

Integration and innovation: working together to improve health and social care for all

Legislative proposals for a Health and Care Bill

Key points

- On 11 February 2021, the government published a white paper setting out a raft of proposed reforms to health and care. Many of the measures introduced under David Cameron's government through the Health and Social Care Act 2012 are set to be abolished, with a broad move away from competition and internal markets and towards integration and collaboration between services.
- Integrated care systems (ICSs) are to be established on a statutory footing through both an 'NHS ICS board' (though this will also include representatives from local authorities) and an ICS health and care partnership. The ICS NHS body will be responsible for the day-to-day running of the ICS, NHS planning and allocation decisions. The partnership will bring together the NHS, local government and wider partners such as those in the voluntary sector to address the health, social care and public health needs of their system.
- A duty to collaborate will be created to promote collaboration across the healthcare, public health and social care system. This will apply to all partners within systems, including local authorities.
- There will be new powers for the Secretary of State for Health and Social Care over the NHS and other arm's-length bodies (ALBs). Under the proposals, the Secretary of State will be able to intervene in service reconfiguration changes at any point without need for a referral from a local authority. The Department of Health and Social Care will also be able to reconfigure and transfer the functions of arm's-length bodies (including closing them down) without primary legislation.
- Certain new duties on the Secretary of State will also be introduced. This will include a statutory duty to publish a report in each parliament on workforce planning responsibilities across primary, secondary and community care, as well as sections of the workforce shared between health and social care (such as district nurses).

- There will be significant changes to procurement. It is proposed that section 75 of the Health and Social Care Act 2012 (including the Procurement, Patient Choice and Competition Regulations 2013) will be repealed and replaced with a new procurement regime. However, it is important that we avoid ending up with local monopolies and continue to work effectively with the independent and voluntary sector.
- The white paper fails to address other key areas where reform is long overdue. The government says that reforms to social care and public health will be dealt with “later in 2021” outside the Health and Care Bill addressed in the white paper, with some minor exceptions.
- We believe that the existing legislative framework created under the Health and Social Care Act 2012 has largely failed and that changes are needed. Following several months of engagement with our members, we found there is clear consensus across our membership that the future of health and care must be based on collaboration and partnership working. These reforms will provide the necessary updates to legislation to help make this happen, though legislative change alone will not be enough.
- However, we have concerns about certain issues – notably the new powers for the Secretary of State over the running of the NHS. Given the NHS costs more than £100 billion a year to run, it is only right to have appropriate accountability to government and parliament. But the NHS is already one of the most centralised health systems in the world and we are urging ministers to resist the temptation to centralise it further. We are clear that the response to the pandemic would not have been improved had there been greater ministerial oversight of the NHS.
- It will also be critical to ensure the new statutory powers for integrated care systems do not overlap and duplicate with the statutory powers of NHS trusts and foundation trusts, and that there is clarity on how the NHS ICS board will operate alongside the wider health and care partnership board that will involve local government.
- We are the only membership organisation for the whole healthcare system. As well as representing the views of leaders across the system, we will also be producing bespoke analysis for specific parts of our membership, and making public representations on their behalf, over the coming weeks.

NHS Confederation viewpoint

These are the most important set of reforms the NHS has had in a decade – we broadly believe they are to be welcomed. The reforms brought in under the Health and Social Care Act 2012 have largely failed and changes are much needed. There is clear consensus across our membership that the future of health and care must be based on collaboration and partnership working at a local level – these reforms will provide the necessary updates to legislation to make this happen.

The reforms will boost efforts to integrate patient care.

There are, of course, risks whenever new NHS legislation is introduced and legislative reforms over recent decades have a chequered history. It is also true that legislation alone will not bring about the changes in behaviours and ways of working that are required. For this reason, the NHS traditionally fears disruptive reorganisations.

However, this time round there is good reason to support the reforms given they will boost efforts to integrate patient care. The use of competition and outsourcing as the main tools to improve quality of care and value for money for taxpayers has been bureaucratic and cumbersome. This is to be replaced, which is what leaders across the NHS want to see. However, that does not mean we should end up with local monopolies. We must continue to work effectively, as we do now, with independent and voluntary sector providers.

It is particularly reassuring that many of the measures we have been publicly calling for over recent months have been included in the white paper. This follows several months of engagement with our members. These measures include:

- a duty on system partners (including local authorities) to collaborate
- the principle of subsidiarity
- allowances for joint committees at place level
- and strengthened clinical leadership.

While we are largely optimistic about the content of the white paper, one area of concern is new powers of intervention over the NHS for the Secretary of State for Health and Social Care. The NHS is a public service that costs more than £100 billion to run and it is right that it has appropriate accountability to government and parliament. However, one of the few successes of the 2012 reforms has been establishing a statutorily independent board – NHS England – to distance politicians from the day-to-day running of the NHS. This has not stopped ministers from being active in setting policy over the last decade. Yet it has

provided greater autonomy to the NHS and allowed the service to quietly get on with making a series of changes that have improved care for patients. The government will need to be cautious here given the NHS is already a highly centralised system.

The proposals set out in the white paper will, of course, affect different stakeholders across the NHS in different ways. We also have further critical comments and questions about some of the specific details of the proposed reforms, which we do not intend to go into in this briefing. As such, over the coming weeks our membership networks will be producing more bespoke analysis for members and making public representations on their behalf.

More detailed summary

For several years, NHS England and NHS Improvement (NHSEI) has been trying to move towards models of integration between services to achieve the triple aim of improving care for patients, improving population health and making most efficient use of NHS resources. In recent years, this has included a focus on sustainability and transformation partnerships (STPs) – to become integrated care systems (ICSs) by April 2021 – and primary care networks (PCNs) as the means through which to deliver the ambitions of the NHS Long Term Plan.

However, such moves towards integration have happened in spite of the Health and Social Care Act 2012, which embedded competitive tendering and the purchaser/provider split across the NHS. As such, NHSEI has long pressed for limited reforms to the existing legislative framework to better enable integration.

At the invitation of the government in 2019, NHSEI worked with us and other key stakeholders to produce a set of proposals for legislation. These included scrapping section 75 of the 2012 Act (to end automatic tendering for certain service contracts) and introducing a ‘triple aim’ duty for NHS organisations.

Under a new Conservative government, NHSEI’s proposals resurfaced in November 2020, with widespread speculation of forthcoming government legislation. A more developed set of recommended reforms to inform legislation were outlined by NHSEI as part of a public ‘engagement exercise’. Our response can be read [on our website](#). NHSEI has also published a summary of responses received and further resulting recommendations for government, which you can [access from NHSEI’s website](#).

The Department of Health and Social Care (DHSC) has based many of the reforms outlined in its white paper on NHSEI’s recommendations. As noted above, we broadly welcome the fact that many of our own recommendations put forward in the consultation response and in our recent [Future of Integrated Care in England](#) report have been accepted by government.

However, the white paper also includes other measures beyond those intended to improve integration. Among the more controversial elements are new measures giving the Secretary of State more control over the direction of NHSEI and new powers to intervene in service reconfigurations. There are also additional proposals relating to other areas, such as public health, obesity and the fluoridation of water.

Over the course of this briefing, we summarise the key points of the white paper and the next steps for legislation.

The white paper at a glance

The white paper is divided into three chapters. Below, we summarise the key points from each.

Chapter 1: The role of legislation

- Recovering from the pandemic will require the right legislative framework; the pandemic has highlighted the critical need for joined-up care and partnership working.
- However, while legislation can help to create the right conditions, it will be the hard work of the workforce and partners in local places and systems across the country that will make the biggest difference.
- The ambition to reduce inequalities and support people to live longer, healthier and more independent lives will demand bold joint and cohesive efforts, working closely with local government and other relevant colleagues.
- Though no single piece of legislation can fix all the challenges facing health and social care, the proposals set out in the white paper will play an important role in meeting longer-term health and social care challenges.

Chapter 2: Proposals for legislation

Establishing integrated care systems

- Legislation will be brought forward to ensure every part of England is covered by an ICS.
- Integrated care systems (ICSs) are to be established on a statutory footing through both an `NHS ICS board' (though this will also include representatives from local authorities) and an ICS health and care partnership. The ICS NHS body will be responsible for the day-to-day running of the ICS, NHS planning and allocation decisions. The partnership will bring together the NHS, local government and wider partners such as those in the voluntary sector to address the health, social care and public health needs of their system.
- The proposals set out minimum consistent requirements, which the partners that make up each system are free to supplement with further arrangements.
- Health and wellbeing boards (HWBs) will remain in place and will continue to have an important responsibility at place level to bring local partners together, as well as developing the Joint Strategic

Needs Assessment and Joint Health and Wellbeing Strategy, which both HWBs and ICSs will have to regard.

- ICSs will be accountable for the health outcomes of the population. Enhancing the role of the Care Quality Commission (CQC) in reviewing system working is being explored.
- All proposed ICS bodies will be given the flexibility to develop decision-making processes and structures that work most effectively for them.
- Place-based arrangements between local authorities, the NHS and between providers of health and care services will be left to local organisations to arrange.
- There will also be a focus on removing the legislation that hinders collaboration and joint decision-making.

ICS NHS bodies

- The proposals include the ICS NHS body being responsible for strategic planning, taking on the commissioning functions of the clinical commissioning groups (CCGs) and some of those of NHS England within its boundaries.
- Each ICS NHS body will be directly accountable for NHS spend and performance within the system, with its chief executive becoming the accounting officer for NHS money allocated to the NHS ICS body.
- The ICS NHS board will, as a minimum, include a chair, the chief executive and representatives from NHS trusts, general practice and local authorities, with others determined locally. ICSs will also need to ensure they have appropriate clinical advice when making decisions.
- The ICS NHS body will be responsible for developing a plan to meet the health needs of the population within their defined geography; developing a capital plan for the NHS providers within their health geography; and securing the provision of health services to meet the needs of the system population.
- NHS England will have an explicit power to set a financial allocation or other financial objectives at system level, with a duty placed on the ICS NHS body to meet the system financial objectives which require financial balance to be delivered.
- The ICS NHS body will not have the power to direct providers, and providers' relationships with the Care Quality Commission will remain unchanged, but there will be a new duty to compel providers to have regard to the system financial objectives.

ICS health and care partnerships

- It is only specified that an ICS should set up a health and care partnership. The details regarding their functions and membership are to be left to the discretion of the local areas.
- However, they will be responsible for developing a plan that addresses the wider health, public health and social care needs of the system, with the NHS ICS board and local authorities having to regard that plan when making decisions. The council's role will be to promote collaboration and will not be able to impose arrangements that are binding on either party.
- Guidance to support the establishment of these partnerships will be developed with NHSEI and the Local Government Association.

Duty to collaborate

- A duty to collaborate will be created to promote collaboration across the healthcare, public health and social care system. The duty will apply to NHS organisations (both ICSs and providers) and local authorities.
- This will allow the Secretary of State for Health and Social Care to issue to guidance as to what delivery of this duty means in practice.
- This duty will replace two existing duties to cooperate in legislation to support our wider ICS policy, where local authorities and NHS bodies work together under one system umbrella.

Triple aim

- Following NHS England and NHS Improvement's recommendation, a shared duty to have regard for the 'triple aim' of better health and wellbeing for everyone, better care for all people and sustainable use of NHS resources is proposed.
- This duty will apply to NHS organisations that plan services in a local area (ICSs) and nationally (NHS England), as well as NHS providers of care (NHS trusts and foundation trusts).
- It is hoped the duty will align organisations around agreed objectives to promote collaborative working, better regard for the wider determinants of health, and strategic working at place level.

Power of foundation trusts' capital spend limit

- Following NHS England and NHS Improvement's recommendation, a reserve power will be sought in the Bill to limit foundation trust's capital expenditure where they are not

working effectively to prioritise capital expenditure within their ICS, and risk breaching either system or national capital delegated expenditure limit (CDEL) limits.

- These powers will be used to ensure the most sustainable use of NHS resources and, as a last resort, to halt foundation trusts' individual schemes so as not to exceed DHSC's CDEL, which foundation trusts' capital expenditure counts towards. The order itself is not a statutory instrument nor will it be subject to any parliamentary control.

Joint committees

- Following NHS England and NHS Improvement's recommendation, provisions will be created to allow for the formation and governance of joint committees between ICSs and NHS providers, as well as the decisions that could be appropriately delegated to them.
- NHS providers will also be permitted to form their own joint committees.
- Both types of joint committees may include representatives from other bodies such as primary care networks, GP practices, local authorities or the voluntary sector.

Collaborative commissioning

- Following NHS England and NHS Improvement's recommendation, legislation will be changed to remove the barriers to collaboration between CCGs and NHSEI, across CCGs, and between CCGs and local authorities (LA) to enable alignment of decisions and pooling of budgets. Governance for this type of decision-making will be streamlined and strengthened.
- These proposals will:
 - Give NHS England the ability to joint commission its direct commissioning functions with more than one ICS board, allowing services to be arranged for their combined populations.
 - Allow ICSs to enter into collaborative arrangements for the exercise of functions that are delegated to them, enabling a "double delegation".
 - Allow groups of ICSs to use joint and lead commissioner arrangements to make decisions and pool funds across all their functions (and not just commissioning functions).

- Enable a greater range of delegation options for section 7A public health services, including the ability for onward delegation of the function into collaborative arrangements, such as a section 75 partnership arrangement.
- Enable NHS England to delegate or transfer the commissioning of certain specialised services to ICSs singly or jointly, or for NHS England to jointly commission these services with ICSs if these functions are considered suitable for delegation or joint commissioning, subject to certain safeguards. Specialised commissioning policy and service specifications will continue to be led at a national level, ensuring patients have equal access to services across the country.

Joint appointments

- Following NHS England and NHS Improvement's recommendation, a power for NHSEI to issue guidance on joint appointments between NHS bodies, NHS bodies and local authorities, and NHS bodies and combined authorities is being proposed to aid the development of integrated care and to set out clear criteria for organisations to consider when making joint appointments.

Data sharing

- The forthcoming data strategy for health and care will set out a range of proposals to address cultural, behavioural and legislative barriers to data sharing and a more flexible legislative framework to improve data access and interoperability. This will include enabling the safe sharing of data in support of individual care, population health and the effective functioning of the system.
- This includes proposals for the following:
 - Require health and adult social care organisations to share anonymised information that they hold between themselves where such sharing would benefit the health and social care system.
 - Introduce powers for the Secretary of State for Health and Social Care to require data from all registered adult social care providers about all services they provide, whether funded by local authorities or privately by individuals (discussed further in the adult social care proposals); and require data from private providers of health care.

- Make changes to NHS Digital’s legal framework to introduce a duty for the organisation to have regard to the benefit to the health and social care system of sharing data that it holds when exercising its functions; and clarify the purposes for which it can use data.
- Introduce a power for the Secretary of State for Health and Social Care to mandate standards for how data is collected and stored, so that data flows through the system in a usable way, and that when it is accessed/provided (for whatever purpose), it is in a standard form, both readable by and consistently meaningful to the user/recipient.

Choice

- Existing patient choice rights and protections will be retained, while the process for any qualified provider (AQP) arrangements will be bolstered.
- It is proposed that section 75 of the Health and Social Care Act 2012, including the Procurement, Patient Choice and Competition Regulations 2013, will be repealed with the powers in primary legislation under which they are made being replaced with a new provider selection regime. This will require bodies that arrange NHS services as the decision-making bodies to protect, promote and facilitate patients’ choice with respect to services or treatment.

Reducing bureaucracy proposals

Competition

- There are proposals to legislate to clarify the central role of collaboration in driving performance and quality in the system.
- The proposals to achieve this include:
 - Removing the Competition and Markets Authority’s (CMA) function to review mergers involving NHS foundation trusts. The CMA’s jurisdiction in relation to transactions involving non-NHS bodies (such as between an NHS trust/foundation trust and private enterprise) and other health matters (such as drug pricing) would be unchanged.
 - Removing NHS Improvement’s specific competition functions and its general duty to prevent anti-competitive behaviour, to support NHS England’s role as an improvement agency, rather than a regulator.

- Removing the need for NHS England to refer contested licence conditions or national tariff provisions to the CMA.
- It is proposed that NHS England’s main role will be to support improvements in health outcomes, the quality of care and the use of NHS resources.

Arranging healthcare services

- As above, the proposals within the Bill will remove the current procurement rules that apply for NHS and public health service commissioners when arranging healthcare services.
- The intention of the proposals is to develop a new provider selection regime that will provide a framework for NHS bodies and local authorities to follow when deciding who should provide healthcare services.
- The proposals will include duties for commissioners of NHS and public healthcare services to act in the best interests of patients, taxpayers and the local population when making decisions about arranging healthcare services.
- The proposals aim to ensure that where there is no value in running a competitive procurement process, services can be arranged with the most appropriate provider.
- The NHS will continue to be free at the point of care and the proposals seek to ensure that where a service can only be provided by an NHS provider, such as A&E provision, that this process is as streamlined as possible.
- These proposals will be informed by NHS England’s public consultation on procurement that aims to enable collaboration and collective decision-making.
- The proposals will only apply to the procurement of healthcare services – including public health services whether commissioned solely by a local authority or jointly by the local authority and NHS as part of a section 75 agreement. The procurement of non-clinical services, such as professional services or clinical consumables, will remain subject to Cabinet Office public procurement rules.

National tariff

- In line with NHS England and NHS Improvement’s proposals, legislation will be amended to enable the national tariff to support the right financial framework for integration while maintaining the financial rigour and benchmarking that tariff offers.

- These proposals include:
 - Where NHS England and NHS Improvement specifies a service in the national tariff, then the national price set for that service may be either a fixed amount or a price described as a formula.
 - NHS England and NHS Improvement could amend one or more provisions of the national tariff during the period which it has effect, with appropriate safeguards.
 - Remove the requirement for providers to apply to NHS Improvement for local modifications to tariff prices.
 - NHS England and NHS Improvement should be able to include provisions in the national tariff on pricing of NHS public health services under section 7A agreements.

New trusts

- Measures will be brought forward to enable ICSs to apply to the Secretary of State to create a new trust where there is the overriding objective of ensuring the health system is structured to deliver the best outcomes for the whole population health and to respond to emerging priorities.
- Should a new trust be established, it will be subject to appropriate engagement and consultation, which the process for will be set out in the guidance.

Removing local education and training boards (LETBs)

- It is proposed that the Care Act 2014, which sets out the functions and constitution of Health Education England (HEE) and LETBs, is amended to remove LETBs from statute with their functions to be undertaken by HEE, which will allow HEE to adapt its regional operating model over time.
- This is accompanied by a proposal for the Secretary of State for Health and Social Care to take a statutory duty to publish a document outlining the workforce planning and supply system at national, regional and local level to provide clarity over responsibilities.

Ensuring accountability and public confidence proposals

- NHS England and NHS Improvement will be legally merged (to be known as just NHS England), which will have a single governance structure and be accountable for all aspects of NHS performance, finance and care transformation.

- A new power will be created for the Secretary of State to direct NHS England (the merged body), including to intervene in service reconfiguration changes at any point without need for a referral from a local authority. However, this will not include power to direct local NHS organisations directly nor to intervene in individual clinical decisions. The Independent Reconfiguration Panel will be replaced.
- Greater flexibility will be introduced for DHSC on the timing for setting the NHS mandate (including the objectives) for NHS England, replacing annual mandate renewal with a new requirement to ensure a mandate is always in place. NHS England's capital and revenue resource limits will no longer be set in the mandate specifically but as part of the annual financial directions; the limit will in future have to be laid before parliament.
- New powers will be introduced for DHSC to reconfigure and transfer the functions of arm's-length bodies (including closing them down) without primary legislation. This power will be subject to safeguards, including formal consultation, consideration to the recommendations of parliamentary committees, and approval by both Houses of Parliament.
- The three-year time limit will be removed for special health authorities (NHS Business Services Authority, NHS Trust Development Authority, NHS Blood and Transplant, NHS Resolution and the NHS Counter Fraud Authority) from legislation, which currently requires DHSC to repeatedly renew them or allow them to expire.
- A statutory duty on the Secretary of State will be introduced to publish a report in each parliament on workforce planning responsibilities across primary, secondary, community care and sections of the workforce shared between health and social care (such as district nurses). This will be co-produced with HEE and other bodies.

Additional proposals

Social care

- The government says that reforms to social care and public health will be dealt with later in 2021 outside the Health and Care Bill addressed in the white paper, with some minor exceptions. These reforms have been long promised and are long overdue.
- There will be oversight of the provision and commissioning of social care, including embedding local authorities in ICSs, through health and care partnerships and a formal duty for ICS NHS boards to have regard to health and wellbeing board plans.

- There will be a new duty for the CQC to assess local authorities' delivery of adult social care and empowering the Secretary of State to intervene where there is a risk of local authorities failing to meet social care duties.
- A new social care payment power for DHSC will be introduced, overturning statutory limitations preventing the Secretary of State from making payments to all social care providers.
- There will be greater flexibility when discharging patients from a hospital to a care setting for assessment, putting in place a legal framework for 'discharge to assess', allowing NHS continuing healthcare and Care Act assessments to take place after discharge from acute care.
- A standalone power for the Better Care Fund will be created, separating it from the NHS mandate setting process.

Public health

- There will be a new Secretary of State power to direct NHS England to take on specific public health functions (complementing the enhanced general power to direct NHS England on its functions).
- Further restrictions on the advertising of high fat, salt and sugar foods will be introduced, as well as a new power for ministers to alter certain food labelling requirements to help tackle obesity.
- The responsibilities for the fluoridation of water in England, including consultation responsibilities, will be moved from local authorities to central government.
- New powers will be introduced for DHSC to implement comprehensive reciprocal healthcare agreements with countries outside the European Economic Area and Switzerland ('Rest of world countries'). These will include the introduction of a reimbursement mechanism to cover healthcare costs, exchange of data between countries to support reimbursement, and ensuring responsibility for paying healthcare charges will lie with governments.

Safety and quality

- The Healthcare Safety Investigation Branch (HSIB) will be put on a statutory footing as an executive non-departmental public body. Investigation reports will make recommendations and require organisations to publicly respond to these measures, within a specified timescale.

- DHSC will be given greater powers to amend the governance of healthcare professionals' regulation, aiming to ensure that the level of regulatory oversight is proportionate to the risks to the public. DHSC will have the power to reduce the number of regulatory bodies and extend professional regulation to NHS managers and leader if it chooses.
- A statutory medical examiner system will be introduced within the NHS to scrutinise all deaths which do not involve a coroner.
- The Medicines and Healthcare products Regulatory Agency will be permitted to develop and maintain publicly funded and operated medicine registries to enable evidence-based decision-making.

Chapter 3: Delivering for patients, citizens and local populations – supporting implementation and innovation

- The legislation is intended to build on and aims to accelerate positive developments observed within the system; in terms of adaptability, collaborative instincts and problem solving.
- Other non-legislative conditions will be needed to continue this positive trajectory, including having the right workforce in place; good leadership at all levels setting out clear guidance; and getting the incentives and financial flows right.
- To be successfully implemented, a range of key non-legislative enablers must be involved in implementation of this Bill and to facilitate wider change within the system.
- As mentioned above, proposals later this year will outline social care reform, under the twin objectives of enabling an affordable, high-quality and sustainable adult social care system that meets people's needs, while supporting health and care to join-up services around people. In the meantime, proposals contained within this Bill will embed system improvements that have been made in response to COVID-19.
- Also driven by the experiences of COVID-19 and future needs, the government will publish in due course an update on proposals for the future design of the public health system which will create strong foundations for the whole system to function at its best.
- In January 2021, the Department of Health and Social Care and the Ministry of Justice published [Reforming the Mental Health Act](#), a white paper which responds to the Independent Review of the Act conducted in 2018. This forms the government's plan to modernise mental health legislation, including giving people greater control over their treatment and ensuring they are treated with dignity and respect.

- On current timeframes, and subject to parliamentary business, the government plan to begin implementation of these proposals for health and care reform in 2022.
- The government will continue to engage with stakeholders across the health and care systems, its arm's-length bodies and the devolved administrations on the detail of these proposals as they progress.

Next steps

We have been informed that the Bill is set to be brought forward in the next, rather than current, parliamentary session. This means the timing is unclear at this stage, but is likely to be in early summer.

Before then, NHSEI is consulting on a proposed new provider selection regime to replace existing procurement requirements under section 75 of the Health and Social Care Act 2012 and the Procurement, Patient Choice and Competition Regulations 2013. We await the detail of this but are planning to respond on behalf of members.

As mentioned above, between now and the tabling of the legislation we will be producing bespoke analysis for members through our constituent member networks. We will also be seeking to influence the content of the legislation to ensure that it best meets the expectations of our members.

Looking further ahead, and as the white paper sets out, there are other pieces of related legislation in the pipeline. These include specific proposals on social care and public health.

Contact us

Should you have any questions on the above, or to offer your view on the white paper, please contact William Pett at William.Pett@nhsconfed.org

About the NHS Confederation

The NHS Confederation is the membership body 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.

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