Department of Health

Fair and transparent pricing for NHS services

Government response to consultation on proposals for revising the objection mechanism to the pricing method

October 2015

Title: Fair and transparent pricing for NHS services: Government response to consultation on proposals for revising the objection mechanism to the pricing method
Author: Finance & NHS/ NHS Group/NHS P&R/ 17183
Document Purpose: Policy
Publication date: October 2015
Target audience: Clinical Commissioning Groups, Foundation Trusts CEs, NHS Trusts CE and Board Chairs, Allied Health Professionals, GPs, Independent Providers, GPs, Voluntary Organisations/NDPBs
Contact details: pricing.consultation@dh.gsi.gov.uk

Published to gov.uk, in PDF format only.

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Fair and transparent pricing for NHS services

Government response to consultation on proposals for revising the objection mechanism to the pricing method

NHS Personalisation and Regulation

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Summary

The consultation[1] "Fair and Transparent Pricing for NHS Services – A consultation on proposals for revising the objection mechanism to the pricing method" ran from 13 August 2015 to 11 September 2015. It sets out proposals on the objection thresholds which apply when the proposed national tariff is published for consultation by Monitor as part of the statutory process.

The objection mechanism for the national tariff was established by the Health and Social Care Act 2012 and certain provisions are set out in the NHS (Licensing and Pricing) Regulations 2013. These set three objection thresholds equally at 51%, for:

- clinical commissioning groups,
- relevant providers; and
- 'share of supply' where the percentage of providers is weighted by the share of services in England that they provide.

The consultation noted how the proposed 2015-16 national tariff had not been implemented after objections had exceeded the 'share of supply' threshold, and the consequences of this. The consultation proposed the objection mechanism for the NHS national tariff should be revised to provide greater certainty on prices in advance of a new financial year. We sought views on whether the objection mechanism should be revised, removing the 'share of supply' objection threshold, and increasing equally the objection thresholds for commissioners and providers to either 66% or 75%.

The consultation was published on GOV.uk and conducted online at consultations.dh.gov.uk where further information about consultation responses is now available.

Having considered the views expressed during consultation, the Department intends to lay draft amending regulations by November 2015.

[1] www.gov.uk/government/uploads/system/uploads/attachment_data/file/453374/pricing_objection_acc.pdf

1. Background on pricing

Rationale for pricing

1.1. The Health and Social Care Act 2012 (the 2012 Act) introduced a new independent, transparent and fair pricing system that requires Monitor and NHS England to collaborate to set prices and further develop new payment models across different services. The intention was to create a more stable, predictable environment, allowing providers and commissioners to invest in technology and innovative service models to improve patient care. Transferring pricing from the Department, and making it an independent function was intended to provide that stability. However, this has been difficult to achieve given the challenging economic circumstances and the funding pressures faced by all public services, including the NHS despite funds being protected.

Pricing and the Health and Social Care Act 2012

1.2. Sections 115-127 of Chapter 4, Part 3 of the 2012 Act give Monitor and NHS England responsibility for designing and implementing the reimbursement framework for NHS-funded healthcare services. This came into effect from 1 April 2014 as the National Tariff Document and specifies:

- a set of healthcare services provided for the purposes of the NHS, which are to have national prices (referred to as currencies);
- the method used for determining the national prices for those specific services;
- the national price for each of those specified services (whether as an individual service, or as a bundle of services or as a group of services);
- specifies the methods used for approving an agreement between a provider and commissioner to modify a nationally determined price and for determining a provider's application to Monitor to modify a nationally determined price (local modifications); and,
- a provision for rules under which providers and commissioners may agree to vary the currency or the national price of services (local variations).

1.3. NHS England has a duty to specify healthcare services which it thinks a national price should be used. Monitor has a duty to set that price and is required to consult and publish the national tariff.

1.4. To develop a national tariff, Monitor and NHS England engage with commissioners and providers of NHS services and other interested parties on their initial tariff proposals. This engagement previously included the publication of a number of detailed documents setting out different aspects of the proposed tariff, which together formed the Tariff Engagement Document (TED). The TED tests the underlying modelling and likely impact of the tariff proposals. Engagement will take a different form this year with more emphasis on working directly with stakeholders, rather than publication of standalone suite of documents.

Background on pricing

1.5. Following this engagement, Monitor is required by section 118 of the Act to undertake a 28-day statutory consultation on the national tariff. Monitor must send a notice to all clinical commissioning groups, relevant providers of NHS services and other such persons as it considers appropriate, informing them of the draft national tariff.

1.6. Sections 118 to 120 of the Act specify an objection procedure which allows commissioners and providers to formally object to the chosen methodology proposed for calculating national prices (rather than the price itself). In relation to the objection procedure, the Secretary of State must prescribe two thresholds for the percentage by overall proportion, of objecting commissioners and providers. The Secretary of State may also prescribe a third threshold for the overall share of supply, which reflects the percentage, by proportion of providers weighted according to share of supply in England of such services as may be prescribed. These thresholds are referred to in this consultation document response as objection thresholds and all three were prescribed at 51% in the NHS (Licensing and Pricing) Regulations 2013.

1.7. Following statutory consultation, Monitor is required to calculate:

- The percentage of commissioners objecting;
- The percentage of relevant providers objecting; and
- The percentage of 'share of supply' held by objecting providers, which allows the objections of providers to be weighted in proportion to the nationally priced services they deliver.

1.8. If the threshold in any one of the three categories is met, Monitor cannot adopt and publish the National Tariff Document consulted on and must choose either to:

- Reconsider the proposed methodology itself and then publish a revised final draft of the national tariff for further consideration; or
- Refer the methodology and the objections received to the Competition and Markets Authority

1.9. The national tariff is developed on an annual basis by Monitor and NHS England. Not all NHS services are included in the national tariff as some services will have locally agreed prices.

2015/16 National Tariff

1.10. Monitor formally consulted on proposals for 2015/16 national tariff. Their analysis showed the following objections to the proposed method:

- 73.7% of relevant providers by share of supply;
- 36.6% of relevant providers by number; and,
- 8.1% of commissioners by number.

1.11. The share of supply threshold was triggered largely due to objections on the efficiency factor of 3.8%. Monitor and NHS England also believe that another significant trigger for

formal objections related to a variation to the payment of national prices for specialised services, rather than the underlying method for the price (to which formal objections are made).

1.12. As the share of supply exceeded 51%, the national tariff was not published and the 2014/15 tariff remained in force. NHS England have calculated cost pressures to commissioners and providers continuing to pay at 2014/15 tariff levels rather than those that would have been introduced through the 2015/16 tariff proposals at an estimated £1 billion. NHS England have indicated that if a similar system were to continue in 2016/17, there would be a negative impact on planned investment in areas such as mental health and community services which would have serious implications for the health service as a whole.

1.13. In February, Monitor and NHS England offered providers the option of agreeing local variations to the 2014/15 (the Enhanced Tariff Offer or ETO) or remain on 2014/15 tariff prices (Default Tariff Rollover or DTR).

1.14. The ETO offered providers a reduction in efficiency savings from the originally proposed 3.8% to 3.5%, an increase in the proposed marginal rate for specialised services from 50% to 70% and an increase in the marginal rate for emergency admissions from 30% to 70%. Providers opting for the ETO will have the opportunity to earn “CQUIN” Commissioning for Quality and Innovation Programme) payments, which are worth up to 2.5% of contract income. As providers on the DTR would not be contributing proportionately to the share NHS-wide 2015/16 efficiency goals through the efficiency factor, providers would not be eligible for discretionary payments, which would also include CQUIN. 88% of providers accepted the ETO.

Going forward

1.15. Commissioners and providers need timely and accurate price information to allow them to plan, consult and make decisions that meet their identified need in advance of the new financial year. This will lead to improved value for the sector and better quality services for patients. The Department, Monitor and NHS England all agree that the objection mechanism process needs to be reviewed to provide for a process that is fair and stable for the sector as a whole as well as ensure such plans are affordable. Financial stability is needed to allow commissioners and providers to make investment decisions to reflect affordability for patient care as well as enable them to achieve financial balance whilst addressing any forecast deficits as soon as possible.

1.16. A new national tariff will also have an impact on existing contracts where these continue into a financial year in which new national prices apply. It is essential for commissioners and providers to have sufficient time to consider the implications of updating prices and where appropriate to negotiate different provisions before the start of the new financial year. It is crucial that the tariff development process operates more efficiently and effectively than has been the case for 2015/16, while being mindful of the views of stakeholders. This is why we have taken the decision to rebalance the objection methodology.

1.17. We consulted on a number of proposed changes to the objection mechanism and thresholds. The Department considers these options represent a range of proportionate responses that will retain the ability of commissioners and providers to object to the chosen methodology, but also balance it in favour of the whole sector. It is imperative that Monitor and NHS England continue to consult and engage with all stakeholders to improve the tariff setting process and bring all stakeholders along with the tough decisions that need to be taken.

2. Key messages from the consultation

The objection mechanism

2.1. The consultation “Fair and Transparent Pricing for NHS Services – A consultation on proposals for revising the objection mechanism to the pricing methodology" ran from 13 August 2015 to 11 September 2015. It sets out proposals on the objection thresholds which apply when the proposed national tariff is published for consultation by Monitor as part of the statutory process.

2.2. We received 221 responses. The largest responses came from providers (123) and commissioners (67). There were also responses from Monitor, NHS England and 16 organisations and 13 individuals/unidentified. A list of respondents can be found in Annex A.

Q1 Do you agree that the objection mechanism for the NHS national tariff should be revised to provide greater certainty on prices in advance of a new financial year?

2.3. The objection mechanism was intended to be a process triggered in exceptional circumstances. It was believed that greater transparency and more formal and informal engagement in the tariff development process would reduce the likelihood of objections and thresholds being triggered. The share of supply threshold in particular has allowed larger providers on specific issues, such as the marginal rate for specialised commissioning and the efficiency factor to use the objection threshold as a veto to protest if and when they disagree with a particular aspect of the method, or changes to the pricing system outside the pricing method as was the case for specialised services. When the thresholds were originally prescribed in 2013, the Department set out in the explanatory memorandum to the regulations that the objection mechanism and thresholds would be kept under review given that there was no precedent from other industries for what an appropriate threshold should be.

Your feedback

2.4. 46% of respondents, which mostly consisted of responses from commissioners and mental health providers agreed with this proposal. However, 52% of respondents disagreed. Respondents thought that our focus on only making improvements to the objection mechanism was seen as too narrow in scope. Instead, there were calls for a wider review of the whole tariff process from development, through engagement to agreement. Many respondents offered alternative proposals which ranged from:

- implementing multi-year tariffs;
- segment the objection process, e.g. clarity what can be objected to more clearly;
- review the definition of ‘relevant provider’ to include mental health, community services and ambulance trust providers; and
- expand the scope of what can be objected to.

2.5. Despite calls for change, respondents felt that the objection mechanism process continues to be a vital tool for providers and commissioners to formally raise concerns, especially where it could have an adverse impact on their ability to provide high quality patient care. It was also felt that the objection process worked as it was intended. 2015/16 represented an exceptional situation where providers, in particular, did not feel sufficiently engaged on tariff proposals especially where the proposal on the marginal rate rule for specialised services was only fully fleshed out at statutory consultation stage. Many wanted improved engagement throughout the tariff process, which would allow the sector additional time to examine proposals and work collaboratively with Monitor and NHS England to further refine proposals before being issued for statutory consultation.

Our response

2.6. We are aware of the key role that the objection mechanism plays in the tariff development process, hence why we chose to focus on this now and not to undertake a wider review. We welcome the suggestions that stakeholders have provided and will continue to keep under review the need for any further changes to the objection mechanism and the tariff development process as a whole to ensure that the system operates optimally. Despite the majority not agreeing with the question, we have decided to revise the objection process.

The objection thresholds

Q2 Do you agree that the objection threshold based on providers' share of supply should be removed? If not, why should this threshold remain?

2.7. The share of supply percentage in section 120(2)(c) of the Act allows Secretary of State the option to prescribe an additional objection threshold which takes account of a relevant provider's scale and share of supply, where this is considered to be necessary. The Act included this option in case it was thought helpful to allow providers of the largest amount of NHS services subject to national pricing greater influence in challenging the proposed method.

2.8. We considered whether it would be appropriate to raise the share of supply thresholds or revise the method for determining the share of supply. We saw no benefits in having a more complex method, but rather for objections to be looked at on a numerical basis alone. Increasing the threshold of share of supply from the current 51% was also discounted because sourcing accurate and reliable data to use in the calculation of a provider's share of supply has proved to be difficult. The current calculation for share of supply also gives weight to a small number of largely urban providers supplying a large share of the healthcare market to the disadvantage of smaller, more rural and local providers. We have decided that revising the share of supply threshold or the method would not sufficiently rebalance the system.

Your feedback

Why it should be removed?

2.9. 34% of respondents agreed with this proposal stating that the share of supply threshold gave too much leverage to large providers of NHS services subject to national pricing, who account for over 70% of the work, yet only represent 30% of relevant providers. Both Monitor and NHS England supported the removal of share of supply objection threshold.

Why it should remain?

2.10. 65% respondents disagreed with removing the share of supply objection threshold, which included 90% of providers. Many respondents argued for this threshold to remain, stating that it represents the volume of patients treated. Removing this threshold would give a provider of limited services the same influence as a large secondary care provider.

2.11. Although the objections caused significant disruption to financial planning, the decision to object was not taken lightly as it reflected the serious financial position that many NHS providers faced that they considered the original 2015/16 tariff proposals would have made worse.

What is the alternative?

2.12. Respondents did offer a number of alternatives including:

- A revision to a more stratified share of supply may allow for a more balanced approach; and
- Share of supply should be set much higher than 51% or alternatively linked with total objections by provider number, so that there will need to be two triggers both by number and share of supply before promoting a review.

Our response

2.13. We considered all responses to the consultation, including any suggestions on alternative ways to address the issue, such as requiring two thresholds to be met rather than one. We believe that a fairer balance will be maintained in the system as a whole if larger providers have the opportunity to object to proposals as part of the overall provider response, rather than as a separate voice. Larger providers will still continue to play a crucial role as part of the tariff development process. In addition, the impact assessment which Monitor is required to prepare for a national tariff will have to consider and report on the differential impacts of tariff proposals, including any impact on larger providers, thus increasing the transparency around the tariff methodology and its potential impact.

2.14. We note the concern to maintain financial stability within the system. As such, we will explore together with NHS England and Monitor the option of introducing multi-year tariffs, which will assist commissioners and providers with financial planning. However, while we recognise strong opposition to removing this threshold, the taxpayer cannot

afford a repeat of 2015/16 tariff process and the financial disruption this has caused. We have therefore decided, as part of a package of measures, to remove the share of supply objection threshold.

Q3 Do you agree that the objection threshold should be raised and, if so, to what level?

2.15. In 2013, there was no existing information on what an appropriate threshold should be. The Department prescribed all the thresholds at 51% (the objection percentage for providers and commissioners). The intention was that the threshold should be high enough to prevent any unnecessary delay to the tariff caused by objections that were not sufficiently representative, but low enough to highlight systematic issues with the method. In 2013, the Department considered that, at 51%, the majority of providers and commissioners must be dissatisfied with the tariff method in order to prevent Monitor adopting and publishing the national tariff.

Your feedback

2.16. 15% of respondents, which consisted mainly of commissioners, agreed with increasing the objection threshold, with many preferring 66% over 75%, which was felt to be too high. However, 82% of respondents, mostly from providers, disagreed with our proposal.

No change to the objection threshold – remain at 51%

2.17. 82% of respondents view the current objection threshold as fair and equitable. The proposed threshold levels of 66% and 75% were seen as unfair, which takes into account that only 62% of relevant providers are either NHS trusts or FTs, even if every provider were to object this would not be enough to breach the objection threshold. However, this is based on two years' of data and the proportions between NHS providers and independent providers continually change. Increasing the objection threshold would only marginalise providers and remove one of the few ways left where providers see an opportunity to raise concerns about the ability to provide quality care within the resources available. Monitor formally responded stating that they supported retaining the current threshold.

66% objection threshold

2.18. 6% of respondents called for the threshold to be raised to 66%. However, there were also calls for better engagement on tariff proposals with Monitor and NHS England working alongside providers and commissioners.

75% objection threshold

2.19. 5% of respondents supported this option. NHS England formally responded stating that they were in favour of increasing the objection threshold to at least 75% so that an objection could only be triggered by the overwhelming, rather than the simple majority.

Our response

2.20. The Department now considers that the objection percentage for providers and commissioners should be higher, but remain equal in the interest of fairness. This retains the ability of commissioners and providers objecting formally to the proposed method, while requiring the level of objection to be more significant to prevent Monitor from publishing the national tariff. We need to maintain financial stability and cannot afford a repeat process of 2015/16, unless exceptional circumstances arise. NHS England have indicated that if a similar system were to continue in 2016/17, there would be a negative impact on planned investment in areas such as mental health and community services which would have serious implications for the health service as a whole.

2.21. This increase in the objection threshold is reasonable and will create stability that is necessary for the tariff setting process. The Department has decided to increase the objection thresholds of both providers and commissioners from 51% to 66%.

Impacts and equalities

2.22. In addition to the other consultation questions, we sought views on whether there could be a significant impact from the new proposals.

Q4 Are you aware of any equality issues or of any particular group for whom the proposed changes could have either a detrimental or differential impact?

2.23. The Secretary of State has a Public Sector Equality Duty (PSED) under the Equality Act 2010 and other general duties, including a duty as to reducing inequalities under section 1C of the NHS Act 2006.

2.24. We considered these duties before making the 2013 Regulations which first prescribed objection thresholds and did not anticipate any adverse impact on equalities as a result of those proposals. We have kept this under review, and have considered all consultation responses and sought views to understand the impact on the sector. The costs incurred by the ETO/DTR could have been diverted to others areas in the health sector such as mental health and community services.

Your feedback

2.25. 73% of respondents answered ‘no’. However, 24% of respondents expressed concerns about future eventualities, not least where the providers of some services found them to be financially unsustainable but without sufficient numbers of providers objecting to meet a threshold.

2.26. The issue raised commonly was the impact on small providers, although at least one respondent acknowledged that this did not relate to equalities legislation. NHS Clinical Commissioners said: “There is some risk that small providers or providers delivering specific services for commissioners are particularly disadvantaged by the new proposals

for a higher threshold as they may not have the leverage to object to a particular tariff issue which affects them directly."

2.27. Other respondents identified impacts on large providers, most often in connection with share of supply although some also argued this in connection with higher thresholds.

2.28. The types of population served by larger providers were described as diverse by several respondents. Specialised services that were mentioned by respondents included cleft-lip & palate, cranial-facial, HIV, and transplantation (renal, liver, etc.). The users of HIV services are disproportionally gay, bisexual and other men who have sex with men so this implies the protected characteristics of sex and sexual orientation. Small numbers of responses referred to other protected characteristics - the elderly, disability, maternity and ethnicity - although without supporting evidence.

Our response

2.29. We acknowledge the concerns expressed by stakeholders. However, we seek to focus on the prospective impacts of removing the share of supply threshold, and changing the commissioners' and providers' objection thresholds equally.

2.30. The current objection mechanism reflects an expectation that threshold levels may only be reached in circumstances when objections represent widely held concerns. It is evident that, for example, the treatment of specialised services generally can generate such concern amongst providers, which could relate to the interests of many groups of patients.

2.31. The current provisions of the objection mechanism permit a number of large providers to veto tariff proposals. The proposed changes would require objections from a larger number of providers in order to reach an objection threshold (rather than the 37% of providers who objected to 2015/16 tariff proposals). The implication is that the overall patient population served by providers who object would thus tend to be more equally representative of the population at large. This is compatible with the PSED and the duty as to reducing inequalities.

2.32. More fine-grained assessments at a service level are applicable in relation to specific proposals in a future consultation where objections may be made. The tariff proposals made by Monitor are subject to impact assessments, across all relevant providers, including analysis of impacts on different types of provider and their patient populations.

Q5 Do you consider there to be any significant impact on the sector as a result of the proposed changes to the objection process?

2.33. The proposals set out allow commissioners and providers to formally challenge the methodology used to calculate the national tariff in a balanced way. As the national tariff is only paid by NHS commissioners for NHS services, we do not consider a business impact assessment needs to be published.

Your feedback

2.34. 66% of respondents answered 'yes', where the majority the majority of responses came from NHS and independent providers. Respondents expressed concerns about the objection mechanism being undermined, that it provided an essential warning signal of whether tariff proposals would be deliverable.

2.35. On the contrary, 31% of respondents (mostly commissioners) did not think there would be a significant impact. A few respondents anticipated a significant positive impact because of the advantages of pricing certainty.

2.36. Respondents anticipated that the adverse impacts as a result of the changes to the objection mechanism would result in an increasing number of providers in both financial distress and financial failure. There were also suggestions that the provider sector might disengage from responding to future consultations.

Our response

2.37. We anticipate that the impact on the sector is likely to negligible, with no direct costs or benefits with regards to changes in the objection thresholds. No direct costs were identified by independent providers who responded to the consultation. The indirect impact of the amended objection thresholds is difficult to measure, as it will depend on the detail of each future proposed tariff and the response to it from commissioners and providers.

Conclusion

2.38. We have decided to remove the share of supply objection threshold and increase the objection threshold for providers and commissioners from 51% to 66%. While we recognise there will be opposition to our proposals, we need to maintain financial stability within the system.

2.39. Our proposed changes to the objection mechanism should be seen as part of a package of measures which seek not only to establish a firmer footing, but which also may allow for the process of tariff-setting to be carried out across a number of financial years. However, we are clear that providers should not have to object to national tariff proposals, instead it needs to be set in a transparent way which is fair and consistent across the system.

2.40. While we cannot predict what the outcome of the Spending Review will be, we want to reassure the sector that the national tariff will align with efficiency expectations outlined in the Five Year Forward View, which describes efficiency opportunities of 2-3% per annum. The efficiency opportunities will be determined locally and will depend on a number of factors, including tariff but also include the developing work programmes on activity, productivity, pay and income as well as the work of Lord Carter which focuses on procurement, workforce, estates, pharmacy and medicines optimisation. Monitor and

NHS England will seriously engage with stakeholders to ensure that the efficiency factor is set at a stretching yet achievable level.

2.41. We will be able to provide the system with more clarity around the numbers in the planning guidance which will be published after the Spending Review.

Annex A: Consultation responses

The following list shows names of respondents under the categories used in the consultation analysis, which mainly reflects respondents' self-description in the online questionnaire. 80 other respondents asked for all or part of their response to be treated as confidential.

Commissioners

Bath & North East Somerset CCG

Canterbury & Coastal CCG and Ashford CCG

Coastal West Sussex CCG

Durham Dales Easington and Sedgefield CCG

Gloucestershire CCG

NHS Bexley CCG

NHS City and Hackney CCG

NHS Great Yarmouth & Waveney CCG

NHS Guildford & Waverley CCG

NHS Leeds West Clinical Commissioning Group

NHS Milton Keynes CCG

NHS Nene CCG

NHS Northumberland CCG

NHS Sheffield CCG

NHS Southampton City CCG

NHS Tameside and Glossop CCG

NHS West Essex

NHS Wigan Borough CCG

North Derbyshire CCG

Northern, Eastern and Western Devon CCG

Swindon CCG

Trafford CCG

Wiltshire CCG

Hardwick CCG

Mid Essex CCG

NHS Nottingham City CCG

NHS Surrey Downs Clinical Commissioning Group

Wigan Borough CCG

Providers

2gether NHS Foundation Trust
Aintree University Hospital NHS Foundation Trust
Airedale NHS Foundation Trust
Alder Hey Children's NHS Foundation Trust
Barking Havering & Redbridge University Hospitals NHS Trust
Barts Health NHS Trust
Basildon and Thurrock University Hospitals NHS FT
Birmingham and Solihull Mental Health NHSFT
Bradford District Care NHS Foundation Trust
Brighton and Sussex University Hospitals NHS Trust
Calderdale & Huddersfield NHS FT
Cambridge University Hospitals NHS Foundation Trust
Central Manchester University Hospitals NHS Foundation Trust
City Hospitals Sunderland NHS Foundation Trust
Colchester Hospital University NHS Foundation Trust
Countess of Chester Hospital NHS Foundation Trust
County Durham and Darlington NHS Foundation Trust
Derby Teaching Hospitals NHS FT
East Lancashire Hospitals NHS Trust
Epsom & St Helier Hospitals NHS Trust
Frimley Health NHS FT
Gloucestershire Hospitals NHS Trust
Great Ormond Street Hospital for children NHS FT
Great Western Hospital NHS Foundation Trust
Guy's & St Thomas' NHS Foundation Trust
Harrogate and District NHS Foundation Trust
Heart of England NHS Foundation Trust
Hertfordshire Community NHS Trust
Hull and East Yorkshire Hospitals NHS Trust
Imperial College Healthcare NHS Trust
InHealth Limited
Ipswich Hospital NHS Trust
James Paget University Hospitals NHS Foundation Trust

King's College Hospital NHS Foundation Trust
Leeds Teaching Hospitals NHS Trust
Lewisham and Greenwich NHS Trust
Liverpool Heart & Chest Hospital NHS Foundation Trust
Liverpool Women's NHS Foundation Trust
Mersey Care NHS Trust
Mid Cheshire Hospitals NHS Foundation Trust
Mid Essex Hospital Services NHS Trust
Mid Yorkshire Hospitals NHS Trust
Milton Keynes University Hospital NHS Foundation Trust
Moorfields Eye Hospital NHS Foundation Trust
Newcastle-upon-Tyne NHS Foundation Trust
Norfolk and Norwich University Hospitals NHS Foundation Trust
North Bristol NHS Trust
North Tees and Hartlepool NHSFT
Northampton General Hospital NHS Trust
Northern Devon Healthcare NHS Trust
Northern Lincolnshire and Goole NHSFT
Nuffield Health
One to One (North West) Ltd - One to One Midwives
Oxford University Hospitals NHS Trust
Papworth Hospital NHS Foundation Trust
Plymouth Hospitals NHS Trust
Portsmouth Hospitals NHS Trust
Princess Alexandra Hospital NHS Trust
Priory Group
Royal Bournemouth & Christchurch Hospitals NHS FT
Royal Brompton and Harefield NHS Foundation Trust
Royal Cornwall Hospitals NHS Trust
Royal Devon & Exeter NHS Foundation Trust
Royal National Orthopsedic Hospital NHS Trust
Royal Surrey County Hospital NHS Foundation Trust
Salisbury NHS FT
Sheffield Teaching Hospitals NHS FT
Shrewsbury & Telford Hospitals NHS Trust
Shropshire Community Health NHS Trust

South Tees Hospitals NHS Trust
Southend University Hospitals Foundation Trust
St George's University Hospitals NHS Foundation Trust
St Helens and Knowsley Teaching Hospitals NHS Trust
Surrey and Sussex Healthcare NHS Trust
Tameside NHS Foundation Trust
Taunton and Somerset NHS Foundation Trust
Tees, Esk and Wear Valleys NHS Foundation Trust
The Christie NHS Foundation Trust
The Clatterbrdige Cancer Centre NHS Foundation Trust
The Royal Free NHS Foundation Trust
The Royal Marsden NHS Foundation Trust
The Royal Orthopaedic Hospital NHS Foundation Trust
The Royal Wolverhampton NHS Trust
The Walton Centre NHS Foundation Trust
University Hospital Southampton
University Hospitals Birmingham NHS Foundation Trust
University Hospitals of Leicester NHS Trust
University Hospitals of North Midlands NHS Trust
Whittington Health
Worcestershire Acute Hospitals NHS Trust
York Teaching Hospital NHS Foundation Trust

Other organisations

Association of British Healthcare Industries
Association of UK University Hospitals
Boston Scientific
British Orthopaedic Association
British Society for Blood and Marrow Transplantation
Cook Medical UK
Federation of Specialist Hospitals
Healthcare Financial Management Association
Monitor
NHS Clinical Commissioners
NHS Confederation

NHS England
NHS Providers
Royal College of Midwives
Royal College of Physicians
Shelford Group

Individuals

Paul Jankowiak
Ulrich Kaltenbronn
James O'Sullivan
Richard Russell
Daniel Sutcliffe
Alan Warren