

# Covering the fall-out: National Voices' members' concerns surrounding the decision to abolish NHS England and cut ICB running costs by 50%

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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 current staff structures across the two organisations accounts 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.

It must be noted that NHSE has only just finished the restructure set in motion in 2023 when approximately 1,000 jobs were lost. We know from speaking to colleagues across the whole of NHSE that appetite and morale to go through another round is currently very low.

Whatever the view on whether abolishing NHSE is the right decision or not, National Voices urges a formal recognition by the Government of the impact felt by NHSE staff due to the way the announcement was delivered to them. At National Voices we work and engage with many NHSE colleagues and witnessed the shock and upset it caused.

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 provider 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. Following this evidence session, a letter was sent to all Trust and ICB chief executives and chairs on [1 April by Sir Jim Mackey, the new Chief Executive of NHSE](#), laying out intentions for 2025/26, given the two announcements above.

This paper covers the evidence given to HSCC as well as providing further evidence and concerns that could not be shared with the committee within the allotted time. It also outlines initial concerns around the recent letter from Sir Jim.

Given we expect to hear further transition plan announcements, this paper is a reflection of National Voices and member concerns at the time of writing and will not be comprehensive.

## Current NHSE and DHSC patient experience teams

Whether it had sufficient impact or not, there has been a very clear organisational focus in NHSE of working directly with people and communities.

When NHSE was set up there was an entire directorate dedicated to patient experience (Patient and Information) initially led by Tim Kelsey with clear functions around patient and public involvement (PPI) and lived experience. These functions have continued, but the team now sits under the nursing directorate which has arguably led to less of a focus on patient voice across the whole of NHSE.

In the early years of NHSE, the direction of patient involvement felt very positive. For example, in response to [The Francis Report](#) (Feb 2013) - which called for a *"patient centred culture"* after the inquiry found *"appalling and unnecessary suffering of hundreds of people"* at Mid Staffordshire NHS Trust - the [Friends and Family Test](#) was set up. While not perfect in its development it does allow for the gathering of vital quantitative and qualitative data from people which can be acted on at service level, and when used appropriately, can provide wider insights into how patients are experiencing care across the country.

Current NHSE leaders in this space have a wealth of knowledge and experience, and a team of approximately 40-50 working with them. PPI leads

across NHSE feed into this team, to provide regional scrutiny of PPI work in ICBs.

In addition to this team, there is also a strategic co-production group and peer leader network which sits in the Primary & Community Transformation team.

In the Department of Health and Social Care (DHSC) there is a team dedicated to improving patient experience but its currently seen through the prism of the elective care waiting list. We know work has already begun to broaden out from this with a desire to be more ambitious, but there is not yet sufficient focus on patient experience in general across the entire NHS. The wider argument that there is a duplication of resources across NHSE and DHSC doesn't quite fit when it comes to patient experience teams.

## Bringing the teams together

National Voices seeks reassurance that the focus on patient experience can be sustained and improved in the context of financial and resource pressure, particularly for primary and elective care.

Legacy organisations have worked hard to involve people in decision-making, and we would want to see that built upon rather than abandoned in a hasty effort to cut costs. It is essential that organisational memory is transferred from NHSE. Starting from scratch means losing momentum and knowledge that is needed to implement the work of the 10 Year Health Plan and enable the Government's three shifts.

The transition process also needs a clear plan, to ensure that the operational day to day work can be done while the move from NHSE to DHSC happens.

NHSE also has several legal duties such as to involve the public and carers that don't apply to DHSC. Alongside this it is understood that a parliamentary bill is being considered to remove some legal responsibilities from ICBs, but it is important to have reassurances that the new department in DHSC would maintain these legal standards and duties and not act to dilute accountability.

## Impact of ICB cuts on patient voice

The downsizing of ICBs looks like a major issue and one we fear will significantly impact their ability to engage with communities and act on what they hear. There is already little clarity in ICBs of where responsibility for

patient experience sits, and we know there is a tendency for systems to not prioritise this area of work. For example, many are already falling short in key areas such as complaints and commissioning behaviours can be poor.

The charity, Mind, reports severe operational disruption in late March:

*"All ICB staff in [one] area have been told they are at risk of redundancy... Most staff are now either on leave or are not responding to emails... decision-making has stalled, commissioners are not responding to enquiries and the day-to-day business of the ICB has stopped."*

With these cuts there is a risk that there will be a shift to provider-led decision making bringing with it a risk of provider bias. For example, 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. While no direction has been set on how ICBs are to realise cost savings, many may likely further delegate decision making and other functions to providers and provider collaboratives, making them the main agents of change. We note that in response to written questions, [on 19 March Karin Smyth said](#): *"NHS trusts will also be required to name an existing director who will be responsible for improving experience of care"*, but it's not clear what this will mean in practice, nor the operational scope of the director's role within its wider ICB shared responsibilities.

It is also thought that the outcome of these cuts will likely be mergers to reduce the number of ICBs – which will make them more distant from their communities. We have seen this before in the 2012 reconfiguration following the Lansley Act. The subsequent move from Clinical Commissioning Groups (CCGs) to ICB came with the risk of moving decisions further and further from what matters to patients, and this warning from past reconfigurations still stands.

It is essential that ICBs continue with one of their [4 core focuses](#) of *"tackling unequal access, outcomes and experience"* if the Government intends to halve the gap in healthy life expectancy between the richest and poorest regions in England, as [stated in its 2024 manifesto](#).

However, we are concerned about how this focus can be maintained while driving through such significant transition, and done in a meaningful way that involves listening and acting on the concerns of minoritised communities (see more on health inequalities below).

As mentioned above, [Sir Jim Mackey's letter](#) to all Trust and ICB chief executives and chairs published on 1 April said ICBs have a *"critical role to play in the future as strategic commissioners"* and any operating cost

reductions should among other things allow ICBs to *"commission and develop neighbourhood health"*.

However, our concerns are increased when we see that the same letter told ICBs they should: *"look carefully at... duplications. This includes... comms and engagement which similarly exist in local authorities, providers and regions"*.

We understand this may incorporate vital patient engagement that is central to ensuring the NHS develops into one that works for all. This diverse and comprehensive engagement will be especially important as the NHS moves to the 10-year plan three shifts. 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 care which delivers the right service offer in the right place.

It also raises concerns about how the [Elective Care Recovery Plan 2025](#) can be delivered as it specifically asks ICBs to *"set a clear local vision for how health inequalities will be reduced as part of elective care reform, and ensure interventions are in place to reduce disparities for groups who face additional waiting list challenges"*.

## Patient experience opportunities

This transition from NHSE to DHSC provides an opportunity to reassert and enhance the importance of patient experience to the health and care service to ensure that people and communities are at the centre of the way DHSC judges success. It is vital we do not lose this opportunity, nor the ICBs engagement expertise along with it, as a result of focusing on short-term cost-reduction exercises.

Indeed, the latest [British Social Attitudes](#) survey shows that dissatisfaction with the NHS continues to plummet lower as people reflect on their own poor experiences of accessing care. Through the survey the public have sent a strong message. The NHS now needs to work with patients and communities to address all these issues together, and we are concerned that the direction laid out to Trust and ICBs in the recent letter by the new NHSE Chief Executive may put improvement at risk.

There is an alternative. To ensure a safer, more equitable and responsive NHS, we need to shift the culture back to the 2000s when patient voice was better listened to and acted upon. There is a strengthening consensus across the health and care sector that we must rethink how we measure patient experience to make it a key success measure for the decade ahead.

This reset can right the wrongs of the last few years where people's voices have not been central to policy making as the centre moved increasingly to focus on finances and operational targets, with the executive-level post for patients, as mentioned above, also discontinued.

To achieve this, we recommend:

- Bringing back a directorate-level patient experience team alongside ensuring patient experience accountability at ICB board level to help drive improvement from what patients are sharing.
- Consolidation of teams under DHSC allows space to be more ambitious in creating new targets. We recommend considering new patient experience data collections that align with the three government shifts – analogue to digital, treatment to prevention, hospital to community – which will allow this government to understand if these shifts are working to people's experience of care.
- Consider a patient experience national metric to sit alongside other national targets such as A&E waiting times and Referral to Treatment waits. This would allow the Government to understand not just the speed of access but the quality of experience and outcomes from care. This would help avoid the scenario where the NHS hits targets but fails patients, a situation we saw play out in the Mid Staffs scandal.
- Consolidate into one place the very large-scale surveys and patient experience data collections taking place across the country. These include The Friends and Family Test (provider led as part of standard contract), CQC National Patient Survey Programme, Health Insights Survey led by ONS, Integrated Care Experience survey and GP patient survey. This single oversight would enable DHSC to understand more about the pathways of care rather than experiences in silos. For example - you could track the experience of care from GP referral through to hospital treatment, and then discharge to social care. This can't currently be achieved as the surveys are too fragmented.

We note that Mr Streeting has meaningfully focused and engaged on the issue of patient experience since the start of his tenure.

Alongside this [on 16 December 2024](#), in response to a written question Karin Smyth said:

*"Although no specific assessment has been made of the adequacy of National Health Service targets for incentivising improvement in patient experience, the Government is committed to making improvements... We also want to improve experience for patients living with complex, long-term, or serious illnesses, like cancer."*



We believe these recommendations align with what the government wants to achieve and without them it is hard to see how it will succeed in increasing its intended focus on patient agency and ensuring the three shifts result in better patient outcomes.

## The wider impact on patients

### 1. Distancing from patient voice and loss of diversity

Costs savings can result in quality and safety to be undermined as we saw in the Mid Staffs scandal – indeed if patient voice and experience had been better heard the appalling care experience by those treated at the Trust may have been noted and action taken earlier.

Our members raised serious concerns about the loss of patient voice from the system, especially those facing inequalities, as well as voluntary, community, and social enterprise (VCSE) programmes around these issues already facing cuts. We already know the [Core20Plus connectors programme](#) has been cut for 2025/26 financial year which means we will lose the connections this programme has built within communities to date.

Multiple organisations told us patient voice groups are being ended or brought "in-house," showing the risk to engagement mechanisms during restructuring.

National Voices is seeking reassurance where accountability will sit for progressing initiatives such as Core20Plus5 and Action on Inclusion Health Framework as well as the strategic duty to work in partnership with people and communities. These concerns are exacerbated by the recent publication of the NHS mandate and priorities which does not have the focus on inequalities we would expect if the Government intends to put this at the heart of operational improvement in the NHS.

Our members told us:

*"Cuts risk destabilising ICB-funded services, including our new East of England HIV Peer Support Service and the Fast-Track Cities initiative, which has expanded clinic-based peer support in London and other key services to support people staying engaged in care. We fear reductions in peer support, mental health services, harm reduction and well-being programmes - especially for marginalised communities which are key to address health inequalities. The Government's 2030 goal to end HIV transmission and eliminate stigma depends on sustained investment."*

Positively UK

*"We are hearing that the likely cuts from the ICB are all equity focussed."*

Mind

Mind has identified specific cuts to: volunteering programs for people with severe mental illness; African Community Heritage community forensic day activities; support to access personal health budgets; LGBT+ and African Community Heritage NHS Talking Therapies service.

*"LGBTIQ+ groups are still too few and far between, I worry they will be even more shut out in future."*

LGBTIQ+ equality focused member

*"The Three year Delivery Plan for Maternity and Neonatal services (March 2023) set the ambition that Maternity & Neonatal Voices Partnerships (MNVPs) listen to local communities, have strategic influence and have the infrastructure they need. Implementation of this has been very variable across England. Money promised in the Spring 24 budget to 'strengthen the neonatal parental voice' (approximately £7,700 per consultant unit) was paid to ICBs last summer but not all of it has gone into MNVP budgets. In some places it has been paid so late that planned neonatal engagement work is only just starting.*

*We fear the least funded MNVPs will suffer most in the forthcoming cuts, and in some areas service users could have little meaningful involvement in local service improvement."*

National Maternity Voices

*"We have anecdotal evidence [that] cuts have already had an impact on patient groups and patient voices being heard over the last year in at least 4 different ICBs. We have a number of examples of coproduction programmes either being ended by ICBs or being brought 'in house' to be delivered by providers. The voices of people with lived experience are critical to improving service provision for people living with mental illness. At Rethink Mental Illness, we advocate that people with lived experience of severe mental illness should be at the heart of services, through co-production to monitoring, improvement and direct service delivery through roles such as peer mentors. Our analysis of responses to the Health and Social Care Committee's inquiry*



*into Community Mental Health Services shows that this was also seen as core to improvements by many respondents across statutory and voluntary organisations."*

## Rethink Mental Illness

One disability focused member raised concerns about the reducing priority NHSE gives to disability equality, in relation to staff and patients. There have been cuts to the specialist disability equality team, complaints of unfair and unequal treatment by NHSE staff and a failure to revise the NHS Accessible Information Standard and urges the shift to DHSC to address these concerns.

## 2. Trust

We have concerns around the impact these changes will have on the trust of patients in the NHS. For example, there is risk that with NHSE's abolishment and ICB cuts, we could lose central policy teams, and local implementation teams. This could impact on members of the public who have given time and effort to engage with NHSE on policy initiatives or have fed back on experiences and been told that improvements are on their way – only for workstreams to now be pulled/at risk. This could arrest any momentum being built up around policy work, and discourage the public from sharing experiences in future.

Kidney Care UK has been working for a number of years to improve access to and experience of [non-emergency patient transport schemes](#) (NEPTS) to ensure that people can also choose to travel to life-maintaining dialysis appointments (which are usually at least 6 journeys a week) using their own patient transport and be reasonably reimbursed for their travel costs. In 2024 the charity had co-produced a universal dialysis transport support offer framework with Professor Sir Stephen Powis, National Medical Director, NHS England and Dr Emily Lawson DBE, Chief Operating Officer, NHS England writing to ICBs in August 2024 instructing them to *"set up a working group with its local dialysis units and other key stakeholders to plan for the implementation of this universal offer as soon as possible"*. Unfortunately, the response to implement the framework and offer choice has been minimal across the 42 ICBs.

This success has been regularly communicated to patients who are struggling to access dialysis services. However, an NHSE stakeholder has since told the charity that NHSE cannot give *"any genuine assurances about what will happen with the NEPTS programme in general, and the dialysis transport support framework in particular moving forwards"*.

### 3. Specialised services

Clarity around plans for future commissioning approaches for specialised services is vital to provide reassurance to people who rely on these services, and to ensure a safe and uninterrupted service offer. We are concerned there is a real potential for patients with long-term conditions to fall through the cracks because the long delegation is taking place within a very unstable environment. We urgently seek a spec com implementation plan that recognises and responds to the new health landscape in which this is now being delivered.

Plans for the future of specialised commissioning are at a very advanced stage with some specialist services expected to be delegated to ICBs from 1 April this year.

There appears to be a central expectation to continue with this legal delegation but one region has been told the services may be delegated before staff with experience in these areas are transferred and it remains unclear when staff transfer might happen.

There is already variation in the approach taken by ICBs to spec com where it has been delegated already, including whether there is a responsible lead commissioner. With headcount likely to fall, there is a risk that specialised services will fall to the bottom of the local priority list, at the same time as significant knowledge and expertise is lost at the national level.

There are also around 80 highly specialised services that have been identified as not suitable for delegation to ICSs with commissioning responsibilities due to stay within NHS England post-delegation (from April 2025). This includes a number of services for people with rare and ultra rare neurological conditions.

Our members have told us:

*"[We are concerned about] what will happen to the commissioning and monitoring of specialised services. A couple of years ago a specialist service for TTP began - creating 9 specialist centres across 11 sites. Our TTPNetwork's rep at NHSE has worked tirelessly with their clinicians to get each centre up to speed and working to a common standard, resulting in world class service for the TTP rare disease group."*

TTPNetwork

*"Commissioning [of trans peoples' care] moved into NHS England from clinical commission groups (CCGs) because of the inequities faced [which appeared] based on a postcode lottery, with some CCGs refusing to fund trans people's care and others being willing to. Commissioning of transition related genital surgery has proved particularly challenging for NHS England and delegation into ICBs would make it more, not less, complex."*

TransActual

*"Many ICBS are yet to take on delegation of Specialised Services commissioning and there are a number of issues yet to be ironed out, including commissioning standards, updated service specifications, and, most worryingly, the finances associated with bringing specialised care closer to home within ICBs if they don't currently have a specialist centre for a specialised services. There is a lot of in and out of service pathway mapping required, and the money flows aren't yet clearly fixed."*

Condition focused member

#### **4. Impact on quality and safety of care**

NHSE has a number of roles that do not currently sit within DHSC and that act to ensure quality and safety is maintained across commissioned services.

For example the role of maintaining clinical leadership currently sits within NHSE and there are clinical networks that do vital work in ensuring and enhancing quality offers. These include cancer alliances, and clinical networks which also ensure a diversity of patient voice underpins different needs and experiences.

Clarity on the future of networks, alliances and transformation programme that drive down postcodes' of access and quality is needed, with assurance that the expertise and resources within them are maintained post-reform.

The Stroke Association told us:

*"The funding/staffing of stroke clinical networks (Integrated Stroke Delivery Networks, ISDN's) has been impacted as a result of system cuts [prior to the March 2025]. ISDNs are hugely important regional sources of clinical expertise, championship for stroke and information -sharing on*

*innovations and good practice in stroke care as one way to reduce the postcode lottery in services that we know patients face."*

The charity told us that two ISDNs have merged due to previous NHSE cuts to workforce while some are facing a recruitment freeze- and there isn't currently a replacement for the lead running a stroke rehab quality improvement project, risking this work not continuing.

Approximately 60% of stroke patients leave hospital with a disability - rehab and life after stroke support is such a critical part of people being able to regain their independence and get back to work, daily activities etc which is also central to the government's focus on helping people back into work.

*"At present the role of National Clinical Director for Neurology and separately for Neurosurgery and Spinal Surgery sit within NHS England. These roles have provided crucial senior clinical leadership on service improvement and transformation and maintaining these roles and expertise during the reform process is critical."*

Member representing a coalition of organisations

The charity also told us that the national neuroscience transformation programme currently sits within NHS England and plays a *"vital role in developing insights and resources to support Integrated Care Systems with service improvement and transformation approaches"*.

The future of the transformation programme is currently unknown as it enters into its final year with additional uncertainty caused by the proposed abolishment of NHS England.

A variety of charities told us about specific programmes of care that seek to prevent worse outcomes for people with long-term conditions, or offer national screening to reduce conditions being diagnosed only when symptoms present.

Screening and vaccination programmes are expected to be delegated to ICBs from March 2026, although this is subject to the Secretary of State approval and a wider review of NHSE's screening services.

An LGBTIQ+ focused member said it was concerned ICB funded work with said organisation on screening campaigns for transgender people are at risk.

Other programmes of care work were mentioned by our members:

*"We understand that for the first-time learning disability and autism funding is not ringfenced for 2025/2026. This is the main traction for prevention - work tackling inappropriate hospitalisations and avoidable deaths."*

Condition focused member

*"We are concerned that there is a risk that moving the work of NHSE into DHSC could result in policy making and commissioning based on politics rather than population need or reliable evidence."*

Equality focused member, on risks of political interference

*"Key mental health deliverables have been removed from the Operational Planning Guidance and the GP contract for 2025/26 and mental health waits were excluded from the Elective Reform Plan. Improving mental health support is fragile and we fear the loss of NHS England could see mental health further deprioritised nationally and locally."*

Mind on structural concerns

## Broader lessons DHSC should take from previous restructures and opportunities

- The shift to a single team under DHSC creates a strong opportunity to enhance the value, role and culture around patient voice and patient experience. We need to place patient experience at the centre of the new organisation that emerges if this merger is to achieve the intention set out by the Secretary of State: "to focus on what matters most - delivering better care for patients"
- Specific engagement with the VCSE sector and national patient organisations on these changes is vital – not least because their budgets, and for some their very survival are impacted by ICB/NHSE contracts, and the work they do on patient support and inclusion is vital and non-replicable
- A formal impact assessment of the abolishment of NHSE and ICB budget cuts should be carried out to ensure that the commitment of health inequalities at the core of ICBs purpose and central to this Government's manifesto can be maintained.
- A clear implementation plan is urgently needed, with an especial focus on spec com given this delegation to ICBs is underway. It must

also be made clear where the patient experience function sits and who will lead on it during the transition.

- Formal patient voice mechanisms within DHSC must be established (especially in light of Sir Jim Mackay's 1 April letter), to address the fact that ICS cost reductions may result in mergers and possibly more robust provider collaborative which risks taking commissioners further away from patients and communities.
- Co-production approaches in service design must be maintained alongside funding protection for patient engagement programs – this will focus resources on outcomes that patients want, while also ensuring the commitment to health inequalities is not lost.