

NHS Modernisation Bill (Health Bill): Patient voice

About Picker

[Picker](#) is an independent health and social care charity with expertise in understanding, measuring, and improving people's experiences of care. We pioneered the [patient experience approach](#), now widely adopted around the world, and advocate for the delivery of the 'highest quality person centred care for all, always' – centred around [our eight principles of person centred care](#).

We work with policy makers, providers, professionals, and patients and the public alike to influence, inspire, and empower person centred care. We are commissioned by the Care Quality Commission (CQC) and NHS England to design, deliver and analyse the NHS patient survey programme, the cancer patient experience surveys, the neonatal care experience survey, and the NHS staff survey.

If you have questions about this briefing, please contact **Olli Potter, Policy and Public Affairs Manager** (oliver.potter@pickereurope.ac.uk).

Background and context

The Prime Minister, Sir Keir Starmer, [announced](#) the abolition of NHS England in March 2025, with a view to reducing headcount and duplication across NHS England and the Department of Health and Social Care (DHSC), and to reforming DHSC's structure. Due to the need for legislation to enact these changes, a Bill on the health service was anticipated in the most recent King's Speech.

In July 2025, the government published its [Ten Year Plan for Health](#), which contained a number of commitments related to the patient voice, including the expansion of Patient Reported Outcome and Experience Measures (PROMs and PREMs) and the establishment of a Directorate of Patient Experience within DHSC. The plan also announced a removal of the requirement for NHS Foundation Trusts to appoint and maintain Councils of Governors, made up of elected members of the public and staff.

Dr Penny Dash's [review of the patient safety landscape](#) followed the plan's publication, and – alongside other commitments – provided further detail on the proposed abolition of Healthwatch England and Local Healthwatch branches, as well as changes to other national bodies involved in work on patient safety.

The NHS Modernisation Bill (Health Bill) was included in [the King's Speech](#) on 13th May 2026, and the [background briefing](#) published by the government following King Charles III's speech outlined that, on patient voice, the Bill will:

- Embed patient voice in national decision making;
- Empower providers through Foundation Trust reform; and

- Ensure that the voices of patients, service users, and local people feed directly into services they receive.

A draft Bill was [published](#) on 14th May 2026, alongside the relevant explanatory notes and impact assessments. The second reading of the Bill [took place](#) on 1st June 2026 in the House of Commons.

DHSC published fact sheets on elements of the Bill on 19th May 2026, [including one](#) focused on patient voice.

Our view on the Ten Year Plan and its proposals

Picker has long advocated for *the highest quality person centred care for all, always* and [broadly welcomed](#) commitments to amplifying the patient voice and improving patient experience as part of the Ten Year Plan. However, **we expressed concern at the planned closure of Healthwatch England and noted the importance of an independent voice for patients and service users.**

In [our response to the Dash review](#), we further noted that providers and commissioners will need practical support on skills, knowledge, and implementation to ensure that patient voice is not weakened as a result of these proposed changes.

Our Chief Executive, Chris Graham, and our Chair, Angela Coulter, [wrote in the British Medical Journal \(BMJ\)](#) about their concerns related to the closure of Healthwatch England, noting that “we can’t rely on large datasets and apps alone to give everyone a voice in health care” – with reference to the plan’s focus on shifting from ‘analogue to digital’ – particularly as **the closure of Healthwatch England “will end England’s 50 year tradition of having independent bodies with statutory duties to promote patient and public voices in local areas”.**

In our view, **the NHS is at an inflection point when it comes to patient voice and power.** On the one hand, Lord Darzi’s [independent review into the NHS](#) in September 2024 noted that “the patient voice is not loud enough” (p.9) and the Ten Year Plan contained ambitious language about “giving power to the patient” (p.142) and “unashamedly... redistributing power in our society” (p.22). The former Secretary of State for Health and Social Care, Wes Streeting, who was in office at the time of the plan’s publication, [said](#), when setting out the principles for the new NHS operating model, that “the most important one of all... [is that] the patient is king”.

We very much welcome the positive messages about the importance of understanding people’s experiences of care and of giving patients power and control. **To realise these changes, our view is that patient voice must be seen not simply as a signal – a data stream competing with other indicators – but as an authority that helps direct action to improve quality.** Given that these positive messages sit alongside plans to dismantle the statutory structures that provide a mandate for independent voice, there is a need for clarity on how patient voice will be amplified and prioritised in the future.

In our recently published [State of Person Centred Care 2025 report](#), we discussed what it would take to make the Ten Year Health Plan’s bold vision for patient power a reality. **We argued that a commitment to patient experience and person centred care must be deeply embedded in the everyday reality of the NHS – both locally and within a reformed DHSC.** Those with

responsibility for understanding and using patient voice should be empowered to enable patients and the public to exercise control and act as a force for change.

Relevant sections of the Bill

The NHS Modernisation Bill is broad in its reach, and Picker's expertise is centred around understanding, measuring, and improving patient and staff experience to deliver person centred care. As such, our focus is primarily on the following elements of the draft Bill:

- **Clause 5:** Patient involvement and choice
- **Clause 29, Schedule 3:** Constitution of NHS Foundation Trusts
- **Clause 64, Schedule 9:** Abolition of Healthwatch England
- **Clause 65, Schedule 10:** Abolition of arrangements with Local Healthwatch organisations

Our overarching concern is that **this draft Bill confers a considerable amount of power to the Secretary of State, centralising powers at a national level.** We recognise that the aim of 'bringing patient voice in house' is to make it a core function of the NHS – but it creates questions about independence.

With reference to our view that the NHS is at an inflection point, we feel this is in opposition to the proposed goal of devolving power to the public and local providers. We acknowledge that a taxpayer funded system should be accountable to the Secretary of State, but **we also note that this approach does not offer safeguards against significant political intervention in the health service in the future,** which could seek to diminish voice and the concept of patient power.

Clause 5: Patient involvement and choice

This clause confers requirements on the Secretary of State that are currently borne by NHS England (under the NHS Act 2006, and its relevant amendments in the Health and Care Act 2012). These powers are related specifically to patient involvement and choice.

It is our view that the wording of this clause and the subsequent Schedules (9 and 10), related to Healthwatch England and Local Healthwatch branches, **do not provide enough detail on how Healthwatch's functions will be safeguarded in a new structure.** We provide further detail below (under Schedule 9 and 10) on how we would prefer to see this approached.

Clause 29, Schedule 3: Constitution of NHS Foundation Trusts

Schedule 3 of the draft Bill is mostly related to the removal of a requirement for NHS Foundation Trusts to have a Council of Governors – particularly Paragraphs 4 to 15. We note in particular:

- **Paragraph 6,** which confers the power to approve changes to an NHS Foundation Trusts' constitution to the Secretary of State instead of the Council of Governors.
- **Paragraph 8,** which confers powers to the Secretary of State instead of the Council of Governors related to the increase of the proportion of the Foundation Trusts' total income by 5% or more in any financial year.

- **Paragraph 9**, which confers powers to the Secretary of State instead of the Council of Governors related to the approval of mergers, acquisitions, separations or dissolutions and ‘significant transaction’ (currently requiring governor approval).
- **Paragraph 15**, which removes provisions related to the role of Councils of Governors in making appointments, approving the selection of auditors, and approval of the final accounts.

The government’s [Ten Year Health Plan](#) outlines that NHS Foundation Trusts will be expected to “put in place more dynamic arrangements to take account of patient, staff and stakeholder insights” (p.81) to replace the Council of Governor model. We acknowledge that the benefits of Councils of Governors have been variable – particularly as there are questions about the representativeness of existing Councils of Governors, and the fact that only NHS Foundation Trusts are required to have this governance model in place. Despite these valid challenges, however:

As the draft Bill currently stands, **a significant number of powers will be transferred from elected members of the public to the Secretary of State. This constitutes a direct removal of patient voice and is in juxtaposition to the Ten Year Plan’s ambition to amplify the patient voice.**

The Impact Assessment (IA) that accompanies the draft Bill acknowledges the variable evidence on the effectiveness of Councils of Governors and states that their removal will allow for NHS Foundation Trusts to have greater flexibility in designing their own approach to engagement. It also notes, however, that moving local powers to the Secretary of State might result in “less tailored approaches to the local population” (IA, p.40) and relies heavily on the success of Patient Power Payments (PPPs) and the proposed changes to Healthwatch England and its local branches as mitigations. **As these mitigations are all in development, there is a risk in the current system being dismantled before a functioning alternative in place.**

Our [recent report on reform of the NHS Friends and Family Test \(FFT\)](#) noted that while mandating the FFT has limited the flexibility of some high performing organisations, it has increased the baseline for all NHS trusts in relation to the collection of patient feedback (it has, we conclude, ‘raised the floor but lowered ceiling’). For this reason, we recommended that the FFT mandate should remain in place nationally, with opportunities for greater flexibility for high performing organisations built in. Additionally, we proposed that high performing organisations should share examples of best practice to support other providers, bringing the best of the NHS to more organisations.

While we acknowledge that NHS England and DHSC are keen to move away from mandates from the centre, **we are of the view that there is a risk to abolishing Councils of Governors without a clear replacement model in place.** The proposed transfer of responsibilities from Healthwatch England to DHSC and the introduction of ‘Patient Power Payments’ could mitigate this risk, but much depends on the detail of these changes and their execution.

Clause 64, Schedule 9: Abolition of Healthwatch England

Clause 64 abolishes Healthwatch England but does not reference the transfer of functions to the Secretary of State or explicitly reference the proposed Directorate of Patient Experience in DHSC. The fact sheet [published](#) by DHSC on patient voice notes that a new National Director of Patient Experience will be appointed, who will be “responsible for overseeing the collection and analysis of feedback from both patients and carers and making it publicly available”. The fact sheet notes that, while not set out in the Bill, the directorate will:

- Develop an approach for gathering, interpreting and acting on feedback, including seldom heard groups;
- Lead on patient voice initiatives and policies on complaints, feedback, and engagement;
- Ensure oversight and performance frameworks include measures of experience;
- Provide internal advice and challenge, including staff training;
- Act as a centre of expertise and a guardian of quality on voice and experience; and
- Actively engage with external stakeholders, with a focus on seldom heard groups.

These points are reflected in the job description for the National Director of Patient Experience role that was recently advertised by NHS England and closed for applications on 11th May.

In our view, there is scope to bolster the wording in the draft Bill to ensure that the closure of Healthwatch England does not result in statutory duties no longer being laid out in legislation. The IA on the patient safety measures that accompanies the Bill states that “the exact approach to implementation of these functions remains uncertain (as it depends on future policy decisions)” (p.10).

We propose that the draft Bill is amended to include a statutory reporting duty for the Secretary of State to provide regular reports to parliament, and in turn the public, on patient experience in the NHS and across social care services. This should not be limited to reporting on survey results and should instead include demonstrations of how improvements in people’s experiences of care have been achieved as a result of listening to and involving patients and service users¹.

We also propose that the Bill includes a duty for the Secretary of State to work with an independent external advisory group on patient experience, which should include patient representation. While the Secretary of State would be accountable for these duties, responsibility for their delivery could be delegated to the National Director of Patient Experience, where appropriate.

¹ The Secretary of State has a duty under the [National Health Service Act 2006 \(Section 247D\)](#) to “publish an annual report on the performance of the health service in England”, however ‘performance’ is not defined and, therefore, does not necessarily include ‘experiences of care’. While there is a definition of ‘quality’ in [Section 1A of the Act](#), it relates to the Secretary of State’s duties to secure continuous improvement in quality. Here a consideration of ‘experiences of care’ is implied but could be more robust.

Clause 65, Schedule 10: Abolition of arrangements with Local Healthwatch organisations

Clause 65 abolishes Local Healthwatch organisations and transfers powers to ICBs for health care and local authorities for social care and public health services.

There will be a new statutory duty for ICBs to report annually to DHSC on their collection of feedback and what this feedback has informed. This is a positive development that we welcome: however, we note that local authorities will instead be *requested* to make a submission on their collections related to social care, instead of this being an annual requirement.

We propose that local authorities are also required to report annually, without a request from the Secretary of State. This puts ICBs and local authorities on the same footing regarding statutory duties related to patient and service user voice and mitigates against the risk of a Secretary of State selectively choosing which local authorities are required to submit this information.

The IA on patient safety measures that accompanies the draft Bill notes a risk that people with protected characteristics might experience “differential impacts” (p.5) as a result of the closure of Healthwatch England and suggests that patients and service users might feel more comfortable reporting concerns to a commissioner (in this case the ICB or local authority) than they would to the provider. **This is an assumption that we would challenge:** it is not clear that patients and the public would have the same confidence in raising their concerns with another public authority as they might currently do in raising concerns with an independent agency.

The IA also states that ICBs and local authorities will be supported with guidance on collecting and understanding patient feedback, which they “will be legally required to have due regard to” (p.16).

Clause 65 does not introduce new requirements for ICBs or local authorities to carry out a full consultation when “planning services or changing how existing services are delivered and operate”, as outlined in the explanatory notes (p.80, paragraph 610). In our view, while ICBs and local authorities will be provided guidance on the collection and use of feedback, the lack of requirement for a full consultation creates a risk of inequalities, specifically in relation to how patient and service user voice is treated and how power is shared across the country.

Paragraph 21 amends the Health and Social Care Act 2008, removing the requirement for the CQC to have regard of the view of Local Healthwatch organisations when performing its functions. **We note that the draft Bill does not transfer a requirement for CQC to have regard of the ICB or local authority patient and service user voice function in its place and propose that an amendment is made to resolve this.**

Paragraph 25 removes the requirement for a Health and Wellbeing Board to include representatives from Local Healthwatch organisations. While the explanatory notes recognise that HWBs will continue to have ICB and local authority representatives on them, **we are of the view that this wording should be tightened to clarify that a representative of the ICB and local authorities’ patient and service user voice function should take the seats of former Local Healthwatch representatives.**

Paragraph 28 amends the Care Act 2014 and removes reference to consulting Local Healthwatch when a Safeguarding Adults Board is developing its strategic plan. As above, the explanatory notes recognise that someone from the local authority will continue to be a member, but it does not explicitly state that this person should have a role within the local authority's service user voice function. **We are of the view that this wording should be tightened to clarify that a representative of the local authority's service user voice function should take the seat of the former Local Healthwatch presentative.**

The above suggestions for amendment would go some way to mitigating risk in relation to the inclusion of patient and service user voice. However, **we note that the overarching risk related to a lack of independence as a result of the abolition of Healthwatch England and its local bodies remains**, unless wider amendments are made to the Bill to secure an independent voice for patient and service user voice outside of government and commissioners.

Further reading

Reports

- [Picker's NHS Manifesto: Our vision for a person centred health service](#)
- [Learning from the Best: Patient Experience and the NHS 10 Year Plan](#)
- [Reforming the NHS Friends and Family Test \(FFT\)](#)
- [State of Person Centred Care 2025](#)

Blogs

- [How patient experience drives person centred care](#)
- [Making the most of experience data to embed person centred care](#)
- [Power to the people? Person centred care and the ten year health plan for England](#)

Press statements

- [Picker responds to the announcement that NHS England will be abolished](#)
- [Picker responds to the publication of the NHS ten year plan](#)
- [Picker responds to the 'review of patient safety across the health and care landscape'](#)