House of Commons

Health and Social Care Committee

# Health Bill 2026–27

First Report of Session 2026–27

HC 219

# Health and Social Care Committee

The Health and Social Care Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Department of Health and Social Care and its associated public bodies.

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The Committee is one of the departmental select committees, the powers of which are set out in House of Commons Standing Orders, principally in SO No. 152. These are available on the internet via www.parliament.uk.

## Publication

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# 1 Health Bill – overview and Committee activity

1. The Health Bill was introduced in the House of Commons on 14 May 2026 and had its second reading on 1 June 2026.[1] The main purpose of the bill is to abolish NHS England (NHSE) and transfer its functions to either integrated care boards (ICBs) or the Department of Health and Social Care, including transferring some powers directly to the Secretary of State for Health and Social Care.[2] Other major provisions in the bill include:

    a. Enabling the creation of a single patient record. The bill would enable the Secretary of State to legally require all NHS providers (including GPs) to disclose data to allow it to be combined in a single patient record.

    b. Implementing changes to the patient safety landscape and accountability recommended by the Dash review,[3] including bringing the Health Services Safety Investigations Body into the Care Quality Commission and abolishing Healthwatch and transferring local Healthwatch functions to ICBs and local authorities.

    c. Changing who is represented on ICBs and removing the requirement for integrated care partnerships to be set up.

    d. Other changes to the governance of NHS trusts and foundation trusts, including removing the requirement for NHS foundation trusts to have a council of governors and members, transferring powers to appoint foundation trust chairs to the Secretary of State, and allowing the Secretary of State to "de-authorise" foundation trusts.

    e. Changing how financial objectives are set across the system, with the Secretary of State being able to set objectives for individual ICBs and specified partner trusts.

    f. Introducing new powers for the Secretary of State to make regulations imposing duties on ICBs in relation to waiting times, patient choice, and appeals concerning commissioned NHS services.

1 HC Deb 1 June 2026, col 886
2 House of Commons Library, Health Bill 2026–27, Research Briefing 10845, 27 May 2026
3 Department for Health and Social Care, Review of patient safety across the health and care landscape, July 2025

**2.** We took evidence on both the bill, and the progress of the merger between NHSE and DHSC on 20 May[4] and 2 June.[5] This report is not intended to be a comprehensive analysis or commentary, although we hope the evidence we have taken is helpful to the House as it considers the legislation. Instead, this report proposes a limited number of amendments to the bill. We have prioritised amendments on topics where there is cross-party agreement, informed by the work we have done this Parliament. Our draft amendments are listed in the report's annex.

4 Health and Social Care Committee, Work of NHS England, 20 May 2026, HC 583
5 Health and Social Care Committee, Health Bill, 2 June 2026, HC 219

# 2 Proposed amendments

## Membership of ICBs

**3.** A recurring theme through this Parliament has been the importance of close and integrated working between the NHS and local authorities if the government wants to deliver the three shifts outlined in the 10 Year Health Plan,[6] particularly shifting treatment from hospital into the community and the shift from sickness to prevention. For example:

**a.** Our report on Adult Social Care Reform heard that the government will not achieve the ambitions set out in the 10 Year Health Plan without reform of the adult social care system, a system delivered by local authorities.[7]

**b.** Our report on Palliative Care highlighted the key role local authorities play in commissioning social care for their populations and the significant part they have to play in supporting individuals as they near the end of life.[8]

**c.** Our report on Healthy Ageing recommended that the government create mechanisms that incentivise departments and local government to jointly act to reduce physical inactivity.[9]

**4.** In the 10 Year Health Plan the government set an ambition to make the NHS "the best possible partner and the world's most collaborative public healthcare provider" including an ambition to work "in closer partnership with local government and other local public services [and] streamline how local government and the NHS work together."[10] However, Sarah Woolnough, Chief Executive of the Kings Fund, told us that despite there being a lot of

6 Department of Health and Social Care, Fit for the future: 10 Year Health Plan for England, -Executive summary, 2 July 2025

7 Health and Social Care Committee, Adult Social Care Reform: the cost of inaction, Second Report of the Session 2024–26, HC 368, para 115

8 Health and Social Care Committee, Palliative Care, Sixth Report of the Session 2024–26, HC1763, para 37

9 Health and Social Care Committee, Healthy Ageing, Eight Report of the Session 2024–26, HC1180, para 86

10 Department of Health and Social Care, Fit for the future: 10 Year Health Plan for England, -Executive summary, 2 July 2025

talk about bringing health and social care closer together, there was still a "power imbalance and dynamic" which "when push comes to shove" can lead to joint working defaulting to being NHS led.[11]

**5.** The Health Bill makes a number of changes to the current Integrated Care Systems (ICSs), which are the partnerships that bring together NHS organisations, local authorities and others to take collective responsibility for planning services, improving health and reducing inequalities across geographical areas.[12] Currently ICSs have two main parts:

- Integrated Care Boards (ICBs), which allocate the NHS budget and commission services for their population. ICBs are currently directly accountable to NHS England for NHS spend and performance within the system. Each ICB must prepare a five-year system plan setting out how they will meet the health needs of their population.[13]
- Integrated Care Partnerships (ICPs), which are statutory joint committees of the ICB and local authorities in the area. They bring together a broad set of system partners to support partnership working and develop an 'integrated care strategy', which ICBs must have regard to when making decisions.[14]

The bill would amend ICB membership requirements to include representatives nominated by the mayors of mayoral strategic authorities and to remove the requirements on ICBs to have at least one member jointly nominated by local authorities, one member jointly nominated by primary medical care providers, and one member jointly nominated by NHS trusts and NHS foundation trusts.[15] The bill also repeals the requirements on ICBs to set up an ICP, and for that partnership to prepare an integrated care strategy.[16]

**6.** Multiple witnesses expressed concerns about the proposed changes to ICB membership. Dr Hugh Alderwick, Director of Policy and Research at The Health Foundation told us:

> The risk is that you will lose the connection with social care and public health at a local level. That is critical for things like managing multimorbidity, and it might make things like pooling budgets more distant or difficult just because the planning together is not as effective.[17]

11 Q51
12 Kings' Fund, Integrated Care System explained, 9 April 2020
13 Kings' Fund, Integrated Care System explained, 9 April 2020
14 Kings' Fund, Integrated Care System explained, 9 April 2020
15 Health Bill, [as introduced], Bill 9, Clause 21
16 Health Bill, [as introduced], Bill 9, Clause 23
17 Q47

Similarly, Dr Wendy Taylor, Chair of the Local Government Association's Health and Wellbeing Committee, said the change was "a backward step" arguing that "if neighbourhood health is going to work, local authorities have to be at the centre of making it work". Dr Taylor also argued that the size of strategic mayoral authorities meant they could struggle to provide meaningful input on local priorities.[18]

**7.** **CONCLUSION**
In our Palliative Care report, we urged the government to reconsider its decision to remove local authority representation on ICBs. We remain convinced that removing their representation from ICBs is a damaging move that will undermine the government's efforts to shift treatment into the community and deliver a more integrated health and care system.

**8.** **RECOMMENDATION**
We recommend that the statutory requirement for ICBs to have at least one member jointly nominated by local authorities be retained.

## Joint financial planning and section 75 arrangements

**9.** Another recurring theme in our reports has been the impact of financial flows in the health and social care system, and how they frustrate efforts to deliver truly integrated care. Melanie Williams, the then President of the Association of Directors of Adult Social Services, told us that the NHS and local authorities spent "a lot of time debating about who pays, rather than having a conversation about how, in the longer term, we can invest in people's outcomes to enable better health and wellbeing" and highlighted concerns around the funding of intermediate care and community health services through section 117 aftercare[19] and NHS Continuing Healthcare.[20][21]

18 Q78
19 Some people who have been kept in hospital under the Mental Health Act can get free help and support after they leave hospital. The law that gives this right is section 117 of the Mental Health Act, and it is often referred to as 'section 117 aftercare'.
20 NHS Continuing Healthcare (NHS CHC) is a package of care for adults aged 18 or over which is arranged and funded solely by the NHS. In order to receive NHS CHC funding, individuals have to be assessed by integrated care boards (ICBs) according to a legally prescribed decision making process to determine whether the individual has a 'primary health need'.
21 Health and Social Care Committee, Adult Social Care Reform: the cost of inaction, Second Report of the Session 2024–26, HC 368, para 105

In our Adult Social Care Reform report we concluded: "it feels that progress is made despite funding mechanisms rather than because of them."[22]

**10.** In our Community Mental Health Services inquiry, we heard that creating pooled budgets within health and social care was an effective and flexible way to focus money on people and outcomes. Section 75 of the NHS Act 2006 provides a legal mechanism for NHS bodies and local authorities to pool budgets and jointly commission health and social care services, and we received evidence of positive examples of such arrangements being used to commission integrated services.[23]

**11.** We also heard that the use of section 75 arrangements was inconsistent. In October 2023, the government launched a call for evidence to explore how Section 75 could be better utilised to support integration. The summary of responses, published in December 2024, identified several areas for improvement, including the need for stronger inter-organisational relationships, clearer governance and financial structures, and better data sharing. We recommended that government should expand the use of Section 75 of the NHS Act 2006, including the range of services it would be used to support.[24]

**12.** In its response the government said that while it recognised the potential benefits of increasing the use of section 75 arrangements, including to support mental health patients:

> these remain voluntary arrangements and NHS bodies and local authorities can choose how they best use and manage these arrangements to meet the care and health needs of their local population. Partners to section 75 arrangements must have appropriate governance and reporting mechanisms in place and formal accountability remains with the bodies which originally hold the relevant NHS or local authority health-related functions, irrespective of who delivers them.[25]

22 Health and Social Care Committee, Adult Social Care Reform: the cost of inaction, Second Report of the Session 2024–26, HC 368, para 106

23 Health and Social Care Committee, Community Mental Health Service, Fourth Report of the Session 2024–26, HC566, para 139

24 Health and Social Care Committee, Community Mental Health Service, Fourth Report of the Session 2024–26, HC566, para 141 - 143

25 Department of Health and Social Care, Community mental health services: government's response to the Health and Social Care Committee's report, 11 March 2026, CP 1525

In our response we argued that the need for accountability was not a reason to discourage greater use of pooling arrangements, and that if the government did not wish to promote such arrangements then the onus was on them to provide an alternative way to promote integration.[26]

13. **CONCLUSION**
We believe that this bill is a missed opportunity for the government to either reform and promote the use of section 75 arrangements, or to provide an alternative mechanism that it believes is more effective in addressing the challenges funding flows present to the integration of health and care service across NHS and local authority services.

14. **RECOMMENDATION**
We recommend that the Health Bill be amended to require the Secretary of State to review the effective use of Section 75 of the NHS Act 2006, and to produce guidance to support NHS bodies and local authorities making use of section 75 arrangements to pool budgets and jointly commission health and social care services.

## Mental Health Investment Standard

15. Achieving parity of esteem between physical and mental health has been a goal of successive governments. Section 1 of the Health and Social Care Act 2012 enshrined into law equivalent duties on the Secretary of State in relation to delivering improvement in physical and mental health services.[27] Despite this, our inquiry into Community Mental Health Services highlighted multiple ways in which parity of esteem is not being delivered, including a lack of access and waiting time standards for community and A&E mental health services,[28] and a fragmented approach to service design and delivery.[29]

16. One of the main ways in which the current disparity of esteem manifests itself is in the level of funding that is provided for mental health services.  Mental health accounts for over 20% of the disease burden

26 Health and Social Care Committee, Community Mental Health Services: Commentary on the Government Response to the Committee's Fourth Report of the Session 2024–26, Seventh Report of the Session 2024–26, HC1180, para 3
27 House of Commons Library, Mental health: Achieving 'parity of esteem', Insight Briefing, 16 January 2020
28 Health and Social Care Committee, Community Mental Health Service, Fourth Report of the Session 2024–26, HC566, para 120
29 Health and Social Care Committee, Community Mental Health Service, Fourth Report of the Session 2024–26, HC566, para 91

but receives less than 10% of NHS expenditure.[30] One of the key policy mechanisms aimed at addressing this gap is the Mental Health Investment Standard (MHIS). Introduced in 2015–16, it required clinical commissioning groups (CCGs)—and from 2022 ICBs—to increase their annual spend on mental health services at a faster growth rate than their overall allocation. While mental health funding is not ring-fenced, local areas are expected to meet the MHIS. The Health and Care Act 2022 requires NHSE and the government to set out publicly whether the MHIS is being met.[31] Lord Simon Stevens, former Chief Executive of NHS England, has previously recommended making the MHIS a statutory requirement.[32]

**17.** NHS England's 2026–27 Medium-term Planning Framework: Revenue Finance and Contracting Guidance states that the MHIS will be based on "flat real funding growth" with a redefined MHIS only requiring the funding increases in line with inflation.[33] Sector leaders expressed concern that the move risked mental health missing out on a share of the three per cent average uplift after inflation, based on the NHS allocation in the last spending review.[34] Concerns have also been raised that NHS England will no longer require detailed audits to check compliance by ICBs.[35] In our report we raised concerns about the government being unwilling to commit to the MIHS beyond 2025–26,[36] and recommended that the government should legislate to make meeting the MHIS a statutory requirement.[37]

**18.** **RECOMMENDATION**

We continue to believe that achieving parity of esteem between physical and mental health requires sustained investment in mental health services and recommend that meeting, rather than just reporting on, the Mental Health Investment Standard should be a statutory requirement on ICBs.

30 Health and Social Care Committee, Community Mental Health Service, Fourth Report of the Session 2024–26, HC566, Summary

31 Health and Social Care Committee, Community Mental Health Service, Fourth Report of the Session 2024–26, HC566, para 179

32 Health Service Journal, Ministers risk 'screwing' mental health, warns Stevens, 27 November 2024 (accessed on 8 June 2026)

33 NHS England, Medium-term planning framework: Revenue finance and contracting guidance, 17 November 2025 (accessed 8 June 2026)

34 Health Service Journal, Government accused of 'weakening' spend on service at 'breaking point', 26 November 2025 (accessed 5 June 2026))

35 Health Service Journal, Equal funding rule disparaged as 'micromanagement' by government, 27 November 2025 (accessed 8 June 2026)

36 Health and Social Care Committee, Community Mental Health Service, Fourth Report of the Session 2024–26, HC566, para 183

37 Health and Social Care Committee, Community Mental Health Service, Fourth Report of the Session 2024–26, HC566, para 185

## Co-production of services

**19.** As part of our Community Mental Health Services inquiry, we asked those with direct experience of using services what good mental health support looked like to them. One of the most frequently emphasised aspects of high quality care was that it involved experts by experience in the design, delivery and evaluation of services. We heard that co-production had to be genuine and go beyond consultation or choosing between pre-set options. Harry Dyson, a peer researcher at the McPin Foundation, reflecting on his experience of participating in and leading on co-production, told us that:

> [t]he real challenge that comes with doing meaningful co-production is that it is ultimately about sharing power, and it does cost money. [ … ] There is a real friction there.[38]

NHS England has recognised the value of co-production across all services, saying on its website that, "Done well, co-production helps to ground discussions in reality, and to maintain a person-centred perspective."[39]

**20.** The Health Bill does not make direct reference to co-production. However, as result of this bill the Secretary of State is taking on some duties for commissioning services that were previously done by NHS England, with others being taken on by ICBs. Section 15 of the Bill places a duty on the Secretary of State to ensure public involvement in commissioning arrangements made by the Secretary of State. The explanatory notes reason that this provision "ensures that public involvement is secured at the planning and foresight stages of commissioning, as well as during the decision-making and operational stages, consistent with the principle that involvement should occur throughout the commissioning cycle."

**21.** **CONCLUSION**

We welcome the duty that the bill places on the Secretary of State to involve the public in the planning of commissioning arrangements. However, it is unclear to us from the language in the bill whether this would go as far as requiring service users to be involved in the co-production of the service design and delivery. We believe that this should be explicitly specified on the face of the bill.

38 Health and Social Care Committee, Community Mental Health Service, Fourth Report of the Session 2024–26, HC566, para 179

39 NHS England, Co-production, accessed June 2026

## Powers of SEND Tribunals in relation to health and social care needs

**22.** Following the Education Committee's report "Solving the SEND Crisis",[40] which identified significant gaps in accountability and engagement from the DHSC and by health services in the Special Educational Needs and Disabilities (SEND) system, we held a one off evidence session to build on its findings, looking at the delivery of health aspects of Education, Health and Care Plans (EHCPs).[41]

**23.** We followed up a recommendation that the Education Committee had made that the powers of the SEND Tribunal Service should be extended to allow it to issue binding recommendations to health services, not just education providers. SEND tribunals are independent national tribunals which decide appeals against local authority decisions about the special education needs of children and young people, including decisions made about an EHCP.[42] Currently they can make binding recommendations in relation to education provision but not in relation to health and social care needs.[43]

**24.** The Education Committee argued that this would ensure that when there is a failure to deliver a health provision specified in an EHCP, health bodies are legally obligated to take corrective action.[44] When we raised it with witnesses at our evidence session, several were supportive of placing this duty in legislation although they noted it would require other reforms to workforce and commissioning arrangements to be successful.[45]

**25.** **CONCLUSION**
As the Health Bill makes provision about the duties of integrated care boards (ICBs), it provides an ideal vehicle to provide a level playing field between education bodies and ICBs, so that ICBs are also under a legal obligation to comply with recommendations from SEND Tribunals.

40 Education Committee, Solving the SEND Crisis, Fifth Report of Session 2024–26, HC 492
41 Health and Social Care Committee, Delivering Health aspect of Education Health and Care Plans, oral evidence taken on 18 March 20026, HC1824
42 Independent Provider of Special Education Advice, What is the SEND Tribunal, accessed 4 June 2026
43 Education Committee, Solving the SEND Crisis, Fifth Report of Session 2024–26, HC 492
44 Education Committee, Solving the SEND Crisis, Fifth Report of Session 2024–26, HC 492
45 Health and Social Care Committee, Delivering Health aspect of Education Health and Care Plans, oral evidence taken on 18 March 20026, HC1824 Q34 - 35

## Health inequalities

**26.** As the government's 10 Year Health Plan acknowledges, health inequalities remain a significant problem in the UK. It states that "evidence shows that people in working-class jobs, those from ethnic minority backgrounds, or who live in rural or coastal areas or deindustrialised inner cities, along with those who have experienced domestic violence or who are homeless, are more likely to experience worse NHS access, worse outcomes and to die younger".[46] As we saw in our report on Healthy Ageing, there is a significant difference in healthy life expectancy linked to deprivation. In 2022–24, children born in Blackpool could expect to live 50.9 (male) and 51.8 (female) years in good health, while children born in Richmond upon Thames could expect to live 69.3 and 70.3 years respectively in good health.[47] The government has committed in the 10 Year Health Plan to "halve the gap in healthy life expectancy between the richest and poorest regions, while increasing [healthy life expectancy] for everyone".[48]

**27.** Clause 4 of the bill makes a technical change to section 1C of the NHS Act 2006. The change provides clarity on the Secretary of State's duty to "have regard to the need to reduce inequalities between the people of England".[49] This is with respect to their ability to access health services and the outcomes achieved for them by the provision of health services, in line with the duty imposed on NHS England by section 13G of the NHS Act 2006.

**28.** The campaign group Health Equals has argued that the legislation should go further and introduce a broader duty to specifically reduce health inequalities. In an article for the Health Foundation it argues that:

> At present, the Health Bill brings together old duties on the health secretary and NHS England to reduce inequalities in access to health care and outcomes (Section 4). These duties are too narrow and do not reflect the wider determinants of health that the government has pledged to tackle.[50]

46 Department of Health and Social Care, Fit for the future: 10 Year Health Plan for England, -Executive summary, 2 July 2025
47 Health and Social Care Committee, Healthy Ageing, Eight Report of the Session 2024–26, HC1180, para 2
48 Department of Health and Social Care, Fit for the future: 10 Year Health Plan for England, 30 July 2025
49 Health Bill, [as introduced], Bill 9, Clause 4
50 The Health Foundation, Blog, The Health Bill can put health at the heart of government, 21 May 2026

They have called for the bill to be amended to strengthen these duties so that the government has the same requirements as strategic authorities to improve health and reduce health inequalities, including those that are due to the building blocks of health such as air quality and housing.[51]

**29.** During the election the Labour party, in setting out its health mission, acknowledged that improving the health of the nation would require a whole government effort:

> Secure jobs, fair pay, adequate housing, safe streets, clean air, accessible transport, the time and affordable facilities to exercise, nutritious food, and a fair society. These are the essential building blocks for a healthy life. [ … ] This mission, like the others, will not be achieved by one department, the department of health, working on it–it will require cross-Whitehall joined-up government and a proper partnership with local communities.[52]

**30.** As part of our Healthy Ageing report we heard concerns that the government's mission-driven approach to government was at risk and that the government needed to create a method to deliver the health mission that removes existing departmental policy and funding silos.[53] We recommended that the government should restore the health mission and develop a cross-government 10-year plan to embed prevention and reduce inequalities in healthy life expectancy.[54] We are currently awaiting the government's response.

**31.** When we took evidence on the Health Bill, the major health think tanks, while broadly arguing that the bill needed to contain less rather than more, did believe that there was a case for additional material to "signal a greater focus on prevention [and] tackling health inequalities". However, they also highlighted the need for non-legislative action.[55] Dr Hugh Alderwick, from the Health Foundation, told us:

> The government need to focus on health and inequalities. A lot of that is about political will and investment. But if you wanted to use the legislation to force that issue, there are a couple of things that you could do. One example is in the new English Devolution and Community Empowerment Act, in which there is a duty on strategic authorities to improve health and reduce inequalities, looking across their functions.

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51 The Health Foundation, Blog, The Health Bill can put health at the heart of government, 21 May 2026

52 Labour Party, Build and NHS for the future, accessed 5 June 2026

53 Health and Social Care Committee, Healthy Ageing, Eight Report of the Session 2024–26, HC1180, para 83–84

54 Health and Social Care Committee, Healthy Ageing, Eight Report of the Session 2024–26, HC1180, para 87

55 Q56

> At the moment, the duty of the Secretary of State in relation to health and inequalities is narrower, but it could be broadened—that is one example [ … ] There are other examples, but this is about having a cross-government strategy, investment and things that have as much to do with policy as they do with legislation.

There was also support for the suggestion that every Minister across government should consider health inequalities when announcing major policies.[56]

**32.** **CONCLUSION**
Health inequalities represent a serious and continuing injustice across the country. The almost 20-year gap in healthy life expectancy between different parts of the country is morally unacceptable. While the government has set out the right vision for a cross government mission to tackle health inequalities we do not think that approach is being delivered in practice.

**33.** **RECOMMENDATION**
We recommend that the Secretary of State's duties in relation to health inequalities in clause 4 of the bill be strengthened and that all ministers should be under a duty to consider how policies they enact might contribute to or reduce health inequalities.

56 Q61

# Annex: Draft amendment text

## Membership of ICBs

Clause 21(a), page 15, line 38, at end insert—

"(2A) The constitution must also provide for the ordinary members appointed as mentioned in sub-paragraph (1)(b) to include at least one member nominated jointly by the local authorities whose areas coincide with, or include the whole or any part of, the integrated care board's area.

Member's explanatory statement

This amendment would require integrated care boards to have a member jointly nominated by local authorities from within the board's area, as is currently the case but would otherwise be removed by clause 21.

Clause 21(a), page 16, line 3 leave out from "mayor" to "sub-paragraph (2)" on line 4 and insert "or local authority nominating an ordinary member as mentioned in sub-paragraphs (2) and (2A)".

Member's explanatory statement

This amendment is consequential on the previous amendment and would require a local authority involved in nominating a member of an integrated care board to have regard to guidance published by the Secretary of State.

Clause 21(c) page 16, line 9 at end insert—

""local authority" has the meaning given by section 2B(5);"

Member's explanatory statement

This amendment is consequential on previous amendments and defines the term "local authority".

# Joint financial planning and section 75 arrangements

To move the following Clause—

**"Arrangements between NHS bodies and local authorities: duty to review**

(1) The Secretary of State must conduct a review of the effectiveness of arrangements entered into by NHS bodies and local authorities under section 75 of the National Health Service Act 2006 (arrangements between NHS bodies and local authorities).

(2) In conducting the review, the Secretary of State must consult—

a. NHS bodies,

b. local authorities, and

c. any another person that the Secretary of State considers it appropriate to consult.

(3) Having conducted the review, the Secretary of State must consider whether the power to make regulations in section 75(1) or the power to issue guidance in section 75(6) of the National Health Service Act 2006 should be exercised in order to improve the effectiveness of arrangements under that section.

(4) The Secretary of State must lay before Parliament, and publish, a report of the review.

(5) The report of the review must explain whether the Secretary of State decided to exercise the powers in section 75(1) and (6) of the National Health Service Act 2006 and the reasons for that decision.

(6) The Secretary of State must comply with the requirements of this section before the end of the 12-month period beginning with the day on which this Act is passed."

Member's explanatory statement:

This new clause requires the Secretary of State to conduct a review into arrangements under section 75 of the National Health Service Act 2006, and to consider whether to require NHS bodies and local authorities to enter into arrangements with each other if this is likely to lead to an improvement in how their functions are exercised.

## Mental Health Investment Standard

To move the following Clause—

**"Duty of integrated care boards to meet Mental Health Investment Standard**

In the National Health Service Act 2006, after section 223GC insert—

**"223GCA Duty of integrated care boards to meet Mental Health Investment Standard**

(1) An integrated care board must exercise its functions with a view to ensuring that expenditure incurred by the board in a financial year in relation to mental health complies with the Mental Health Investment Standard.

(2) For the purposes of this section, expenditure by an integrated care board complies with the Mental Health Investment Standard where the expenditure is greater than or equal to the amount specified for that board by the Secretary of State in accordance with subsection (3).

(3) The Secretary of State must specify an amount of expenditure for an integrated care board which secures that the proportion of the board's expenditure in a financial year in relation to mental health is larger than the proportion of the board's expenditure in relation to mental health for the previous financial year."

Member's explanatory statement:

This new clause puts the Mental Health Investment Standard on a statutory footing by requiring the Secretary of State to specify an increasing amount of expenditure by integrated care boards on mental health and then requiring integrated care boards to incur that expenditure.

## Co-production

Clause 15 page 1, line 35 at end insert—

(d) in the design of service and arrangement for service delivery (co-production)

Member's explanatory statement:

The amendment would explicitly require the Secretary of State to make arrangements for the co-production of any health service commissioned by the Secretary of State.

# Powers of SEND Tribunals in relation to health and social care needs

To move the following Clause—

**"Appeals against health and social care provision in EHC plans**

(1) The Special Educational Needs and Disability Regulations 2014 (S.I. 2014/1530) are amended in accordance with subsections (2) and (3).

(2) After regulation 42, insert—

**"42A Other matters relating to EHC plans against which appeals may be brought**

(1) In addition to the matters set out in section 51(2) of the Act, a child's parent or a young person may appeal to the First-tier Tribunal against the matters set out in paragraph (2), subject to section 55 of the Act (mediation).

The matters are—

a. a decision of a local authority, following an EHC needs assessment, that it is not necessary for health care provision or social care provision to be made for the child or young person in accordance with an EHC plan;

b. where an EHC plan is maintained for the child or young person—

   i) the child's or young person's health care or social care needs as specified in the plan;

   ii) the health care provision or social care provision specified in the plan."

(3) In regulation 43 (appeals), after paragraph (2) insert—

"(3) When determining an appeal on the matters set out in regulation 42A(2)(a), the First-tier Tribunal has the power to order that—

a. health care needs, or health care needs of a particular kind, which relate to the child or young person's special educational needs are specified in the EHC plan in accordance with regulation 12(1)(c);

b. social care needs, or social care needs of a particular kind, which relate to the child or young person's special educational needs or to a disability are specified in the EHC plan in accordance with regulation 12(1)(d).

(4) When determining an appeal on the matters set out in regulation 42A(2)(b), the First-tier Tribunal has the power to order that—

a. the health care needs specified in the EHC plan in accordance with regulation 12(1)(c) are amended;

b. the social care needs specified in the EHC plan in accordance with regulation 12(1)(d) are amended;

c. health care needs, or health care needs of a particular kind, which relate to the child or young person's special educational needs are specified in the EHC plan in accordance with regulation 12(1)(c) where those needs have not been specified in the plan;

d. social care needs, or social care needs of a particular kind, which relate to the child or young person's special educational needs or to a disability are specified in the EHC plan in accordance with regulation 12(1)(d) where those needs have not been specified in the plan.

(5) When determining an appeal on the matters set out in regulation 42A(2)(a), the First-tier Tribunal has the power to order that—

a. health care provision, or health care provision of a particular kind, is specified in the EHC plan in accordance with regulation 12(1)(g);

b. social care provision, or social care provision of a particular kind, is specified in the EHC plan in accordance with regulation 12(1)(h).

(6) When determining an appeal on the matters set out in regulation 42A(2)(b), the First-tier Tribunal has the power to order that—

a. the health care provision specified in the EHC plan in accordance with regulation 12(1)(g) is amended;

b. the social care provision specified in the EHC plan in accordance with regulation 12(1)(h) is amended;

c. health care provision, or health care provision of a particular kind, is specified in the EHC plan in accordance with regulation 12(1)(g) where that provision has not been specified in the EHC plan;

d. social care provision, or social care provision of a particular kind, is specified in the EHC plan in accordance with regulation 12(1)(h) where that provision has not been specified in the EHC plan.

(7) When the First-tier Tribunal makes an order in respect of health care needs or health care provision, it must send a copy of the order to the responsible commissioning body.

(8) When sending a copy of an order, the First-tier Tribunal may also send a copy of the decision which disposes of any appeal brought under section 51(1) of the Act or under regulation 42A to the responsible commissioning body.

(9) The responsible commissioning body must respond within 5 weeks beginning with the date of the order to—

a. the child's parent or the young person, and

b. the local authority that maintains the EHC plan.

(10) The time limit specified in paragraph (9) does not apply where the First-tier Tribunal directs that a different time limit is to apply for the responsible commissioning body's response.

(11) A response under paragraph (9) must—

a. be in writing,

b. state what steps, if any, the responsible commissioning body has decided to take following its consideration of the order, and

c. give reasons for any decision not to follow the order, or any part of it.

(12) The local authority must send a copy of the response received from the responsible commissioning body under paragraph (9)(b) to the Secretary of State within 1 week beginning with the date it was received.

(13) When the First-tier Tribunal makes an order in respect of social care needs or social care provision, the local authority must issue the amended EHC plan to the child's parent or the young person within 5 weeks beginning with the date of the order.

(14) The time limit specified in paragraph (13) does not apply where the First-tier Tribunal directs that a different time limit is to apply.

(15) The local authority must send a copy of the amended EHC plan under paragraph (13) to the Secretary of State within 1 week beginning with the date on which this is issued to the child's parent or the young person."

(3) The Special Educational Needs and Disability (First-tier Tribunal Recommendations Power) Regulations 2017 (S.I. 2017/1306) are revoked.

(4) In consequence of the revocation made by subsection (3), the following provisions of the Special Educational Needs and Disability Regulations 2014 are also revoked—

a. regulation 10(3)(e);

b. regulation 14(2)(e);

c. regulation 201(11)(e);

d. regulation 21(10)(e);

e. regulation 22(5)(e);

f. regulation 25(2)(e);

g. regulation 31(3)(e).”

Member’s explanatory statement

This amendment extends the powers of the First-tier Tribunal so that when it is determining an appeal it may order that Education, Health and Care plans must include health and social care needs and provision, rather than just making recommendations on these matters.

## Health inequalities

Clause 4, page 3, line 22, leave out from ““1C Duty as to reducing inequalities” to “health services.”” and insert

“1C **Health improvement and health inequalities duty**

(1) When considering whether or how to exercise any functions, the Secretary of State must have regard to the need to—

a. improve the health of persons in England,

b. reduce health inequalities between persons in England, and

c. reduce inequalities between persons in England with respect to their ability to access health services and to the outcomes achieved for them by the provision of health services.

(2) Health inequalities “between persons” living in England means health inequalities between persons, or persons of different descriptions, living in, or in different parts of England.

(3) “Health inequalities” means inequalities in respect of life expectancy or general state of health which are wholly or partly a result of differences in respect of general health determinants.

(4) “General health determinants” are—

a. standards of housing, transport services or public safety,

b. environmental factors, including air quality and access to green space and bodies of water,

c. employment prospects, earning capacity and any other matters that affect levels of prosperity,

d. the degree of ease or difficulty with which persons have access to public services,

e. the use, or level of use, of tobacco, alcohol or other substances, and any other matters of personal behaviour or lifestyle, that are or may be harmful to health, and

f. any other matters that are determinants of life expectancy or the state of health of persons generally, other than genetic or biological factors.

(5) In subsection (1)(a), the reference to improving the health of persons includes a reference to mitigating any detriment to health which would otherwise be occasioned by the exercise of the Secretary of State's functions.

(6) In subsection (1)(b), the reference to reducing health inequalities includes a reference to mitigating any increase in health inequalities which would otherwise be occasioned by the exercise of the Secretary of State's functions.

Member's explanatory statement

This amendment would amend clause 1C of the National Health Service Act 2006 to introduce a duty on the Secretary of State to have regard to health improvement and health inequalities, reflecting the duties placed on combined authorities and CCAs in the English Devolution and Community Empowerment Act 2026.

Clause 4, page 3, line 29 at end insert –

(2) In discharging this duty the Secretary of State must have regard to need to involve all departments of Government in reducing health inequalities and must take reasonable steps to ensure that other all departments consider the impact of their policy proposals on health inequalities.

Member's explanatory statement

This amendment would support the government in taking a whole government approach to addressing health inequalities by ensuring that the Secretary of State involved all departments in the discharge of their duty in relation to health inequalities and took reasonable steps to ensure other departments consider the impact their policies might have on health inequalities.

# Conclusions and recommendations

## Proposed amendments

1. In our Palliative Care report, we urged the government to reconsider its decision to remove local authority representation on ICBs. We remain convinced that removing their representation from ICBs is a damaging move that will undermine the government's efforts to shift treatment into the community and deliver a more integrated health and care system. (Conclusion, Paragraph 7)

2. We recommend that the statutory requirement for ICBs to have at least one member jointly nominated by local authorities be retained. (Recommendation, Paragraph 8)

3. We believe that this bill is a missed opportunity for the government to either reform and promote the use of section 75 arrangements, or to provide an alternative mechanism that it believes is more effective in addressing the challenges funding flows present to the integration of health and care service across NHS and local authority services. (Conclusion, Paragraph 13)

4. We recommend that the Health Bill be amended to require the Secretary of State to review the effective use of Section 75 of the NHS Act 2006, and to produce guidance to support NHS bodies and local authorities making use of section 75 arrangements to pool budgets and jointly commission health and social care services. (Recommendation, Paragraph 14)

5. We continue to believe that achieving parity of esteem between physical and mental health requires sustained investment in mental health services and recommend that meeting, rather than just reporting on, the Mental Health Investment Standard should be a statutory requirement on ICBs. (Recommendation, Paragraph 18)

6. We welcome the duty that the bill places on the Secretary of State to involve the public in the planning of commissioning arrangements. However, it is unclear to us from the language in the bill whether this would go as far as requiring service users to be involved in the co-production of the service design and delivery. We believe that this should be explicitly specified on the face of the bill. (Conclusion, Paragraph 21)

7. As the Health Bill makes provision about the duties of integrated care boards (ICBs), it provides an ideal vehicle to provide a level playing field between education bodies and ICBs, so that ICBs are also under a legal obligation to comply with recommendations from SEND Tribunals. (Conclusion, Paragraph 25)

8. Health inequalities represent a serious and continuing injustice across the country. The almost 20-year gap in healthy life expectancy between different parts of the country is morally unacceptable. While the government has set out the right vision for a cross government mission to tackle health inequalities we do not think that approach is being delivered in practice. (Conclusion, Paragraph 32)

9. We recommend that the Secretary of State's duties in relation to health inequalities in clause 4 of the bill be strengthened and that all ministers should be under a duty to consider how policies they enact might contribute to or reduce health inequalities. (Recommendation, Paragraph 33)

# Formal Minutes

## Wednesday 10 June 2026

### Members present:

Layla Moran, in the Chair

Jen Craft

Josh Fenton-Glynn

Andrew George

Paulette Hamilton

Joe Robertston

Greg Stafford

## Health Bill 2026–27

Draft Report (*Health Bill 2026–27*), proposed by the Chair, brought up and read.

*Ordered*, That the draft Report be read a second time, paragraph by paragraph.

Paragraph 1 to 33 agreed to.

Annex agreed to.

*Resolved*, That the Report be the First Report of the Committee to the House.

*Ordered*, That the Chair make the Report to the House.

## Adjournment

Adjourned till Tuesday 16 June at 1.45 pm

# Witnesses

The following witnesses gave evidence. Transcripts can be viewed on the inquiry publications page of the Committee's website.

## Tuesday 2 June 2026

**Dr Hugh Alderwick**, Director of Policy and Research, The Health Foundation; **Sarah Woolnough**, Chief Executive, The Kings Fund; **Thea Stein**, Chief Executive, Nuffield Trust Q1–61

**Councillor Dr Wendy Taylor**, Chair, Health and Wellbeing Committee, Local Government Association; **Dr Victoria Tzortziou**, Chair, Royal College of GPs Q62–98

# Published written evidence

The following written evidence was received and can be viewed on the inquiry publications page of the Committee's website.

HTB numbers are generated by the evidence processing system and so may not be complete.

| | | |
|---|---|---|
| 1 | Care Quality Commission (CQC) | HTB0001 |

# List of Reports from the Committee during the current Parliament

All publications from the Committee are available on the publications page of the Committee's website.

## Session 2024–26

| Number | Title | Reference |
|---|---|---|
| 8th | Healthy Ageing: physical activity in an ageing society | HC 1180 |
| 7th | Community Mental Health Services: Commentary on the Government Response to the Committee's Fourth Report of the Session 2024–26 | HC 1769 |
| 6th | Palliative Care | HC 1763 |
| 5th | First 1000 days: a renewed focus | HC 802 |
| 4th | Community Mental Health Services | HC 566 |
| 3rd | Black Maternal Health | HC 895 |
| 2nd | Adult Social Care Reform: the cost of inaction | HC 368 |
| 1st | Appointment of the Chair of NHS England | HC 743 |
| 4th Special | Evaluation of Palliative care in England: Government Response | HC 1722 |
| 3rd Special | Expert Panel: Evaluation of Palliative care in England | HC 632 |
| 2nd Special | Expert Panel: Evaluation on meeting patient safety recommendations: Government Response | HC 617 |
| 1st Special | Pharmacy: Government Response | HC 602 |