How Integrated Care Boards can work together with health and justice services to support patient pathways and commissioning opportunities: a briefing document

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revolving doors

About Revolving Doors

Revolving Doors is a national charity. We champion long-term solutions for justice reform that tackle the root causes of reoffending and support people's journeys towards better lives. We focus on the 'revolving door' group of people, those who have repeat contact with the criminal justice system whose behaviours are largely driven by unmet health and social needs. We recognise that to fulfil our ambition we need to work to drive systems change in the criminal justice sphere and related sectors.

About Clinks

Clinks is the infrastructure organisation supporting voluntary organisations in the criminal justice system in England and Wales. We support, promote and represent the voluntary sector working with people in the criminal justice system and their families - currently that's over 1,700 voluntary organisations working in England and Wales. Our over 600 members, which range from large organisations through to unstaffed community groups, work in prisons and the community in a variety of ways to help people turn their lives around and also offer support to their families.

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1. Introduction

Purpose of this guide

We want this guide to be a useful tool that, building on insights from across the different regions, supports future collaboration between Integrated Care Boards (ICBs), NHS England Health and Justice and the Voluntary Community Sector. In addition, we hope that by showing different approaches and lessons learnt, the guide can support decision-making around patient pathways and community input into NHS England's Health and Justice activities.

Background

In 2022, Revolving Doors were commissioned by Clinks to collate learning on how Integrated Care Partnerships (ICPs) and Integrated Care Boards (ICBs) can work together with health and justice services to support patient pathways and commissioning opportunities.

Through conducting desk-based and primary research, we wanted to learn more about existing good practice and experiences of joint working within ICPs and ICBs, as well as what more is needed to support collaboration between health and justice services and ICPs/ICBs. The purpose of the research was to better understand what does, or could, enable joint working between ICPs/ICBs and health and justice services, and how challenges might be overcome.

Methodology

Information included in this report is from a desk-based review of relevant documents and online resources as well as interviews with individuals representing either an Integrated Care Board or NHS England Health and Justice.

2. What are Integrated Care Systems?

Integrated care systems (ICSs) are partnerships, including NHS organisations and local authorities, that are responsible for planning and delivering joined up health and care services, and which aim to improve the lives of people who live and work in their area. ICSs have replaced Clinical Commissioning Groups (CCGs). The intention is that ICSs will improve population health and healthcare outcomes, tackle health inequalities, enhance productivity and value for money and help the NHS to support broader social and economic development.[1.]

42 ICSs were established across England on a statutory basis on 1st July 2022. The main components of an ICS are:

1. **Integrated Care Partnership**: individuals with responsibility for creating an integrated care strategy for the ICS area that will meet the health and wellbeing needs of their local population. Membership is determined locally, but will include ICB, local authority and Healthwatch representatives.
2. **Integrated Care Board:** individuals responsible for managing the NHS budget, commissioning health services in the ICS area and producing a five-year system plan for health services. ICBs are led by an independent chair and chief executive. Membership will depend on local requirements but must include members nominated by NSH trusts/foundation trusts, local authorities and general practice as well as someone with expertise in mental health service.
3. **Place-based partnerships**: due to the large geographical footprint of ICSs – place-based partnerships lead the detailed design and delivery of integrated services across their localities and neighbourhoods. The partnerships will involve the NHS, local councils, community and voluntary organisations, local residents, people who use services, their carers and representatives and other community partners with a role in supporting the health and wellbeing of the population.
4. **Provider collaboratives:** these are partnership arrangements that exist to make better use of shared resources between at least two NHS trusts who will work at scale across multiple places to reduce unnecessary variation in access, experiences and outcomes and improve resilience and value.

The statutory requirements of ICSs give local areas scope to determine an approach to designing and delivering health and wellbeing services that meets the specific needs of their population. The flexibility of ICSs should be seen positively. As Kings Fund explain:

> The flexibility ICSs have been given has the advantage of enabling them to develop arrangements to suit their local contexts, respond to population needs and build on their existing strengths, and could help to engender a greater sense of local ownership of and commitment to the changes than in previous NHS restructures.[2]

[1] https://www.england.nhs.uk/integratedcare/what-is-integrated-care/
[2] https://www.kingsfund.org.uk/publications/integrated-care-systems-explained#what-are-icss

It is important to note that the commissioning responsibility for health and justice, sexual assault and abuse service (SAAS) functions remained with NHS England and were not delegated to ICSs.

3. The role of Integrated Care Boards

Each Integrated Care System has an Integrated Care Board, so there are 42 in total which are generally in line with either upper tier (county council) or unitary local authority boundaries. (See Annex A for a map showing where these are).

Integrated Care Boards (ICBs) replaced Clinical Commissioning Groups and therefore are responsible for controlling most NHS resources in hospitals and the community as well as planning health care services in their area. ICBs are expected to work with patients and communities to design and commission services. Services commissioned directly by the ICB include:

- Planned hospital care.
- Rehabilitative care.
- Maternity services.
- Urgent and emergency services, including ambulance and out-of-hours services.
- Community health services.
- Mental health services.
- Learning disabilities services.
- Abortion services.
- Infertility services.
- Continuing healthcare.

ICBs operate as single boards led by a chair and chief executive officer. There is flexibility to tailor membership locally, but at a minimum there needs to be ten members, including a director of finance, medical director and director of nursing: working alongside an individual representing NHS trusts and foundation trusts, someone drawn from primary medical services (e.g., GP practices) and someone from a local authority within the ICBs geographical footprint. There also needs to be at least one member with knowledge and expertise in mental ill health and two non-executive members who do not have a role in another health and care organisation in the ICS area but who bring relevant skills and knowledge that can support the ICBs success.[3]

ICBs are accountable to NHS England for improving outcomes for patients and for getting the best possible value for money from the funding they receive, and to the public and patients.

NHS England provide funding to ICBs to commission NHS services. The main allocation is based on a formula that accounts for the number of people registered with each GP, the sparsity of the local population and which is guided by the aim to improve health outcomes and reduce inequalities.

[3] https://www.england.nhs.uk/wp-content/uploads/2021/06/B1551--Guidance-to-Clinical-Commissioning-Groups-on-the-preparation-of-Integrated-Care-Board-constitutions-.pdf

4. Why collaboration between NHS England Health and Justice and Integrated Care Boards is important

NHS England Health and Justice is the body that is responsible for commissioning healthcare services that support both children and adults in the criminal justice system – both in custody and in the community. Examples of services that come under NHS England Health and Justice's remit include the RECONNECT: Care after Custody Pathway, Liaison and Diversion, and the Community Sentence Treatment Requirement (CSTR) programme.

There is growing understanding that people who are in contact with the criminal justice system experience significant health inequalities, which are compounded by multiple disadvantage when criminal justice contact is experienced alongside issues such as problematic substance use, homelessness, mental ill health, and domestic abuse.

Despite serving a population that experience significant health inequalities, NHS England Health and Justice has not been delegated to ICSs and remains separate. Reasons for this include the complexity of services such as prison healthcare, which require highly specific governance mechanisms and extensive national stakeholder networks. In addition, there were concerns about maintaining quality and consistency of healthcare provision across the prison estate, and/or for those with complex health and social needs, if not commissioned centrally.[4] Nonetheless, there remains an ambition to work towards a model of joint working, and more broadly there is a need for ICBs and NHS England Health and Justice to work together to ensure that the needs of patients who are in contact with the criminal justice system, who also engage with more general healthcare services, are met.

ICB stakeholders reflected that particularly for groups who experience entrenched health inequalities, it is essential that services adapt to their needs and operate in a person-centred way, to build trust and support engagement, which will help to avoid poorer outcomes further down the line.

"How do services adjust what they do to be acceptable, accessible, trusted, credible amongst these communities? There is a huge amount of mistrust with people who experience problematic substance use. There is something about how you adopt that approach to get in there early enough, do the job before it gets to the point where people are having amputations or long periods of hospitalisation, restricted hospitalisations." (ICB stakeholder)

"ICSs have to challenge issues around people not accessing services, due to not meeting threshold or for other reasons. Birmingham and Solihull have the youngest population, and high pockets of inequalities." (ICB stakeholder)

Ensuring that people who do not access services due to barriers or mistrust is essential to address health inequalities and avoid crisis situations, and it is clear that NHS England Health and Justice and ICBs will need to work closely together for this to take place.

[4] Edge et al. (2022), Integration, population commissioning and prison health and well-being – an exploration of benefits and challenges through the study of telemedicine, *Journal of Integrated Care*, 30(5), pp.108-124

"We work with a collective population…[individuals] that will need to be plugged in to community services that are commissioned by the ICB." (NHS England Health and Justice Stakeholder)

Mental Health Treatment Requirements are now fully mobilised in South West England, and this was considered to be a good example of co-commissioning services and collaboration, as ICBs in the region have either put in funding towards these and/or are members of the regional MHTR steering groups.

ICB stakeholders that we spoke to were keen to facilitate further joint working with NHS England Health and Justice in the future, to enable a focus on people who experience health inequalities and an improvement to their access to services.

"Part of the ICB approach is to try and bring elements of specialised commissioning into ICBs, but Health and Justice are not coming in […], if specialised commissioning for Health and Justice comes into 1 or 2 ICBs, I think there would be a move to try and move multiple areas like this into one larger more focused team. This would be helpful, and it could happen." (ICB stakeholder)

Bristol, North Somerset and South Gloucester CCG initially funded a framework to enable the integration of existing services working with children and young people with additional needs. Originally the ICB was funded to deliver this framework, but now the ICB funds the project manager itself, which was felt to be evidence of strategic buy-in to this approach. The use of a framework was also considered to help with sustainability because it was about creating a set of principles that guided how different services worked with this group to create impact and outcomes, rather than funding a particular service for a short period of time. The project is a good example of NHS England Health and Justice organisations working collaboratively with the third sector and criminal justice sector, and of co-production, as children and young people have had a voice in the design and delivery of the framework and services within this.

<u>The Bristol, North Somerset and South Gloucestershire (BNSSG) Vanguard</u>

The BNSSG Vanguard is delivering the Framework for Integrated Care. This was developed as a response to the NHS Long Term Plan commitment to provide additional support for the most vulnerable children and young people (CYP) with complex needs.

The aim of the framework has been to support and strengthen existing community services, enable collaboration within and across those agencies with the vision to facilitate integrated trauma-informed and responsive systems that enable children and young people with complex needs to thrive. It will also aim to reduce inequalities and improve outcomes.

The overall objectives of the project are to:

- Improve children and young people's wellbeing,
- Reduce high-risk behaviours,
- Reduce mental health concern,
- Organisations are more trauma-informed,
- Individuals have improved purpose/occupation, and
- Individuals have improved stability of home.

Six key principles which underline the service and are intended to enable the project to meet its objectives and have an impact. This includes a focus on building and supporting positive collaborative relationships, a commitment to create and sustain trauma-informed organisations and a focus on developing an understanding of each person's behaviours and needs based on their story.

There are seven Vanguard Pathways across BNSSG, which are all delivered by existing organisations in the area who have enhanced their service with additional expertise and agreed to embed the principles for Trauma Informed Practice. This includes:

- Bristol Drugs Project's New Leaf project for 11–19-year-olds.
- Young Victims Service hosted by North Somerset Youth Offending Team (YOT) delivered across BNSSG.
- Enable Inclusion Team hosted by Enable Trust for children and young people at risk of exclusion in South Gloucestershire.
- Psychological provision delivered by Child and Adolescent Mental Health Service (CAMHS)the Be Safe multi-agency team and Barnardo's Mental Health Practitioners.
- Enhanced Case Management delivered to all the Youth Justice Teams in BNSSG, Psychology delivered by FCAMHS.
- Advice and Support in Custody and Court Delivered by Avon and Wiltshire Partnership service is called Youth Liaison and Diversion

The Vanguard also includes a Trauma Informed System Manager hosted by the ICB to support the pathways and align to the wider development of trauma informed systems and measuring impact.

Each of the seven pathways work collaboratively and are built on genuine co-production with children and young people with complex needs, and their families. Lived Experience advisors are informing these pathways through a programme of work supported by Barnardo's. The overarching governance of the project is provided by the BNSSG Integrated Models of Care Programme Board.

An independent evaluation of the project is currently underway, with interim findings expected in Autumn 2023.

5. The role of the Voluntary Community Sector

Organisations in the Voluntary Community Sector (VCS) are an example of the many local partners that will be play an important role in helping ICSs to meet their objectives. National guidance states that VCS organisations should be involved in system-level governance and decision-making arrangements of ICSs.[5]

As explained by Victor Adebowale, Chair of the NHS Federation, earlier in 2022, the VCS has an "important contribution to make in shaping, improving and delivering services and developing and implementing plans to tackle the wider determinants of health."[6] VCS organisations hold successful local relationships, bring expertise and different, creative perspectives and have demonstrated considerable resilience in turbulent and uncertain times, particularly throughout the Covid-19 pandemic.

One way that ICSs have engaged with the VCS has been through Voluntary, Community and Social Enterprises (VCSE) alliances, which are groups of organisations that have a common set of aims/principles and which act as a single point of contact into the sector for the ICS. It is intended that the alliances will help the sector to act in a coordinated way when engaging with the ICS and therefore have greater impact. There does not appear to be a single list of each VSCE alliance operating in England, but information for some areas available online, including in the Black Country, Nottingham and Nottinghamshire, North East and North Cumbria. and South East London.

ICB stakeholders spoke positively of the work being done in collaboration with the VCS. This included work in Derby and Derbyshire to support residents experiencing mental ill health access support in the community.

"The biggest bit of collaboration is with Mind and Rethink. Delivery of a community mental health framework is a national push, to want to push and change how mental health care is delivered in community. It's the biggest shake up of how we do things since 1989, an onion skin of support – fairly light touch support vs. structured support vs. peer support, guided by a professional. We're rolling that out across whole of Derbyshire next year. We need to grow the model at pace as we go along. We've never had partnerships on this scale before, but it's working quite well, though not without its problems relating to recruitment and retention." (ICB stakeholder)

The need to focus on collaboration, rather than competition, when working with VCS organisations was emphasised, which the framework of ICBs and their approach to commissioning can facilitate.

"We have been in conversations with team leaders and managers from P3, Mind, and Rethink. They wouldn't have dreamed of working collaboratively with each other because they're typically competitive, they're surprised at themselves working in same county with a similar client group to create a pathway of care. You facilitate the environment to do something different, and the climate to do something different." (ICB stakeholder)

[5] https://www.england.nhs.uk/wp-content/uploads/2021/06/B0905-vcse-and-ics-partnerships.pdf
[6] https://www.nhsconfed.org/articles/voluntary-sector-game-changer-integrated-care-systems

VCS organisations collaborating alongside statutory health agencies is also key to addressing dual diagnosis, i.e. people experiencing both mental ill health and problematic substance and/or alcohol issues as the same time. As those who have experienced dual diagnosis put it, services will often see them as being 'too complicated' and will therefore exclude them from services that address either issue, due to not meeting either services' criteria or threshold.[7] Focusing on collaboration, rather than competition, can help to better meet the needs of cohorts of people experiencing dual diagnosis.

In addition, moving away from Clinical Commissioning Groups (CCGs) and towards ICSs was seen to be aiding in this collaborative approach because under the new structure, it was felt that there is an incentive for organisations to work together.

"Before, with Clinical Commissioning Groups (CCGs) things were commissioned based on contracts. It did not incentivise working together, it actually discouraged it." (ICB stakeholder)

"CCGs beforehand had tariffs, they were clunky, did not incentivise providers to work together, they created competition." (ICB stakeholder)

[7] https://revolving-doors.org.uk/breaking-the-stigma-dual-diagnosis-awareness-is-crucial-during-mental-health-awareness-week/

6. Enablers to joint-working

Examples seen above with regards to the VCS clearly demonstrate that the focus on collaboration, rather than competition, is a strong enabler to joint working and therefore meeting the needs of people experiencing multiple disadvantage.

Research by NCVO, published in 2020 identified five essential components of successful partnerships.[8] These were building relationships, shared vision and values, principles of joint working, investment and resources and leadership. Similar themes were picked up in the conversations had as part of this research. For example, one respondent spoke of the benefits of "strong clinical leadership" where an individual is intuitive, confident and empathetic and can demonstrate to others "how it can be done". There was also agreement that relationships were key, and existing relationships helped joint working to develop more quickly.

"It took a lot of effort from all sides…to work out how we could share and make things fair to reduce a postcode lottery." (NHS Health and Justice stakeholder)

A factor that helped relationships to develop were opportunities to communicate and identify shared goals, such as at different local board meetings, which in turn enabled joint-working.

"Relationship enablers – the police come to the board. They also have safer communities board which we attend, so there are plenty of opportunities to talk to each other, and off the back of that, alliances and meetings are set up." (ICB stakeholder)

It was positive to see examples of joint working between the ICB and agencies such as the Office for the Police and Crime Commissioner (OPCC) and the local police force. We spoke to one ICB stakeholder by being put in touch by the OPCC, as the Police and Crime Commissioner is represented on the Integrated Care Partnership Board.

Furthermore, examples were given of shared investment into a new or continuing service, which in turn supported joint-working and good relationships. For example, in Bristol, North Somerset and South Gloucestershire, the ICB had contributed a large amount of funding to a co-commissioned all-age, all gender sexual violence service. This had been a collaboration between the ICB, NHS England Health and Justice, the local authority and the OPCC, who pooled their budgets to co-commission and co-produce a "great service". This was seen as a success story that was enabled by individuals that were "fighting" for the service, a more mature provider alliance and pre-existing partnerships. Partners were also supported by the Commissioning Academy who helped to identify the shared priorities amongst the funders.

Another theme of the research was the idea that generating evidence of success either of Health and Justice programmes, or joint-working initiatives more generally, would be useful to help demonstrate the value of this and to thereafter be able to use this to generate ICB buy-in and resource. In addition, stakeholder events were also considered a useful tool to support commissioning and collaboration, especially as there was felt to be a risk that learning only goes back to national NHS England teams and is not picked up amongst regional stakeholders – so such local events could help to prevent this.

[8] https://www.ncvo.org.uk/news-and-insights/news-index/creating-partnerships-success/#/

Although ICSs are regional, focusing on 42 areas across England, patients can be transient and services in different regions need to be in communications to ensure joined up working. In enabling this, we saw an example where a stakeholder from an ICB spoke of monthly meetings with ICB officers from nearby areas to share learning and discuss emerging challenges.

An ICB representative also felt that provider collaboratives were useful in that they created an incentive for people to work together because providers and commissioners were “in the same room” and commissioning services as one entity.

7. Barriers to joint-working

Previous research has identified three main barriers to collaboration between the VSCE sector and statutory sector.[9] These are commissioning, service design and delivery, sharing data, intelligence and insight and funding and sustainable investment.

Similarly, a common theme that arose with regards to barriers to joint-working in our conversations were the issues of ICS maturity, finances and resources, and trust. For example, limited finances were felt to result in organisations to turn inwards rather than collaborate.

"We've got a good relationship with who we have relationships with. When money gets tight, there is a natural instinct for each organisation to remain sovereign and think its own way out of the problems it has. You need a lot of trust and maturity, and we're not quite there yet." (ICB stakeholder)

In terms of commissioning approaches, in contrast to the positive views expressed about provider collaboratives by one respondent, another expressed concern that they prevented specialist approaches. This was because the focus was on a specific patient group, which risked services not being flexible and responding to the local population's needs as they emerged because they were "not commissioned to do that."

Another theme reflected was the level of change that has been going on within the NHS for the past few years, and how this was affecting a sense of stability. It was explained that it takes time to understand different ways of working, gradually embed change and create confidence amongst individuals who are part of this new system. Regular reform was felt to hamper the opportunity to do this effectively.

"The reality we're working in, is we're working around parliamentary cycles. Any major change that tries to be delivered, it has to deliver in a time-limited way. For wide-scale change, part of the principle is to have a few 'movers and shakers', create a coalition of the willing, and then grow that to give them that confidence, let others jump on board. If you've been told to change everything about how something is delivered, that does not match with large scale change principles. We're eternally bound by the forces that dictate in terms of whether something becomes an opportunity or not. If there was stability of vision, that was consistent for long enough, we could do more." (ICB stakeholder)

Linked to this, it was also recognised that it takes time to change cultures and ways of working. Many people have experienced changes in their role and wider team, and so it was felt that appropriate support needed to be provided so that such staff members could value the new structures and approach, and to be able to hold on to them.

"It's a cultural change for the workforce as there has been lots and lots of change in people's role/teams. The challenge is to let go of hierarchy, and workforce retention." (ICB stakeholder)

Another concern raised was around the needs of those requiring NHS England Health and Justice services being misunderstood and/or overlooked by ICBs. There were concerns that there was a "fear" around people who have committed criminal offences, and a lack of

[9] Lozito and Horsley, 2020; Baylin et al., 2021

understanding of sexual violence and the implications of this. This was reflected in a recent study on relationships between prison healthcare and ICSs which found that prisoners were not seen as a priority patient group to the hospital or ICS given the small potential patient numbers, and wider challenges facing the broader community population.[10]

[10] Edge et al. Integration, population commissioning and prison health and well-being…

8. Looking to the future

Our research and attempts to engage with stakeholders at various ICBs has indicated that ICSs are still at an early stage, and time will tell how successful they will be as they mature and are mainstreamed into health and care policy and practice. The potential for success is clear, with emerging examples of positive relationships with stakeholders within the VCS and agencies such as OPCCs, as well as feelings of the ICS structure being more conducive to collaborative working.

Nevertheless, this is not the first time that we have seen a major shift in the structure of how health and care services are commissioned and delivered, and it remains to be seen how any political shift may affect the longevity and stability of ICSs, particularly in the context of a tightening public budget and sustained pressure on the NHS. However, the Labour party have stated that ICBs would lead on Labour's new 'neighbourhood health service' plan for the NHS, if in power.[11]

It is clear that in order to meet the needs of patients who experience multiple co-occurring needs, including those who are in contact with the criminal justice system, collaboration with multiple agencies is needed to ensure that patients receive holistic, well-rounded support and do not fall through the gaps between services. The hope is that, as ICSs mature and joint working becomes more mainstreamed, collaborative working across not only health and care services but with stakeholders such as the police and probation will become normalised.

For now, NHS England Health and Justice remains separate from ICSs, but this could change. In the meantime, it is essential that ICSs work to engage with NHS England Health and Justice, in order to understand the needs of their populations who are in contact with the criminal justice system, and therefore apply a more localised approach to commissioning and service delivery for all of those who come under their regional remit.

Part of this collaboration should involve education and awareness raising to support ICB members better understand the needs of those in contact with the criminal justice system so that the services being commissioned in the community are accessible and account for these. The VCS can play an important role here, and in ensuring that their local ICB recognises the views and experiences of residents and can take meaningful action to address health inequalities.

[11] https://healthcareleadernews.com/integrated-care-boards/icbs-to-lead-labours-primary-care-reform/

9. Further resources

Department for Health and Social Care (2023), The Hewitt Review: an independent review of integrated care systems

National Audit Office, Integrated Care Systems visualisation

National Audit Office (2022), Introducing integrated care systems: joining up local services to improve health outcomes

National Care Forum, Find your ICS and partners

NHS England, Integrated care in action: Health inequalities

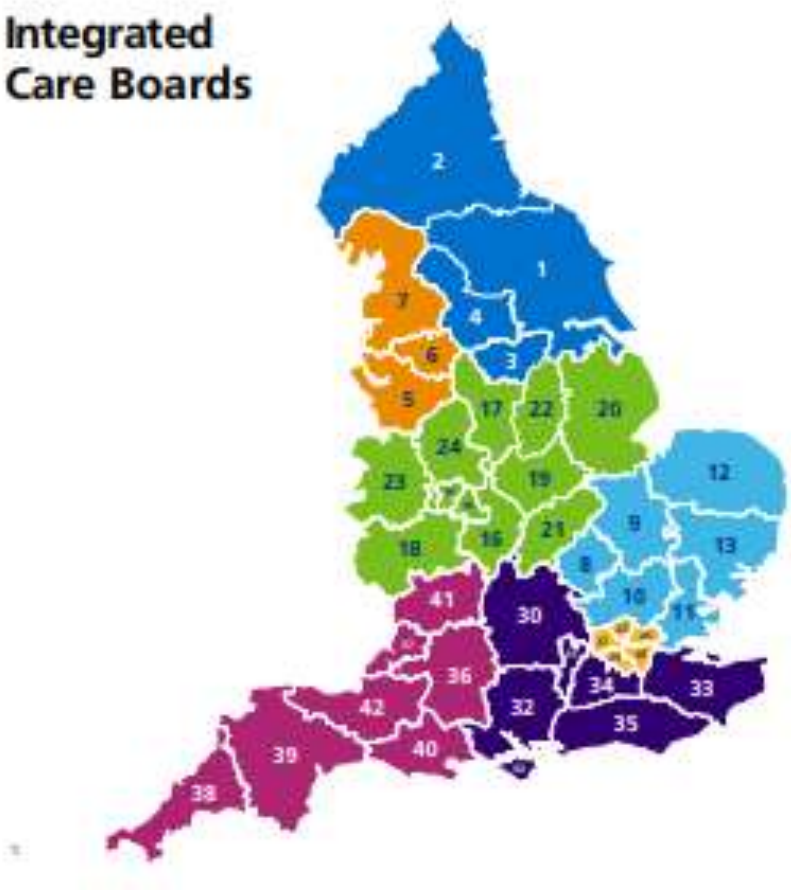
NHS England (2021), Building strong integrated care systems everywhere: ICS implementation guidance on partnerships with the voluntary, community and social enterprise sector

NHS England (2021), Building strong integrated care systems everywhere ICS implementation guidance on working with people and communities

The Health Foundation, Integrated care systems: what do they look like?

The Kings Fund, Integrated care systems explained: making sense of systems, places and neighbourhoods

Annex A: NHS England Integrated Care Board Map



North East & Yorkshire

1 NHS Humber and North Yorkshire
2 NHS North East and North Cumbria
3 NHS South Yorkshire
4 NHS West Yorkshire

North West

5 NHS Cheshire and Merseyside
6 NHS Greater Manchester
7 NHS Lancashire and South Cumbria

East of England

8 NHS Bedfordshire, Luton and Milton Keynes
9 NHS Cambridgeshire and Peterborough
10 NHS Hertfordshire and West Essex
11 NHS Mid and South Essex
12 NHS Norfolk and Waveney
13 NHS Suffolk and North East Essex

Midlands

14 NHS Birmingham and Solihull
15 NHS Black Country
16 NHS Coventry and Warwickshire
17 NHS Derby and Derbyshire
18 NHS Herefordshire and Worcestershire
19 NHS Leicester, Leicestershire and Rutland
20 NHS Lincolnshire
21 NHS Northamptonshire
22 NHS Nottingham and Nottinghamshire
23 NHS Shropshire, Telford and Wrekin
24 NHS Staffordshire and Stoke-on-Trent

London

25 NHS North Central London
26 NHS North East London
27 NHS North West London
28 NHS South East London
29 NHS South West London

South East

30 NHS Buckinghamshire, Oxfordshire and Berkshire West
31 NHS Frimley
32 NHS Hampshire and Isle of Wight
33 NHS Kent and Medway
34 NHS Surrey Heartlands
35 NHS Sussex

South West

36 NHS Bath and North East Somerset, Swindon and Wiltshire
37 NHS Bristol, North Somerset and South Gloucestershire
38 NHS Cornwall and The Isles Of Scilly
39 NHS Devon
40 NHS Dorset
41 NHS Gloucestershire
42 NHS Somerset

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