Final stage impact assessment

Title: Health Bill: abolishing NHS England

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: DHSCIA9712

RPC reference number: not required

Contact for enquiries: healthlegislation@dhsc.gov.uk

Date: 23/04/2026

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 current approach with 2 organisations overseeing the NHS faces several challenges (including complexity and duplication resulting in additional cost and administrative requirements)
- NHS England's functions are framed in quite rigid terms by current legislation, making it challenging to adapt to changing circumstances and generating bureaucratic overheads for the system.
- The abolition of NHS England and the conferral of most of its functions on the Secretary of State for Health and Social Care (Secretary of State) aligns with wider Government commitments to streamline arm's length bodies (ALBs)
- A better designed national centre without duplication and a more agile and flexible approach (partly but not wholly enabled through legislative change) will help to ensure the delivery of the 10 Year Health Plan for England (10 Year Health Plan) and other policy goals.

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

Abolishing NHS England and creating a new lean, agile centre aims to:

- reduce excessive bureaucracy in the system
- reduce the burden that central bodies place on integrated care boards (ICBs) and providers; freeing up capacity to support delivery of the 10 Year Health Plan reforms
- streamline the system (by changing some existing NHS England functions as they are conferred on the Secretary of State)
- improve clarity on the role and responsibilities of the new centre, to ensure it is able to make effective, sustained improvements for patients, communities and taxpayers in partnership with NHS organisations

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

The Prime Minister announced the abolition of NHS England on 13 March 2025, there are therefore 2 options presented in this impact assessment. Further options, such as restructuring the existing DHSC and NHS England, were not deemed viable as it does not meet the terms of streamlining the system and reducing the bureaucracy and costs of running 2 separate organisations.

Option 1 (business as usual): NHS England continues as a separate Arm's Length Body with operational independence. DHSC continues as the central policy, funding, and oversight department.

Option 2 (preferred option): NHS England is abolished, and its functions are conferred on the Secretary of State or ICBs; enabling the Transformation programme to reorganise central functions and introduce new governance structures.

Will the policy be reviewed? It will be reviewed. If applicable, set review date: Not applicable				
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: 11.5.26

Summary: Analysis & Evidence

Policy Option 1

Description: Abolition of NHS England

Full economic assessment

Price Base Year	PV Base Year	Time Period Years	Net Benefit (Present Value (PV)) (£m)		
N/A	N/A	N/A	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'

Overarching costs of abolishing NHS England and conferring functions on the Secretary of State (impacts of specific function movements are considered in detail in the Evidence Base):

- **Productivity loss**: short-term cost as organisations are brought together.
- **Transitional costs**: one-off costs, such as integration of data and digital.
- **Redundancy costs**: one-off cost of redundancies to achieve economies of scale benefits.

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'

Overarching benefits of abolishing NHS England and conferring functions on the Secretary of State (impacts of specific function movements are considered in detail in the Evidence Base):

- **Reduced bureaucracy and complexity**: ongoing benefit of more efficient ways of working in a more streamlined system.
- **Reduced cost of the centre**: ongoing benefit of economies of scale for corporate functions (like Human Resources).
- **Reduced administrative costs**: ongoing benefit of reducing administrative requirements (like the NHS England sponsor team or data sharing agreements).

Distributional impacts

N/A

Key assumptions/sensitivities/risks	Discount rate	N/A

Overarching risks (of abolishing NHS England and conferring its functions on the Secretary of State), to be mitigated through Transformation programme:

- Short-term disruption to the delivery of DHSC and NHS England functions during the transition period .
- Loss of expert knowledge from DHSC or NHS England
- Digital integration: if access to data, information and IT platforms doesn't happen on time

Assumption:

- Most of NHS England's functions will be conferred on the Secretary of State or ICBs as-is (or removed if the Secretary of State already holds those same responsibilities), meaning the same functions will continue. Therefore, in these cases, this IA assumes a neutral impact on the NHS system (such as patients and providers)

Business assessment (Option 1)

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

Evidence Base

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Problem under consideration and rationale for intervention

The role of NHS England

The Department of Health and Social Care (DHSC) and NHS England currently operate as separate organisations: in theory, DHSC sets policy and strategy, while NHS England oversees delivery. In practice, though, their responsibilities often overlap.

NHS England was originally created as an arm's length body to give the NHS greater freedom, increase transparency, and reduce political micromanagement[1]. Although independent, it remains accountable to DHSC through formal governance structures. This arrangement introduced an extra layer between the frontline and accountability to Parliament.

NHS England was also originally intended to streamline bureaucracy and strengthen accountability and to focus on commissioning – its initial name was the NHS Commissioning Board. Its role has expanded over the past decade (such as through the mergers with NHS Digital and Health Education England in 2023[2]) making the organisation larger and more complex.

As NHS England's functions grew, it increasingly took on policy setting roles (such as in the Five Year Forward View and Next Steps on the NHS England Five Year Forward View), creating ambiguity about where accountability sits between DHSC and NHS England[3]. One study suggests NHS England acts as a 'metagovernor'[3], shaping governance across the NHS in ways that limit local flexibility to design services around local needs. Therefore, the benefits expected from originally establishing NHS England were never fully realised (due to challenges set out below).

This creates several challenges in the current way of working (see following sub-sections for more detail):

- complexity and excessive bureaucracy
- cost of having 2 organisations at the centre with overlapping responsibilities
- additional administrative costs

These challenges would be expected to persist without changes to how the centre operates.

Complexity and excessive bureaucracy

The current DHSC and NHS England structure creates confusing accountability for the system, with overlapping processes and legal responsibilities blurring who is ultimately responsible. The Hewitt Review of integrated care systems highlighted challenges from competing requests for information from both NHS England and DHSC to the system. For example:

> *"Notwithstanding the severe performance issues in December 2022, in one instance one integrated care system (ICS) received 97 ad-hoc requests from DHSC and NHS England, in addition to the 6 key monthly, 11 weekly and 3 daily data returns."*

There is complexity inherent in the communication between the centre and the system. This is also illustrated by the priority setting for the NHS. The NHS Mandate sets out the DHSC's

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[1] Department of Health (2011), Health and Social Care Bill 2011: Memorandum for the House of Lords Delegated Powers and Regulatory Reform Committee - GOV.UK, page 7, (viewed October 2025)

[2] NHS England (2023), Health Education England, NHS Digital and NHS England have merged into a single organisation - NHS Transformation Directorate, (viewed November 2025)

[3] Hammond, Speed and others (2018): Full article: Autonomy, accountability, and ambiguity in arm's-length meta-governance: the case of NHS England, page 2, (viewed November 2025)

objectives for NHS England; NHS England then translates these objectives into the NHS operational planning guidance, which outlines specific, actionable priorities for the system to deliver. These types of elaborate processes increase the cost of operating the current system.

The National Audit Office (NAO) found that challenges with frequent, often duplicated, requests for information can undermine good working relationships between government departments and ALBs.[4] It also highlights that if arrangements and responsibilities between organisations are not clear, it can lead to tensions and even service failures. The examples mentioned above indicate that these challenges may be present in the DHSC and NHS England relationship as structured by the current legislative framework.

Finally, the challenges created by a lack of clear accountability and additional layers of bureaucracy makes achieving the aims and level of ambition of the 10 Year Health Plan more challenging. For example, delivering the Neighbourhood Health Service (such as bringing care closer to communities), requires a centre that supports rather than hindering local transformation, removing barriers and competing demands.

Cost of having 2 organisations at the centre

There is a cost to having 2 organisations managing the NHS; creating challenges like duplication but also missed opportunities for achieving economies of scale. For example, 2 sets of corporate functions are required, such as Human Resources (HR), communications and Information Technology (IT). These higher central overhead costs divert funding that could be spent on frontline services, but the scale of savings possible is uncertain.

Higher administrative burden on DHSC

NHS England operating as an Arm's Length Body (ALB) creates additional administrative tasks required of each organisation. For example, data sharing agreements are often required to support information to be shared between organisations. Therefore, the ALB model creates extra administrative obstacles to efficient and effective working, compared to a single centre approach.

In addition, in line with good practice on ALB sponsorship the Department has an NHS England sponsorship team. There are opportunity costs of this, which wouldn't exist if NHS England didn't exist.

Description of options considered

Option 1: Business as usual

Under this option, NHS England continues as a separate ALB with operational independence. DHSC continues as the central policy, funding, and oversight department. Existing governance, commissioning, and accountability structures would remain.

Option 2: Abolition of NHS England and creation of restructured DHSC (preferred option)

Under this option, NHS England is abolished, and its functions are conferred on the Secretary of State or ICBs. This enables the reorganisation of central functions and new governance structures, through the Transformation programme.

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[4] National Audit Office (2016), Departments' oversight of arm's length bodies: a comparative study - NAO report, page 34, (viewed October 2025)

Policy objective

The overall objective is to reform the NHS system operating model, where the centre sets the strategic direction and empowers ICBs and providers to deliver high quality, effective care to their local populations. Abolishing NHS England and creating a new lean, agile centre aims to:

- reduce excessive bureaucracy
- reduce the burden that central bodies place on ICBs and providers and free up capacity to support delivery of the reforms set out in the 10 Year Health Plan
- streamline the system (by changing some functions as they are conferred on the Secretary of State)
- improve clarity on the role and responsibilities of the new centre, to ensure it is able to make effective, sustained improvements for patients, communities and taxpayers in partnership with NHS organisations

DHSC and NHS England officials conducted a comprehensive review and analysis of legislation underpinning NHS England duties and responsibilities to inform the development of the bill, so that it would clarify and streamline legislation in line with these aims.

The bill also proposes to introduce a power for the Secretary of State to transfer the property, rights and liabilities of NHS England to the Secretary of State or another NHS or public body. The proposed transfer scheme provides a legal mechanism to transfer NHS England employees to DHSC or an NHS body, such as ICBs, or another public body when the functions of NHS England are conferred on the Secretary of State and ICBs.

Through the Transformation programme, the abolition of NHS England also aims to reduce the overall cost of the centre so resources can be freed up for delivery of services on the front line.

Summary and preferred option with description of implementation plan

Proposed intervention

The intervention is the **Health Bill** (the bill), which will provide the legal framework to abolish NHS England and confer its functions on the Secretary of State or ICBs. This will create a single central organisation responsible for strategy, policy, oversight, and support across the health and care system.

Responsibility for NHS England functions

Abolishing NHS England supports economies of scale to be achieved through a single organisation, as well as reducing the administrative costs of the ALB model. This approach of reduced central oversight costs could enable funding to be re-directed to the frontline.

In order to abolish NHS England, the existing functions, powers and duties of NHS England will be shifted to the Secretary of State or other bodies. The functions will either be:

- conferred on the Secretary of State
- conferred on ICBs, or
- changed as they are conferred on the Secretary of State or ICBs

To create the restructured DHSC, NHS England’s functions have been reviewed to identify ways to streamline current workflows and reduce bureaucracy. Therefore, changes are being made to some functions as they are conferred on the Secretary of State. In some cases, these are being done to enable ambitions of the 10 Year Health Plan, such as setting the clearer purpose of ICBs as strategic commissioners.

Most functions (12 of 25) will simply be conferred on the Secretary of State following the abolition of NHS England (while abolishing duplicative duties and powers). The details of all functions are set out in the Annex. However, where functions are being conferred on ICBs, or where changes are being made to functions that are being conferred on the Secretary of State, these have been set out in more detail below.

Functions to be conferred on ICBs

Some of NHS England's current functions will be conferred on ICBs, where that change supports the ambitions of the 10 Year Health Plan, as well as in cases where these roles are already undertaken by ICBs in practice. These are:

- **Commissioning:** Responsibility for commissioning primary Care and some specialised services (which are already delegated to ICBs) will be conferred on ICBs. Health and Justice commissioning functions will be new areas for ICBs to commission, for which they will have primary legal accountability. While the Secretary of State will retain primary legal accountability for public health functions, several will be delegated to ICBs to deliver, such as vaccinations and screening. Primary legal accountability for commissioning Armed Forces and high-secure psychiatric services will be conferred on the Secretary of State.
- **Arrangements with devolved governments and Crown Dependencies:** Most existing NHS England powers to make arrangements with devolved authorities and crown dependencies will be conferred on the Secretary of State. There will also be a new duty on ICBs (equivalent to the duty currently held by NHS England) to have regard to the likely impact of commissioning decisions on the provision of health services for persons who reside in an area of Wales or Scotland that is close to the border with England. It is anticipated that this consideration is already undertaken in practice by the few ICBs which exist near or on the Scottish and Welsh borders with England, but this will ensure there is a statutory requirement on ICBs to consider this.
- **Integration:** NHS England currently hold duties to ensure integration of services with other bodies, which will be conferred on ICBs and the Secretary of State as appropriate for their respective commissioning responsibilities.
- **Primary Care:** Beyond the commissioning changes mentioned above, NHS England's powers to recognise local pharmaceutical committees (covering primary care and pharmacy) will be conferred on ICBs, as well as the market entry system for pharmacy, and establishing and maintaining pharmaceutical lists. They will also be responsible for establishing local pharmaceutical services pilot schemes, which will allow initiatives to be tested on a smaller scale ahead of a national rollout. The Secretary of State will become responsible for central pharmaceutical services functions (determination of national terms of services), as well as setting up and managing performers lists, if they are needed, or delegating those functions to another body.

Functions changing as they are conferred on the Secretary of State

As with the previous sections, further details of these functions and changes are captured in the Annex. The changes being made to functions are summarised below:

- **Better Care Fund (Finance):** the Better Care Fund (BCF) is an approach to pooling funding between the NHS and local government. BCF arrangements currently mandate the use of Section 75 (s.75) arrangements by NHS bodies and local authorities, which enables the NHS to pool funding with local authorities for the purposes of service integration. As the BCF function is conferred on the Secretary of State, it will be changed to make the use of s.75 agreements as part of setting up the BCF discretionary (so that

the Secretary of State can decide on its use), rather than s.75 being mandatory for this purpose.

- **Delegation**: Some delegation powers will be conferred on the Secretary of State, and others will be repealed. The Secretary of State will be added to Section 65Z5 of the NHS Act 2006, allowing the Secretary of State to form arrangements with persons (such as ICBs, NHS trusts, and local and combined authorities) to delegate or jointly perform a Secretary of State function. The powers to direct ICBs to perform the Secretary of State functions, in Section 7B of the NHS Act 2006, which the Secretary of State currently holds only in relation to public health functions, will be expanded to all functions relating to the health service in England. This enables the Secretary of State flexibility to delegate functions in the future, if it is more appropriate to ICBs to deliver those.
- **Economic regulation:** Responsibilities in relation to the NHS Payment Scheme will be conferred on the Secretary of State. The duty to ensure a level playing field for providers will also be extended as it is conferred on the Secretary of State so that it applies to a broader range of functions. A new exemption will also be added to the level playing field duty to enable the Secretary of State to vary the proportions of activity by provider where it is in the interests of the health service to do so.
- **Data and information**: As NHS England's data functions are conferred on the Secretary of State, the functions will be amended to make clear the range of data processing activities these cover (which would support any future AI-related processing activity). Changes to powers to publish or disclose information obtained by establishing and operating information systems will mean, for example, that practitioner or other personal data could be published or disclosed where necessary and appropriate. Powers allowing the National Institute for Health and Care Excellence (NICE) and the Care Quality Commission (CQC) to require NHS England to set up information flows will be repealed as those organisations will be able to request data from DHSC via the Data Access Request Service instead. Requirements (held currently by NHS England) to assess the quality of information it collects will also be repealed. Finally, the bill will make changes to the provisions about special health authorities (SpHAs) to make clear that they can be established for the purpose of exercising functions conferred on them by or under any Act (which will include the Secretary of State's new data functions where delegated to SpHAs).
- **ICBs:** While most of NHS England's functions relating to ICBs will be conferred on the Secretary of State following the abolition of NHS England, some existing powers of direction (PoDs) will be repealed and a new, general power of direction will be established over ICBs in relation to the exercise of their functions. The Secretary of State will also have a new general power to issue guidance to ICBs on the discharge of their functions to which ICBs will have to have regard to. A direction creates a legal duty on the body named in the direction to do something, or to refrain from doing a specific thing. A new, more general power to direct ICBs will enable the Secretary of State flexibility to direct ICBs as required, as well as to create nationally set standards applicable to the new commissioning functions being conferred on ICBs.
- **Medicines and medical devices**: NICE produces independent, evidence-based guidance and advice to improve health and social care in England. Currently, NHS England are required to make funding available for treatments recommended in NICE technology appraisals and highly specialised technology evaluations, normally within 3 months of the publication of NICE's final guidance. The bill will enable regulations to provide that the Secretary of State *or* NICE may decide on variations to the 3-month standard implementation period, rather than it being solely NICE.
- **NHS trusts and foundation trusts (FTs)**: Most functions of NHS England in relation to the oversight of NHS trusts and FTs which are to be conferred on the Secretary of State will be conferred on the Secretary of State without change. However this IA also covers changes to the process for Trust Special Administration (TSA) (which is a process for

dealing with failing trusts), which reflect the abolition of NHS England but also make it more streamlined and aligning the process, where appropriate, between NHS trusts and FTs, and removing part of the current role of the Care Quality Commission. The bill also provides for there to be an additional purpose for which the Secretary of State may impose, or vary, conditions in the provider licence (subject to consultation), namely the purpose of promoting or securing compliance with obligations under any enactment.
- **Reconfigurations**: Reconfigurations are a change in the arrangements made by an NHS commissioning body for the provision of NHS services where that change affects the range of services or how individuals access services. The Secretary of State can intervene in reconfigurations under existing legislation. With the Secretary of State taking on commissioning functions and to avoid duplicating powers, changes will narrow the scope of the call-in power so that it excludes service change decisions taken as part of the Secretary of State's new commissioning responsibility. Further changes to include removing the requirement for ICBs to notify the Secretary of State about reconfigurations, as this information will be obtained through working closely with Regional Teams which will form part of the restructured DHSC.
- **Role of CQC**: The bill places the Secretary of State under a duty to consider CQC recommendations for appointing a Trust Special Administrator, rather than giving the CQC the power to require the Secretary of State to appoint one (as is presently the case for NHS England).
- **Workforce, education and training**: These functions will remain substantively the same, however, some features of the existing legislation will no longer be required when the functions are discharged directly by the Secretary of State. For example, the Secretary of State will no longer have a duty to publish an Education Outcomes Framework, which was previously used to hold NHS England to account for delivery of workforce functions.

Clarifying the scope of this assessment

Separate Transformation programme changes

This impact assessment sets out, and considers the impacts of, the legislative changes required to abolish NHS England and confer its functions on the Secretary of State or ICBs. There is separate design activity taking place to develop the operating model for the restructured DHSC, including any structural changes and headcount reductions required to implement it. However, these changes are beyond the scope of this impact assessment.

The bill will be an enabler of the transformation, so, for context, an overview of the Transformation programme policy decisions is set out below. The Transformation programme covers more than headcount reductions; it aims to create a more effective and dynamic organisation to focus national support where the centre genuinely adds value.

Organisational design of the restructured DHSC

Organisational redesign will also be a substantial part of the Transformation programme. The redesigned centre will bring policy and delivery together, seeking to break silo working and excess bureaucracy and build a culture on trust, collaboration and empowerment. These activities are underway in 2026 and involve conversations with current DHSC and NHS England teams to help shape the new structure.

Increased patient focus

The Dash Review of patient safety across the health and care landscape (the Dash review) concluded that the health and care system is fragmented, with multiple organisations conducting overlapping investigations with limited strategic coordination, leaving public voices

undervalued and engagement inconsistent. To address these issues, the review recommended the establishment of a Director of Patient Experience within DHSC to improve the patient voice and the complaints function across the NHS.

The design and development of the future patient experience directorate will be led by the Transformation programme. Separately, this bill proposes to abolish Healthwatch England (HWE) and Local Healthwatch (LHW) and repeal their functions. Following the abolition of LHW, ICBs will continue their responsibility of collecting feedback on the services they commission and their existing duties will be strengthened. Also, local authorities will be responsible for collecting feedback on their social care and public health functions. The bill also proposes to transfer Health Services Safety Investigations Body (HSSIB) functions into the CQC. These bill proposals are also relevant to patient experience (in response to Dash recommendations) and are covered by separate impact assessments (see the Impact Assessments Summary Document).

Clarity on oversight and accountability

Creating the restructured DHSC can help reduce duplication and streamline oversight by creating a single leadership and accountability framework. This is consistent with the 10 Year Health Plan aim to reduce unnecessary bureaucracy and give local leaders greater freedom to plan and deliver services for their populations.

These changes should also make system-level decision-making and oversight clearer, with one organisation responsible for the health and care system and a single set of priorities communicated through agreed routes.

Headcount reductions

Headcount reductions can be made by DHSC without legislation, so this impact assessment does not consider their specific impacts.

For context, by creating a single organisation, some staff redundancies will happen as part of the Transformation programme. The budget in November 2025 announced bringing forward funding (£860m) to cover NHS England, DHSC and ICB headcount reductions[5], estimated to enable savings of £1billion per year by the end of this Parliament in 2029.

Estates rationalisation

As part of the creation of the restructured DHSC, DHSC is reviewing the estates and contracts as part of the detailed transition planning. A long-term estates strategy will be implemented when the final shape and size of the organisation is agreed. The estates portfolio will be reviewed to ensure that it delivers value for money for the taxpayer.

Separate ICB changes

Wider ICB changes happening beyond this bill include a clearer role in the health and care system, reducing running costs and ICB boundary changes. These changes support ICBs to transform the NHS into a neighbourhood health service, with a greater focus on preventing illness.

ICBs will, as a result of the changes proposed in this bill, have a clearer purpose as strategic commissioners, which is intended to be a more focussed role than previously. This new focus for ICBs also removes duplication between NHS England and ICB activities, allowing ICBs to focus effort on commissioning. For example, holding trusts to account against the National

[5] HM Treasury (2025), Budget 2025 document - GOV.UK, page 47, (viewed December 2025)

Oversight Framework is now clearly an NHS England (to become the Secretary of State) responsibility.

The government has also committed to reducing ICB running costs by 50% by forming leaner organisations, with money saved invested in frontline services. Redundancy schemes have been launched to enable ICBs to reduce headcount and meet these targets.

The 10 Year Health Plan also introduced an aim for ICBs to share the same geographic boundaries as strategic authorities, wherever feasibly possible. This means that there will be mergers and boundary changes to ICBs taking effect in April 2026 and April 2027.

The ability of ICB leaders to manage such mergers and boundary changes at the same time as preparing to take on new commissioning functions will influence how successfully they can deliver the policy. These wider changes happening outside of the bill do not require legislation, however legislation helps enable these changes, such as through conferring NHS England commissioning functions on ICBs, which will allow them to focus on their strategic commissioner role.

Analytical approach to assessing costs and benefits

Option 1: Business as usual

For this impact assessment, option 1 assumes the business-as-usual arrangements will continue where DHSC and NHS England operate under the current ways of working and existing baseline costs would continue. 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.

Option 2: Abolition of NHS England and creation of restructured DHSC (preferred option)

Analytical approach

This IA seeks to provide 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 those costs and benefits at this stage.

There are 25 functions being conferred on the Secretary of State or ICBs as a result of abolishing NHS England. Presenting the individual costs and benefits for each function movement was not considered proportionate for this impact assessment because:

- most of the functions NHS England hold will be conferred on the Secretary of State and will simply transfer responsibility to the Secretary of State to exercise these functions, and
- some functions will be abolished as they are no longer needed following the abolition of NHS England (such as overseeing NHS England)

However, changes to the legislation that are considered to have the most substantial impacts, such as those being conferred on ICBs or where changes are being made to functions as they are conferred, have been considered in more detail in the following section.

There are also mentions of NHS England in Acts of Parliament beyond those related to health (such as Acts relating to Local Government). Legislative changes required to these Acts is set out in the annex and, given the scale of these changes, these are also not assessed individually for proportionality reasons.

Uncertainty surrounding future decisions

Following the abolition of NHS England, the bill proposes to confer many of NHS England's functions on the Secretary of State or other bodies. But how the Secretary of State (or other bodies) decide to exercise those functions is dependent on future decisions, including through guidance, directions and regulations (as is currently the case); working within the legislative framework and with direct accountability to Parliament.

This IA includes commentary to describe the range of possibilities in those cases where it has not been possible to quantify impacts. This assessment also recognises that the movement of functions and other changes may, if not managed well, carry potential risks for delivery, especially in the wider context of the Transformation programme (see risk section).

Overarching impacts

Table 1 below summarises the overarching impacts of creating the restructured DHSC and abolishing NHS England, including the broader impacts on the system. These are considered in more detail in the 'overarching costs' and 'overarching benefits' sections.

Table 1: Overarching impacts of abolishing NHS England

Costs	Benefits
Productivity loss: short-term cost as roles are defined and working cultures are brought together.	**Reduced bureaucracy and complexity**: ongoing benefit from more efficient ways of working through a more streamlined system.
Transitional costs: one-off costs associated with the integration of data and digital and potential external consultancy costs	**Reduced cost of the centre**: ongoing benefit from economies of scale for corporate functions (like HR, IT, communications).
Redundancy costs: one-off cost of potential headcount reductions that enable the economies of scale benefits.	**Reduced administrative costs**: ongoing benefit for example of removing the opportunity cost of an NHS England sponsorship team or requirements for data sharing agreements.

Impacts on the NHS system

Most of NHS England's functions will simply be conferred as-is on the Secretary of State or ICBs (or removed if the Secretary of State already holds those same responsibilities), meaning the same functions will continue. Therefore, in these cases, this IA assumes a neutral impact on the NHS system (such as providers, patients, voluntary sector).

The delivery risk associated with these function movements happening at the same time as the Transformation programme is noted in the risk section.

Where functions are being changed as they are conferred on the Secretary of State, an assessment of the specific impacts has been made (see Tables 2, 3 and 4). In most cases the impacts on the NHS system are uncertain as they are dependent on future policy decisions on how these powers are exercised. Where potential costs and benefits on the NHS system have been identified, these have been included in the tables. In most cases, the rationale for changing functions as they are conferred on the Secretary of State is to streamline processes or support delivery of the 10 Year Health Plan.

Monetised and non-monetised costs and benefits of each option

To consider all costs and benefits of this policy proposal, the impacts are summarised in these sub-sections:

- Overarching impacts of abolishing NHS England and creating the restructured DHSC
- Impacts of conferring specific NHS England functions on the Secretary of State
- Impacts of conferring functions on ICBs
- Impacts of changing functions as they are conferred on the Secretary of State

Overarching costs

This section summarises the overarching costs of creating the restructured DHSC, they are inclusive of the broader impacts on the system.

Productivity loss at the centre

The costs of short-term productivity loss are uncertain and carry associated risks which are addressed in the risk section. Creating a new organisation may impact on DHSC's productivity as working arrangements and cultures are brought together. The impact on productivity could pose as a delivery risk to DHSC and NHS England objectives (see Risk section).

In 2019, the Institute for Government noted the potential for high costs in lost productivity resulting from mergers.[6] An example of a productivity cost is the impact of uncertainty as the restructured DHSC refocuses, and officials spend time engaging with organisational design changes rather than tackling policy issues.[7]

There is also the potential for reduced employee satisfaction, or uncertainty around the future of the restructured DHSC for a prolonged period. A survey by the NAO found that following reorganisations in central government, three-fifths of respondents reported short-term declines in staff morale and a third reported a short-term decline in staff productivity.[8]

Transition costs

There are a range of one-off transitional costs associated with creating the restructured DHSC as it will require some corporate functions to be integrated, such as Digital, Data, and Technology. Other one-off costs associated with the transition to the restructured DHSC may include consultants and contingent labour being used to increase the ability to manage the transition. These costs include aspects like support from external consultancy, executive recruitment and actuarial advice.

Any delays to the creation of the restructured DHSC could cause an increase in these transitional costs as both DHSC and NHS England must remain operational for a longer period

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[6] National Audit Office (2024), Progress with the merger of the FCO and DFID - NAO report, page 44, (viewed September 2025)

[7] Institute for Government (2019), Creating and dismantling government departments | Institute for Government, pages 11-14, (viewed September 2025)

[8] National Audit Office (2010), Reorganising central government - NAO report, page 13, (viewed September 2025)

than originally planned. This could lead to increased payroll, administrative, estate, and IT costs.

Further, some staff may choose to leave during the transition period, which could impact on skills and experience which may then affect how the restructured DHSC exercises its new functions.

Redundancy costs

From an economic perspective, redundancy costs are treated as economic transfers, rather than economic costs in the HMT Green Book[9]. However, there will be one-off financial redundancy costs for enabling the economies of scale benefits achieved by a single organisation. Where redundancies are made rather than re-allocating staff to alternative roles, there will be redundancy costs for functions that overlap between the 2 existing organisations. Examples of this include the NHS England Board, or corporate functions like HR or IT services.

The budget in November 2025 announced bringing forward £860million of funding[10], and this is intended to cover both the abolition of NHS England and wider ICB cost reductions. Therefore, the exact scale of redundancy costs relating to the abolition of NHS England alone are uncertain and are ultimately dependent on Transformation programme decisions on the approach to future headcount reductions. Any potential redundancy costs that would be required to enable the economies of scale benefits of abolishing NHS England would only be a subset of these redundancy costs, as the Transformation programme headcount reductions also reflect the wider organisational re-design work taking place.

Costs of conferring specific NHS England functions on the Secretary of State

This section summarises the costs of the functions being conferred on the Secretary of State that are expected to differ from the overarching uncertain impact mentioned above:

- **Research & Innovation:** While existing duties relating to research and innovation are being conferred on the Secretary of State as-is, they will apply to the functions the Secretary of State is responsible for. The Secretary of State is responsible for more functions than NHS England is, so the application of these existing duties would be broader following the abolition of NHS England, which comes with associated opportunity costs. The scale of these costs is uncertain and dependent on further detail on the application of these duties.

Costs of conferring functions on ICBs

This section summarises the impacts of the 3 functions being conferred (either partially or fully) on ICBs from NHS England, which are: Commissioning (including Primary Care), Arrangements with devolved governments and Crown Dependencies and Integration.

There will be a familiarisation and ongoing costs for ICBs whose responsibilities will increase. While some of the commissioning functions were already delegated to ICBs (so they are largely gaining primary accountability for things they already do in practice), some are new roles for ICBs (such as health and justice services).

Where NHS England’s current responsibilities are conferred on ICBs for roles they have previously not undertaken, ICBs will incur ongoing opportunity costs for delivering these functions. There may also be transitional costs associated with setting up the structures and

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[9] HM Treasury (2026), The Green Book - GOV.UK, page 57 (viewed April 2026)

[10] HM Treasury (2025), Budget 2025 document - GOV.UK page 47, (viewed December 2025)

governance processes for managing these commissioning functions, as well as enabling collaboration with other ICBs.

As set out in a recent NHS commissioning update, expert staff are expected to transfer to ICBs to support their new commissioning responsibilities along with funding resources. Working closely with regional colleagues, ICBs are designing the necessary structures for these functions in advance of transfers planned for April 2027.

As ICBs commission more services, their responsibility to gather feedback on the services they commission will also expand. Please see the Impact Assessments Summary Document for more information on the *Abolition of Healthwatch England and Local Healthwatch impact assessment* which details this duty to collect feedback.

ICBs will be responsible for considering the impact of commissioning decisions on the provision of health services for people who live in Wales or Scotland but close to English borders, due to their role in Primary Care commissioning. This will largely impose an opportunity cost on the few ICBs which exist near or on the Scottish and Welsh borders with England, although it is expected to already be considered by these ICBs in practice.

Costs for those functions that are changing as they are conferred on the Secretary of State

Table 2 below summarises the costs of the functions that are changing as they are being conferred on the Secretary of State. Full details of each policy can be found in the Annex (under the section number referred to in Table 3). Most costs outlined in Table 2 are considered opportunity costs on the Secretary of State or ICBs as a result of these functions changing.

Table 2: Costs of functions which are changing as they are conferred on the Secretary of State

Policy Area	Costs
Better Care Fund (BCF)	All ICBs will be required to familiarise themselves with the changes to legislation surrounding the BCF and consider any potential legal impacts. These are considered opportunity costs and are expected to be relatively minimal as ICBs will already be familiar with the BCF arrangements.
Delegation	The costs of introducing a new power for the Secretary of State to direct ICBs to perform functions is uncertain as it will depend on the future use of these powers. The power may impose opportunity costs on ICBs or the Secretary of State, depending on the future use of the power.
Economic regulation	The wider duty to ensure a level playing field between providers is considered an opportunity cost to the Secretary of State, as this duty will be required to be considered across more functions than currently.
Data and information	The costs associated with data and information-related legislative changes are expected to be minimal and are summarised below. The financial cost associated with establishing and operating a new data system or new processing activities (like machine learning), that could be enabled by these legislative changes, would be dependent on future decisions on the collection and analysis of data. As

Policy Area	Costs
	these costs are uncertain and would be considered as part of the decision to undertake future work, they are not considered as part of this impact assessment. **Amending powers for establishing and operating information systems:** Minimal costs expected as the legislative change essentially outlines existing data activities. **Adjusting the scope for publishing or disclosing personal information of practitioners or others**: changes being made to powers to publish or disclose information obtained by establishing and operating information systems mean that, in appropriate circumstances, personal information of practitioners or others could be published or disclosed. Minimal costs are expected. **Repealing the power of NICE and CQC to make mandatory requests for information:** Minimal costs expected as these organisations can still request information through other means. **Assessing the quality of information:** minimal costs as information quality standards are still required to be met. **Special Health Authorities (SpHAs)**: expanding the purpose for which SpHAs may be established to enable data functions to be conferred on them may impose opportunity costs on SpHAs if the Secretary of State decides to direct them to exercise these additional data and digital functions.
ICBs	There are minimal costs associated with repealing some of the existing powers of direction (PoDs), as they will effectively be replaced by the new general Power of Direction. The new general Power of Direction could impose opportunity costs on ICBs, but these are uncertain as it depends on the future use of these powers by the Secretary of State. Where these new powers are expected to be used, as is the intention for nationally set standards applicable to commissioning functions, there would be opportunity costs for ICBs to familiarise themselves with the implications of the standards.
Medicines and medical devices	This legislative change enables the Secretary of State to make regulation to enable the Secretary of State or NICE to determine the timelines for implementing NICE recommendations, which could be longer than 3 months (the current requirement). However, as the timelines will be determined by the Secretary of State or NICE on a case-by-case basis following the same criteria as currently used for

Policy Area	Costs
	extending the timelines, the cost of this change is expected to be minimal.
NHS trusts and FTs	The proposed process for Trust Special Administration (TSA), which is the last resort process for cases of extreme failure by a trust, is being streamlined as the functions under it are conferred on the Secretary of State. Therefore, this is expected to have minimal costs. A new purpose (which is to promote or secure compliance with obligations arising under any existing legislation) under which conditions in the provider licence may be set or modified does not impose direct costs on providers. This change provides the Secretary of State with a permissive power under which he may decide to impose or vary licence conditions in future, subject to a statutory consultation. If, after consultation, the Secretary of State decided to set or modify licence conditions, to ensure compliance with existing legislation, (such as enactments dealing with procurement), this would lead to minimal costs on providers given they should already be complying with applicable legislation. However, there would be an opportunity cost to providers who don't currently comply with existing laws. The scale of this opportunity cost is uncertain as it is dependent on the new conditions added.
Reconfigurations	2 changes are being made to reconfiguration functions. The first is removing the requirement on ICBs to notify the Secretary of State of reconfigurations. This has minimal expected costs, as it mainly carries the risk of reduced information flows, which is presented in the Risk section. The second is changing the scope of the Secretary of State's call-in power surrounding reconfigurations to only apply to ICB-commissioned services. As this is removing an unnecessary power for the Secretary of State, minimal costs are expected.
Role of CQC	A change to the legislation means the Secretary of State would not be required (as is the case for NHS England) to appoint a Trust Special Administrator based on CQC's advice but will still have to consider their advice. Therefore, limited costs are expected (mainly captured in the Risk section).
Workforce, education & training	These functions will remain substantively the same, with some features of the legislation which were used to hold NHS England to account (such as the publication of an Education Outcomes Framework) being removed. Therefore, minimal costs are expected from this change.

Overarching benefits

Reduced bureaucracy and complexity of the system

The challenges associated with the complexity of the current system are:

- siloed working and the associated risk of duplication across teams
- inefficient work processes, for example multiple requests for similar data from the local NHS
- lack of or unclear accountability

The restructured DHSC aims to reduce these negative impacts, reduce bureaucracy and support delivery of the 10 Year Health Plan ambitions.

Reduced cost of the centre

Creating a restructured DHSC provides an opportunity to reduce duplication and generate economies of scale. The ongoing savings for this may be generated from corporate services like HR and IT, where creating one organisation will likely lead to reduced costs.

The budget in November 2025 announced estimated savings of £1billion per year by the end of Parliament[11], covering both the abolition of NHS England and wider ICB cost reductions. However, these savings are attributed to separate organisational design decisions made by the Transformation programme, so are not covered in more detail in this impact assessment.

Reduced administrative costs

Conferring NHS England's functions on the Secretary of State and removing the ALB layer benefits DHSC by, for example, removing the need for data sharing agreements to enable NHS England data to be shared with Ministers to inform decision making.

A further example of this is the process for providing information for Ministerial briefings or Parliamentary Questions. This currently requires the relevant policy team in DHSC to commission NHS England, and the relevant team in NHS England is then identified to provide the information back to the DHSC team. Following the abolition of NHS England, this will be streamlined as the relevant team in DHSC would have access to the information required to respond to these requests directly.

Furthermore, there will be no requirement on DHSC to have a sponsorship team for NHS England.

Benefits of conferring specific NHS England functions on the Secretary of State

This section summarises the benefits of the functions being conferred on the Secretary of State that are expected to differ from the overarching impacts otherwise captured:

- **Research & Innovation:** As the Secretary of State will have to apply research & innovation duties to more policy areas than currently is the case, this could raise awareness of these policy areas within DHSC. The application and use of this duty, however, is uncertain and dependent on future policy decisions, so the scale of this benefit is not quantified.

[11] HM Treasury (2025), Budget 2025 document - GOV.UK page 47, (viewed December 2025)

Benefits of conferring functions on ICBs

This section summarises the impacts of the 3 functions being conferred (either partially or fully) on ICBs, which are: Commissioning (including Primary Care), Arrangements with devolved governments and Crown Dependencies and Integration.

Where commissioning functions are already delegated to ICBs, conferring primary legal accountability for those functions will provide clarity by aligning accountability and responsibility. Also, primary legal accountability for delivering functions allows ICBs to commission services with more autonomy than is the case when operating under delegation agreements. This allows them to tailor services more effectively to their local populations, but also while having a large enough footprint to be suitable for commissioning specialised services[12].

For new services that ICBs will commission, like health and justice functions, this will enable stronger local integration with mental health, acute, community and primary care services, which are already commissioned by ICBs. It will also enable healthcare outside of prisons to be more aligned with prisoner needs, as a single commissioner would plan and manage both.

This could also lead to a reduction in duplication as currently ICBs and NHS England commission separately for prisoners and the wider population of patient services. Under a single commissioner, contracts for both populations could be combined, potentially reducing transaction costs and enhancing administrative simplicity for both ICBs and providers.

Research has noted that the benefits of conferring specialised commissioning functions to ICBs depends on the design of the new system striking the right balance between national consistency and local autonomy[12].

Formalising the consideration of the impact of commissioning decisions on the provision of health services for people who live in Wales or Scotland but close to English borders ensures there is a statutory requirement which aims to achieve effective working in these areas.

Benefits for those functions that are changing as they are conferred on the Secretary of State

Table 3 below summarises the rationale and intended benefits of the functions that are changing as they are being conferred on the Secretary of State. Full details of each policy can be found in the Annex (under the section number referred to in Table 4).

Table 3: Benefits of functions which are changing as they are conferred on the Secretary of State

Policy Area	Benefits
Better Care Fund (BCF)	Changes to this legislation will increase flexibility for pooling funding for service integration (via the BCF) in the future, enabling new ways of working across the health system. This also would enable alignment to wider reforms to the BCF set out in the 10 Year Health Plan. The benefits of these BCF changes will depend on future policy decisions around their use and, as such, are uncertain and unable to be quantified.

[12] Peckham (2025): Delegating specialised service commissioning: will the latest changes establish an effective structure in England? | British Journal of Healthcare Management page 8, (viewed November 2025)

Policy Area	Benefits
Delegation	The expanded powers to direct ICBs to perform functions and adding the Secretary of State to section 65Z5 allow the Secretary of State flexibility to delegate additional functions, if appropriate, for ICBs or other parts of the health system to deliver. The benefits of delegating those functions are uncertain and would depend on the future use of these powers but could enable greater alignment of those functions with local needs or increased autonomy for ICBs.
Economic regulation	The benefit of extending the level playing field duty is that it ensures decisions affecting the balance of provision to continue to be taken on a fair and neutral basis. The new exemption to this duty, which will allow the Secretary of State to vary the proportion of provision by provider type where it is in the interests of the health service, also provides the Secretary of State with more flexibility than the existing legislation.
Data and information	**Modifying powers around establishing and operating information systems:** These provisions will set out a framework for the collection and uses of data relevant to the provision of health and adult social care services at a national level, including what is and is not permitted in the use of personal information. This includes changes to support the use and integration of machine learning and AI related processing activities across the restructured DHSC. **Adjusting the scope for publishing or disclosing personal information of practitioners or others**: changes being made to powers to publish or disclose information obtained by establishing and operating information systems mean that, in appropriate circumstances, the Secretary of State would have flexibility to publish or disclose personal information of practitioners or others where necessary, which may improve transparency. **Repealing the power of NICE and CQC to make mandatory requests for information:** streamlined legislation to remove powers no longer required following the abolition of NHS England. **Assessing the quality of information:** reduced administrative costs as the Secretary of State (previously NHS England) will not be required to publish an assessment on the quality of information collected. **Special Health Authorities (SpHAs)**: expanding the purpose for which SpHAs may be established to enable data functions (including those relating to social care) to be conferred on them would provide the Secretary of State with flexibility to exercise data and digital functions through SpHAs in the future.

Policy Area	Benefits
ICBs	The new power of direction over ICBs allows the Secretary of State to set standards and hold ICBs directly accountable for their performance and use of public funds. These new powers would also provide a practical mechanism for the Secretary of State to address things like underperformance, inefficiency, or unresponsiveness within individual ICBs or groups of ICBs. These new powers also build resilience into the legislative powers the Secretary of State holds, by providing them flexibility to respond to unforeseen circumstances. As ICBs autonomy grows in line with 10 Year Health Plan ambitions, such as through new commissioning responsibilities, the power acts as a safeguard. Therefore, this allows the Secretary of State to step in to protect patient interests or national priorities.
Medicines and medical devices	Changes to legislation will enable the Secretary of State to determine the implementation period for NICE recommended medicines (currently 3 months) more easily than under the current legislation. The main benefit of this change is enabling increased flexibility for the Secretary of State to deliver NICE recommended treatments. There are some cases where longer delivery timelines for medicines are beneficial to balance their introduction against the opportunity costs or other impacts on the health service, as well as to enable effective staff training.
NHS trusts and FTs	The proposed process for Trust Special Administration (TSA), which is the process used in cases of extreme failure in a trust, is being streamlined. This change should improve efficiency and may reduce the administrative costs of this process if it is required to be used. Including a new provider licence purpose to enable the Secretary of State (subject to consultation) to impose or vary licence conditions to ensure compliance with existing legislation gives the Secretary of State an additional tool to ensure providers comply with existing legislative obligations (if this power is exercised)). This may lead to improved compliance with standards, like procurement law, which could improve value for money of healthcare services.
Reconfigurations	Updating the scope of the Secretary of State's call-in powers to remove them for the functions they are responsible for commissioning simply removes unnecessary legislation. Removing the requirement on ICBs to notify the Secretary of State of reconfigurations taking place may have a slight positive impact on ICBs. This is because they will no longer be required to determine whether a reconfiguration is notifiable and submit notification forms to the Secretary of

Policy Area	Benefits
	State. The Secretary of State has received 8 notifications since the requirement came into effect on 31 January 2024. The removal of this process may also reduce the time it takes to action reconfigurations.
Role of CQC	Following the abolition of NHS England, the Secretary of State would be under a duty to consider CQC advice to appoint a Trust Special Administrator (TSA), rather than a requirement to appoint a TSA (as is the case for NHS England). This allows the Secretary of State more flexibility to decide whether to appoint a TSA based on CQC's advice. Therefore, limited impacts are expected (this is mainly captured within the risk section).
Workforce, education & training	The changes to these functions also streamline the legislation by reducing some of the obligations in legislation that were only necessary when NHS England exercised these functions (in order to aide the Secretary of State's oversight of NHS England). Therefore, these changes are expected to have minimal benefits.

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

As outlined in the costs and benefits section, the legislative changes cover both the conferral of functions on the Secretary of State, as well as the transfer of assets, liabilities and staff to enable the creation of the restructured DHSC. There are overarching risks, as well as specific ones linked to some functions as they are conferred on the Secretary of State or ICBs. These are each set out below.

Overarching risks

Delivery risk for the centre due to reduced operational capacity

If redundancies are required to enable economies of scale benefits, there could be reduced operational capacity in central functions (like HR and IT services), which may pose delivery risks in those areas. Mitigations for this would be managed via the Transformation programme, which will consider the needs of the restructured DHSC to ensure sufficient resource is available to deliver these services.

Also, as functions move to different parts of the system there is a risk of disruption to the business-as-usual service, as the restructured DHSC takes on new responsibilities previously undertaken by NHS England. Absorbing these functions could result in increased pressures that could lead to bottlenecks in the decision-making process depending on decisions about the level and type of Ministerial approvals.

These risks will be mitigated by the Transformation programme's development of a detailed target operating model that will set out governance and accountability processes. The target operating model will consider expert insight of officials from both DHSC and NHS England and will provide clarity about where and how decision-making needs to happen in the restructured DHSC.

Loss of institutional knowledge

The process of transferring staff may lead to higher attrition rates than business-as-usual operations. Previous experience of mergers has been that a high turnover of senior leadership slows progress and risks the loss of corporate knowledge and expertise.[13] This means the restructured DHSC could lose institutional knowledge from expert employees in either DHSC or NHS England.

Loss of institutional knowledge and experience risks affecting the restructured DHSC's ability to perform its functions (like operational delivery or policy design) effectively. This is because it takes time to train new staff and inefficiencies could arise, for example if new staff revisited previous policy ideas that didn't work or don't have the experience of required processes to follow (such as the policy development cycle). This also leads to more time being spent on re-working or revisiting past documentation, where previous knowledge was lost, which would be a further efficiency cost to the organisation.

The Transformation programme approach to managing headcount reductions aims to mitigate this risk. Both NHS England and DHSC are applying careful selection criteria during voluntary exit schemes to help ensure the relevant skills and capabilities are retained. Exits are also being staggered to help with knowledge transfer across colleagues, which aims to minimise disruption.

Delays to full digital integration

There are also potential risks associated with delays to full integration including changes to data platforms and digital solutions to ensure staff have access to the information required to fulfil their roles. For example, if there isn't immediate access for all relevant employees to data on specific platforms, that could create a barrier to effective working.

The Transformation programme aims to mitigate this risk by having a dedicated workstream for designing and implementing technology, which prioritises consistency and continuity following the abolition of NHS England. The ambition is that user access to platforms, data and applications will be in place for the first day that the restructured DHSC begins operating. Where roles change and access needs to change, there will be processes in place to efficiently manage those changes.

Risk of reduced transparency

Following the abolition of NHS England, there will no longer be a requirement to publish the NHS mandate or NHS England's annual report and accounts. There is a risk that removing these would reduce transparency with the health system on financial and performance data or objectives which are summarised in these documents. However, DHSC will continue to set out its priorities for the NHS and will still be required to publish its own annual report and accounts, which should mitigate this risk.

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[13] National Audit Office (2024), Progress with the merger of the FCO and DFID - NAO report page 27, (viewed September 2025)

Potential delivery risk to the NHS system

While the roles and responsibilities of NHS England are largely transferring to the Secretary of State or ICBs, there will be a period of time where the system familiarises with the new role of the centre (such as how it communicates with the restructured DHSC). This may create a delivery risk if this familiarisation process diverts the system from delivering NHS services.

Risks of conferring functions on ICBs

This section summarises the risks of the 3 functions being conferred (either partially or fully) on ICBs, which are: Commissioning (including Primary Care), Arrangements with devolved governments and Crown Dependencies and Integration.

Some of the commissioning functions being conferred on ICBs will be new for ICBs to deliver (health and justice services), which could create a potential delivery risk. This risk includes the potential skills gap due to the specialist skills required to commission specialist services. However, the transfer of expert staff from NHS England to ICBs announced in the NHS commissioning update and policy proposals (separate to this bill) for commissioning to be undertaken by expert teams in 7 offices for pan-ICB commissioning (OPICs) aim to mitigate this risk.

The changes proposed as part of this bill are intended to support ICBs with reducing running costs by 50%. However, the ability of ICBs to make these wider changes to deliver savings, while also preparing to take on some new commissioning functions and undergoing changes to ICB boundaries (see section 4 on policy details), will influence how successfully they can deliver the policy. This poses a short-term risk to the continuity of those services that will be commissioned by ICBs for the first time, leading to risks to their accessibility for patients and service users. The Model ICB Blueprint and the Strategic Commissioning Framework (including the strategic commissioning development programme) mitigate this risk, by providing guidance and support to ICBs to achieve these changes.

There is also a risk to delivery if ICBs, when directed to do so, do not collaborate effectively. Under the new arrangements (beyond this bill), ICBs will be required to collaborate with each other to deliver more specialised services over a larger footprint than individual ICBs, due to small patient populations covered by these services. DHSC will support ICBs by providing guidance on collaborating effectively to mitigate this risk. This risk is also mitigated by the transfer of teams and funding to a single OPIC hosted by an ICB in each area, which the ICBs in that area will use to coordinate commissioning of services.

Risks for those functions that are changing as they are conferred on the Secretary of State

Table 4 below summarises the risks of the functions that are being changed as they are conferred on the Secretary of State. Full details of each policy can be found in the Annex (under the section number referred to in Table 5).

Table 4: Risks of functions which are changing as they are conferred on the Secretary of State

Policy Area	Risks
Better Care Fund	**Risk:** Removing the mandatory requirement for the BCF to use section 75 arrangements (automatically involving local authorities) could lead to less joint working at local levels. This is because there will no longer be a requirement for

Policy Area	Risks
	ICBs and Local Authorities to work together to pool budgets as part of the Better Care Fund. **Mitigations**: the Secretary of State will still be able to require the use of the section 75 via discretionary powers. Also, ICBs and Local Authorities can still voluntarily enter into a section 75 arrangement if they believe it will lead to an improvement in the way their functions are exercised, so this risk is considered minimal.
Delegation	**Risk:** Directing ICBs to perform the Secretary of State functions and adding the Secretary of State into Section 65Z5 in order to delegate or perform functions jointly with certain persons may come with risks. However, these risks are uncertain. **Mitigations**: Risks would be assessed at the time of deciding that a function should be delegated, so that mitigations can be identified and factored into the approach taken. Also, while ICBs would be responsible for any liabilities incurred carrying out delegated functions, the Secretary of State would remain ultimately accountable for any functions ICBs are directed to deliver. The Secretary of State is also accountable to Parliament for any delegations. In addition, Secretary of State's decisions to delegate functions, either through S7B or S65Z5, would need to be consistent with public law principles, including rationality.
Economic regulation	**Risk:** Introducing an exemption to the level playing field legislation aims to minimise risks as the changes clearly set expectations for when the Secretary of State could legitimately alter the proportion of provision by provider type. However, this risk is dependent on the future use of these powers, which is currently uncertain but likely to only be used in rare cases.
Data and information	**Modifying powers around establishing and operating information systems:** These changes may reduce existing risks associated with these powers, by ensuring clarity in the legislation and reducing ambiguity. **Adjusting the scope for publishing or disclosing personal information of practitioners or others**: Under these changes, personal information about individuals may be published or disclosed (only) on a limited number of grounds such as consent or where it is "a proportionate means of achieving a legitimate aim". Personal information of practitioners could also be published or disclosed. Any publication or disclosure would be subject to the requirements of the UK GDPR. **Risk:** While the risks of broadening these powers is, therefore, expected to be limited

Policy Area	Risks
	(due to strict data protection standards), as with any changes to data policy there are privacy risks associated with them. **Mitigations**: Data sharing always requires consideration of the safe and lawful sharing and use of data. Some data policy changes have higher risks than others, depending on the purpose and use of the data and whether it involves sharing individual level data. This would be considered at the point that future decisions are made around publishing or disclosing information. **Repealing the power of NICE and CQC to make mandatory requests:** This change removes an unnecessary power following the abolition of NHS England and existing data privacy risks for the Data Access Request Service will have been identified as part of normal operating procedures. **Assessing the quality of information:** This change is not expected to change the data quality risk as applicable information standards are required to be followed by DHSC regardless of whether this assessment is produced and published. **Special Health Authorities**: Expanding the purpose for which SpHAs may be established (to enable data functions to be conferred on them) is expected to have minimal risks, as any delegation of data functions to SpHAs would be accompanied by safeguards and controls and the changes would ensure any existing or future SPHAs are able to exercise data and digital functions (and for both health and social care rather than just health care) where these are delegated to them.
ICBs	**Risk**: There is the potential that the new power of direction is used in a way that crowds out other forms of change and improvement through the adoption of a top-down approach. **Mitigations**: There is greater clarity of roles that ICBs and other organisations now have as part of wider reforms. The ongoing commitment of the government to reduce centralisation and increase the role that local organisations play in shaping and delivering effective health and care also aims to mitigate this risk.
Medicines and medical devices	**Risk:** Enabling the Secretary of State to adjust the timescale for implementation of NICE guidance could risk increasing the time taken for patients to access NICE recommended medicines. **Mitigations**: The restrictions on the Secretary of State directing NICE as to the substance of its guidance would remain unchanged (such as the criteria for changing the

Policy Area	Risks
	timescales), so the change in risk from timescales is considered minimal. These changes also aim to enable effective management of the delivery risks for implementing NICE recommended treatments, by enabling the Secretary of State flexibility to set appropriate timescales for implementation depending on the treatment being considered. Finally, the Secretary of State remains accountable to Parliament, where questions around the timings for introducing recommended medicines could be raised and debated.
NHS trusts and FTs	**Risk:** There will be some necessary adaptations made to the TSA process as the functions are conferred on the Secretary of State, as the role will move from having 2 decision makers (NHS England and the Secretary of State) to one (the Secretary of State). There may be a small risk of additional considerations being missed due to the second layer of review (previously NHS England) being removed as part of the TSA process. **Mitigations:** The TSA process risk is considered minimal and can be mitigated through internal processes and the maintenance of relevant expertise.
Reconfigurations	**Risk:** Following the changes, the call-in power which applies to reconfiguration decisions will be reduced in scope. This is so that reconfigurations decisions made by the Secretary of State in relation to their commissioning functions will no longer be in scope of the call-in power. As this removes a layer of scrutiny that currently exists via NHS England, this change may increase the risk of unintended consequences for reconfiguration decisions led by the Secretary of State. Also, removing the requirement on ICBs to notify Secretary of State about reconfigurations risks reducing information flows to the Secretary of State about service changes. **Mitigations:** The risk of reducing the scope of the call-in power can be mitigated through clarity (such as statutory guidance) about the administrative processes that are followed when there are concerns about a reconfiguration decision made by the Secretary of State. Judicial review will also remain as the ultimate backstop. As regional teams move into DHSC to enable closer working, this aims to mitigate the risk of reduced information flows and may even lead to greater oversight of reconfiguration activity than achieved via the current notification process.

Policy Area	Risks
Role of CQC	**Risk:** The Secretary of State will only hold a duty to consider CQC advice on appointing a Trust Special Administrator, whereas NHS England held a requirement to appoint one. Therefore, there is a minimal risk of the Secretary of State choosing not to appoint a trust special administrator despite a CQC recommendation. **Mitigations:** The Secretary of State will still have a duty to consider CQC's recommendation and has wider duties to ensure the effective running of the health service, which aim to mitigate this risk.
Workforce, education & training	**Risk:** There are no risks associated with removing legislation details related to holding NHS England to account, following the abolition of NHS England.

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 A: Overview of NHS England functions

This Annex provides detail on the movement of functions. Table 5 sets out the destination of the functions, noting any changes being made or broader impacts. This table is intended to summarise the changes at a high-level, with more details provided in the text following this table. The table is ordered by who will be responsible for the function following the abolition of NHS England.

Table 5: Summary of the destination of NHS England's existing functions following its abolition

Policy area	Who will be responsible for this function	Specific points to note
1. Emergency Preparedness (civil contingencies) *Annex B*	Confer on the Secretary of State	The Secretary of State retains existing responsibilities for emergency preparedness and response and will also take on NHS England's role (ensuring that the health system is prepared for an emergency). A minor amendment ensures all trusts providing ambulance or A&E services are included as Category 1 responders, which formalises their existing role.
2. Finance *Annex B*	Confer on the Secretary of State	Functions are being conferred on the Secretary of State. A separate impact assessment covers financial controls and accountability changes being made.
3. Governance and accountability *Annex B*	Confer on the Secretary of State	Functions are being conferred on the Secretary of State, or reference to NHS England being removed. Removal of requirement to publish a mandate.
4. Health inequalities *Annex B*	Confer on the Secretary of State	The Secretary of State will retain existing responsibilities to have regard to the need to reduce inequalities. The duty will be amended to provide clarity on what is intended by reducing inequalities.
5. Mental Health *Annex B*	Confer on the Secretary of State	Existing duties will be conferred on the Secretary of State and references to NHS England will be removed.
6. Patient choice *Annex B*	Confer on the Secretary of State	The duty to act with a view to enabling patient choice will be conferred on the Secretary of State in the exercise of their healthcare functions. The Secretary of State will also inherit NHS England's powers to investigate and direct ICBs in the event of non-compliance with patient choice requirements, and the duty to publish guidance on how the Secretary of State intends to exercise their patient choice enforcement powers.

Policy area	Who will be responsible for this function	Specific points to note
7. Patient involvement *Annex B*	Confer on the Secretary of State	The duty to promote the involvement of patients in decisions about their care will be conferred on the Secretary of State.
8. Patient Safety *Annex B*	Confer on the Secretary of State	NHS England patient safety functions will be conferred on the Secretary of State. NHS England's requirement to work with HSSIB will be removed as HSSIB is merging into CQC as part of this bill (see Impact Assessments Summary Document for more information).
9. Public Health *Annex B*	Secretary of State retains existing duties NHS England functions repealed	The Secretary of State will retain existing public health responsibilities, and some services will be delegated to ICBs from Secretary of State (see Commissioning section). NHS England's duty to consult with public health professionals to obtain advice on the discharge of its functions will be repealed and not transferred to the Secretary of State.
10. Research & Innovation *Annex B*	Confer on the Secretary of State	The duty to promote and facilitate innovation will be conferred on the Secretary of State, although it will apply to the broader scope of functions held by the Secretary of State. The power to make payments as prizes will also be conferred on the Secretary of State.
11. Wider functions *Annex B*	Changing as they are conferred upon the Secretary of State	NHS England net-zero and environmental duties will be repealed as the Secretary of State is bound to comply with wider governmental standards. NHS England's Triple Aim guidance-making power and duty (a legal obligation for NHS bodies to pursue 3 main objectives) will be repealed due to other duties on the Secretary of State in relation to the performance of the health system. However, the duty for providers and ICBs on Triple Aim will continue.
12. Commissioning *Annex C*	Confer on the Secretary of State & Confer on ICBs	Conferred on the Secretary of State: High-secure psychiatric services. The Secretary of State will have the power by regulations to require Armed Forces and some specialised commissioning to be carried out by the Secretary of State. There is then

Policy area	Who will be responsible for this function	Specific points to note
		the option for the Secretary of State to use powers to delegate functions to ICBs. Public Health functions will be retained by the Secretary of State, but the Secretary of State will have the ability to require ICBs to deliver these functions (which would be new functions for ICBs to deliver). Conferred on ICBs: Primary Care, some specialised services and Health and Justice functions.
13. Arrangements with devolved governments and Crown Dependencies *Annex C*	Confer on ICBs and Confer on the Secretary of State	The responsibility to have regard to the likely impact of commissioning decisions on the provision of health services for people who live in Wales or Scotland but close to English borders will be conferred on ICBs due to their role in Primary Care commissioning. Duties to make arrangements with the devolved governments to carry out certain functions will be conferred on the Secretary of State, with minor clarificatory changes.
14. Integration *Annex C*	Confer on the Secretary of State & Confer on ICBs	Mostly removing reference to NHS England and conferring integration duties on the Secretary of State where legislatively appropriate. Some duties will be conferred on ICBs where they will be commissioning services.
15. Primary Care *Annex C*	Confer on ICBs & Confer on the Secretary of State	ICBs will become responsible and accountable for primary care commissioning and the market entry system for pharmacy. ICBs will also become responsible for the function of Local Professional Committees (covering primary care and pharmacy). ICBs will also have powers to establish local pharmaceutical services pilot schemes and will establish and maintain the pharmaceutical lists. The central pharmaceutical services functions (determination of national terms of service) will be conferred on the Secretary of State. The Secretary of State or an NHS body will also be responsible for manging performer lists.

Policy area	Who will be responsible for this function	Specific points to note
16. Better Care Fund (Finance) *Annex D*	Changing as they are conferred upon the Secretary of State	To build in flexibility for future funding flows, the currently mandatory requirement to pool budgets is being changed to make it a discretionary power.
17. Delegation *Annex D*	Changing as they are conferred upon the Secretary of State	Some delegation powers will be conferred on the Secretary of State, and others will be repealed or amended. Powers to form arrangements with persons (such as ICBs, NHS trusts, and local and combined authorities) to delegate or jointly perform a Secretary of State function, will be conferred on the Secretary of State. The powers to direct ICBs to perform the Secretary of State functions, which the Secretary of State currently holds only in relation to public health functions, will be expanded to functions relating to health services in England. This enables the Secretary of State flexibility to delegate functions in the future, if it is more appropriate to ICBs to deliver those.
18. Economic Regulation *Annex D*	Changing as they are conferred upon the Secretary of State	Responsibilities in relation to the NHS Payment Scheme will be conferred on the Secretary of State. The duty to ensure a level playing field for providers will also be extended as it is conferred on the Secretary of State. At the same time, a new exception will be introduced to allow the Secretary of State to vary the proportion of provision by provider type if it is in the interests of the health service to do so.
19. Data and information *Annex D*	Changing as they are conferred upon the Secretary of State	Most functions will be conferred on the Secretary of State. Some changes include: Scope of data processing activities and powers to publish or disclose personal data of practitioners and others, where necessary, in appropriate circumstances. There are also some powers being repealed where no longer required. These proposals also extend the scope of the purpose for which SpHAs may be established, so that they can be established to carry out functions under any enactment, to enable them to be delegated certain data and digital functions

Policy area	Who will be responsible for this function	Specific points to note
		including those relating to adult social care in England.
20. ICBs *Annex D*	Changing as they are conferred upon the Secretary of State	Most of the NHS England powers and duties over ICBs will be conferred on the Secretary of State. The power to publish guidance on joint appointments will be removed, as this would be covered by existing powers for the Secretary of State to publish guidance to ICBs. Some existing specific powers of direction will be retained as they either apply more broadly than ICBs, or they apply only in exceptional circumstances. Some specific powers will be removed as a new general Power of Direction to direct ICBs in relation to the exercise of their functions will be established. This also requires amendments to some wider regulation making powers (Section 6E) to enable use of these powers. Wider reforms to ICBs, such as ICB membership and statutory planning changes are covered in a separate impact assessment (see Impact Assessments Summary Document).
21. Medicines and medical devices *Annex D*	Changing as they are conferred upon the Secretary of State	Powers of direction to generate quality standards will be conferred on the Secretary of State. In addition, legislative changes will be made so that the Secretary of State or NICE can determine the length of time within which the NHS is required to implement NICE recommendations.
22. NHS trusts and FTs *Annex D*	Changing as they are conferred upon the Secretary of State	NHS England's functions are being conferred on the Secretary of State with some necessary changes being made to reflect this. This includes changes to the process for Trust Special Administration for NHS trusts and FTs. The updated process is streamlined (only involving the Secretary of State, rather than the Secretary of State and NHS England) and aligns the process, where appropriate, between NHS trusts and FTs. A new purpose for which licence conditions may be set or modified in the NHS provider licence is added by the bill, which will

Policy area	Who will be responsible for this function	Specific points to note
		enable the Secretary of State to consult on adding new conditions to the licence for this purpose. The purpose will be to ensure compliance with existing legislation, which aims to strengthen the use of the provider licence as a regulatory tool. Further changes to the NHS trust and FT model (such as conversion of an FT to NHS trust, also known as FT de-authorisation, and governance changes) are covered in a separate impact assessments. Please see the Impact Assessments Summary Document for more information.
23. Reconfigurations *Annex D*	Changing as they are conferred upon the Secretary of State	Removing requirement on ICBs to notify the Secretary of State about reconfigurations. Limiting scope of call-in power so that it excludes commissioned services that the Secretary of State is responsible for.
24. Role of CQC *Annex D*	Changing as they are conferred upon the Secretary of State	CQC will perform their role in respect of the Secretary of State rather than NHS England. CQC will continue to be able to conduct special reviews and investigations where relevant to their role as investigator of care quality and provision. There will be a power to specify the Secretary of State commissioning functions that will form part of CQC's remit for these reviews. Also, a change is being made to place the Secretary of State under a duty to consider CQC recommendations to appoint a Trust Special Administrator (TSA). This replaces, and is different from, what NHS England's role is in appointing a TSA (currently NHS England can be *required* to appoint a TSA by CQC).
25. Workforce, education and training *Annex D*	Changing as they are conferred upon the Secretary of State	These changes reduce the level of legislative detail (such as publishing certain documents, which existed to hold NHS England to account for delivery of workforce functions).

Policy area	Who will be responsible for this function	Specific points to note
26. Non-health related Acts of Parliament *Annex D*	Minor updates to existing Acts	In most of these cases, reference to NHS England is being removed and, where required, the Secretary of State will replace NHS England.

Annex B: Functions being conferred on the Secretary of State

1. Emergency Preparedness (civil contingencies)

Context:

While the Secretary of State has existing functions in relation to emergency preparedness and response, NHS England take the lead on ensuring that the health system is prepared for an emergency. For example, this includes monitoring ICB and provider compliance with emergency preparedness legislation and maintaining national frameworks and standards. This ensures there is national oversight of how prepared the health service is for an emergency, while ensuring operational delivery continues at a local level.

Operational delivery of emergency response is led by responders. The Secretary of State and NHS England are currently Category 1 responders (but for the Secretary of State only in relation to public health emergencies). ICBs and trusts are also Category 1 responders for the health service and work with organisations that are commissioned to provide NHS services.

Functions being conferred:

Following the abolition of NHS England, the Secretary of State will continue their existing work in relation to emergency preparedness and response but will also take on NHS England's role in ensuring the health system is prepared for an emergency. What is defined as an emergency within NHS England's role (section 252A) differs to that within the Civil Contingencies Act. This results in the Secretary of State being prepared for a broader set of emergency situations that could affect the health system than under the Civil Contingencies Act, in order to maintain the current level of preparedness.

On operational delivery, the Secretary of State will continue to be a category 1 responder in relation to public health emergencies only. NHS England will no longer be listed (and will not be replaced by another national-level responder). ICBs and trusts will continue their roles as responders. A minor amendment ensures all trusts providing ambulance services or hospital accommodation and services relating to accidents and emergencies are included as Category 1 responders, which clarifies their existing role.

2. Finance

Context:

NHS England have statutory provisions relating to financial powers, payment-making functions, and the provision of grants, loans, and support. Some powers, like the ability for NHS England to reward ICBs based on performance, are only held by NHS England. Whereas others, like those relating to grants, or loans, are held by both the Secretary of State and NHS England.

More specifically, there are also powers that underpin the commissioning and funding of community services, such as those allowing ICBs to make payments to local authorities and voluntary organisations.

NHS England have further financial control powers which relate to:

- **System financial controls**: general power to set financial objectives for ICBs and their partner trusts to retain optionality, as well as mandatory requirements for system balance to better reflect the role of ICBs as commissioners
- **ICB controls**: duties and powers over ICBs to set financial envelopes

- **Allocating of funding to ICBs**: powers to provide funding to ICBs towards meeting the expenditure of the ICB which is attributable to their exercise of its functions each year.
- **NHS trust controls**: the power to give directions to any NHS trust about its exercise of any functions. The Secretary of State has parallel powers.
- **Power to issue guidance for ICBs**: power to issue guidance on the duties of ICBs and their constituent NHS trusts and FTs to produce annual capital plans
- **Financial direction to ICBs:** power to direct ICBs on the financial use or management of their financial or other resources
- **Capital limits on FTs**: powers to impose capital limits on FTs and accompanying guidance. This is used to ensure responsible capital expenditure and to avoid a risk of DHSC breaching its Delegated Expenditure Limit

In addition, the Secretary of State currently holds financial controls powers used to issue directions to NHS England.

Also, both DHSC and NHS England produce statutory annual accounts. DHSC produces the Annual Report and Accounts (ARA) for the DHSC group, while NHS England prepares an annual report and accounts for NHS England and the NHS England group (including ICBs plus Supply Chain Coordination Ltd). NHS England also prepares the consolidated provider accounts ('CPA') which brings together the accounts of all 210 providers. These documents are all audited by the National Audit Office (NAO).

This section does not include provisions relating to the better care fund (BCF) (see section 16 of this Annex), or new financial provisions which are covered by a separate impact assessment. Please see the Impact Assessments Summary Document for more information.

Functions being conferred:

Following the abolition of NHS England, the provisions that confer powers solely on NHS England which must continue will be conferred on the Secretary of State to ensure continuity. NHS England powers that are already duplicated within existing Secretary of State powers, are being repealed.

ICB powers underpinning the commissioning and funding of community services are being retained to support continuity of service delivery and the integration agenda. The Secretary of State will have the same powers conferred.

The NHS England power to direct ICBs as to their management and use of financial or other resources is being conferred onto the Secretary of State and combined with the power to direct ICBs to use funds for service integration. The streamlined power of financial direction will also include an expanded funding clawback power should an ICB fail to comply with any direction issued.

Transitional provisions will be included where required to maintain legal and operational continuity, particularly in relation to existing payments, and obligations. Collectively, these changes are intended to streamline the statutory framework, reduce duplication, and ensure clarity and accountability for functions previously discharged by NHS England.

Table 6 below sets out who will be responsible for financial control functions following the abolition of NHS England.

Table 6: Proposed future responsibilities for NHS Englands financial control functions

NHS England financial power or function	Who will be responsible for functions
System financial controls	Conferred on the Secretary of State, but repeal the mandatory requirements for system balance
ICB financial controls	Conferred on the Secretary of State
Allocating of funding to ICBs	Conferred on the Secretary of State
NHS trust and FT financial controls	Conferred on the Secretary of State
Financial directions on ICBs	Conferred on the Secretary of State
Capital limits on NHS FTs	Conferred on the Secretary of State See Impact Assessments Summary Document for details on the separate impact assessment on financial accountability, which covers the extension of the backstop power to also be able to impose an expenditure limit on revenue spending.
DHSC and NHS Statutory Accounts	Retain (Conferred on the Secretary of State) A single consolidated account for the NHS (comprising providers and ICBs) will be prepared and audited by the National Audit Office (NAO) and using the same data collection as currently.

3. Governance and Accountability

Context:

NHS England currently exists as a statutory body which has contracts, liabilities, property (including intellectual property and knowledge assets) and staff. In addition, these governance and accountability duties exist in relation to NHS England:

- the statutory duty for the Secretary of State to publish a mandate to NHS England
- the duties to hold meetings in public
- NHS England is included in the definition of a health service body and an NHS body and is referenced in relation to information disclosure

Functions being conferred:

Following the abolition of NHS England, the Secretary of State will have a new power to make schemes to transfer the property, rights and liabilities from NHS England. Transfers may be made to the Secretary of State, any ICBs or other relevant bodies.

The transfer scheme may make provision which is the same as or similar to the Transfer of Undertakings (Protection of Employment) (TUPE) regulations.

As NHS England will no longer be an existing statutory body, anything that underpins it as a statutory body or determines the way that it is set up internally will be repealed. The

requirement to publish a mandate and hold meetings in public will be removed, as government departments are subject to transparency and accountability via different routes. Finally, any references to NHS England in clauses and definitions will also be removed.

4. Health Inequalities

Context:

The Secretary of State holds existing duties to have regard to the need to reduce inequalities. NHS England also hold duties in relation to this, which includes a duty to have regard to need to reduce inequalities between:

- people with respect to their ability to access health services
- patients with respect to the effectiveness and safety of health services, and
- patients with respect to the quality of their experience of the health service.

This role includes work to identify areas for improvement at a national level, provide strategic direction and guidance to the NHS, and monitor progress in reducing inequalities across the system. ICBs also have separate duties.

Functions being conferred:

Following the abolition of NHS England, the Secretary of State duty to have regard to the need to reduce inequalities will be amended slightly to provide clarity on what is intended by reducing inequalities. It will specifically refer to the need to reduce inequalities between people with respect to their ability to access health services and the outcomes achieved for them by the provision of health services. This change does not materially change the duty but is necessary to ensure work carried out by NHS England to tackle inequalities continues. ICBs will also continue to have their duty to have regard to the need to reduce inequalities.

5. Mental Health

Context:

There are several mental health-related functions that apply to NHS England, which include:

- the Mental Health expenditure document required to be published by the Secretary of State, which includes expenditure by NHS England
- NHS England has a duty to share information requested by the court (such about available hospital accommodation and facilities) when hospital orders may be made that could lead to the admission of a person, where it relates to services or provision arranged by NHS England. This duty also applies to ICBs and Local Health Boards.
- After-care services for people discharged from specific sections of the Mental Health Act are primarily a duty of ICBs, Local Health Boards and local social services authorities. However, the Secretary of State can change that duty to be imposed on another ICB or NHS England if required.

There are also references to NHS England in legislation in these instances:

- in high-security hospitals, incoming mail to a patient can be withheld if the managers think it’s necessary to protect the safety of the patient or protect others. NHS England, alongside the Secretary of State and ICBs, are named on the list of organisations the mail cannot be withheld from.
- NHS England are currently listed as having legal protection for carrying out duties under the Mental Health Act

- the Secretary of State can require NHS England or a Special Health Authority or the Board to exercise an approval function of the Secretary of State (such as approving persons as ‘approved clinicians’)
- NHS England are included as a relevant authority that is required to have regard to the Secretary of State guidance on the steps it would be appropriate for them to take to meet the needs of persons with Down syndrome
- NHS England are also referred to in the Mental Health Act 2025 which makes changes to the Mental Health Act 1983.

Functions being conferred:

Following the abolition of NHS England, the reference to NHS England in Mental Health expenditure legislation will be removed and the duty to share information with courts will be conferred on the Secretary of State (alongside retaining the duty on ICBs and Local Health Boards). For after-care services, this bill proposes removing the ability to impose the duty on NHS England and allows the Secretary of State to take up this duty themselves through regulations.

Where there are references to NHS England in legislation mentioned above, these will be simply removed. Any functions set out for NHS England in the Mental Health Act 2025 (such as making arrangements for Care, Education and Treatment Reviews) will be conferred on the Secretary of State.

6. Patient Choice

Context:

NHS England is currently required to act with a view to enable patients to make choices with respect to their healthcare.

NHS England also have a power to make guidance, covering how ICBs should comply with the ‘patient choice requirements’. In addition to this NHS England must publish guidance covering what should be done in the case an ICB is non-complaint with the ‘patient choice requirements’, which includes a power to direct and investigate ICBs. Although, NHS England have never used these powers.

Functions being conferred:

Following the abolition of NHS England, the duty to ensure that patients can make choices with respect to their healthcare will be conferred on the Secretary of State. NHS England’s role publishing guidance to ICBs and investigating non-compliant ICBs will also be conferred on the Secretary of State.

How this duty and enforcement powers would be implemented in practice will be detailed in secondary legislation or alternative non-statutory policies.

7. Patient Involvement

Context:

NHS England currently hold a duty to promote the involvement of patients, and their carers and/or representatives (if any), in decisions about a patient’s illness, care or treatment. This results in NHS England taking steps at a national level to ensure patients (and their carers or representatives) are involved in decision-making. For example, by issuing national advice and

guidance, conducting work on patient experience, and gaining assurance through regional teams.

Functions being conferred:

Following the abolition of NHS England, this duty will be conferred on the Secretary of State. Other parts of the system will continue to be engaged largely as they are currently. For example, ICBs will need to have regard to national advice and guidance and monitor provider performance, and providers will involve individuals in decisions relating to their health and care.

8. Patient Safety

Context:

While the Secretary of State has existing obligations to improve the safety of health services, NHS England lead patient safety in the NHS from a clinical, policy, strategy, digital, leadership, education, training and improvement perspective. There are specific duties NHS England hold in relation to patient safety, which include:

- establishing and operating systems for collating and analysing patient safety data, in part by maintaining and operating the Learning from Patient Safety Events (LFPSE) service
- using patient safety data to provide advice and guidance for those working within the health system to improve the safety of health services.

This national oversight helps to identify national patient safety issues, bring together various intelligence, and act as a central point of leadership for implementing patient safety improvements.

NHS England is also required to work with HSSIB on aspects like training on the Patient Safety Strategy, recommendations to improve patient safety, sharing reported patient safety concerns.

The Secretary of State also has an existing duty to improve the quality of services provided to individuals for, or in connection with, the prevention, diagnosis or treatment of illness. NHS England also has this duty, which involves monitoring the health system, and providing advice and guidance to those working in the health system.

Finally, the National Medical Examiner (NME), while appointed by the Secretary of State, is employed by NHS England.

Separately, the Secretary of State is required to ensure NHS bodies in England appoint sufficient medical examiners and that the funds and other resources made available to medical examiners are adequate to enable them to discharge their functions. They also have the power to direct NHS bodies regarding resources and the appointment of medical examiners.

Functions being conferred:

Following the abolition of NHS England, NHS England's duty to monitor and improve the safety of services will be conferred on the Secretary of State. The Secretary of State will retain the duty to improve the quality of services provided for individuals, while NHS England's duty will be repealed.

As part of this bill, Health Services Safety Investigations Body (HSSIB) functions will be transferred to CQC so the Secretary of State will not be required to work with HSSIB in the same way as NHS England does. Therefore, HSSIB's assistance will be called on as needed.

The transfer of HSSIB functions into CQC is covered by a separate impact assessment (see Impact Assessments Summary Document for more detail).

The Secretary of State will retain their existing duties in relation to medical examiners and the statutory appointment of the NME. The NME will continue to be accountable to the Secretary of State, but the employment of the role will be conferred on the Secretary of State and will be undertaken in DHSC via a clinical ring-fenced post. There is no impact on arrangements in Wales.

9. Public Health

Context:

The Secretary of State has existing functions relating to public health, which include the duty to protect public health and the function of improving public health.

Whereas, NHS England have the role of ensuring there is consistency across the system's public health functions. Their role involves setting national standards and service specifications and gaining assurance of the system's public health functions.

Functions being conferred:

The Secretary of State will largely retain their existing functions in relation to public health and NHS England's functions will also be conferred on the Secretary of State. The Secretary of State will take on responsibility for handling the execution and operational aspects of some public health programmes that require national coordination (such as some screening programmes). These changes are covered in more detail in the commissioning section (see section 12 of this Annex).

Using existing powers, the Secretary of State will continue to arrange or direct bodies in the health system to exercise its other public health functions. This includes functions that are currently exercised by NHS England. ICBs are (and will continue to be) the main body tasked with exercising these public health functions (for example, the commissioning of some vaccination and screening services that benefit from being tailored to local populations). The Secretary of State will retain flexibility to determine which public health functions should be delegated to ICBs and how. The Secretary of State will take on NHS England's current role in setting national standards and service specifications for NHS public health programmes. These changes are covered in more detail in the commissioning section (see section 12 of this Annex).

NHS England's duty to consult with public health professionals and persons with experience in the prevention, diagnosis or treatment of illness, in order to obtain advice on the discharge of its functions will be repealed and not conferred on the Secretary of State. This is because the Secretary of State is bound by other duties that serve a similar purpose. These existing duties serve to ensure that decisions made by the Secretary of State are rational and work to improve the mental and physical wellbeing of all people in England. This means that, even without a legal requirement to consult with professionals, the Secretary of State should still continue to engage with professionals to help them effectively discharge their public health functions and continually evaluate and aim to avoid or minimise any negative impacts of their decision making.

Separately, some existing Secretary of State powers to make arrangements with relevant bodies for them to deliver the Secretary of State public health functions will be repealed, as it will be possible for the Secretary of State to make arrangements to delegate the Secretary of

State public health related functions via expanded wider powers. Please see the Delegation section of the annex for more details.

10. Research and Innovation

Context:

NHS England holds a duty to promote innovation in the provision of health services. This duty is accompanied by a power to make payments as prizes to promote innovation. The prize may relate to work at any stage of innovation including within research.

In addition, the Secretary of State currently has the power to make payments for prizes to promote innovation and establish an advisory committee to support this. Currently, it has not been commenced and can be commenced if necessary. This power would allow the Secretary of State to support innovation more flexibly.

There are other references to NHS England in legislation, such as:

- promoting research and the use of evidence (the Secretary of State has equivalent duties)
- conducting, commissioning or assisting the conduct of research (the Secretary of State has an equivalent power)
- a duty to cooperate with the Health Research Authority (HRA) to exercise their data functions when HRA are exercising their data functions on health care research (also applies to the Secretary of State)

Functions being conferred:

Following the abolition of NHS England, the innovation duty will be conferred on the Secretary of State, but the scope of application for this duty will be broader as the Secretary of State has a wider scope of functions than NHS England. The power to make payments as prizes is being repealed and then replicated as a new power for the Secretary of State. Further references to NHS England in legislation will be removed.

11. Wider functions

Wider functions of NHS England within legislation that are not captured in the other policy areas are covered below.

Duty to exercise functions effectively, efficiently and economically

NHS England's duty to exercise functions effectively, efficiently and economically will be repealed as NHS England will be abolished. The Secretary of State is already accountable to Parliament and the public for the overall performance of the health service, so the need to ensure that they are exercising their functions effectively, efficiently and economically is captured through their direct accountability to Parliament, without requiring an explicit statutory duty.

Triple Aim

The Triple Aim duty requires that NHS England have regard to the likely effects of its decisions on:

1. the health and well-being of the people of England
2. the quality of services provided and
3. efficiency and sustainability in the use of resources relevant to the NHS

The power to publish guidance on the Triple Aim will be repealed, as will NHS England's duty to have regard to the Triple Aim. This is because the Secretary of State is already accountable to Parliament for their decisions and has overarching duties that cover the scope of the Triple Aim duty. The Triple Aim duty will remain in place for ICBs and providers.

Net-Zero and environmental duties

Currently NHS England, trusts, FTs and ICBs all have legal duties on climate change in the NHS Act 2006. The duties require these bodies to have regard to the need to contribute to targets set under the Climate Change Act 2008 and the Environment Act 2021, and the need to prepare for and adapt to climate change. In complying with the duties, these bodies are required to refer to statutory guidance issued by NHS England under a specific power granted through the same Act.
Through the abolition of NHS England:

1. **NHS England's duties will be repealed.** It is not deemed necessary to confer these duties on the Secretary of State as all members of the government are already expected to have regard to the government's own legislative ambitions. Moreover, ministers are bound to consider specific environmental requirements and policy statements, such as the Environmental Principles Policy Statement[14], when making policy.
2. **The climate duties on trusts, FTs and ICBs will be retained** alongside consequential amendments requiring that these bodies have regard to any related guidance issued by the Secretary of State.
3. **NHS England's power to issue guidance on the discharge of climate change duties will be repealed**. This is because the Secretary of State will be able to issue guidance to trusts, FTs and ICBs under wider powers, which these bodies will be legally required to have regard to as part of the retained duties.

This approach will ensure continuity and consistency in the NHS's work on net zero and other environmental matters, ensuring this continues to align to tailored system guidance (such as through the current Green Plan guidance) which in the future will be issued by the Secretary of State.

Public-Private Partnerships

Following the abolition of NHS England, the rights and liabilities for where NHS England has formed, invested in, or offered loans to companies under s223 will be conferred on the Secretary of State. It is not anticipated to cause significant impacts as the status quo is expected to be maintained.

Guidance for the adult autism strategy

NHS England have a duty in the Autism Act 2009 to act under the Secretary of State's guidance. With the abolition of NHS England, it will no longer be included in the definition of 'NHS body' whereby NHS bodies have to act under the Secretary of State's guidance on the adult autism strategy.

Co-operation between NHS bodies

The duty to cooperate currently applies to 'NHS bodies'. The definition of 'NHS bodies' will no longer include NHS England.

[14] Department for Environment, Food & Rural Affairs (2023), Environmental principles policy statement, (viewed November 2025)

Annex C: Functions being conferred on ICBs (and in some cases the Secretary of State)

12. Commissioning

Context:

Commissioning, sometimes referred to more simply as purchasing, is the process by which health services are planned, purchased and monitored. Primary legal accountability for commissioning services within the NHS is shared between NHS England and ICBs (with the Secretary of State delegating its public health commissioning functions to NHS England).

NHS England has, since 2014, gradually delegated responsibility for a number of its commissioning functions to ICBs (and their CCG predecessors). By 2024, ICBs held full delegated responsibility for NHS England’s primary medical care, pharmacy, ophthalmology, and dental commissioning functions. As of April 2025, ICBs also commission 70 specialised commissioning services. All of NHS England’s functions were delegated via standard delegation agreements. This has enabled NHS England to retain certain control of certain elements of the functions (such as those which can only be exercised on a national basis), establish a bespoke governance and oversight framework, and retract functions in the event of serious failure.

The legal framework which underpins delegation (Section 65Z5 of the Health and Care Act 2022) transfers responsibility for exercising delegated functions to the receiving body. It also assigns liability to the latter body. Despite this shift, ultimate legal responsibility remains with the sending body. This means delegation is always a partnership, and this is reflected in the existing NHS England and ICB delegation agreements (as per the description above).

Table 7 below summarises where primary legal accountability for each commissioning function that NHS England currently holds would be placed following the abolition of NHS England.

Table 7: Summary of the future responsibilities for commissioning functions

Function	Current	Future
Primary Care	NHS England (delegated to ICBs)	ICBs
Specialised services*	NHS England (some currently delegated to ICBs)	The Secretary of State (highly specialised services) ICBs (non-highly specialised services)
High-secure psychiatric services	NHS England	The Secretary of State
Public Health: Vaccinations, screening, child health & immunisation services	The Secretary of State (delegated to NHS England)	The Secretary of State for national screening programmes, other sensitive national functions

Function	Current	Future
		The Secretary of State (delegated to ICBs) for vaccinations, immunisations, and screening
Armed Forces	NHS England	The Secretary of State
Health & Justice	NHS England	ICBs

* There are 154 specialised services for diseases listed in the 2012 Standing Rules Regulations. As of April 2026, ICBs commission 70 such services[15] via a delegation agreement with NHS England, and NHS England commissions the remaining services.

Subject to the passage of the bill, the specialised services and armed forces services to be commissioned by the Secretary of State will be set out in regulations made under the amended Section 3B of the NHS Act 2006. It is proposed that the Secretary of State will issue directions to ICBs on the specialised services and health and justice services that ICBs will commission.

Changes to functions:

Following the abolition of NHS England (and in addition to the changes outlined in Table 7), to enable ICBs to deliver specialised services effectively, the general power of direction over ICBs (see section 20) will be used to:

- set out the specialised services and health and justice services that ICBs will commission
- set out the nationally set standards (for example service specifications and commissioning policies) applying to those services
- require ICBs to collaborate with other ICBs on commissioning (such as when commissioning at-scale is required) through the offices of pan-ICB commissioning (OPICs)

As set out in Table 7, ICBs already control the commissioning of primary care services (GPs, pharmacy, dental and optometry) via a delegation agreement with NHS England. They also control the commissioning of secondary dental services, such as paediatric dentistry, via a delegation agreement with NHS England. This means that when primary legal accountability is conferred on ICBs via primary legislation and subject to Parliament, in practice, ICBs will be continuing with their existing work (albeit with less constraints from delegation agreements).

NHS England also commission a range of healthcare services that support children and adults throughout the youth justice and criminal justice systems in England (health and justice functions). The bill proposes to confer the legal responsibility for commissioning these services to ICBs, and this will be a new responsibility for ICBs. As for specialised services, ICBs will commission health and justice services through the OPICs that are being established in each area. It is also the intention for the Secretary of State to issue directions to ICBs on these functions.

As the number of services ICBs commission increases, it will also impact on their wider responsibilities, such as their duty to collect feedback on the services they commission. While this responsibility remains as it is, their commissioning functions will increase in number and lead to more feedback needing to be collected (see the Impact Assessments Summary

[15] NHS England (2025), NHS England » Commissioning integration: delegation of specialised services to integrated care boards 2025/26, Annex A (viewed December 2025)

Document for more information on the *Abolition of Healthwatch England and Local Healthwatch impact assessment* which discusses this duty).

On direct payments, references to NHS England will be removed where the same powers exist for the Secretary of State, and adjustments will be made to ensure the Secretary of State can make direct payments for anything they are responsible for commissioning.

Rationale for changes:

When different commissioners are responsible for different stages of the same pathway, care can become fragmented, and incentives for allocating resources to prevention and early intervention are weakened. The 10 Year Health Plan ambition to enable whole-pathway commissioning, and to establish ICBs as the NHS's strategic commissioners, means that ICBs should hold commissioning functions in their own right (rather than to share responsibility with the centre). The use of delegation agreements to date has evidenced the fact that commissioning led by ICBs can operate safely and effectively. However, it has also created a long-term role for the centre in managing these functions, which does not enable ICBs to work autonomously.

The proposed legislation will build on delegation and create a durable commissioning framework, aligning legal responsibility with the bodies closest to patient populations. As some services require specialist expertise and a larger footprint than a single ICB, DHSC's delivery model will mandate multi-ICB collaboration via Offices for Pan-ICB Commissioning (OPICs). This operating framework will ensure that scale and capability is retained, while legal responsibility shifts permanently to individual ICBs.

13. Arrangements with devolved governments and Crown Dependencies

Context:

NHS England has several powers to make arrangements with the devolved authorities and the Crown Dependencies, such as:

- powers to enable NHS England to enter into arrangements with Northern Ireland and Scottish Ministers for NHS England to commission services on their behalf.
- powers to provide advice or support to a public authority in the devolved governments and crown dependencies, in relation to education and training.
- powers to provide advice or assistance to the crown dependencies.

Additionally, NHS England has a further duty to have regard to the likely impact of commissioning decisions on the provision of health services to people living in Scotland and Wales, but close to the English border.

Functions being conferred:

Following the abolition of NHS England, its functions will be conferred on the Secretary of State to ensure the existing duties are maintained. The policy intention is for the use of these powers to remain unchanged, however there are some changes in drafting to reflect the difference between the role of the Secretary of State and NHS England. Additionally, there have been some clarificatory updates to the powers. For example, the powers to make arrangements with devolved governments have been made clearer, alongside a clearer power to delegate functions to a public body.

The duty to take have regard to the likely impact of commissioning decisions on the provision of health services to people who live in Wales or Scotland but close to English borders will be conferred on ICBs. This will align with primary care commissioning functions being conferred on ICBs. This places some greater responsibility on ICBs; however, this would only likely have

impact on the few ICBs which exist near or on the Scottish and Welsh borders with England. Additionally, the expectation is that these considerations are already being made, and inclusion in law would only strengthen those considerations in line with the greater primary care functions ICBs will hold.

14. Integration

Context:

Current NHS England duties and responsibilities set out that the NHS should work with local authorities (LAs), public bodies and other partners to work together (through integration) to deliver more effective and efficient health services and care for adults and children. There are general facilitative duties, as well as specific duties relating to care of adults, children, and supporting the justice system. There are duties to integrate to:

- promote children's wellbeing and welfare
- support children with SEND
- deliver support to adults and support their carers
- support in relation to domestic abuse
- disclose information relating to crime

Functions being conferred:

Following the abolition of NHS England, necessary updates are required to the arrangements which support integration, including that NHS England is removed as a partner. As the Secretary of State and ICBs will have commissioning responsibilities following the abolition of NHS England (see Commissioning in section 12 of this Annex), the Secretary of State will retain the integration duties as legislatively appropriate for the services for which the Secretary of State has commissioning responsibilities, as well as having oversight as to how ICBs discharge their duties. Some integration duties will also be conferred on ICBs where they are responsible for commissioning services.

15. Primary Care (primary medical, dental & primary ophthalmic services)

Context:

Currently, NHS England is legally responsible for commissioning primary care services, but ICBs deliver these on behalf of NHS England under a delegation agreement. For **primary medical, dental and primary ophthalmic services**, this includes:

- powers to secure provision of general medical service (GMS), general dental service (GDS) and general ophthalmic service (GOS) contracts
- ICBs will enter into GMS, GDS and GOS contracts.
- ICBs will make payments relating to GMS, GDS and GOS contracts
- ICBs will provide assistance or support to persons providing primary medical services (applies to medical, dental and ophthalmic services)
- NHS England are listed as entering into primary care contracts in primary legislation and are therefore required to protect employees during protected disclosures (such as in whistleblowing instances).

The Secretary of State also holds duties and powers relating to **strategy and the national contract** to:

- make regulations that relate to national contracts, such as regulations relating to variations made to contracts and dispute resolution
- make regulations and directions relating to charging and contractor fees, but ICBs will make the payments

- direct ICBs in the functions relating to primary medical, dental and ophthalmic services (see below)

Amendments to the National Health Service Act 2006 by the Health and Care Act 2022 provided NHS England the power to direct ICBs in the functions relating to primary medical, dental and ophthalmic services (see below).

While the Secretary of State can currently **direct NHS England** to exercise the Secretary of State's primary care functions and about the exercise of their primary care functions, NHS England has delegated their primary care functions to ICBs and the Secretary of State cannot direct ICBs.

There are separate **performers lists** for the different areas of primary care. NHS England currently manages the performers lists for medical, dental and ophthalmic practitioners providing NHS primary care services in England.

Currently, NHS England can recognise **local professional committees**, with ICBs having delegated responsibility for consulting with committees. These bodies represent the local primary care professionals (there are separate committees for medical, dental and ophthalmic professionals) and act as a point of contact between the primary care professionals and commissioners.

Conferred on ICBs:

Following the abolition of NHS England, **commissioning of** most **primary care services** will be conferred on ICBs, who will become legally responsible and accountable as commissioners of primary care in statute. This will enshrine in legislation the delegation to ICBs already in place, and these changes align with policy intent to have clear roles and responsibilities within the system. This will also bring primary care in line with other functions of ICBs, reduce duplication of parallel accountability approaches and increase integration. ICBs will also be required to protect employees during protected disclosures, due to entering into primary care contracts.

Also, ICBs will have the power to recognise **local professional committees**, which will ensure continued oversight of the recognition of committees.

Conferred on the Secretary of State and ICBs:

Some of NHS England's functions will be conferred on the Secretary of State and NHS bodies, such as the responsibility to manage the **performers lists**.

Separately, the Secretary of State has a power to provide accommodation to persons providing some primary care services (medical and dental) and they will retain responsibility for this.

15. Primary Care (pharmaceutical services)

Context:

Most pharmaceutical services are not directly commissioned. Instead, anyone who is approved to be added to the **NHS pharmaceutical lists** (which are currently prepared by reference to each local authority area and then consolidated into a national list) can provide NHS pharmaceutical services, and this is known as the **market entry system**. NHS England is currently responsible for publishing the consolidated list of contractors who are on the pharmaceutical lists for each local authority area, while ICBs are responsible for operating the market entry system.

Beyond this, only NHS England can **establish pilot schemes** for local pharmaceutical services, a contract-based mechanism for service commissioning, and the Secretary of State can make regulations relating to pilot scheme and piloted services.

In addition, **central pharmacy functions** held by NHS England are:

- determining the apportionment of pharmaceutical remuneration to ICBs
- recognising local pharmaceutical committees (this is delegated to ICBs)
- responsibility for the 2 sets of standard arrangements for providing NHS community pharmaceutical services (the provision of "pharmaceutical services" and "local pharmaceutical services" (LPS))
- establishing **Local Pharmaceutical Services schemes**, which is a joint the Secretary of State and NHS England responsibility, that NHS England currently delegate to ICBs. This role designates certain areas as falling outside of the usual rules for entry on the pharmaceutical list. In these areas, pharmaceutical services are procured and contractors some of their terms of service set under the Pharmaceutical and Local Pharmaceutical Services Regulations and some under NHS standard contract instead.

Conferred on ICBs:

Following the abolition of NHS England, responsibility for operating the **market entry system** will be conferred on ICBs, these functions are broadly the same as the current delegation agreement to ICBs. The powers to establish **LPS schemes** will also be conferred on ICBs, as will the powers to pilot services under **LPS pilot schemes**. This allows new approaches to be tested on a smaller scale ahead of a national rollout.

The power to **recognise local pharmaceutical committees** will also be conferred on ICBs.

ICBs will also be responsible for establishing and maintaining the **pharmaceutical lists**.

Conferred on the Secretary of State:

The **central functions** (principally around national determination of terms of service – the standard arrangements mentioned above – and national determination of remuneration) will also largely be conferred on the Secretary of State. Determining the apportionment of remuneration of ICBs is also a function that will be conferred on the Secretary of State.

Annex D: Functions changing as they are being conferred on the Secretary of State

16. Better Care Fund (Finance)

Context:

NHS England have existing powers to support service integration between local authorities and the NHS, and for the functions of the Better Care Fund (BCF).

In the current form of the BCF, the NHS and local authorities must pool budgets for the purposes of service integration, as there is a mandatory requirement to use section 75 agreements. This means to pool budgets, the BCF must involve Local Authorities.

Changes to functions:

Following the abolition of NHS England, the function will be conferred on the Secretary of State. In addition, this mandatory requirement on the use of section 75 will change to a discretionary power. Therefore, the Secretary of State still retains the power to require pooled budgets should they wish, but it will not be the default position.

Rationale for changes to functions:

This change is required because, while pooling budgets is a feasible option for delivering integrated care, it is not the only way to achieve integration. Allowing the Secretary of State discretion as to whether they exercise this power or not, will permit a level of flexibility, so that where funding is committed to integration, it does not have to be pooled.

17. Delegation powers

Context:

Current delegation powers under Section 65Z5 of the NHS Act 2006 enable health bodies such as NHS England, ICBs, NHS trusts or FTs to form arrangements to delegate functions to or perform functions jointly with each other or local authorities or combined authorities. These require delegation agreements to be set up between parties to enable the delegation to happen.

Delegation facilitates collaboration across the health system to commission services across several systems where appropriate, to enable integration and good value for money. Notably, accountability for the exercise of a function remains with the delegating party. The powers of delegation are broad, but the Secretary of State may place limits on the functions that may be included in S65Z5 arrangements through regulation powers in S65Z5(3).

Where parties have agreed to deliver a function jointly, Section 65Z6 allows for the creation of joint committees to carry this out. They may also arrange for one of the parties, or joint committee, to create and maintain a pooled fund.

The Secretary of State has the power in Section 7A of the NHS Act to make arrangements with relevant bodies (including ICBs, LAs, and other prescribed bodies) for them to deliver the Secretary of State's public health functions. The Secretary of State retains accountability for functions delegated through this route and arrangements are made through agreement between the parties.

In addition, the Secretary of State and NHS England both hold existing powers to direct ICBs to perform their functions, these are section 7B and section 13YB respectively. These powers to

direct require ICBs to deliver functions without needing delegation agreements. The current Section 7B power currently only enables the Secretary of State to direct ICBs to perform their public health functions. It requires the Secretary of State to publish the directions as soon as practicable after they are issued. The NHS England powers are more detailed (such as detailing what is required of NHS England to allow them to direct ICBs) and are more limited in scope. These powers are different to the more general powers of direction mentioned in section 20.

Separately, the Health and Care Act 2022 gave the Secretary of State the power to make regulations to transfer functions between relevant bodies. This Act also allows the Secretary of State to make regulations to delegate Secretary of State functions relating to the health service in England and functions for a Special Health Authority to a relevant body. NHS England is listed as a relevant body in relation to both of those powers.

Functions being conferred:

Following the abolition of NHS England, NHS England’s delegation powers will be conferred on the Secretary of State. The delegation powers being conferred on the Secretary of State includes the:

- Section 65Z5 and 65Z6 power to delegate or jointly exercise statutory functions, form joint committees and pooled funds.
- Section 65Z7 power to issue guidance on collaborative arrangements under S65Z5, which the relevant bodies must have regard to.

Changes to functions:

The bill will update sections 65Z5 to 65Z7 of the NHS Act 2006 to allow the Secretary of State to make arrangements with certain persons to delegate or jointly carry out the functions of the Secretary of State in relation to the health service in England. The reference to NHS England is being removed. Including the Secretary of State in these provisions will ensure that flexibility is maintained to delegate statutory functions, enable joint exercise of functions, formation of joint committees and pooled funds with relevant bodies such as ICBs and local authorities. This continues to support the exercise of functions at the correct level and to support collaboration. Due to the expansion of S65Z5 to include the Secretary of State, the bill also repeals S7A as it will be possible for the Secretary of State to make arrangements to delegate Secretary of State’s public health related functions via the updated S65Z5.

Presently, Section 7B only allows the Secretary of State to direct ICBs to perform Secretary of State’s public health functions. If there were to be a situation where it would be appropriate to delegate additional functions by direction to ICBs, the current legislation would limit this option. Therefore, this bill proposes to expand these 7B powers to cover all of Secretary of State’s functions relating to the health service in England.

Following the abolition of NHS England, the NHS England powers to direct ICBs to perform functions under 13YB will be repealed as the newly expanded Secretary of State powers will supersede these powers.

Where there is an existing intention to do so, this bill already proposes to confer or delegate functions on ICBs. Therefore, the use of these expanded powers is expected to be very limited but is ultimately dependent on future policy decisions.

18. Economic Regulation

Context:

Currently, NHS England is responsible for establishing, maintaining and publishing the **NHS Payment Scheme** under Chapter 4 of Part 3 of the Health and Social Care Act 2012. The Scheme contains binding rules that determine the amounts payable by commissioners to providers for relevant NHS healthcare services. The duties also include requirements to carry out an impact assessment and consultation before publication, as well as requirements to address objections, amend the Scheme and powers to enforce compliance where commissioners fail to follow the rules.

NHS England also hold an existing duty (section 12E) to ensure a level playing field between providers.

Transfer of functions:

Following the abolition of NHS England, these functions would be conferred on the Secretary of State. The intention is to preserve the Scheme's existing processes and powers in full. This is because its national pricing framework, and the consultation and enforcement mechanisms, are essential to providing financial stability to the system, and reducing unwarranted (price-driven) variation. Conferring these functions on the Secretary of State is intended to strengthen direct ministerial accountability for a core NHS financial lever, enabling payment rules to be managed alongside wider policy levers (covering system policy and oversight, financial controls, and provider regulation).

Changes to functions:

Following the abolition of NHS England, section 12E will be amended as it is conferred on the Secretary of State. The updated duty will apply when the Secretary of State exercises functions in relation to the health service. Without an updated provision, the duty would apply to some functions (like sections 6E and 12ZB of the NHS Act 2006) and not others (such as the NHS provider licence, or the power of direction), with no clear policy justification for that distinction.

The effect of the new clause is to place a single duty on the Secretary of State when exercising functions in relation to the health service. It also defines more precisely the prohibition's limits, as the Secretary of State will be able to deliberately vary the proportion of provision by provider type if it is in the interests of the health service to do so.

For ICBs and providers, it preserves continuity by ensuring that decisions affecting the balance of provision continue to be taken by on a fair and neutral basis, and relate to the interests of the health service, protecting against arbitrary judgment. The clause does impose some limited costs. These would be opportunity costs for the Secretary of State as the new duty requires additional scrutiny of a broader range of decisions than under the current duty.

19. Data and information

Context:

NHS England have several data functions, which broadly relate to:

- the collection, sharing and other processing of information, including personal data (including special category data for the purposes of Art 9 UK GDPR, colloquially described as "**confidential patient information**"), in relation to the commissioning and provision of health and adult social services in England; and
- operating national IT systems

Functions being conferred:

Following the abolition of NHS England, information functions will be conferred on the Secretary of State, largely in their entirety, but with some adjustments as necessary to account for the new arrangements. This is essential to ensure the continuity and quality of vital live services and data collections.

There are also some current functions which will be abolished as there is no longer a need for them, or because current needs or practices are not met by the existing legislation. This includes a duty for NHS England to assess whether the information collected meets published information standards, as well as certain functions of NHS England that originated from NHS Digital.

Changes to functions:

This section summarises the updates being made to the legislation which will have some impact on the system and how it operates. These are laid out below:

Modifying powers around establishing and operating information systems (Section 254 of the Health and Social Care Act 2012)

- This currently enables the Secretary of State to direct NHS England to establish and operate a system for the collection or analysis of information of a description specified in the direction. Provision will be made for the Secretary of State similarly to establish and operate such systems, and to process information, which includes the collection and analysis of information, and its linkage with other information.
- This better reflects the scope of how this provision is currently interpreted and applied in practice. It also provides greater clarity and flexibility in relation to processing activities that may be required in the future, including to support AI-related processing activity.

Publishing and disclosure of personal information (sections 260 and 261 of the Health and Social Care Act 2012)

- The scope of these powers will be changed to allow the Secretary of State to publish personal information in a broader range of appropriate circumstances, including personal information of practitioners (where necessary). It will also expand the current dissemination powers to allow for data sharing based on a principle of legitimate interest or for research (in addition to existing bases such as consent).
- These changes: rationalisation of the Health and Social Care Act 2012 to cater to the changing landscape and setting out the circumstances in which information can be published or shared, will allow more flexibility in how data is used for beneficial outcomes for health and adult care services. These changes do not substantially change the scope of what data can be collected, or analysed, or used.

Repealing the power of NICE and CQC to make mandatory requests (Section 255 of the Health and Social Care Act 2012)

- This power currently allows CQC or NICE to make mandatory requests to NHS England to establish an information system (or another body prescribed in regulations).
- This power has rarely been used and does not exist for other agencies, so its removal will have limited impact. CQC and NICE can make requests via the usual Data Access Request Service route, which DHSC will continue; such requests are then subject to independent consideration.
- In addition, the duty on NHS England to co-operate with the CQC will also not be conferred on the Secretary of State. CQC instead has a broader power to require information from organisations that could be used.

Repealing the duty as to assessment of the quality of information (section 266 of the Health and Social Care Act 2012).

- The current duty on NHS England to assess the quality of the information it collects from time to time and publish a record of the results of this assessment, will not be conferred on the Secretary of State. This is, in practice, an administrative burden on NHS England. While ensuring the quality of information is fundamental to any work to establish and maintain an information system, the duty is not considered the most effective means of ensuring high-quality information is collected.

Special Health Authorities

- Special Health Authorities (SpHAs) are independent bodies that may be set up by the Secretary of State, by order, for the purpose of exercising any functions that may be conferred on them by or under the NHS Act 2006. Functions are then conferred on SpHAs by means of the Secretary of State direction. In the future, new SpHAs may need to be formed, or existing functions may need to be conferred on existing SpHAs (specifically those relating to NHS England's existing health and social care data and digital functions).
- Amendments will be made in the bill to expand the purpose for which an SpHA may be established, so that it covers functions under any enactment, and not just the NHS Act 2006. This is aimed at ensuring that the Secretary of State will be able to direct a SpHA to carry out certain data related functions under the Health and Social Care Act 2012, including in relation to adult social care (and, if necessary, establish a new SpHA to carry out these functions).

20. ICBs

Context:

NHS England have several powers over ICBs, which include:

- the powers that NHS England have over ICBs in instances of failure, such as ICBs ceasing functions and where these functions can be taken over by another ICB
- the power to require an ICB to provide NHS England with any document or other information
- to be able to direct an ICB as to the approach to the preparation of accounts, their form and content
- to establish ICBs by order and abolish, change or make transfer schemes for ICBs
- a duty to publish rules for determining the individuals ICBs have commissioning responsibilities for
- powers to publish a document about the circumstances in which an ICB is liable to make payments to providers in respect of the provision of services to individuals
- powers to publish guidance assisting ICBs in understanding and applying the document referred to above
- duty to publish guidance for ICBs on the discharge of their functions, to which ICBs must have regard
- a power to publish guidance if required regarding joint appointments

These powers offer protections to patients and the public, supporting their continued access to a broad range of health services.

Powers of direction

Currently, the Secretary of State holds PoDs over NHS England, while NHS England holds PoDs over ICBs. If the NHS England PoDs over ICBs were conferred on the Secretary of State as-is, the Secretary of State would not be able to direct ICBs (individually or altogether) on areas that fall outside the specific scope of the NHS England powers. This inflexibility risks a lack of ability for the Secretary of State to intervene when new emerging issues arise. For

example, this power would not currently provide the Secretary of State with the option to direct ICBs in deficit on their use of resources.

Changes to functions:

Following the abolition of NHS England, most of NHS England's functions and powers over ICBs will be conferred on the Secretary of State to enable the continued delivery of services and ability to intervene in cases of failure. There will no longer be a need for a specific power for a body to publish specific guidance on joint appointments (as existing broader powers will cover this), so this will be repealed.

As the current NHS England PoDs are conferred on the Secretary of State, some will be retained and some will be repealed. Specific PoDs will be retained for 7 areas (like emergency interventions and ICB failure) because those powers are applicable more broadly than ICBs alone, or they allow the Secretary of State to intervene in these exceptional circumstances.

A new general PoD will also be established. This will only apply to ICBs and will carry some exemptions which are largely based on the current exemptions for the Secretary of State's powers of direction over NHS England (which will be repealed as NHS England is abolished). There will also be a requirement on the Secretary of State to publish any directions made to ICBs.

Currently section 6E, which is a power to make regulations to impose the Standing Rules covers some of the ground that it is intended the general PoD will be used for. It will therefore be repealed. New regulation making powers, instead of directions, will be used for patient choice, waiting times and individual appeals.

Rationale for changes to functions:

Current NHS England PoDs are narrowly focussed, so if they were conferred on the Secretary of State as-is, they would not provide the Secretary of State with as much flexibility to respond to certain situations. For example, this power could encompass directing an ICB in deficit towards a prescribed course of action. These powers would act as a useful backstop over unresponsive ICBs and help reduce the variation in health outcomes across England. They could also help future proof against unforeseeable circumstances by building flexibility into the system, particularly given there are wider ambitions (as set out in the 10 Year Health Plan) for progressive devolution to ICBs.

In practice, the intention is to use these powers to create a rules-based framework that can be more efficiently updated over time. For example, nationally set standards could be applied to the new commissioning functions being conferred on ICBs. These powers will be used alongside the Secretary of State powers to issue guidance to ICBs; requirements for ICBs will be set via directions, and these requirements will be explained in detail via guidance.

There are some exceptions where the Secretary of State would have to impose requirements on ICBs by way of regulations rather than directions are: patient choice, waiting times for specified services or treatments, individual funding requests, NICE approvals, NHS contract requirements.

21. Medicines and medical devices

Context:

NHS England currently has powers to develop quality standards, as well as disseminate advice and guidance regarding the provisions of NHS Services. At present NICE can be directed to prepare quality standards in relation to health services, public health and social care, by a 'relevant commissioner' which is a power shared between NHS England and the Secretary of State.

There are standard timeframes within which the NHS is required to fund NICE-recommended treatments; currently, the body responsible for determining when and whether these periods should be varied is NICE. Current provisions in legislation mean there is no alternative to NICE being the decision-maker.

Functions being conferred:

Following the abolition of NHS England, the direction-making power needs to be conferred on the Secretary of State. Also, the Secretary of State will be the relevant commissioner for health services as well as Social Care and Public Health. As such, the powers afforded to NHS England with respect to working with NICE on quality standards will need to apply to the Secretary of State where they do not already. This will enable the status quo to continue (national leadership, and co-ordinated working between national, regional and local bodies) and minimises disruption.

In addition, the legislation requiring NHS England to fund NICE-recommended treatments will be conferred on the Secretary of State.

Changes to functions:

Following the abolition of NHS England, the Secretary of State would have the power to alter the timescales to fund NICE recommended treatments. There is no intention to change the requirement for the NHS to make funding available for NICE recommended treatments, but the amended powers will provide flexibility in the future for the Secretary of State, not NICE, to be the decision-maker on any variations to the standard implementation period.

For some NICE-recommended medicines, a longer timescale for implementation is required where rollout within 3 months is unfeasible due to affordability or service delivery challenges (such as training or staff time). For example, the implementation period for NICE's guidance on the weight loss drug tirzepatide was recently extended to 12 years to manage the pressures on other NHS services.

22. NHS trusts and FTs

Context:

There are several powers and functions that NHS England has over providers, which include NHS England's:

- general functions regarding provider licences applying to NHS FTs, NHS trusts and Independent Providers (IPs) and associated regulatory functions or powers e.g. application or grant of licence, revocation or refusal and associated appeals process; modification of licence; oversight; enforcement undertakings and directions
- duty of oversight and power of direction over NHS trusts
- authorisation powers for NHS trusts to become FTs
- functions applying to transactions (such as trust or FT dissolutions, transfers, mergers and acquisitions)
- functions related to trust Special Administration, Health Special Administration and Financial Assistance in special administration cases.

- power to appoint, suspend and remove chairs and NEDs of NHS trusts

Functions being conferred:

Following the abolition of NHS England, NHS England's powers and functions in relation to providers will largely be conferred on the Secretary of State as they need to be exercised at a national level.

Changes to functions:

There will be some necessary changes to some functions as they are conferred on the Secretary of State, for example where there will be only one statutory role for the Secretary of State in transactions, rather than also including the role of NHS England.

The Trust Special Administration (TSA) function will also be conferred on the Secretary of State. Appointing a TSA (an independent person appointed to take over an NHS trust that is failing or unsustainable) would continue to be an intervention used only in cases of extreme failure, with poor performance and failure at provider level dealt with by a range of other pre-existing powers and levers before its use would be considered. They have only ever been used twice.

There will be some necessary adaptations made to the TSA process as it is conferred on the Secretary of State, as the role will move from having 2 decision makers (NHS England and the Secretary of State) to one (the Secretary of State). This simplifies the TSA process for FTs and NHS trusts and aligns the process, where possible, between FTs and NHS trusts. The Secretary of State would receive the report from the TSA and have 20 working days to consider what action to take in response, before publishing and laying notice before parliament. The role of CQC with regard to TSAs is detailed in section 24 of this annex.

Further, the final change to this area of legislation covered in this IA is that a new purpose is added to section 96(2) of the Health and Social Crae Act 2012 for which the Secretary of State may set, or modify, conditions in the NHS Provider Licence. Adding a new purpose for which licence conditions may be set or modified does not automatically add new conditions to the licence, but it enables new conditions to set or modified for that purpose, subject to statutory consultation with the relevant bodies.

This new purpose is to promote or secure compliance with obligations arising under any enactment and this will enable the Secretary of State, if the power to set or modify conditions for this purpose is used, to use the Provider Licence to ensure compliance with existing legislative requirements on providers. This solidifies the role of the Provider Licence as a regulatory tool and provides an additional tool for the Secretary of State to ensure providers comply with existing legislative obligations. An example could be ensuring compliance with procurement law.

There are also wider changes being made to FT governance and the conversion of an FT to NHS trust (also known as FT de-authorisation), please see the Impact Assessments Summary Document for details.

23. Reconfigurations

Context:

Reconfigurations are where there is a change in the arrangements made by an NHS commissioning body for the provision of NHS services, where that change has an impact on the way a service is delivered to individuals or the range of health services available to individuals. Within the reconfiguration legislation, there are 2 powers to note as the bill proposes changes to these powers:

- **The call-in power**: currently legislation allows the Secretary of State to intervene in any reconfiguration at any stage. Intervention allows the Secretary of State to take any decision that could have been taken by the NHS commissioning body responsible for the change. Statutory guidance sets expectations around use of this power and the processes that should be followed if the Secretary of State wishes to request a call in.
- **Notifiable reconfiguration proposals:** there is currently a requirement on NHS England and ICBs to notify the Secretary of State of reconfiguration proposals that meet the criteria (as outlined in The National Health Service (Notifiable Reconfigurations and Transitional Provision) Regulations 2024[16]).

Changes to functions:

Following the abolition of NHS England, the call-in power scope is being changed to exclude services the Secretary of State commissions, as the Secretary of State will not require a call-in power to cover their own decisions. Also, the requirement to notify the Secretary of State about reconfigurations will be removed.

Rationale for changes:

While the call-in powers will remain, the scope will be changed to exclude services that the Secretary of State commissions. Reconfiguration decisions about services commissioned directly by the Secretary of State (like specialised commissioning) will not be subject to an intervention power in legislation. As the Secretary of State will have some responsibility for commissioning and, as they will be able to revisit their own commissioning decisions, they will not require the call-in power to cover their own decisions. However, the ultimate backstop of a judicial review of reconfiguration decisions will remain in place following the abolition of NHS England.

The call-in power will remain for the Secretary of State to intervene in NHS service changes proposed by ICBs.

Also, repealing the notification duty will reduce the administrative requirements on ICBs to submit notification forms to DHSC. Following the abolition of NHS England, the Secretary of State would have access to contested reconfigurations via the Oversight Group for Service Change and Reconfiguration (currently a role undertaken by NHS England). Therefore, with access to this group and new ways of working in the restructured DHSC, the requirement on ICBs to notify the Secretary of State will be redundant.

24. Role of CQC

Context:

The Care Quality Commission (CQC) was legislated for under Part 1 of the Health and Social Care Act 2008. CQC is an Arm's Length Body (ALB), a public body established with a degree of autonomy from the Secretary of State and plays an important role in supporting the health and social care system. This Act conferred and imposed certain powers and duties on CQC in respect of both NHS England and the Secretary of State. For example, CQC holds investigatory powers for commissioning functions held by NHS England.

Functions being conferred:

Following the abolition of NHS England, CQC will perform functions that it currently discharges (from the 2008 Act) in respect of NHS England in respect of the Secretary of State instead. This

[16] UK Government (2024), The National Health Service (Notifiable Reconfigurations and Transitional Provision) Regulations 2024, (viewed November 2025)

does not substantially change the role and remit of CQC but rather affects to whom it exercises those functions. The original spirit of the legislation is maintained and the role and function of CQC as an independent ALB is not altered.

With regards to the CQC being able to conduct special reviews and investigations, this will still be the case, and they must do so if the Secretary of State orders them to. Other than NHS England's commissioning functions, the scope of CQCs special investigations and reviews remain unchanged, including the provision of NHS care and adult social services. Instead of investigating, with the Secretary of State's permission, the functions of NHS England in arranging for the provision of NHS care, the CQC's investigatory scope in relation to the Secretary of State's commissioning functions will be set out in regulations, to ensure that CQC can continue to effectively investigate care quality and provision. Broadly, this provides visibility of CQC's regulatory functions to the Secretary of State, where that specific CQC to the Secretary of State reporting or consultation pathway has not already been legislated for. They also remove certain duties imposed on CQC to NHS England which would be duplicative if they were conferred on the Secretary of State.

Changes to functions:

Role changes are only made where they are consequential to functions being conferred on the Secretary of State, or where they are required to reflect the nature of the relationship between the Secretary of State and an ALB (like CQC), which is necessarily different than the relationship between 2 ALBs (in this instance, CQC and NHS England). For example, the duty on NHS England to cooperate with the CQC will be repealed, and no equivalent duty placed on the Secretary of State, as other legislative mechanisms enable CQC to access information where required.

Therefore, rather than CQC *ordering* the Secretary of State to appoint a trust special administrator (TSA), as would have been the case under NHS England, CQC will instead be under a duty to *recommend* that the Secretary of State make a TSA appointment. This is unlikely to have significant impacts to the process of appointing a TSA, as the Secretary of State will be placed under a duty to consider CQC's recommendation.

25. Workforce, education and training

Context:

Legislation currently provides detail regarding NHS England's duties in relation to workforce, training and education. This is so that NHS England, as a non-departmental public body had the appropriate powers in relation to workforce, education and training, as well as to allow the Secretary of State to have appropriate oversight of these functions.

Functions being conferred:

All workforce, education and training functions are being conferred on the Secretary of State, meaning the Secretary of State will take on central responsibility for planning, delivery and payments for education and training. The Secretary of State already has a general duty in relation to education and training at 1F of the National Health Service Act 2006. Which includes a duty to exercise relevant functions, to ensure there is an effective system for the planning and delivery of education and training. A duty previously sat on NHS England at section 98 of the Care Act 2014, to ensure sufficient skilled health workers for the purpose of the health service; this will now be incorporated within the Secretary of State's general duty at 1F. The Secretary of State and ICBs will also continue to have duties to secure facilities required by a university which has a medical or dental school.

Changes to functions:

As these functions will be conferred on the Secretary of State directly, rather than by NHS England as an ALB, some features of the legislation which were previously used to enable oversight of NHS England will no longer be required. Therefore, the legislative provisions being removed includes the:

- requirement to publish the Education Outcomes Framework, which sets the objectives for NHS England to achieve in relation to education and training
- current NHS England duty regarding continuous improvement of the quality of education and training
- current duty on NHS England to secure education and training in a way that promotes the NHS Constitution
- existing duty to obtain advice on the exercise of its function in relation to education and training
- existing provision for the Secretary of State to publish the Education and Training Tariff and duty on NHS England to make payments by reference to it.

26. Non-Health related Acts of Parliament

Context:

NHS England is also mentioned in wider Acts of Parliament, beyond those relating to health.

Legislative changes:

In these wider Acts, reference to NHS England is being removed and, where required, replaced by the Secretary of State to continue that responsibility.