

NHS Modernisation Bill (Health Bill): House of Commons Second Reading

Summary and key messages

The King's Speech to Parliament on 13 May 2026 opened the new legislative session and outlined its next areas of focus. One of the key pieces of legislation laid before Parliament was a new health bill – introduced in The King's Speech as the 'NHS Modernisation Bill'.

The main aim of the NHS Modernisation Bill is to provide a legal basis for the largest reorganisation of the NHS in more than a decade. It is the government's primary legislative vehicle for delivering its commitment to abolish NHS England (NHSE) and to implement its 10 Year Health Plan. The proposals mark a significant shift in how the NHS is run at national and local levels.

This government has already shown what can be achieved with legislation to improve the health of the nation through the [historic Tobacco and Vapes Act](#). The Bill has the potential to shape how health care is experienced and who is accountable for delivering it. However, **much of the Bill focuses on structural change rather than directly addressing patient experience and outcomes.** Evidence from previous reorganisations suggests [structural reform alone can be a huge distraction and rarely improves care](#) unless it is clearly linked to practical changes in how services are delivered.

The Bill therefore presents both opportunities and risks. **Its most promising element is the potential to link data and improve co-ordination of care through a single patient record.** Its biggest risk is that organisational change absorbs leadership attention and capacity without delivering tangible improvements for patients. Whilst structures do matter to how a health service runs, ultimately, they aren't what patients care about. They are far more interested in the quality and speed of the care they receive.

The government says that it would like to devolve power from Whitehall and give patients more control over their care. However, there is a risk that this Bill does the opposite with **more power centralised and the disbanding of the independent organisations set up to listen and ensure patient voices are heard across health and care services.**

This briefing examines the main provisions of the Bill and proposes key questions and areas of scrutiny for MPs ahead of the **Second Reading in the House of Commons on Monday 1 June 2026.**

Headline provisions in the Bill

The NHS Modernisation Bill includes the following key measures:

- abolition of NHSE and transfer of its functions into the Department of Health and Social Care (DHSC)
- expansion of the Secretary of State's powers over commissioning, performance, and resource allocation
- changes to the statutory duties and role of Integrated Care Boards (ICBs)

- creation of a single patient record and changes to data governance
- abolition of Healthwatch and establishment of a new patient voice function
- merging of the Health Services Safety Investigations Body (HSSIB), which investigated patient safety issues, into the Care Quality Commission (CQC) regulator.

Key issues for MPs to consider

The provisions in the Bill are intended to align the system more closely with the government's strategic priorities. However, their implications for accountability, local autonomy and delivery are significant and require careful scrutiny. Key tests for the Bill include whether it will:

- make a difference to patient care
- reduce bureaucracy
- strengthen patient voice
- improve patient safety
- stabilise the NHS.

1. Abolition of NHS England and transfer of powers to the Secretary of State and DHSC

At the heart of this debate is the balance of powers and accountability at the 'centre' of the system, particularly what the Secretary of State has the power to do. The stated rationale for abolishing NHSE and other arm's length bodies and pulling functions back into DHSC is that there are too many bodies with overlapping responsibilities. Local health systems are overrun with directives and are servicing 'two centres' in NHSE and DHSC.

The Bill may simplify accountability and reduce duplication between organisations. However, this change raises several risks:

- First, **over-centralisation**. Bringing operational functions closer to the Secretary of State may increase political control over day-to-day NHS decisions, potentially reducing system stability and stifling local innovation.
- Second, **creating bottlenecks in decision-making**. Concentrating authority at the centre could slow down responsiveness, particularly in a complex system that requires local adaptation.
- Third, there are lessons from previous reorganisations. Structural change can be disruptive, **diverting leadership capacity away from service improvement** and creating uncertainty for staff.
- Additionally, there is a risk that too high a proportion of how these changes will work in practice are to be set out in further guidance and regulations, rather than 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.

The King's Fund agrees that 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, performance management and spending allocations**. The risk is an interventionist health chief who could destabilise an already jaded workforce with a slew of new directives and politically charged appointments.

We would like to see:

- increased detail on the statutory reallocation of the roles from NHSE and defined clear lines of accountability between the Secretary of State and ICBs

- additional powers for the Secretary of State, for instance, over how local NHS leaders are appointed, to be **targeted, proportionate and subject to robust guardrails**
- publication of an **accompanying operating model**.

MPs may wish to consider how the Bill ensures there are appropriate checks and balances on the expanded role of the Secretary of State, including mechanisms for scrutiny, transparency and operational independence.

2. Reconfiguration of ICB duties

The Bill 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. At the same time, ICBs are to become directly accountable to DHSC rather than NHSE. This represents a significant shift in the system architecture. The Bill is also expected to require statutory mayors (or a nominated deputy) to be members of ICBs, alongside introducing changes to strategic planning requirements to align more closely with the [priorities set out in the 10 Year Health Plan](#).

If ICBs are to deliver on the government's ambitions, 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.

Key risks include:

- **undermining partnership work between the NHS, social care and public health** at a local level with the removal of mandatory local authority representatives within ICBs
- **capacity constraints** within ICBs, particularly following recent cost-reduction requirements to radically downsize headcount by 50 per cent
- **unintended consequences** of granting greater financial control to high-performing organisations.

The King's Fund welcomes **the separation of performance management and strategic commissioning roles**. [The dual role of ICBs supporting local system development, whilst 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.

Additionally, involving mayors more closely could strengthen local accountability and community engagement, working with ICBs to fulfil 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**.

We would like to see:

- **explicit responsibilities for ICBs around long-term population health planning**, not detailed day-to-day working of the health service
- powers for ICBs to hold providers accountable for delivery.

MPs may wish to seek clarity on how precisely the Bill changes the role of ICBs, how much autonomy they will have, and whether it equips them to act as genuine strategic commissioners.

3. Single patient record

As well as moving some of the statutory data functions currently held by NHSE into DHSC, there are also provisions in the Bill for a single patient record. The single patient record is a unified, longitudinal record for each patient, that will be accessible via the NHS App by 2028. The intention is for people to see their primary, secondary and social care record all in one place, ending decades of frustrations around fragmented information and care. This is one of the most significant opportunities within the Bill to shape how people experience services, and for research to improve health and care.

A well-functioning single patient record could address long-standing issues in the NHS, including fragmented records, repeated patient histories and poor communication between services. It has the potential to support more integrated, person-centred care and reduce administrative burden for both patients and staff.

However, delivering this ambition is complex. Successive governments have promised to join up patient data for improved care but have struggled to deliver at scale. Key issues therefore include:

- **Accountability:** currently, GPs are data controllers for the patient data they hold, which means they decide the purposes and means of processing. There has been some debate around moving away from GPs as sole controllers and towards a National Data Trust or a similar entity to enable research and innovation, which would require legislative changes. However, the Bill currently doesn't seek to shift the data controller, but this is an area we should keep a close eye on.
- **Governance and trust:** safeguards around privacy, consent and security. Public engagement exercises show that people support their health data being used to benefit themselves and others and can see the benefits of a single patient record. However, there is also concern around the use of data. Public trust in NHS use of health data is generally high, but there is a significant minority that still hold valid concerns.
- **Implementation:** the single patient record will require interoperability across systems and providers, particularly if it is to include social care. There is too little detail on how it will be rolled out and work in practice. Lessons must be learned from past digital initiatives that too often failed at this stage. A major reason for these failures has been an inability to create sufficient capacity and resource to enable such initiatives to be adopted, including resource to ensure issues around data quality and cleansing, among other problems, are unblocked.
- **Engagement:** it is very important that patients, clinicians and data controllers are involved in the design of the new single patient record.

The King's Fund strongly welcomes the goals of the single patient record and believes it has the potential to bring many benefits to patients, empowering them to **better understand their own health and advocate for their own needs** as well as improving the co-ordination and administration of care. However, **it must be designed properly and carefully** to allay fears around privacy and to be empowering and accessible for all.

We would like to see:

- **clarity over who controls and is responsible for patient data**
- **frameworks for shared governance** or delegated access models
- consideration and mitigation of digital exclusion.

MPs may wish to seek clarity on who is accountable for the data, what safeguards are in place, and more detail on implementation.

4. Abolition of Healthwatch

[Healthwatch England and Local Healthwatch organisations](#) are independent statutory bodies that play an important role in ensuring NHS leaders and other decision-makers listen to patient feedback and improve standards of care. The Bill proposes abolishing Healthwatch and its 150+ local branches and replacing it with a new patient voice function within DHSC, bringing the responsibility for listening to (and acting on) concerns raised by patients closer to decision-makers. These changes come alongside other changes relevant to how the NHS listens and learns from local communities, such as the removal of the requirement for foundation trusts to have a council of governors.

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 effectively gathered insights from communities about health and care services to draw attention to crucial issues when they were being overlooked by the wider system but had limited levers to bring about change.

“If what comes next is essentially providers marking their own homework, then we will have very little scrutiny and ability to shift practice.”

Member of the public interviewed for the research

The King's Fund believes that the newly created Patient Experience Directorate and reimagined local patient voice network must enhance – not weaken – the system's capacity to hear, understand and respond to people's experiences. There is a risk that bringing this function into DHSC could weaken independence. While the new DHSC Director of Patient Experience role could give patient experience the prominence it needs, it must have **real influence on decision-making**. Any new approach must **embed patient and service user voice at its core**, requiring leadership and cultures that genuinely listen, learn and act together across health and care.

We would like to see the Patient Experience Directorate and local patient voice network 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, including **a robust package of transparency and accountability measures**
- capacity to gather **unsolicited, varied and rich community insight**, including from underserved groups
- scale and scope that **supports both local insight, and system- and national-level influence** with clarity on how this aligns more deliberately to local government, new ICB clusters and neighbourhood structures and footprints.

MPs may wish to challenge how independence will be ensured for the relevant work of the new Patient Experience Directorate and seek clarity over what powers it will have.

What is missing from the Bill?

The **absence of adult social care** from the Bill reflects its absence from the government's overall reform programme. This highlights the need for urgency and focus. Interim action should not wait for the Casey Commission's final recommendations in 2028.

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. Without such measures, it is **unclear how the government will deliver on its stated shift towards preventing ill health**. Likewise, it lacks action to address the deep health inequalities across the country.

Context: current state of health and care

Last summer, the government published its [10 Year Health Plan](#) and has begun implementing its three shifts: from hospital to community, from analogue to digital, and from sickness to prevention. But delivery is still at an early stage. Health and care services remain under significant strain:

- [Waiting lists remain above 6 million](#) people, with performance meeting interim improvement targets, but still falling far below NHS constitutional standards.
- Public satisfaction has recovered slightly but remains historically low, [with just a quarter of people saying they are satisfied](#), and uneven across services.
- [Healthy life expectancy has declined to around 61 years](#) and inequalities between the most and least deprived continue to widen.
- [Adult social care faces rising demand](#), longstanding workforce shortages and constrained local authority budgets.
- There are widespread failures in basic NHS administration and communication, [with two thirds of patients and carers reporting at least one problem in the past year](#), at a time when the NHS App is expected to become the front door to the NHS.

Taken together, these trends underline that while there has been some progress, access to timely, joined-up health and care remains a major challenge and **the health of the nation is not improving overall**. The Bill also comes against a backdrop of political instability.

Contact

If you would like further information or have any questions about the Bill, please contact **Steph Kleynhans, Head of Responsive Policy and Public Affairs** at s.kleynhans@kingsfund.org.uk

Further reading

- [Five tests for the NHS Modernisation Bill](#)
- [Why do politicians restructure the NHS?](#)
- [Before the next bill lands: What history tells us about NHS reorganisation](#)
- [How to navigate the political pitfalls of health legislation](#)
- [The future of patient voice: learning from the Healthwatch model](#)