Bold thinking for better health

Written submission

NHS Modernisation Bill (Health Bill): Public Bill Committee submission from The King's Fund

About The King's Fund

The King's Fund is an independent charity working to improve health and care in England. As well as our work to inform and improve health and care policy, we run a significant programme of leadership support and organisational development in the health and care sector. This evidence submission is grounded in both our policy research and analysis, and our experience of working day to day with senior leaders throughout the NHS.

Executive summary

The Health Bill provides a legal basis for the abolition of NHS England and other measures set out in the 10 Year Health Plan. The proposals mark a significant shift in how the NHS is run at national and local levels, with many functions currently devolved to NHS England to be moved into the Department of Health and Social Care (DHSC). This evidence submission focuses on the key areas of the Bill that we believe will benefit from closer parliamentary scrutiny.

Single patient record (SPR)

1. The King's Fund strongly welcomes the goals of the SPR. It is one of the most significant opportunities within the Bill to shape how people experience services and enable research to improve health and care. A well-functioning SPR could address longstanding issues in the NHS, including fragmented records wherein a record from one part of the health and care system cannot be seen by clinicians in another, patients having to repeatedly tell their histories, and poor communication and co-ordination between services. It has the potential to bring many benefits to patients, empowering them to better understand their own health, advocate for their needs, and control their data, as well as health and care staff having a fuller picture of the patient.
2. England is well positioned to develop an SPR; nevertheless, delivering this ambition is complex. The SPR will require interoperability across numerous digital systems, particularly if it is to include social care. Developing and mandating appropriate data standards will be essential. There is too little detail in the Bill on how it will be rolled out and work in practice. It must be designed carefully, with the input

of patients, clinicians and data controllers, in order to allay fears around privacy and to be empowering and accessible for all. This includes ensuring there is mitigation against digital exclusion.

3. Public engagement exercises show that people support their health data being used to benefit themselves and others and can see the benefits of an SPR. However, there is also concern around the use of data, including privacy, security and accountability. Public trust in NHS use of health data is generally high, but there is a significant minority that still hold valid concerns.
4. The Secretary of State for Health and Social Care's powers around data disclosure as contained within the Bill are very broad. Robust measures on data governance, security safeguards around privacy and consent will be essential for the public and parliament to have confidence in the SPR. Data controllership should be a key consideration of the work needed to maintain public trust.
5. In order to be future-proof, it is essential to consider how the SPR will incorporate health and care information beyond what is currently routinely captured. This information includes independent and private sector records and genomic data, for example, direct-to-customer health test results and data from wearables and continuous blood glucose monitors. This will require the government and service providers to agree data and interoperability standards for data sharing.
6. Legislation is just one early step in establishing the SPR; implementation must be managed well for its success. Successive governments have promised to join up patient data for improved care but have struggled to deliver at scale. Lessons must be learned from past digital initiatives that too often have failed at the implementation stage.
7. **We recommend that the committee does the following.**
    i. Support the elements of the Bill enabling the provision of an SPR.
    ii. Consider whether the Bill provides sufficient measures to ensure clear governance and safeguards, and ensure public trust in the SPR. These should be developed through consultation and engagement with the public, via check and challenge groups, for example.
    iii. Provide scrutiny of and support an amendment to limit the Secretary of State's powers around data disclosure, as the powers contained within the Bill are very broad.
    iv. Support an amendment to strengthen accountability for inappropriate data sharing. Consider mandating data control options for patients, audits of access to patient data, and provision to enable patients to see who has accessed their data.
    v. Request greater clarity over who controls and is responsible for patient data. Frameworks for shared governance and delegated access models should also be sought.
    vi. Support amendment 8, which makes it explicit that 'nominated carers' can access the SPR on behalf of those they care for. Proxy access to the SPR for parents and carers is important for equity, although appropriate safeguards against misuse of proxy access will be essential.

Abolition of NHS England and transfer of powers to the Secretary of State

8. While we recognise that having two 'centres' in NHS England and DHSC, as well as numerous arm's length bodies, can result in overlapping responsibilities, confusion around accountability and an excess of directives to local health systems, we have concerns that the Bill gives rise to an over-centralisation of power with the Secretary of State for Health and Social Care, potentially reducing system stability and stifling local innovation. It may also create bottlenecks in decision-making, for example if the Secretary of State wished to intervene in an appointment to a role.
9. Additionally, there is risk in setting out how these changes will work in practice in further guidance and regulations rather than in the Bill itself. This limits the opportunity for legislative scrutiny over how the NHS – which accounts for a large share of the expenditure covered by the parliamentary vote – will operate in future.
10. The Secretary of State should have the tools to assure patient safety, uphold national standards and ensure system alignment. However, we have concerns about unchecked statutory powers over

commissioning, board appointments, performance management and spending allocations. There is a risk that an interventionist health chief could distract the health and care workforce from their core duty to deliver high-quality care, with a slew of new directives and politically charged appointments. In extremis, a Secretary of State could choose to defund services or parts of the NHS with these new powers at their disposal, with funding allocations based on political reasoning rather than clinical need.

11. We strongly believe that additional powers for the Secretary of State should be targeted, proportionate and subject to robust guardrails.
12. **We recommend the committee consider amendments to strengthen parliamentary scrutiny of the Secretary of State's powers via the following.**
    i. Set out in legislation the criteria for making decisions around how the NHS is run (similar to section 57B that lists five criteria and a consultation process a Secretary of State should follow before de-authorising a foundation trust).
    ii. Require independent panels to provide advice and scrutiny of decisions, including reconfiguration of services, de-authorisation of foundation trusts, the setting of spending limits and appointment of chairs and non-executives, and regular public reporting on progress in making appointments assessed against performance targets.
    iii. Require the government to provide more detail on the statutory reallocation of the roles from NHS England, defined clear lines of accountability between the Secretary of State and Integrated Care Boards (ICB), and the publication of an accompanying operating model.

Changes to ICB duties

13. The Bill makes ICBs directly accountable to DHSC as NHS England is abolished. It seeks to strengthen ICBs as the primary strategic commissioners within local systems, including taking on greater responsibility for primary care commissioning and long-term planning. These changes represent a significant shift in the system architecture, and will require sufficient commissioning capacity and expertise to deliver the desired impact
14. The King's Fund welcomes the separation of performance management and strategic commissioning roles and is supportive of ICBs taking more commissioning responsibility. The current dual role of ICBs supporting local system development, while also being taskmasters for national priorities, hasn't been working. Immediate priorities of access and finance have crowded out the opportunities for ICBs to prioritise long-term development and improvement in services. For this to improve will also require a change to how ICBs are held to account. The metrics in the NHS Oversight Framework are still heavily balanced towards short-term operational delivery.
15. If ICBs are to deliver on the government's ambitions as set out in the 10 Year Health Plan, particularly the shift towards prevention and community-based care, the legislation needs to strike a careful balance. On one hand, ICBs need sufficient autonomy to respond to local population needs and to develop long-term strategies. On the other hand, they must operate within clear national priorities and accountability frameworks.
16. The Bill sets a new ICB membership requirement of at least one representative nominated by the mayor of each strategic authority within each ICB's area. Involving mayors more closely could strengthen local accountability and community engagement and support both mayors and ICBs to carry out their respective duties around health and health inequalities. However, it also raises questions about the balance of influence within ICBs and how ICBs will reconcile any differences between nationally determined NHS priorities and local political priorities.
17. Furthermore, removing the requirement to have at least one local authority representative within each ICB risks undermining partnership work between the NHS, social care and public health at a local level.
18. **We recommend the committee consider amendments to include the following.**

   i. Require the government to provide more detail on how, and in which circumstances, the Secretary of State's powers of direction for ICBs, as set out in clause 11, might be used.
   ii. Set explicit responsibilities for ICBs around long-term population health planning and commissioning to ensure that securing long-term improvement in health outcomes for the local population is central to decision-making and prioritisation.
   iii. Scrutinise how the benefits of having representation to enable partnership work between the NHS, social care and public health at a local level will be maintained if not prescribed by legislation.

Neighbourhood health plans

19. The Bill sets out in clause 24 changes to strategic planning requirements through the replacement of health and wellbeing strategies with neighbourhood health plans for health and social care. Health and Wellbeing Boards (HWBs) will have lead responsibility for producing the neighbourhood health plan and we welcome the requirement that local people are involved in this approach.
20. A key question is how much influence neighbourhood health plans will have on decision-making in the NHS. ICBs are also required to produce a population health improvement plan (PHIP) describing how they intend to commission services for the population they cover. Since ICBs now cover bigger geographies than in the past, they will have to take account of a larger number of local plans, and so the influence of any one plan will inevitably be less direct.
21. In previous legislation, there were specific provisions designed to ensure that planning processes in ICBs reflected local health and wellbeing strategies (for example, there was a clause in the 2022 Act that allowed a HWB to give NHS England its formal opinion on whether an ICB's commissioning plans sufficiently reflected the health and wellbeing strategy). In contrast, the 2026 Bill only contains the more nebulous requirement for ICBs to 'have regard to' neighbourhood health plans in exercising any of their functions.
22. **We recommend the committee consider amendments to include the following.**
    i. Require ICBs to be able to demonstrate how local neighbourhood health plans have influenced their PHIP.

Abolition of Healthwatch

23. Since 2013, Healthwatch England and the 153 local Healthwatch organisations have gathered the views of people using the health and care system in England to share this information with government bodies and local systems to inform policy and service development. The Bill proposes abolishing Healthwatch England and local Healthwatch organisations, replacing it with a new patient voice function within DHSC, and transferring the statutory responsibilities of local Healthwatch to ICBs for health services and to local authorities for social care and public health services.
24. Earlier this year, The King's Fund published research on the learnings from Healthwatch and what the future of the patient voice should look like. We found that Healthwatch's independence from central government ensured it was able to provide objective scrutiny of issues affecting patients and enabled local Healthwatch organisations to develop trusting relationships with their local communities. At its best, Healthwatch's 'hub and spoke' structure successfully combined local reach with national influence. Healthwatch has collected significant volumes of qualitative and quantitative feedback, including unsolicited insight not always captured elsewhere. This has helped the health and care system capture emerging issues that mattered to patients and communities and place these issues higher on the national agenda.
25. However, Healthwatch's limited statutory powers meant that although it could report on issues, it could not hold the health and care system to account for addressing them. The overall Healthwatch budget, particularly at a local level, has fallen over time, which has placed limitations on its impact and

effectiveness, and there is variation in funding between local Healthwatch organisations, affecting capability.

26. In our view, whatever replaces Healthwatch must build on the core conditions that enabled it to have a positive impact: a voice independent of government and services; the capacity to gather unsolicited, varied and rich community insight, including from seldom-heard groups; and a geographical scale that supports both local insight and system- or national-level influence.
27. The new patient experience directorate and local patient experience functions must have sufficient independence to ensure that people feel able to come forward with their experiences and the authority to hold DHSC to account and challenge when necessary. Where full structural independence cannot be guaranteed, this must be offset by a robust package of transparency and accountability measures, for example by producing annual reports or giving annual public hearings, such as through the Health and Social Care Select Committee. Any new function should routinely set out what it has learnt from data collection and engagement and clearly explain what actions will follow.
28. The capability to gather unsolicited, varied and rich community insight, including from underserved and seldom-heard groups, must be maintained. The new functions should have both the scale and the scope to support both local insight and national-level influence, and we would like to see more clarity on how this aligns more deliberately to local government, new ICB clusters and neighbourhood structures and footprints. We are concerned that separation of responsibility for feedback on health and for feedback on social care and public health (to ICBs and local authorities respectively) limits the gathering of insight across the whole system, risking engagement focused on organisational silos.
29. **We recommend that the committee does the following.**
    - vii. Support amendments that mitigate against the risk of the loss of independence of the patient voice function, such as a robust package of transparency and accountability measures.
    - viii. Ensure that the capability to gather unsolicited, varied and rich community insight – including unsolicited feedback – is maintained through the Bill.
    - ix. Consider the role of local authority overview and scrutiny committees in reviewing and acting on feedback collected by local authorities.

Health Services Safety Investigations Body (HSSIB)

30. The transfer of the functions of HSSIB into the Care Quality Commission (CQC) also raises questions around people being able to trust the system and come forward with their concerns and issues. We are concerned that by merging HSSIB with the regulator for health and social care, people would not feel comfortable to come forward and speak openly, which would negatively affect the efficacy of HSSIB. The change would also make it difficult for HSSIB to comment on how the CQC was managing safety considerations.
31. **We recommend the committee considers the following.**
    - i. What further clarity around governance is required, and how that would work to protect independence.

Considerations not included within the Bill

32. **Health inequalities:** The Bill lacks action to address the deep health inequalities across the country and ensure genuine accountability for delivery of improvement in health and inequalities for the long term. To help drive action, we need a cross-governmental approach to health, to consider the wider determinants of health and healthy life expectancy, with requirements for independent reporting on progress.
33. **Prevention:** The lack of focus on prevention means opportunities are being missed on obesity, alcohol misuse, the promotion of clean air and generally shifting the balance of health spending away

from hospitals. This contrasts starkly with the 10 Year Health Plan's stated shift towards preventing ill health.

34. **Social care:** The absence of adult social care from the Bill reflects its absence from the government's overall reform programme, despite the urgent need for action to improve the social care system. Interim action should not wait for the Casey Commission's final recommendations in 2028.
35. **Climate change:** The 2022 Act required NHS England to report annually to parliament on progress in decarbonising the NHS. The omission of this from the Bill represents a backwards step in terms of accountability and is not consistent with the government's stated position on the urgency of climate change mitigation.
36. **We recommend the committee considers the following.**
    i. Support an amendment to include a broad duty to improve health and reduce inequalities through action on the building blocks of health, mirroring the new duty for combined authorities, as set out in the letter to Minister Karin Smyth MP by Health Equals and co-signed by The King's Fund.
    ii. Back this broad duty by a strong statutory framework to improve health and tackle health inequalities that would require government to set long-term targets.
    iii. Support an amendment to develop a cross-government strategy on health inequalities and report publicly on its progress.
    iv. Consider what action can be taken to improve the social care system sooner than 2028 when the Casey Commission's final recommendations are published.
    v. Consider what further action can be taken to ensure progress against the 10 Year Health Plan's stated shift towards preventing ill health.
    vi. Support an amendment to include a reporting duty for the Secretary of State to ensure recent progress in carbon reduction within the NHS does not stall.