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Assessing the impact of NHS England's abolition and Integrated Care Board funding cuts on research and evaluation



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Context

On 13 March 2025, the Secretary of State for Health and Social Care, Wes Streeting, announced the Government was “abolishing the biggest quango in the world” by scrapping NHS England (NHSE) and “bringing [it] into the Department [of Health and Social Care] entirely.”


He said the process is expected to be completed within two years. In the interim period, “NHS England will have a much clearer focus...It will be in charge of holding local providers to account for the outcomes that really matter, cutting waiting times and managing their finances responsibly.”

NHSE was established by the 2012 Health and Social Care Act and has been running ever since. The Government has announced it will bring in new legislation to abolish NHSE and has stated its intention to start this process in 2025, and this [may have the detrimental impact](#) of shifting attention and resource away from patient outcomes and experience.

The current staff structures across NHSE and the Department of Health and Social Care (DHSC) account for 18,000 roles, although not all are filled, with final staffing numbers expected to become half that total. It is not clear if both organisations will share the redundancies equally.

On the same day as the NHSE announcement, Integrated Care Boards (ICBs) were also told they needed to reduce their running costs by 50% by Q3 2025/26, and that NHS trusts will need to make further reductions in their corporate costs. In 2023 ICBs were also asked to reduce their operating costs by 30% by 2025/26, with at least 20% of that reduction expected in 2024/25.

In light of these announcements National Voices was asked to give evidence at a specially convened [Health and Social Care Committee \(HSCC\) meeting on 26 March 2025](#). National Voices highlighted to this committee its concern that the value of patient experience could be lost in the transition, especially in terms of how the NHS and ICBs engage with people from diverse backgrounds such as those facing health inequalities and/or those with protected characteristics. We know sustained dialogue with patient advocacy groups, people with lived experience and local communities are crucial to ensuring a future research environment develops evidence, treatment and technologies that supports the wide diversity of the UK's population.



Further information on the role of patient engagement during the restructure was given to the health and care system at the start of April in a letter from Sir Jim Mackey, the new CEO of NHSE. It told ICBs they should: “look carefully at... duplications. This includes... comms and engagement which similarly exist in local authorities, providers and regions”.

Since then, NHSE’s ICS model blueprint was released in May to give further detail and clarity to this initial letter. The blueprint said NHS providers would be “responsible for delivering... positive patient experience”, with ICBs charged with “co-producing strategy with communities, reflecting unmet needs and targeting inequalities” and embedding experience within its expected shift in operating focus from provider oversight to population health outcomes.

Much of the detail of how this will work is being worked through by ICBs and trusts through the second half of 2025 and beyond.

This focus on co production and patient experience will be especially important as the NHS moves to implement the [10-year plan](#) and the Government’s three shifts: from an analogue system to a digital one; from care in hospitals to care in the community; and from a system that treats sickness to one that prevents ill health. None of these ambitions can be achieved without local conversations with communities about what is needed to reduce digital exclusion, improve prevention and create community-based care which delivers the right service offer in the right place.

Some key national elements remain untouched, such as the National Institute of Health and Care Research (NIHR). Current discussion among the [Accelerated Access Collaborative](#) and as part of Roland Sinker’s [Innovation Ecosystem Programme](#) have suggested a need to establish a similar infrastructure to NIHR to support innovation in the NHS which would focus on the adoption and roll out of research and evaluation.

However, commitment to other parts of the infrastructure, such as the [Health Innovation Networks](#), are much less clear as these are currently funded through NHSE.

The impact of ICB cost reductions on the research community

Integrated Care Systems legal duties towards research

Integrated Care System (ICS) is the umbrella term for the ICB board and the Integrated Care Partnership (ICPs) – the ICS itself is an entity in name only as it has no board or staff. The ICB is focused on provision and commissioning of care. The ICP is a non-statutory forum that has a responsibility for considering how wider determinants of health should shape the health offer to populations and holds the ICB to account for its population health strategies.

Given the above, while guidance is nominally aimed at ICSs, its predominantly the ICB that will enact and be held to account for fulfilling the duties it lays out.

In March 2023 NHSE published [new research guidance](#) for ICSs on how to fulfil their legal duty to promote, facilitate, and report on research.


The NHSE guidance includes advice for ICSs to meet the legal requirements under the [Health and Care Act](#), to:

- Promote and facilitate research
- Facilitate the use of research evidence (e.g. in commissioning decisions)

And via statutory NHSE guidance to:

- Include research in their five-year plans for health and social care provision (i.e., Joint Forward Plans)
- Report on research activity to NHSE

The NHSE guidance also calls for ICSs to develop a research strategy that is aligned with their overall 5-year plan and to appoint an executive lead for research. The guidance also offers advice on how ICSs can deliver research more efficiently by reducing bureaucracy, coordinating study delivery across providers, and tailoring research to better meet local needs.




With the ICBs now under pressure to cut running costs, it remains unclear what staffing pattern will emerge from January 2026 onwards when the 50% cost reductions are expected by DHSC to be in place. We know that approximately half of ICB staff costs go towards its mandatory duties around delivering NHS Continuing Health Care. While ICBs and DHSC are willing to look at how this responsibility can be shared across multiple ICBs or, as the ICB model blueprint states, “test and explore options to streamline and transfer some [this activity] out of ICBs” a further update on the [blueprint issued on 29 May](#) makes it clear that these activities cannot be in the scope of current spending cuts. This is because “accountability changes will require legislative changes”.

This downsizing is also occurring in a space where ICBs are at very different levels of maturity when it comes to meeting their research obligations. It’s not clear how many ICBs have their own research strategy, some have a board member nominated Senior Responsible Officer (SRO) research director but what this means in practice varies widely. Cuts to running costs significantly reduces the chance of ICBs being able to develop their own research strategy or build on what they already have.

Crucially the model blueprint states that “research development and innovation [will] transfer to regions over time, with ICBs retaining and building strategic partnerships to support population health strategy.” There is no clear timeline in which this will happen but it’s reasonable to assume this will take place before NHSE is abolished in two years’ time and NHSE already have regional systems in place that could be adapted to this end. It is unclear if NHSE’s rules for ICB on research accountability will be transferred as is.

As a result of reduce spending power mergers between ICBs are being underway, with [HSJ reporting ICBs being reduced from 42 to 27](#). The boundaries of some may change if it’s felt they need to align with mayoral or local authorities’ boundaries if they do not currently do so.

Mergers will not only distant themselves from their communities and impact but also create risk that knowledge on research and innovation at an ICB level will be lost, or legacies not built on.



We have seen this before in the 2012 reconfiguration following the Health and Act 2012. The subsequent move from Clinical Commissioning Groups (CCGs) to ICBs came with the risk of moving decisions further and further from what matters to patients, and this warning from past reconfigurations still stands.

Provider focus

With these cuts there is also a risk that there will be a shift to provider-led decision making bringing with it a risk of provider bias, with the risk of focusing on acute trusts. Some ICB leaders believe the cost reductions may wipe out the local place and partnerships work, which is key to ensuring local communities are heard and their needs are acted on. However, this may lead to closer working with providers and provider collaboratives, making them the main agents of change.

It may well be that the “coordinating of study delivery across providers,” as laid out in the March 2023 NHSE guidance, could be led by providers not ICBs. It is worth noting that for many providers (in particular acute providers) research activities are often revenue generating and so there may be more scope to grow investment here in the coming years as the whole system faces significant resource pressures.

Yet, its commercial research, such as medication trials, that brings large monetary incentives, leaving non-commercial trials less attractive to invest time in.

The impact of NHSE abolition on the research community

NHSE research duties

Within NHSE itself senior stakeholders are still working through the impact NHSEs abolishment will have on research and development teams that hold the knowledge and legacy within this space, and whether the role the organisation itself plays in research will still exist in another entity.

As DHSC needs to bring in new legislation to allow for the removal of NHSE as an arms' length body, it's important to clarify the research duties NHSE inherited from DHSC.

Under the National Health Service Act 2006 – NHSE inherited a duty from DHSC to: a) research on matters relevant to the health service, and (b) [make] use in the health service of evidence obtained from research.

In addition to these statutory duties, NHSE has a reporting oversight function of how ICBs are fulfilling their own statutory requirements (outlined above) on joint forward plans and annual reports. In the 2023 NHSE guidance noted above, there also a commitment for ICBs to report to NHSE on research activity. These metrics are still under development, with NHSE poised to publish a report on the metrics ICBs should use to measure how well they do are doing against their research commitments.

However, the launch date is now delayed with NHSE now retesting the metrics to make sure they work for ICBs amid concerns that the data they rely on is not robust. For example, there is no way of knowing how many roles in the workforce are actively doing research work or involved in clinical service development at the ICB level. The delay to this publication must also now be seen within the context of the future shift of research functions to regional level.

National Voices member concerns

National Voices' larger members who invest heavily in research currently feel quite removed from the impact the NHS restructure might have on their research activities. This is because a very large proportion of their research funding goes direct to universities. Yet, charities rely on getting their research outcomes into NICE guidance and then often on cancer alliances, clinical networks or directors to advocate for any new guidance additions.



As such, concerns [National Voices heard from its members](#) about the long-term continuation of such alliances and networks suggests any cull to these may detrimentally impact on how research innovation is spread in the future.

Key influencing opportunities

The Government will be required to bring forward primary legislation to abolish NHSE. It is also not yet clear what appetite the Government has to enact legal changes to of the same scale of the Health and Social Care Act 2012, which totally overhauled the previous system. But it is likely to take this opportunity to shift legal requirements from NHSE to DHSC and reduce some of the statutory duties placed on ICBs. The ICB blueprint suggests research and innovation is highly likely to be one duty shifted out of ICBs. However, is unlikely to water down such duties given the current Government's focus on growth and productivity, outlined below.

This view is bolstered by the Secretary of State's appearance at a [Health and Social Care Select committee on 8 April 2024](#) where he discussed the NHS' national role as an enabler for research and the value of patient data. Given the other opportunities outlined below, it is clear the Secretary of State sees a strong national role in stimulating research to help make the UK a global contender within the life sciences sector.

It is also important to note that the NHS Constitution gives patients the right to be informed about research opportunities. Although the constitution is due to go back out to consultation in 2025, it is likely to retain a research commitment similar to that in its current statement that states "the offer to be part of research should be integrated into health and care across the NHS". The constitution itself sits under NHSE's remit, but given DHSC is involving itself in other patient promises that formally sit under NHSE (such as the minimum standards patients can expect from elective care), the constitution will likely just shift to sit under DHSC.

However, these opportunities must be balanced against the [Darzi review in 2024](#) which commented: "For the NHS, partnerships with the life science sector for research or treatment too often fall into the category of 'important but not urgent'. It is doubtful that there is an NHS leader in the country who would not recognise that research and innovation are important. It has simply not been a high enough priority in a world where waiting lists are long, and finances are tight. But in the medium term, it is innovation that can make the NHS more sustainable."

In a system where we are seeing clear messages to providers to make headway in the elective waiting list – with caps on incentives to do so now removed – this tension will continue to exist even with NHSE's abolishment.

Government strategy documents

In addition to future legislation, there are three key strategy documents which will help set the research landscape going forward and which will be essential to ensure research is recognised as both important and urgent.

1. The Industrial Strategy

This strategy [green paper](#) published at the end of 2024 helps set the scene for the research environment the Labour Government wants to create.

It said: “Over the next decade, the life sciences sector holds enormous potential to drive economic growth and productivity while significantly improving health outcomes for thousands of patients across the country. This sector delivers goods that are critical to the functioning of our economy and society and increases the UK’s resilience, for example, to epidemics. Recent breakthroughs, such as the development of promising new vaccines targeting cancer, underscore the transformative impact of the sector.”

It believes the life sciences sector can offer “unparalleled opportunities for future economic growth”, propelled by six key areas: new discoveries; data availability; AI; groundbreaking treatments; personalised healthcare; innovative manufacturing processes.

We have seen this Government be very bold in its vision for the NHS, attempting a restructure that is wider in remit and in a shorter timeframe than expected. This confidence may offer some reassurances to the research community as this green paper is based on the UK taking bold action to achieve its very ambitious aims “to transform public health, enabling people to live longer and healthier lives, and boosting productivity, while driving high-value job creation and attracting significant investment.”

However, such ambition must be balanced against how patient experience can remain at the centre of innovation when such change is pursued rapidly. As we have noted above, the speed of the NHS restructure risks destabilising patient experience involvement in the NHS, alongside losing organisational legacy, and similar risks may appear if this industrial strategy is pursued without a clear implementation plan that recognises and maintain the value of patient experience to research.

2. The NHS 10 Year Plan

Research has not featured particularly strongly in 10 Year Plan discussions nor was it a prominent feature from public feedback. When it has been mentioned it has been discussed in loose terms such as expectations that the NHS will make best use of new technologies to ensure patients have access to cutting edge treatments.

National Voices has worked hard to ensure that health inequalities feature across the plan and is not seen as a siloed activity. Given the drastic changes in America under the Trump administration, there is ongoing discussion in the global research community about shifting diversity and equality work within research into the UK and Europe. This shift would provide a great opportunity for ICBs to meet both their research duties and one of their four core focuses of “tackling unequal access, outcomes and experience.”


3. The Life Sciences Plan

There is a new Life Sciences Plan being developed by the Office for Life Sciences – a joint unit between the DHSC and Department of Science, Innovation and Technology. This will likely build on [a Life Sector plan document](#) produced by Labour whilst they were in opposition. The Life Sciences plan was originally due out in May 2025 although this may now shift, especially as to some extent it has been co-written alongside the 10-year plan that is now due out at the end of June.

The alignment with the 10-year plan may ensure that there is a single point of accountability to commit to research across the Health and Social Care system.

Funding promises likely under consideration are:

- Place life sciences and innovation directly under the Health Secretary’s ministerial responsibilities, representing a key priority for the DHSC.
- Commit to long-term workforce planning across the NHS and social care and review training with the intention to create new types of health and care professionals that draw on a diverse skills mix, including the skills staff need to support clinical trials and recruit patients.

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- Create a Regulatory Innovation Office (RIO) to hold regulators accountable for driving innovation where appropriate and for delays that are holding back innovation.
 - Increase the number of spinouts coming out of universities, and structure the innovation funding system to ensure more of them successfully scale-up.

Conclusion

The abolition of NHSE and the mandated 50% reduction in ICB running costs represent seismic shifts in the English health and care landscape, with profound implications for research and evaluation. While government ambitions to boost life sciences, innovation, and economic growth are clear, the practical realities of these restructures risk creating significant gaps in the research infrastructure, particularly at local system levels.

Without careful management of the shift of services from NHSE to DHSC, there is a real risk that community engagement, diversity of research participation, and patient-centred innovation could be deprioritised in favour of provider-led agendas or the national drive to cut elective waiting lists while tightly controlling NHS finances. The dismantling or merging of ICBs and loss of expertise within NHSE, also threaten to erode any recent gains in embedding research within commissioning, service delivery, and health inequalities agendas.

However, the forthcoming legislation, the NHS 10-Year Plan, and the new Life Sciences Plan also present critical opportunities. If research duties are preserved and strengthened, and if patient experience is genuinely embedded in the transformation (alongside accountability structures), there is a chance to create a more sustainable and inclusive research ecosystem.

It is vital that throughout this period of upheaval, the focus remains firmly on improving services and outcomes for patients. Collaborative research and evaluation - built on strong partnerships between communities, providers, and system leaders - must be central to achieving that aim. Maintaining a clear commitment to inclusive, meaningful research is essential if the NHS is to deliver innovation and improvement that meets the needs of all.

The future success of NHS research will depend on how well local voices are heard, how equitably innovation is spread, and how robustly the sector can champion research as both an economic driver and a fundamental lever for health equity.

Practical Recommendations

1. Safeguard research and evaluation duties during restructuring

- Ensure that legislative changes to abolish NHSE retain and strengthen the statutory duties for research and evaluation at both national and system levels.
- Embed clear expectations that ICBs must continue to promote, facilitate, and report on research in any revised structures, including any larger regional footprints.
- Require the DHSC to publish guidance on maintaining research responsibilities during and after the transition.

2. Protect and enhance local research infrastructure

- Recommend that every ICB (or successor structure) maintains a designated executive lead for research and evaluation, ensuring continuity of leadership and accountability.
- Require that local research strategies - co-produced with communities - remain a condition of ICB/regional system operation, especially to avoid provider-only research dominance.
- Resource regional infrastructures (e.g., existing NHSE regional teams) to coordinate and support local research, ensuring research remains connected to place-based needs.
- Provide guarantees that alliances, clinical networks, and transformation programmes focused on research spread and health equity will be protected during and after restructuring.

3. Prioritise patient and community involvement

- Ringfence funding for diverse community engagement in research development and evaluation, especially for groups facing health inequalities.
- Innovate new models of engagement (e.g., digital platforms, community co-researchers) to ensure that even with leaner structures, patient voice remains central.
- Establish clear national and regional accountability mechanisms to monitor diverse patient involvement in research activities

4. Influence key policy opportunities

- Shape the forthcoming legislation by advocating for:
 - Patient experience to be central to research development and innovation, with health inequalities seen as a core outcome of research investment
 - Preservation of patient rights to research involvement (as enshrined in the NHS Constitution)
 - Establishment of clear national and regional accountability metrics and mechanisms to monitor research activities, with these metrics publicly reported to drive transparency and accountability

National Voices

National Voices is the leading coalition of health and social care charities in England. We have more than 200 members covering a diverse range of health conditions and communities, connecting us with the experiences of millions of people. We work together to strengthen the voice of patients, service users, carers, their families and the voluntary organisations that work for them.

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