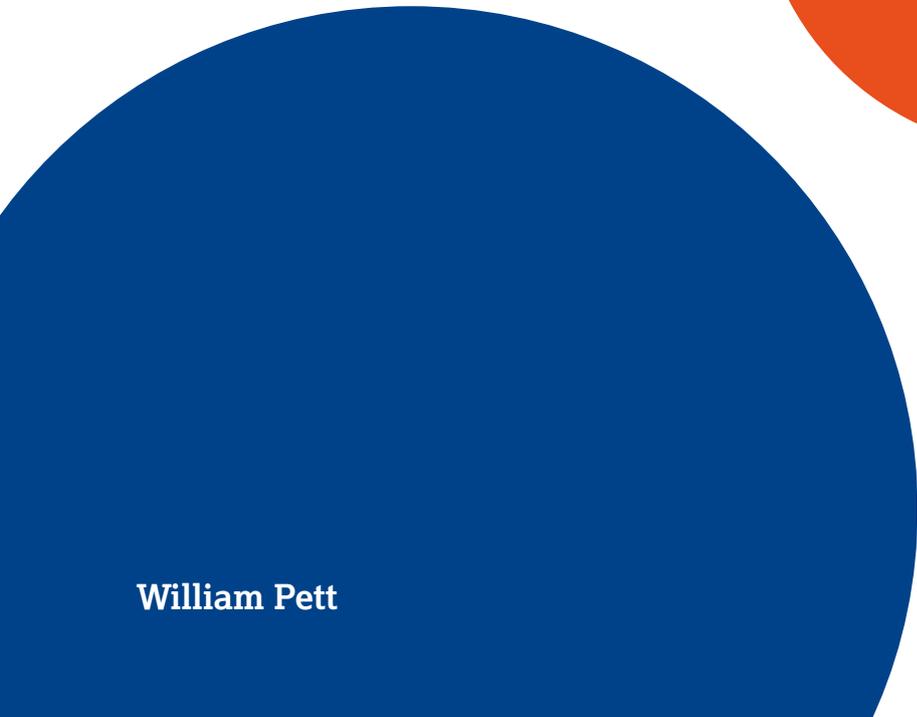
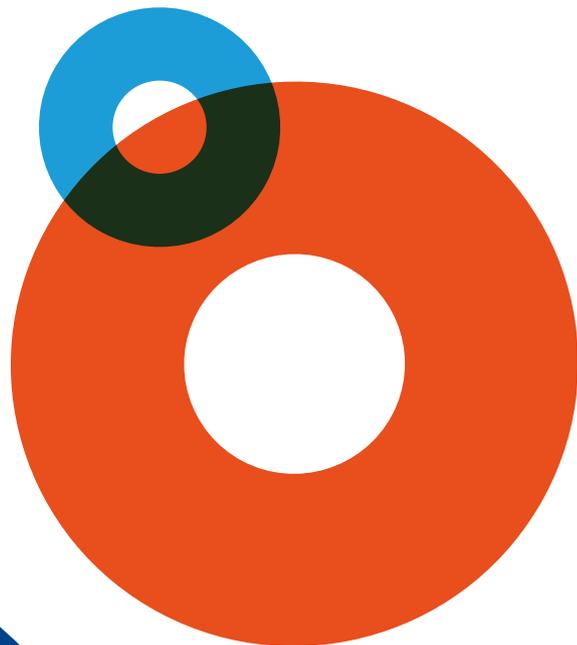


Legislating on the future of health and care in England



About the NHS Confederation

The NHS Confederation is the membership body that brings together and speaks on behalf of organisations that plan, commission and provide NHS services in England, Northern Ireland and Wales. We represent hospitals, community and mental health providers, ambulance trusts, primary care networks, clinical commissioning groups and integrated care systems.

To find out more, visit www.nhsconfed.org and follow us on Twitter @NHSConfed

Mental Health Network
NHS CONFEDERATION



**NHS Clinical
Commissioners**

The independent collective voice
of clinical commissioners



NHS CONFEDERATION



NHS Employers

NHS CONFEDERATION
Integrated Care Systems Network



NHS CONFEDERATION
PCN Network



Key points

- This report outlines the views of healthcare leaders on the recent [white paper](#) on the future of health and care in England, the implications for the forthcoming health and care bill and a set of recommendations to government as it develops the finer detail of the legislation.
- Our members – spanning acute, mental health and community providers, as well as commissioners, primary care networks and integrated care systems – have strongly welcomed and endorsed the direction of travel set in the white paper. The experience of recent years, and especially the pandemic, have shown the very real benefits of collaboration within the NHS and also with other public services. Our members are clear that the complex challenges facing the health and care sector over the coming years will require ever-closer collaboration, risk-sharing and flexibility, which the proposed legislation will facilitate.
- There is also a widespread view across the NHS that the forthcoming legislation should aim to be as permissive as possible. One of the most welcome features of the white paper is that it recognises the contribution that local leaders will make to addressing the specific needs of their communities. It is especially welcome, therefore, that the white paper provides scope for local flexibility. We urge the government and those that regulate and oversee the NHS to ensure that the bill, and especially the wider guidance to support its implementation, continues to embrace this principle.

There are, however, some concerns shared across our membership in four key areas that the government may wish to address in the bill:

1. Increased powers for the Secretary of State over the NHS

The measures in the forthcoming bill should not return us to an environment in which there is heavy-handed ministerial involvement in the operation of the NHS. There must be clear and robust checks and balances in place for the circumstances under which the Secretary of State for Health and Social Care can

intervene in issues such as service reconfigurations and senior appointments within ICSs, which should as far as possible be left to local discretion.

2. Governance and accountability

The forthcoming bill is set to create two bodies within ICSs: an 'ICS NHS body' and a 'health and care partnership'. While it is right for there to be flexibility on the form, governance and interaction between the two, it must be clear in legislation what the statutory function of each body is. Similarly, the wording around representation on the board governing the ICS NHS body must be handled carefully to ensure that it does not imply a hierarchy of different providers.

3. The duty to collaborate

While the principle of a duty to collaborate is welcome, the duty outlined in the white paper is vague and our members have raised concerns over the implications it will have for their organisations. The government may wish to develop the notion of a 'duty to collaborate on improving health inequalities'. This would require careful wording, but it would have the benefits of enshrining the goal of tackling health inequalities into law and offering a shared goal that is universally supported across health and care organisations.

4. Pace and timescales

The anticipated timescales, both in terms of the bill receiving royal assent by autumn and statutory systems to be operational from April 2022, are very ambitious. Whether through the bill or guidance, arrangements should be in place to allow more time for less developed systems to become operational as statutory bodies. The government should take timely action to resolve ongoing issues that threaten implementation timescales, including around appointments and boundaries, if the April 2022 deadline is to be kept.

- The content of the forthcoming bill is, of course, just one factor that will determine the future success of the future health and care framework. We are aware that much of the detail will be provided through policy and implementation guidance. We therefore intend to work closely with the Department of Health and Social Care and NHS England and NHS Improvement to ensure that this guidance is pragmatic, enabling and supported by healthcare leaders across the NHS.

Introduction

In February 2021 the government published a white paper, [Integration and Innovation: Working Together to Improve Health and Social Care for All](#). This sets out the key elements of a forthcoming health and care bill, the first piece of new primary legislation on health and care in England since the Health and Social Care Act 2012 (HSCA 2012).

We have broadly welcomed the proposals set out in the white paper. The increasingly complex challenges facing health and care – such as bringing care closer to patients’ homes, addressing health inequalities and streamlining patient discharge processes – are not easily addressed through the existing framework, which broadly aims to incentivise competition between services and focuses on individual organisational performance. Rather, they require closer collaboration, risk-sharing and flexibility, which the white paper proposals aim to facilitate. The commitment to devolving decision-making powers down to place level is welcome.

There are a number of other steps envisaged within the proposed legislation, which aim to modernise and update the management and regulation of health and care delivery. We are particularly supportive of the important changes to professional regulation, which will allow those organisations that regulate healthcare professionals much greater ability to align their activities and to respond to the changing delivery of healthcare.

It should be emphasised that the type of integrated working envisioned in the white paper is not new – it is already happening to positive effect on the ground within integrated care systems (ICSs) across the country, most notably at neighbourhood and place levels. In that sense, the legislation is ‘playing catch up’ with the environment, rather than seeking to change it significantly.

“This is not a new thing – it has been policy for almost five years. Systems are in existence already. We need to maintain a sense that this is legislation catching up with policy. There will be lots of pressure on DHSC and NHSEI to be more prescriptive – please let's resist this!”

ICS Executive Leader

There is broad support for the steps envisaged within the legislation proposed for the white paper. However, this document sets out the concerns that our members, healthcare leaders across the NHS, have on four specific aspects of the white paper:

1. Increased powers for the Secretary of State over the NHS
2. Governance and accountability
3. The duty to collaborate
4. Pace and timescales

It is hoped that the comments we outline will be helpful both for the Department of Health and Social Care (DHSC) and NHS England and NHS Improvement (NHSEI) as they develop the final wording of the health and care bill over the coming weeks. Our member networks, representing providers (including mental health), commissioners, integrated care systems (ICSs) and primary care networks (PCNs), will also be conveying more detailed concerns to government and NHSEI separately.

It is important to note our view that the legislation should aim to be as permissive as possible, allowing systems the maximum ability to set priorities which reflect the particular needs of the populations they serve. One of the most welcome features of the white paper is that it provides scope for local flexibility. This should remain a feature of the bill.

In addition, we are clear that there are limits to what this legislation alone can achieve. The future success of ICSs will depend as much on wider non-legislative factors, including implementation guidance. We will be engaging with NHSEI and the government to ensure that this guidance builds on the permissive nature of the bill and does not unduly restrict local flexibility.

As such, there are many issues that will be of fundamental importance to the future of ICSs but which are not focused on in this report, as they require action outside of the forthcoming bill.

As we consistently explain, the success of health and care requires concerted action by the government in relation to the people and infrastructure required to meet the needs of the population, particularly in light of the impact of the pandemic. The future plans for public health and social care especially have significant implications for health and care, and the success of ICSs. We lead Health for Care, a coalition of 15 national health organisations calling for a clear and sustainable long-term plan and settlement for social care.

Methodology

To understand the likely impact of the white paper proposals on NHS services, each of our networks conducted an extensive engagement process with its members. Through late February and early March 2021, this involved a series of meetings, roundtables and webinars with healthcare leaders across the NHS. This included engagement with acute and integrated providers, ambulance services, community providers, mental health providers, primary care networks, clinical commissioners and integrated care systems.

Qualitative and quantitative data gathered throughout this engagement process has been used to inform our position and recommendations.

The four topics outlined in this paper have been chosen according to the following criteria:

- The topic is of shared concern across our membership.
- The topic will need to be addressed in the forthcoming legislation, rather than through guidance, policy or other means.
- It is a topic on which we have a clear set of recommendations for government as they finalise the wording of the legislation.

Areas of concern for healthcare leaders

1. Increased Secretary of State powers over the NHS

The issues

The white paper includes proposals to give the Secretary of State for Health and Social Care (SoS) new powers over all arm's-length bodies (ALBs), including the ability to transfer functions and abolish them. It also increases the SoS' powers on the direction and operation of the NHS, including around service reconfigurations.

On the latter, under Chapter 5 (5.83), it reads:

'We are therefore proposing to broaden the scope for potential ministerial intervention in reconfigurations, creating a clear line of accountability, by allowing the Secretary of State to intervene at any point of the reconfiguration process.'

There has also been recent speculation over the SoS' powers on appointments. While the white paper states that new powers of intervention 'will not allow Secretary of State to direct local NHS organisations directly', [Matt Hancock indicated](#) to the Health and Social Care Committee on 16 March 2021 that new legislation will give the SoS power to 'sign off' or 'veto' senior appointments to local NHS boards. DHSC subsequently [clarified his comments](#), stating that while the proposed legislation will not change the current process for appointments to trusts or foundation trusts, it does plan for the health and social care secretary to have a joint role in appointing integrated care system chairs.

Our position

Over recent decades and through successive reforms, the pendulum has swung between strong ministerial involvement in the running of the NHS and more independence for the service. The HSCA 2012 moved the pendulum towards the latter. It allowed for greater autonomy for the NHS and freed it from political intervention. While it is right for the NHS to be accountable to ministers, we must avoid the pendulum once again swinging too far the other way.

The move towards ICSs represents an opportunity to place power in the hands of local leaders, who our members believe should be trusted to make the right decisions for their populations. We have long argued in support of 'letting local leaders lead' and that broadly there should only be intervention from DHSC or NHSEI when strictly necessary.

On managing local service reconfigurations, the Independent Reconfiguration Panel (following local authority referral) has provided a clear mechanism for resolving disputes. While the process can be slow and extremely resource intensive, it offers the opportunity to clinicians, managers and the public to set out their cases so, should Secretary of State intervention be required, information about local circumstances and opinions is clear. Our members believe that any future resolution process should continue to be based on transparent, local consultation in the first instance, only requiring central intervention where local accountability mechanisms have proved ineffective. If the Secretary of State will be able to intervene earlier in future, we believe there must be a minimum level of supporting information requirements upon which the SoS would base a decision either in support or opposition of a service reconfiguration. Further, this information should be made public by the Secretary of State when confirming their decision.

To support this point, we are concerned about the health and social care secretary's [recent intervention](#) in a local reconfiguration before local authority referral or even a public consultation had concluded. Careful consideration must be given to legal process on this issue to avoid the SoS intervening when it is not clear what the views of local communities are and to avoid the power being misused for political reasons. At the heart of any new powers for the Secretary of State must be transparency.

On the issue of appointments, it is unclear what problem the Secretary of State is trying to solve by wanting a joint role in appointing ICS chairs. Again, there are concerns about decisions becoming politicised. Local NHS organisations already have clear processes for how they recruit and appoint senior leaders, which are supported by good governance and

informed by the Nolan Principles of Public Life, albeit there is important work to do to improve the diversity of NHS boards. We are concerned about the Secretary of State overruling local decisions on this in future.

Recommendations for the health and care bill

- Broadly, the direction in the bill should not return to an environment in which there is heavy-handed ministerial involvement in the operation of the NHS. We accept NHSEI must be accountable, and the organisation will require its own culture change if ICSs are to be given the freedom they need. However, statutory allowances for central intervention (from both DHSC and NHSEI) risk frustrating the ambition of the bill and must be limited.
- There must be clear and robust checks and balances in place for the circumstances under which the Secretary of State can intervene in service reconfigurations and a minimum level of supporting information requirements. These should include clear processes for local resolution in the first instance; criteria indicating when and how Secretary of State intervention is needed; a requirement for the Secretary of State to consider local clinical advice and any other advice offered by the affected ICS on a service reconfiguration decision, all of which should be in the public domain.
- Similarly, if new powers are proposed around market intervention, such powers should be deployed only after the Secretary of State has taken account of local opinion and advice.
- While we understand that the government is already able to intervene in NHS trust appointments, we believe that (as in the case of foundation trusts) senior appointments within ICSs should be left to local discretion. At the very least, the language in the bill should make clear that any Secretary of State power of veto should be reserved for exceptional circumstances (and these should be detailed).

2. Governance and accountability

The issues

The white paper establishes ICSs with two bodies – an ‘ICS NHS body’ (an unclear term as these will also include local authorities) and a ‘health and care partnership’ (HCP). This is in addition to the continuation of health and wellbeing boards.

The white paper also establishes a set of minimum standards around representation on the unitary board governing the ICS NHS body.

The ICS NHS body is set to feature, as a minimum:

‘a chair, the CEO, and representatives from NHS trusts, general practice, and local authorities, and others determined locally for example community health services (CHS) trusts and mental health trusts, and non-executives.’ (Chapter 6, 6.18)

In regard to the HCP, representation will be at the discretion of individual systems but members:

‘could be drawn from a number of sources including health and wellbeing boards within the system, partner organisations with an interest in health and care (including Healthwatch, voluntary and independent sector partners and social care providers), and organisations with a wider interest in local priorities (such as housing providers).’ (Chapter 6, 6.20)

Our position

It is welcome that there have been efforts to formalise partnership working between health services and local authorities within ICSs. This is something that we called for prior to the publication of the white paper in our report, [The Future of Integrated Care in England](#).

There is a clear sense across our membership that, while there should be allowances for governance and form within both, there does need to be clarity on what the statutory responsibility of each body is within the ICS. Without such clarity, there is a real risk of conflict and/or stalemate within systems in future. In practice the NHS body and the partnership board will share accountability for key areas of the strategy of the ICS, particularly relating to population health and where resources are pooled.

The NHS body, our members assume, will be accountable (along with the organisations providing NHS-funded services) for delivering those services commissioned using NHS funds and meeting nationally set priorities for access, quality and value for money.

The partnership board will, we assume, in broad terms (and subject to important discussions with our local authority colleagues) be responsible for:

- agreeing shared priorities and strategies for the members of the partnership
- setting a joint strategy for improving population health to be recommended to the NHS body and the local authority
- agreeing and monitoring the contributions of all partners to delivery of this strategy
- setting joint budgets and investment plans (with the NHS body approving the NHS contribution and the local authority cabinet and senior executive approving the local authority contribution).

At present, ICS chairs and executive leads are responsible for the direction and performance of their system. However, which individual(s) will ultimately hold accountability for the performance of the ICS – and from which body – under the new framework does need to be clearly described. Similarly, there is uncertainty over the boundaries of accountability between the system and individual organisations when it comes to performance.

“We welcome less prescription overall, but we do need to be crystal clear on the accountability of various parts of the system. For example, who decides on the capital plan? Who will hold the legal responsibilities for public engagement?”

ICS Executive Leader

In terms of accountability and governance at place level, we welcome that there is a commitment to flexibility of arrangements at place. However, our members are unclear about how budgets will be delegated down to place level, who will be legally responsible for spending decisions at this level and how they will be held to account. The health and care bill, and/or its supporting guidance, must clarify this.

Finally, one of the most contentious aspects of the white paper is the issue of representation, particularly in relation to the board of the ICS

NHS body. While we are reassured that the white paper sets out that decision-making powers should be devolved down to place level where possible, the ICS NHS body will, by statute, hold the budget for health services within its boundaries and so representation on its board will be important over the longer term.

This has led to different stakeholder groups across health and care arguing that there should be minimum legal standards to ensure they are represented on boards. We do not believe that legislation should be rigid (with requirements for representation from across a range of different clinical areas), as this could lead to arduous and unnecessary 'tick-box exercises' for system leaders in future.

We do, however, believe that the wording in the white paper is unhelpful as it implies a hierarchy of providers. There should be some statutory commitment for balanced representation to ensure that, for example, providers responsible for both physical and mental health are represented. This is an issue that our mental health members are understandably concerned about.

“While we hope that integrated care systems will want to have representatives from mental health organisations at the top table, the current proposals do not put mental health on an equal footing and there is a risk that some ICSs will not include mental health representatives. We believe this would be a considerable step backwards for the parity of esteem for people who use mental health services.”

Chair, Mental Health Trust

Similarly, we believe there should be a statutory requirement for ICSs to have lay membership and clinical leadership representation at ICS board level, not just mandated 'clinical advice', as accountability for many ICS functions will by necessity require clinical skillsets at board level.

In regard to the wording around primary care representation on the ICS NHS board, we feel this is unnecessarily rigid. It makes reference to 'general practice' rather than 'primary care', yet a central goal of the move towards primary care networks (PCNs) is to broaden the scope of primary care beyond simply general practitioners.

“The model for PCNs is far more than just general practice. We have the power to form alliances between practices, with wider health and social care partners and the voluntary sector and as such we have a critical role in shaping and supporting our ICS.”

Programme Director, Primary Care Network

Recommendations for the health and care bill

- While it is right for there to be some flexibility on the form, governance and interaction between the two ICS bodies, it must be clear in legislation what the statutory function of each body is.
- Clarification is needed in the bill on who will be the individual ultimately held accountable for the work of an ICS, and to whom they are accountable.
- Similarly, the bill should offer clarity on how budgets will be held and who will be legally responsible for spending decisions at place level.
- While we understand that conversations about regulation are ongoing, the bill should ensure clarity on the question of how systematic failures or serious quality issues will be handled. It must be clear who is holding organisations to account as well as the system, and on which aspects of performance.
- We accept the need for systems to have some discretion on board representation, but we recommend that there is at least a statutory commitment for the NHS ICS board to have lay and clinical leadership representation, as well as 'balanced representation' from all types of provider organisations to ensure inclusivity (for example of mental health, primary care and community providers).
- To improve flexibility and recognise the multidisciplinary nature of PCNs, the wording of the bill should refer to 'primary care' representation instead of 'general practice' on the ICS NHS board.

3. The duty to collaborate

The issues

The white paper includes a new duty on partners within systems to collaborate. It states:

‘This proposal will place a duty to collaborate on NHS organisations (both ICSs and providers) and local authorities. This policy also provides the Secretary of State for Health and Social Care with the ability to issue guidance as to what delivery of this duty means in practice, in recognition of the fact that collaboration may look very different across different kinds of services.’ (Chapter 5, 5.15)

Our position

While we accept that the issuing of guidance will help to clarify what delivery of the statutory duty to collaborate looks like in practice, the wording of it in the forthcoming bill will be important. The wording on the duty in the white paper is vague and our members have raised concerns over the implications it will have for their organisations.

It should be noted that foundation trusts already have a duty relating to integration. Under the [NHS provider licence](#), which applies to foundation trusts in addition to other NHS providers, it states that the licensee shall not do anything that could ‘reasonably be regarded as detrimental’ to enabling integrated care.

The white paper sets out that the collaboration proposal is set to replace two existing duties to cooperate in legislation, but there is concern about doing so unless there is clarity on what exactly providers are being asked to do through the duty.

“I feel it is unnecessary to be told again that we have a duty to collaborate, and it risks organising structures without having the clarity of form.”

Chair, Foundation Trust

It is unclear how a new duty to collaborate will be defined, assessed or what penalties will be associated with neglecting the duty. Our provider members have expressed relief that broadly the white paper does not significantly impede the autonomy of foundation trusts. But the extent to which the duty to collaborate may do so is an area of uncertainty. There will be concerns if the new duty significantly restricts foundation trust autonomy, with a heavy focus on resource transaction as opposed to population health outcomes.

“There is a risk as part of the duty to collaborate that if organisations are not ‘behaving’ in a particular way someone else could step in. I feel the direction of the duty to collaborate won’t focus on achieving the outcomes for communities and population, but rather on how we share and use resources. This would benefit the notion of a drop in the spend of the public purse to deliver services.”

Chair, Foundation Trust

As such, our members feel that there would be scope to frame the duty around a shared objective between partners. This in effect would mean a duty to collaborate towards a goal rather than collaboration for collaboration’s sake. There is otherwise a risk of the definition of ‘collaboration’ being unclear and the question remaining: collaboration to what end?

We have heard disappointment about the lack of reference to addressing health inequalities. The government may wish to develop the notion of a ‘duty to collaborate on improving health inequalities’. This would require careful development and clear wording, but it would have the benefits of enshrining the goal of tackling health inequalities into law and offering a shared goal that is universally supported across health and care organisations. Support for this has already been demonstrated by both us and the Local Government Association.

Finally, we believe that on the issue of how system partners’ adherence to the duty to collaborate is assessed, we should resist any moves that effectively make the ICS a regulator. Our members are concerned about the idea of a duty to collaborate making the ICS a ‘judge, jury and executioner’, as this would significantly alter the dynamics of trust and cooperation that have developed in many systems over recent years. Rather, we would prefer to see assessment of performance against the duty focused on self-regulation, peer assessment and, where possible, lay input (that is to say, local service users and citizens).

Recommendations for the health and care bill

- The duty to collaborate should not significantly impede the autonomy of foundation trusts.
- The government should develop the duty to collaborate in relation to a shared goal, such as collaboration to improve health inequalities.
- Assessment of system partners' adherence to a duty to collaborate should focus on self-regulation and peer assessment, with clear roles for service users and local citizens. This will help to ensure the focus of ICSs is, as far as possible, on enabling rather than regulating.

4. Pace and timescales

The issues

The white paper states that:

'On current timeframes, and subject to Parliamentary business and successful passage, our plan is that these proposals for health and care reform will start to be implemented in 2022.' (Chapter 4, 4.6)

There is an assumption across the health and care sector that more specifically this will be from the beginning of the financial year next April.

Our position

The anticipated timescales, both in terms of the bill receiving royal assent by autumn and statutory systems to be operational from April 2022, are incredibly ambitious. There has been no formal consultation on the content of the white paper and the only pre-legislative scrutiny has come through a handful of sessions conducted by the Health and Social Care Select Committee.

History shows that rushing through legislation in this way leads to poor outcomes. While NHSEI conducted a consultation on some of its proposals (now included in the white paper), we have strong concerns over the lack of wider consultation on the full scope of the legislation – including around proposed timescales.

NHSEI plan to begin recruitment of chairs and chief executives of statutory ICSs at the bill's second reading in the Commons (expected May/June). Clinical commissioning group (CCG) leaders advise that appointments must be in place by September 2021 to deliver the transition to ICSs in time for April 2022 – this leaves a very small window for recruitment.

Equally, with legislation likely not to be passed until late autumn at the earliest, this will leave a matter of months until a statutory framework comes into operation by April. Whether through legislation or guidance, there must be a degree of flexibility on this deadline to avoid slower systems being in breach of legislation. We are concerned about nascent statutory ICSs being overloaded with statutory responsibilities, including immediately taking over certain commissioning responsibilities from NHSEI. These must be built up over time.

Finally, there are heated discussions ongoing around ICS boundaries. The recent implementation guidance to support NHSEI's planning guidance for 2021/22 states that 'ICS boundaries will align with upper-tier local authority boundaries by April 2022, unless otherwise agreed by exception'. While this report does not plan to go into the detail of this issue, it should be noted that this requirement will have implications for timescales – threatening to set back significantly the progress of affected systems.

Recommendations for the health and care bill

- The government must think carefully about proposed timescales set out in the bill. In light of the concerns raised above, it should take timely action to resolve ongoing issues that threaten implementation timescales, including around appointments and boundaries, if the April 2022 deadline is to be kept. Additional support will be required for some ICSs – for example those impacted by boundary change – to ensure that no ICS is disadvantaged by delays to these decisions.
- Whether through the bill or guidance, arrangements should be in place to allow more time for less developed systems to become operational as statutory bodies. This may, for example, include arrangements for statutory ICSs 'in shadow form' for a limited period of time with a reasonable timetable for ICSs to take on certain functions (for example, in regard to commissioning) over time, as opposed to from April 2022.

NHS Confederation viewpoint

We remain supportive of the direction of travel set out in the white paper and, with the caveats set out above, feel optimistic about the forthcoming health and care bill. We look forward to assessing the content of the draft legislation against the recommendations laid out in this document.

As mentioned in the introduction, we believe that the content of the bill will be one of several contributing factors towards the future success of ICSs and the wider health and care sector. The adage that 'the devil will be in the detail' rings true in relation to the future of system working, and that detail will largely be provided through implementation guidance. We therefore intend to work closely with DHSC and NHSEI to ensure that this guidance is pragmatic, enabling and supported by healthcare leaders across the NHS.

Finally, it should be reiterated that while this report has focused on the four areas outlined above, there are other important areas we plan to engage on in relation to the forthcoming legislation. The workforce planning requirement, in particular, should go much further than presently described. The proposed five-yearly description of process by the Secretary of State is insufficient to this vital task. We believe that a more regular update (every two or three years) to parliament is required. It is also important that this addresses not only the process but also the outcome in terms of numbers of staff and the required investment. The role of ICSs in workforce planning should also be described in the forthcoming bill.

NHS Employers will be taking forward this issue within the NHS Confederation and similarly our other stakeholder networks will be influencing on issues relating to their members over the coming months.

Contact

Should you have any questions or would like further information on any of the information set out in this report, please contact William Pett, senior policy adviser, at william.pett@nhsconfed.org

Acknowledgements

We are grateful to a wide range of representatives from organisations across health and care, who met with us to discuss the content of the white paper and who helped us to refine the ideas set out in this report. These include:

- Arthritis and Musculoskeletal Alliance
- The British Medical Association
- General Medical Council
- Healthwatch England
- The King's Fund
- The Local Government Association
- National Voices
- Neurological Alliance
- NHS England and NHS Improvement
- NHS Providers
- The Nuffield Trust
- The Royal College of General Practitioners
- The Royal College of Nursing
- The Royal College of Physicians
- The Royal College of Surgeons
- The Shelford Group



NHS CONFEDERATION



18 Smith Square, Westminster, London SW1P 3HZ

Tel **020 7799 6666**

Email enquiries@nhsconfed.org

www.nhsconfed.org

Follow the NHS Confederation on  [@nhsconfed](https://twitter.com/nhsconfed)

If you require this publication in an alternative format, please email enquiries@nhsconfed.org

© NHS Confederation 2021. You may copy or distribute this work, but you must give the author credit, you may not use it for commercial purposes, and you may not alter, transform or build upon this work. Registered Charity no. 1090329