would need to be allocated to undertake these functions in place of other responsibilities. The potential delivery risk (as well as possible limitations) for SoS to exercise these additional functions is noted in the risk section as they depend on policy implementation.

Less tailored approach to Council of Governor (CoG) functions

Conferring CoG functions on SoS means responsibility for these functions will be at the national level. This may come at a cost of less tailored approaches to the local population for these functions. This is mainly considered a risk because it depends on future policy decisions on the approach to implementation for these functions.

Introducing foundation trust de-authorisation

There are no immediate costs of introducing de-authorisation powers, however this section considers the potential costs and benefits if the powers were to be used in the future.

As de-authorisation is only to be used in serious cases of failure, it is assumed that there would be minimal costs associated with the function being an additional SoS responsibility. This assumption depends on the future performance across FTs and the desire to use de-authorisation in cases of serious failure.

Transition costs

These powers are expected to be used very sparingly given the availability of other levers. If an FT were deauthorised, it would face one-off transition costs to align with NHS trust structures and processes. This could include changes to financial reporting, transitional costs (such as renaming the trust), and senior management and staff time to prepare for governance and legal changes (like a new Provider Licence).

Benefits

Removal of FT Council of Governors and members

Flexibility for foundation trusts to tailor their approach to patient voice

As set out in the 10 Year Health Plan, FTs are expected to put in place more tailored mechanisms for patient, staff and stakeholder insight. Removing the requirement for CoGs allows FTs to determine their own engagement processes which can best represent the views and priorities of the diverse communities they serve. This change, along with wider changes like ‘patient power payments’ (as well as Healthwatch and ICB changes) aims to strengthen the role of patient voice in health and care services.

Potential administrative cost savings

There may be savings to the FT from the removal of the requirement for CoGs. Staff time and resources could be saved as the secretariat function of the CoG (including managing a database of members) would no longer be required, as well as potential travel expenses from governors attending meetings. Also, FTs would no longer have to incur the costs of running governor elections.

These savings would vary across FTs because the way CoGs operate is varied across FTs. These savings are likely to be offset by the FT’s new mechanisms on gathering patient feedback and staff engagement, as well as other responsibilities, such as additional 10 Year Health Plan requirements for FTs and NHS trusts to place more importance on PROMs and PREMs. Therefore, as the savings are expected to be minimal and varied across FTs, they have not been quantified.

Reducing regional variation of Council of Governor functions

Conferring most CoG statutory functions on SoS may make processes simpler and the approach more consistent across all FTs. For example, SoS will now be responsible for appointing all Chairs and NEDs instead of each individual CoG. This may also be the case for function to approving external auditors being conferred on local 'auditor panels' as the functions are being integrated into similar existing functions, where the benefit could be a more streamlined process.

However, the scale of this benefit is dependent on the approach to implementation of these functions. For example, whether regional teams or national teams are responsible for FT Chair and NED appointments on behalf of SoS. This is dependent on future policy decisions on organisational design, such as those forming part of the Transformation programme (see Impact Assessments Summary Document for more information).

Introducing foundation trust de-authorisation

Ability for SoS to intervene in serious cases of failure

De-authorisation will mean that in cases of serious failure, FT status could be removed by SoS. This helps to ensure the interests of patients, staff and the wider public are prioritised by introducing government intervention when it is both necessary, and the right thing do. Examples of its use could be cases of significant patient safety or quality failings. As set out in the 10 Year Health Plan, the Trust (which was previously an FT) will then need to demonstrate excellent delivery on waiting times, access and quality of care to be re-authorised.

Existing powers to direct NHS trusts could be used following de-authorisation to enable SoS to intervene to the fullest extent in cases of failure. This would be focussed on the highest priority deliverables which align with the ambitions of the 10 Year Health Plan.

Incentivising challenged foundation trusts

Introducing de-authorisation in serious cases of failure (and the subsequent loss of statutory autonomy) is also intended to act as an incentive on challenged FTs to improve. In the rare cases that these powers are expected to be used in, FT leaders may be more incentivised to rapidly tackle the failure to avoid being de-authorised.

Specific impacts of conferring or repealing Council of Governor functions

Assigning former CoG functions to the SoS, rather than retaining them locally, aligns most closely with the intended future structure of the healthcare system set out in the 10 Year Health Plan. Both national and local approach deliver benefits, although the nature of the benefits would differ. The benefits of the proposed approach are highly dependent on future policy decisions around implementation; therefore, the costs and benefits are uncertain.

Table 1 sets out the specific details of what will happen to each CoG function and the expected impacts of this.

Table 1: Summary of FT CoG functions with proposals to repeal or confer on other bodies

CoG role or function	Proposal	Expected impacts
Appointing or removing Chair and NEDs	**This power will be conferred on SoS.** The detailed approach taken by SoS to appointing or removing Chairs or NEDs is still to be determined and will be set out in	This primarily means the same role will be undertaken by a different body. The impact of conferring this function on SoS is

CoG role or function	Proposal	Expected impacts
	guidance rather than primary legislation.	uncertain as it depends on future policy decisions around how this function is exercised in practice.
Approving Chair and NED remuneration	**This power will be conferred on SoS**. The detailed approach taken by SoS is still to be determined and will be set out in guidance rather than primary legislation.	This primarily means the same role will be undertaken by different body. The impact of conferring this function on SoS is uncertain as it depends on future policy decisions around how this function is exercised in practice.
Approving significant transactions – ***noting "significant" is defined in individual FT constitutions and so may vary from FT to FT.***	**Repeal CoG statutory duty but SoS will already hold an oversight function following the abolition of NHSE.** The 'significant transaction' concept does not exist for NHS trusts and is a local construct to set out which transactions governors have a role in approving. There is an existing process within NHSE (which will be conferred on SoS following the abolition of NHSE) to review transactions, so this function will no longer be required. It is possible that some FTs have definitions of significant transactions which are wider than the transactions that SoS will review. However, those transactions are not considered to require review from a central oversight perspective.	This change removes a duplicative process across NHSE and CoGs. SoS has an existing role in approving transactions so this function would be absorbed within that. The abolition of NHSE (including conferring oversight functions on SoS) are captured in a separate impact assessment, see the Impact Assessments Summary Document for more details.
Approving applications to SoS (currently NHSE) to merge, acquire, separate and dissolve	**Repeal CoG statutory duty but SoS will already hold an oversight function following the abolition of NHSE.** This is currently a multi-stage process where CoGs have a role in assuring themselves that the Board of Directors have followed due process ahead of applying for a transaction. The last stage of the process is the final decision in granting the application for the transactions,	SoS has an existing role in approving transactions (currently alongside NHSE too). Therefore, a duplicative role is being removed and SoS will remain the ultimate decision-maker. The benefit of this is streamlining the transaction approval process.

CoG role or function	Proposal	Expected impacts
	which currently sits with NHSE and SoS. SoS will have sole oversight following the abolition of NHSE.	
Appointing external auditors	**This power will be conferred on local 'auditor panels' (commonly the audit committee in practice).** Currently, NHS trusts and ICBs appoint auditors by establishing an 'auditor panel' (commonly the audit committee). Therefore, this change aligns with NHS trusts and ICBs. The English Devolution and Community Empowerment Act 2026 amended the audit approach for NHS trusts and ICBs. The FT audit process is expected to align with these proposals for NHS trusts and ICBs.	Local auditor panels already exist for NHS trusts and ICBs, so FT auditor appointments will be absorbed into this process. There may be some opportunity costs or familiarisation costs for the panels to appoint appropriate auditors for FTs, in addition to their existing role.
Approving increases in private patient income (PPI) >5% of FT total income in any financial year	**This power would be conferred on SoS.** Internal review of finance data suggests the use of these powers is limited.	This primarily means the same role will be undertaken by different body.
Approving changes to FT constitution	**This power will be conferred on SoS.** SoS currently has the power to approve ICB constitution changes, so this type of function is already held by SoS for other bodies. The approach to this role that may have been taken by CoGs will have varied for each FT. Therefore, SoS taking on this role will enable a consistent approach to all constitution amendments.	This primarily means the same role will be undertaken by different body. The impact of conferring this function on SoS is uncertain as it depends on future policy decisions around how this function is exercised in practice.
Reviewing trust plans	**Repeal CoG statutory duty but SoS will retain oversight function.** SoS will take on oversight of these plans following the abolition of NHSE, so this would be a duplicative function if retained.	This change removes a duplicative role in the system, as NHSE and CoGs were both previously responsible for this function.
Holding Chair and NEDs to account for the performance of the board	**Repeal CoG statutory duty but SoS will be given oversight function.** SoS will take on oversight of FTs following the abolition of NHSE, so	This change removes a duplicative role in the system, as NHSE and CoGs were both previously responsible for this function.

CoG role or function	Proposal	Expected impacts
	this would be a duplicative function if retained.	
Approving CEO appointment	**This power will be repealed**. Appointment of the CEO will continue to be the responsibility of the FT NEDs via the appointments committee. This exists already and is the route in which other executive director appointments are currently approved. The approval function of CoGs for the CEO's appointment supports the process, but ultimately responsibility for approving CEO appointments lies with NEDs.	FT NEDs already hold responsibility to appoint the CEO. The impacts of this change will vary depending on how beneficial NEDs have found the CoG view on CEO appointments previously. Repealing this power also carries potential benefits in streamlining the process.

Direct costs and benefits to business calculations and impact on small and micro businesses

There are no direct costs and benefits to businesses as a result of this measure.

Risks and mitigations

Removal of FT Council of Governors and members

Risk of a loss of local accountability and representation

There is a risk that once the requirement for CoGs and members are removed, there will be a loss of local accountability and a failure to represent the interests of the public and local communities. However, FTs will still be expected to ensure effective engagement processes which best represent the views of their patients, staff and communities. This, and the new 10 Year Health Plan expectation for FTs to place more importance on patient's experiences and outcomes (PROMs and PREMs data), should help to mitigate the risk of losing representation from the local community.

There are also risks with conferring several of the CoG statutory functions on SoS. For example, decision-making process could be slower as SoS takes on responsibility for these functions. The mitigations for this delivery risk will be considered as part of the design during the creation of the restructured DHSC (decided by the Transformation programme), please see the Impact Assessments Summary Document for further details on the Abolition of NHS England impact assessment.

In addition, for some CoG functions, SoS may be less in touch with local views compared to Governors, so there is a risk that less effective decisions are made in those cases. A mitigation for this could be utilising existing links to gather information from the system on local intelligence, for example through regional teams, that could assist SoS by informing their decision making. Regional teams will have a more direct link to SoS as they will become part of the restructured DHSC following the abolition of NHSE (see Impact Assessments Summary Document for more information).

Introducing foundation trust de-authorisation

Risk of reduced staff morale

There is a risk that any proposal to de-authorise a particular FT might affect the morale of the staff in the affected FT. However, SoS would be required to consult the FTs before making the order to de-authorise. This may mitigate the risk by providing the FT opportunities to improve their situation ahead of de-authorisation being required.

Secretary of State (for health) using powers beyond the intended purposes

While the intention of the policy is for de-authorisation to only be used as a last resort once other measures have been exhausted; there is a risk of a SoS using these powers beyond the intended use set out in this IA. However, there are several mitigations in place, such as consideration of the 5 factors listed in legislation before making an order to de-authorise and SoS will then need to consult with the FT before the order can be made. While not set out in legislation, further policy design of de-authorisation may implement other mitigations, for example, an independent panel may be used when deciding whether to make an order to de-authorise. SoS will also remain accountable to Parliament, which also acts as a mitigation for this risk.

Monitoring and Evaluation

Monitoring and evaluation for this proposal will be considered as part of the wider approach covering all the Health Bill proposals, please see the Impact Assessments Summary Document for more details.

Final stage impact assessment

Title: Financial accountability reform

Type of measure: Primary legislation

Stage: Final

Source of intervention: Domestic

Department or agency: Department of Health and Social Care

Other departments or agencies: N/A

IA number: DHSCIA9716

RPC reference number: N/A

Contact for enquiries: healthlegislation@dhsc.gov.uk

Date: 28/08/2026

Summary: Intervention and Options

Cost of preferred (or more likely) option (base year = year of IA)

Total net present social value (in £m): N/A

Business net present value (in £m): N/A

Net cost to business per year (in £m): N/A

What is the problem under consideration? Why is government action or intervention necessary?

- NHS providers (NHS Trusts and Foundation Trusts) in England have been in deficit at the national level since 2013 to 2014. This is with the exception of the COVID-impacted years of 2020 to 2021 and 2021 to 2022.
- Systems and providers are spending more than their budgets. This must be recouped from other parts of the healthcare system to avoid breaching department spending limits.
- The 10 Year Health Plan sets out a new financial framework for the NHS, but the Secretary of State for Health and Social Care (Secretary of State) does not currently have a full set of financial controls to support these ambitions.

What are the policy objectives of the action or intervention and the intended effects?

- The 10 Year Health Plan proposals seek to reinvigorate and reinforce financial responsibility on individual providers.
- The aim of this proposal is to complete the financial controls available to the Secretary of State and the Accounting Officer (AO) to support DHSC to delivery national finance balance in aggregate.

What policy options have been considered, including any alternatives to regulation? Please justify preferred option (further details in Evidence Base)

- **Option 1 (Business as usual)** – under this option, the current financial limit setting powers remain in place, with no option for the Secretary of State to set limits on revenue spending.
- **Option 2 (preferred option)** – this option extends existing limit-setting powers for FT capital spending, to also include revenue spending. This would align with the powers available to the Secretary of State in relation to NHS Trusts.

Will the policy be reviewed? It will be reviewed. If applicable, set review date: N/A				
Is this measure likely to impact on international trade and investment?		No		
Are any of these organisations in scope?	Micro No	Small No	Medium No	Large No
What is the CO_2 equivalent change in greenhouse gas emissions? (Million tonnes CO_2 equivalent)		Traded: N/A	Non-traded: N/A	

I have read the Impact Assessment and I am satisfied that, given the available evidence, it represents a reasonable view of the likely costs, benefits and impact of the leading options.

Signed by the responsible Minister:  Date: 8-9-26

Summary: Analysis & Evidence

Policy Option 4

Description: Financial accountability reform

Full economic assessment

Price Base Year N/A	**PV Base Year** N/A	**Time Period Years** N/A	Net Benefit (Present Value (PV)) (£m) N/A		
			Low: N/A	**High:** N/A	**Best Estimate:** N/A

COSTS (£m)	Total Transition (Constant Price) Years		Average Annual (excl. Transition) (Constant Price)	Total Cost (Present Value)
Low				
High				
Best Estimate	N/A		N/A	N/A

Description and scale of key monetised costs by 'main affected groups'

N/A

Other key non-monetised costs by 'main affected groups'

- If the power is exercised, it would limit FT's freedom to make revenue spending decisions while the order is in effect.

BENEFITS (£m)	Total Transition (Constant Price) Years		Average Annual (excl. Transition) (Constant Price)	Total Benefit (Present Value)
Low				
High				
Best Estimate	N/A		N/A	N/A

Description and scale of key monetised benefits by 'main affected groups'

N/A

Other key non-monetised benefits by 'main affected groups'

- Provides the Secretary of State with powers to manage overspend at the national level, by giving complete flexibility in the tools available to them.
- Supports delivery of 10 Year Health Plan ambitions to improve NHS financial discipline.

Distributional impacts

N/A

Key assumptions/sensitivities/risks	Discount rate	N/A

- Risk to delivery of FT services if this power were to be used. This is mitigated by the duty to consult ahead of the Secretary of State making an order, to ensure its use is appropriate and proportionate.
- Risk of limited use of powers, given revenue spending is more difficult to switch 'on and off'.
- Risk of adverse FT spending behaviour to avoid achieving a surplus. This is mitigated by the fact the order would only remain in place for the financial year it was set within.

Business assessment (Option 4)

Direct impact on business (Equivalent Annual) £m:		
Costs: N/A	Benefits: N/A	Net: N/A

Evidence Base

Problem under consideration and rationale for intervention

NHS aggregated deficit overview

NHS systems and providers have been spending more than they are allocated to them in their budgets. In 2024, the National Audit Office (NAO)[1] reported that the (at the time) 42 NHS integrated care systems (ICSs) in England recorded an estimated aggregate deficit of £1.4 billion in 2023 to 2024, based on provisional figures. This was significantly higher than their planned aggregate deficit of £720 million for the same year.

NHS providers, which are NHS Trusts and Foundation Trusts (FTs), collectively returned to a deficit position of £685 million in 2022 to 2023. This followed 2 surplus years in 2020 to 2021 (£205 million) and 2021 to 2022 (£331 million) due to increased COVID-19 related financial support. Prior to the pandemic, NHS Trusts had been in a collective underlying deficit since 2013 to 2014, reaching an annual aggregated deficit of £3.6 billion in 2019 to 2020[2].

Rationale for a new financial approach

A new way of managing money in the NHS is needed to help get spending under control. Robust financial control matters at all levels and in all parts of the health system. This is so the NHS can live within its budget and also prevent the loss of financial control in one part of the system being needed to be recovered elsewhere.

Delivery of overall financial balance across the NHS can require surpluses or underspends in some organisations to offset deficits elsewhere. To now, this has been operating at the 'local system' level, such as within integrated care boards (ICBs) and their partner Trusts and FTs, using system control totals (total budgets set for the ICS). However, the ambitions of the 10 Year Health Plan are to move towards putting more emphasis on financial responsibility for individual organisations.

Part of this also means a change in the role of integrated care boards (ICBs) away from 'managing' financial performance within their system towards focusing on their role as strategic commissioners. Responsibility for ensuring financial balance across the NHS will therefore be a responsibility for the Secretary of State, following the abolition of NHS England.

Gap in existing legislation

There is currently no mechanism for the Secretary of State to set limits on resource departmental expenditure limits (RDEL) for FTs. Currently, the Secretary of State can set spending limits on RDEL and capital departmental expenditure limits (CDEL) covering only NHS Trusts, and NHS England can set spending limits for CDEL on FTs, but this does not extend to RDEL. The powers held by NHS England will be conferred on the Secretary of State following the abolition of NHS England as part of this bill.

As covered in the impact assessment for the Health and Care Act 2022, voluntary approaches had been explored but there were a "lack of proportionate legal mechanisms to require solvent FTs to adhere, [so] there was a risk that these [existing legal mechanisms] would be unsuccessful in protecting the NHS's overall capital limits."[3]

[1] National Audit Office (2024), NHS financial management and sustainability 2024 - NAO report page 4, (viewed September 2025)
[2] National Audit Office (2024), NHS financial management and sustainability 2024 - NAO report page 20, (viewed September 2025)
[3] DHSC (2022), Health and Care Act 2022: combined impact assessments - GOV.UK, Core measures impact assessment, page 33 (viewed September 2025)

This lack of powers on FT RDEL creates a risk that FTs may not have due regard to the aggregate NHS financial position. This, in turn, could cause an aggregate deficit that would need to be offset by savings in other key Government health and care programmes. Offsetting savings through wider Government health and care programmes could then risk the delivery of these programmes.

Therefore, this bill proposes to expand existing powers to allow the Secretary of State to set limits on FT RDEL expenditure. The proposal is clearly focussed on the intent for the power only to be used as a last resort in cases where there is deemed to be a clear need for FTs to hold to a specified financial position in the interests of overall financial balance. This allows the Secretary of State to meet the department's objectives, including protecting against a breach in the department's expenditure limit set by HM Treasury.

Description of options considered

Option 1: Business as usual

This option retains existing powers which do not provide the Secretary of State an option to set revenue (RDEL) limits on FTs. The costs or benefits have not been quantified in absolute terms as this section focusses on the differences between the business-as-usual option and the preferred option.

Option 2 (preferred option): Introduction of 'backstop' power to impose a revenue limit on FTs

Under this option, section 42B of the NHS Act 2006 is expanded to introduce a 'backstop' power to allow the Secretary of State to impose a revenue limit on FTs.

Policy objective

The 10 Year Health Plan sets the goal for the NHS to move into surplus, with most providers doing so by 2029 to 2030, allowing for reinvestment in innovation and operational improvements. This includes building a transparent financial regime that will hold leaders to account for meeting financial plans.

Therefore, the policy objectives of this bill proposal are:

- to support the NHS to live within the budget allocated, reduce the number of providers in deficit, and the overall quantum of the provider sector deficit
- to support DHSC to deliver national financial balance in aggregate in the short term, and for the NHS to move towards a surplus over time

Summary and preferred option with description of implementation plan

Overview of the powers

Section 42B of the NHS Act 2006 currently affords NHS England powers to impose a limit on the CDEL expenditure of an FT in respect of a single financial year. Though it has never been used, the existence of such power acts as a 'backstop' power. These powers enable NHS England (currently, or the Secretary of State following the abolition of NHS England) to ensure responsible CDEL expenditure, manage its overall financial position, and avoid breaching departmental expenditure limits.

The proposal is to expand this CDEL limit setting power to allow the Secretary of State to place a limit on RDEL expenditure, extending the 'backstop' power to provide the Accounting Officer (AO) and the Secretary of State with a complete set of controls to manage NHS finances in aggregate. This aims to further protect the Secretary of State against breaches in departmental expenditure limits.

Use of the powers

As is the case with the current capital limit power, its application would be discretionary and only as a last resort. In practice, there will aways be a choice over whether it is appropriate to exercise the power on each occasion, considering the FTs position during a required period of consultation (details of which would be set out in statutory guidance). The existing capital power has not been used in the 3 years since it was introduced, and the intention is that the extension to revenue will continue to be subject to the same prudence.

Though RDEL expenditure considerably outweighs CDEL expenditure, the intention is that the application of the revenue power is subject to the same prudence as the capital power. The power would only be used on a reactive basis, and it would not affect or feature in financial planning, and FTs should not expect the power to be used in normal circumstances.

It would not be appropriate or practical to unconditionally restrict all RDEL expenditure upon application of the power. The proposal offers numerous protections against such a scenario, starting with a requirement for DHSC to consult the FT before any limit is placed. There is also a requirement to express the limit as a target end-of-financial-year position (such as level of surplus or deficit).

Taken together, it means the AO and the Secretary of State must consider the spending plans for the FT during a period of consultation before deciding whether to impose the order and, if so, on the appropriate limit to put in place. The FT can continue to carry out expenditure so long as it does not 'breach' the limit set for the end of the financial year.

The limit only applies to one financial year so the FT would be able to spend the money they were prevented from spending once the limit expires, subject to normal considerations.

Monitoring and enforcement

The order would set a limit for the end of a specified financial year and DHSC would monitor adherence to the limit using existing monthly financial reporting infrastructure which includes details of the financial position of each FT. In practice, this means DHSC regional teams could take proactive steps in cases where an FT subject to an order under this power appears to be at risk of a breach at year end. Should a breach occur at year end, it may warrant a breach in the NHS Provider Licence Standard Conditions. Where this happens, DHSC may choose to take enforcement action in accordance with the relevant enforcement guidance. Any repercussion for a breach in the order would be at the discretion of the Secretary of State.

Monetised and non-monetised costs and benefits of each option (including administrative burden)

The impact of introducing the backstop power to impose capital limits on FTs was explored in the Core Measures Impact Assessment[4] for the Health and Care Act 2022. The findings from that impact assessment are relevant for the proposal to introduce a backstop power to impose a revenue limit on FTs, although there may be differences owing to the scale and usages of revenue spending (see Risks and mitigations section).

[4] DHSC (2022), Health and Care Act 2022: combined impact assessments - GOV.UK, Core measures impact assessment, page 33 (viewed September 2025)

This IA provides a proportionate assessment of costs and benefits based on the best available evidence and in line with HMT Green Book guidance. However, these proposals depend on future policy decisions regarding the application of the powers and therefore, as those policy decisions have not yet been made, it is not possible to quantify costs and benefits at this stage.

Costs

Reduced FT financial freedom

This provision does not create a direct cost to the health system, as the revenue spending envelope remains constant for the NHS. However, if the power were to be exercised, imposing a revenue limit changes the freedom FTs have to make revenue spending decisions while the order is in effect.

Benefits

Ability to manage national overspend

Introducing this power would help to prevent overspend in parts of the health service that would need to be recouped in others. This supports all organisations in adhering to planned levels of spend which, in turn, means delivering the agreed upon levels of activity and patient care with a lower likelihood of having to curtail expenditure elsewhere.

The primary benefit of this power is that it provides complete flexibility to the AO and the Secretary of State to manage NHS finances in aggregate. This would be done to meet the department's objectives, including protecting against a breach in the department's expenditure limit, as the NHS moves into a new phase of financial management.

Though the power is most likely to be used if an FT is running a surplus position, it could, for example, be used in cases where an FT is running a deficit in order to prevent the FT from running further into deficit. This would be done in cases where the AO deems it appropriate to intervene. Ultimately, overspends need to be offset elsewhere which risks delivery in other key Government health and care programmes. Increasing the controls available to the AO to manage the financial position of the NHS in aggregate serves to reduce the risk of unrestrained overspends.

The risk to patient care is set out in the next section, it would serve to protect and limit the adverse impact of financial mismanagement felt nationally.

Supporting the delivery of the 10 Year Health Plan

A secondary benefit is that the introduction of such a power serves to reinforce the broader shift in financial discipline set out in the 10 Year Health Plan, by emphasising this change in approach. This change is a material and meaningful shift in how DHSC and the NHS will approach financial management. Though challenging to quantify, it is reasonable to expect this to contribute to the broader cultural and behavioural changes needed to bring about the desired financial changes. Ultimately, these changes support a more financially sustainable NHS that will benefit patients for years to come.

Direct costs and benefits to business calculations and impacts on small and micro businesses

There are no direct costs and benefits to businesses as a result of this measure.

Risks and mitigations

Risks to delivery of FT services

Any restriction of expenditure may bring about risks to delivery of FT services, including patient care. However, the duty to consult, combined with the general accountability of the Secretary of State to Parliament, mean that any risk to patient care would be considered prior to imposing any order or determining the appropriate limit to put in place.

The consultation period would in include consideration of the FTs spending plans to protect 'essential' expenditure such as current staff salaries to ensure the order is appropriate and proportionate. It would also allow time to put mitigations in place should any risks to patient care be identified. The discretionary nature of the power acts as a key protection against patient care risks on the grounds the Secretary of State could decide against using the power if the consultation period raised material risks that could not be effectively mitigated.

DHSC regional teams will engage regularly with any FT subject to an order to provide ongoing support in adhering to the order, and the existing duties and requirements of FTs as they relate to patient safety will continue to apply. Careful management on the timing and extent of its use must be considered to avoid any unwarranted disruption to the provision of NHS services.

One could argue this delivery risk is most applicable to investment in things like technology (specifically the revenue commitment such investments generate) and service development by individual FTs. The mitigations described above (such as the discretionary nature of the power and requirement to consult) limit the risk, but it cannot be wholly ruled out. However, this is considered an acceptable risk on the grounds that the NHS must operate within its allocated budget in order to be sustainable in the long term, and sustainable investment decisions must be taken in that light.

Further, in other ways this change serves to protect and limit the adverse impact of financial mismanagement felt nationally, which could act as a prevention for risks to patient care in other aspects of the system.

Risk of limited use of powers

The NHS revenue budget is substantially larger than the capital budget, and revenue spending may be considered less easy to turn 'on' and 'off'. Capital projects, for example, could be more easily paused, while day-to-day spending on NHS service provision is less flexible, particularly if there is a high level of demand for services in a given area. Therefore, there is a risk that these powers are limited in their ability to support financial balance in cases where the revenue spending is less easy to adjust. The consultation period provides mitigation for this, as the discretionary power would only be used where it is deemed beneficial.

Risk of adverse effects

As is the case with any new power, there are FT behavioural risks worth considering. There could be a risk that the introduction of a revenue 'backstop' power, regardless of the last resort intentions, has an adverse effect on FTs in that achieving a surplus becomes less desirable. In reality, however, this is likely to be negligible on the grounds no money is being taken from FTs if the order is enacted. An order would not permanently remove or restrict an FT from spending its surplus, it would simply prevent them from doing so beneath a set level within a given financial year. Once the order expired, the FT would still retain the surplus and be able to spend it as normal.

Monitoring and Evaluation

Monitoring and evaluation for this proposal will be considered as part of the wider approach covering all the Health Bill proposals, please see the Impact Assessments Summary Document for more details.