



Royal College
of Physicians

RCP briefing | Health Bill: House Lords Second Reading

Summary

The Health Bill proposes substantial changes to NHS leadership, accountability and service planning. It would abolish NHS England (NHSE), transfer functions to the Secretary of State for Health and Social Care and integrated care boards, establish the framework for a single patient record, change responsibility for specialised commissioning and move national patient-safety investigation functions into the Care Quality Commission.

The RCP supports the ambition to modernise the NHS and broadly welcomes the single patient record. However, the government must provide stronger assurances on clinical involvement, interoperability, digital inclusion, privacy, data governance and the resources needed for safe implementation.

The abolition of NHSE must not result in the loss or fragmentation of clinical leadership and specialist expertise. The government should clarify which clinical functions will be retained, where they will sit and how independent clinical advice will continue to shape national policy and commissioning.

The Bill should strengthen the Secretary of State's duty to tackle health inequalities, to ensure a strong focus on addressing the wider determinants of health and the causes of unequal health outcomes.

The Bill should require the Secretary of State to issue annual progress updates to Parliament on NHS emissions and environmental sustainability, to ensure no dilution of accountability for environmental sustainability following the abolition of NHSE.

About the Royal College of Physicians

The Royal College of Physicians (RCP) is the membership body for physicians, with around 40,000 members and fellows in the UK and internationally from over 30 medical specialties. These range from cardiology and gastroenterology to geriatric medicine.

Single patient record

The RCP broadly supports the introduction of a single patient record. Bringing together information held across different settings could give clinicians a more complete picture of a patient's health, reduce the need for patients to repeat their history and help staff use their time more effectively. It could also improve patients' access to and understanding of their own information.

However, the Bill creates an enabling framework and leaves important questions to secondary legislation and delivery decisions. There is a risk of optimism bias if the programme moves ahead without first fixing the NHS's fragmented digital foundations. Poor implementation could increase clinical burden, reduce usability, widen inequalities and undermine public confidence.

These concerns are shared by organisations working on the use of health data. Understanding Patient Data has warned that legislation alone cannot create public trust and that successful delivery will depend on clear governance, clinical engagement and practical implementation. Evidence submitted to the Commons Bill Committee by the Association of British HealthTech Industries similarly stressed that the effectiveness of the single patient record will depend on clear data-sharing duties and robust interoperability standards.



For the single patient record to work effectively, it must be interoperable with existing electronic patient record systems across primary care, secondary care and social care. Common data standards will be essential to ensure that information can follow patients safely between services and that clinicians can access a clear and consistent record of care.

Clinical input will also be critical. Doctors and other frontline staff should be meaningfully involved throughout the procurement, design, testing and implementation of the record. A system may be technically functional but still create additional work or patient-safety risks if it does not reflect clinical workflows or is difficult to use. The government should therefore set out how clinicians and patients will shape the programme and how usability will be tested before wider rollout.

The implementation of the single patient record must also address digital exclusion. Access to technology and confidence in using digital services remain uneven, particularly among some groups already experiencing poorer access to healthcare. The record must not make it harder for people who cannot or do not use digital services to manage their health or access care. Appropriate non-digital routes and support should remain available.

Clear arrangements for privacy, data governance and accountability will be vital to maintaining public trust. The government should explain who will control the information brought together within the record, who will be permitted to access it, the purposes for which it may be used and the safeguards that will apply. This includes resolving uncertainty around responsibility for data originating in general practice and other care settings. With appropriate governance in place, joined-up health data could support valuable research and improve understanding of population health. However, where information may be made available to public or private researchers, this must be governed by clear safeguards, transparency and effective accountability. Patients and the public should be able to understand how their information may be used and have confidence that decisions about access will be made in the public interest.

Finally, the government should set out a realistic and properly resourced implementation plan. This should address the full costs of developing and maintaining the record, the workforce and training required to introduce it safely, and the arrangements for cybersecurity, testing and independent evaluation. It should also explain how organisations with weaker digital infrastructure will be supported, so that implementation does not create further variation between different parts of the NHS.

RCP ask: The government should give clear commitments on the safe and effective delivery of the single patient record. This should include meaningful clinical and patient involvement in its design and implementation; interoperability with existing electronic patient record systems; support for people who are digitally excluded; and clear arrangements for privacy, data governance, accountability and secondary uses of data. The government should also set out which safeguards will appear in primary legislation, which will be left to regulations and how Parliament will scrutinise their development.

Abolition of NHS England and clinical leadership

The RCP recognises the government's aim of creating clearer accountability and reducing duplication by abolishing NHSE and transferring its functions to the Department of Health and Social Care (DHSC) and integrated care boards (ICBs). However, this represents a major reorganisation at a time when the NHS is already under considerable operational pressure. The transition must therefore be carefully managed to avoid disrupting patient care or slowing progress against the government's wider health priorities.

The RCP's principal concern is the future of clinical leadership and specialist expertise within the reformed system. National clinical directors, clinical reference groups and other clinical leadership functions currently



provide expert advice on service design, quality improvement, workforce planning and specialised commissioning.

DHSC will also need sufficient clinical capacity to carry out its expanded responsibilities effectively. The transfer of functions should not weaken the quality of policy development, operational oversight or long-term planning. The government should explain how clinical expertise will be embedded within the restructured Department and how ministers and officials will continue to receive independent clinical advice.

There must also be clear and dependable routes for wider clinical and patient input into national decision-making. Medical royal colleges, professional bodies, patients and frontline staff should be able to provide advice, evidence and constructive challenge as the new arrangements are developed and implemented. This engagement should be formal and meaningful, rather than taking place only after key decisions have already been made.

Finally, greater ministerial accountability must not lead to day-to-day political micromanagement of clinical or operational decisions. Clearer accountability to Parliament is welcome, but clinical decisions should continue to be guided by evidence, professional expertise and patients' needs.

RCP ask: The government should set out how clinical leadership will be protected following the abolition of NHSE. It should confirm which national clinical leadership roles and functions will be retained, where they will sit and how their independence, authority and influence will be maintained. This should include the future of national clinical directors, clinical reference groups and other sources of specialist advice. Ministers should also explain how clinical expertise will inform decisions while preventing day-to-day political micromanagement of clinical and operational matters.

Health inequalities

The Bill transfers to the Secretary of State a duty to consider inequalities in access to health services and the outcomes achieved. While this proposal is welcome, the RCP does not believe that a duty merely to consider health inequalities is strong enough. These inequalities remain persistent and are shaped by decisions across government, as well as within the NHS.

The Bill should place a clearer duty on the Secretary of State to act to reduce health inequalities. This call is supported by Health Equals, a coalition of more than 120 organisations, which has [proposed](#) a statutory health improvement and inequalities duty backed by a cross-government strategy, long-term objectives and public reporting. Health Equals has highlighted a 16-year gap in life expectancy between different UK postcodes, demonstrating the scale of the challenge and the need for coordinated action beyond the NHS.

The RCP has, since 2020, been advocating for the government to implement a cross-government strategy to tackle health inequalities. Health can be affected by a wide range of factors, ranging from the food we eat, where we live, and the air we breathe. Not all social determinants of health fall within the scope of the Department of Health and Social Care, and to prevent health inequalities, all departments must take action to prevent inequalities where possible.

RCP ask: The government should strengthen the duty on the Secretary of State to act to reduce health inequalities. This should be supported by coordinated action across government and transparent reporting on progress.



Environmental sustainability

Currently, NHSE has a duty to consider the environmental impact of its operations and publishes data on emissions across the NHS. The Bill does not transfer this duty to the Secretary of State, meaning the abolition of NHSE risks creating a gap in system-wide accountability for the NHS's environmental impact. Existing duties on government would not provide the same transparency, particularly if DHSC reports only on its own activities rather than the health service as a whole.

The effects of climate change and extreme weather are already placing pressure on patients, staff and NHS infrastructure. Environmental sustainability should therefore be treated as an issue of public health, patient safety and service resilience, rather than as an optional additional objective.

NHS action and leadership are also essential because healthcare delivery itself has a significant environmental impact. Reaching the NHS's net zero target will require changes across clinical practice, including prescribing, diagnostics, care pathways, travel and the use of resources. As the RCP's [Actions for sustainable healthcare](#) guidance sets out, these changes can reduce emissions while also improving patient care, avoiding unnecessary appointments and investigations, reducing waste and making services more efficient. Physicians are well placed to lead this work, but they need clear national direction and organisational support so that effective local action can be adopted consistently across the health service.

RCP ask: The RCP supports the recommendation from The King's Fund and the Centre for Sustainable Healthcare that the Bill should introduce a new statutory duty requiring the Secretary of State for Health and Social Care to report annually to Parliament on NHSE's progress in meeting its environmental sustainability duties. This would preserve parliamentary oversight of NHSE's environmental performance and help ensure that progress does not stall as NHSE's functions transfer to DHSC.

Specialised commissioning and ICBs

As part of the abolition of NHSE, ICBs will take on responsibility for commissioning most specialised services, with only highly specialised services commissioned directly by DHSC. Where services need to be planned across a larger population than a single ICB covers, the government expects boards to work together through multi-board arrangements.

The RCP supports decisions being made at the most appropriate level, but many specialised services depend on significant clinical expertise, consistent standards and planning across large populations. ICBs are also undergoing substantial organisational and financial change. The government should therefore demonstrate that boards have the capacity, data and specialist clinical advice needed to take on these responsibilities before further services are transferred.

Clinical reference groups, or equivalent expert structures, should remain available to support evidence-based commissioning. These arrangements provide access to specialist knowledge that may not be available within every ICB. The government should explain how this expertise will be retained and how clinicians will continue to influence the planning, design and commissioning of specialised services.

Although local decision-making can allow services to respond to the needs of their populations, there must be national safeguards against unjustified variation in access to specialised care. Patients should be able to access appropriate treatment regardless of where they live. National standards, transparent data and effective oversight will be needed to identify and address unacceptable differences in provision or outcomes.

RCP ask: The government should clarify how clinicians will be represented in specialised commissioning arrangements. Meaningful clinical input will be important to ensure that decisions are informed by specialist expertise and support consistent access to high-quality care.



Independent patient-safety investigation

The Bill would abolish the Health Services Safety Investigations Body (HSSIB) and transfer its investigative functions to the Care Quality Commission (CQC). The RCP supports retaining an independent national patient-safety investigation body. Patient-safety investigation has a different purpose from regulation and enforcement. Its effectiveness depends on independence, specialist expertise and the confidence of patients and staff.

Bringing these functions within the regulator risks blurring the distinction between learning from safety incidents and taking regulatory action, even if the investigative function is administratively separate. These concerns are supported by analysis from the Nuffield Trust. Its House of Commons report-stage [briefing](#) concluded that there is no clear case for abolishing HSSIB and merging its functions into the CQC. It warned that the change risks disruption and would reduce independence, while not reducing the number of ways in which NHS trusts are held accountable. It also noted that comparable bodies in other sectors and countries do not combine safety investigation with regulation.

Any new model must also protect confidential information and the safe-space principle, retain experienced investigators and ensure that ongoing investigations and recommendations are not lost during the transition.

RCP ask: The government should reconsider the proposed abolition of HSSIB and retain an independent national patient-safety investigation body. Any model must preserve operational independence, confidential safe-space protections, specialist expertise and the ability to publish findings without interference. The government should also guarantee continuity for existing investigations and recommendations during any transition.

We would be grateful if peers could raise the following:

- **Seek firm commitments on the delivery of the single patient record.** The government should explain how it will ensure clinical involvement, interoperability with existing systems, digital inclusion and robust arrangements for privacy and data governance. These commitments should be placed on record so that Parliament can hold the government to account as the detail is developed through secondary legislation and implementation.
- **Call for clarity on clinical leadership following the abolition of NHSE.** The government should confirm which clinical leadership roles and functions will be retained, where they will sit and how independent clinical advice will continue to influence national policy, service planning and commissioning.
- **Call for stronger commitment to action on health inequalities.** The Bill should strengthen the Secretary of State's duty to tackle health inequalities and address the wider determinants of health through coordinated cross-government action.
- **Maintain the Secretary of State's statutory duty to report on environmental sustainability.** The Bill should ensure that there is no reduction in accountability and parliamentary oversight for the NHS's environmental sustainability performance.

For further information, please contact Jasneet Samrai (Jasneet.Samrai@rcp.ac.uk) or Adam Beazley (Adam.Beazley@rcp.ac.uk)