Health and wellbeing boards and criminal justice system agencies: building effective engagement

November 2012

Key points

- Effective joint working between criminal justice system agencies and health and wellbeing boards will support improved commissioning to achieve better health, justice and community safety.
- Improving health outcomes for offenders can significantly reduce re-offending rates, so bringing health benefits to a wider population.
- Local community safety partnerships, criminal justice boards and health and wellbeing boards will have some of the same member agencies and responsibility for delivering some priority shared outcomes.
- A key responsibility of each health and wellbeing board is to undertake Joint Strategic Needs Assessments (JSNAs) and develop Joint Health and Wellbeing Strategies (JHWSs).
- JSNAs and JHWSs are the key mechanisms by which health and wellbeing boards will engage with their local partners.

Offenders, ex-offenders and those at risk of offending experience significant health inequalities, compared to the general population. They experience higher rates of mortality and suicide; drug and alcohol misuse; mental and physical health problems; homelessness, literacy and numeracy difficulties, and unemployment; and poor access to and uptake of health and care services.

Since there is an identifiable link between health inequalities and offending behaviour, improving their health outcomes can markedly reduce re-offending rates. In turn, a reduction in re-offending is likely to bring health and wellbeing benefits to a wider local population as a result of improved community safety.

Reforms to the health and social care system and criminal justice system (CJS) in England present new opportunities for effective joint working at the local level between health and wellbeing boards and CJS agencies, to improve commissioning and achieve better health outcomes for people in contact with the CJS, including those at risk of offending and re-offending, as well as victims.

At a glance

- **Audience:** This guide is aimed at all health and wellbeing board members and criminal justice system agencies.
- **Purpose:** To provide practical information and learning on building effective engagement between health and wellbeing boards and local criminal justice system agencies.
- **Background:** This document was developed by a working group which was part of the National Learning Network for health and wellbeing boards (see back cover) and is supported by the Department of Health, the NHS Confederation, the Local Government Association and the NHS Institute for Innovation and Improvement.

Supported by

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Health and wellbeing boards will bring together representatives from across **local government, the NHS, local Healthwatch**, and other key local partners, including **CJS agencies**, to coordinate their commissioning processes. A key responsibility of each health and wellbeing board is to undertake Joint Strategic Needs Assessments (JSNAs) to assess current and future health and social care needs of their local population and, based on this, develop Joint Health and Wellbeing Strategies (JHWSs) to address these identified needs. JSNAs and JHWSs will inform commissioning plans for local health and social care services and can influence wider services to inform outcomes.

This guide aims to inform effective engagement between health and wellbeing boards and local CJS agencies. It sets out the benefits of developing strong and dynamic working relationships in terms of improving health outcomes for those in contact with the CJS, as well as highlighting some of the shared interfaces and structures.

The new local commissioning landscape for criminal justice services and health and wellbeing

The Health and Social Care Act 2012 introduced major changes to local health and social care

Significant health inequalities exist amongst offenders and ex-offenders

- In the week following their release:
  - female prisoners are 69 times more likely to die than females in the general population
  - male prisoners are 29 times more likely to die than males in the general population.
- It is estimated that up to 30 per cent of offenders have a learning difficulty/disability.
- Among children and young people in custody:
  - over 75 per cent have serious difficulties with literacy and numeracy
  - over 30 per cent have a diagnosed mental health problem
  - more than 30 per cent have experienced homelessness
  - over 30 per cent of young women and over 25 per cent of young men report a long-standing physical complaint.
- 24 per cent of prisoners with a drug problem are injecting drug users. Of these, 20 per cent have hepatitis B, and 30 per cent have hepatitis C.
- Among female prisoners, 40 per cent have a long-standing physical disability, and 90 per cent have a mental health or substance misuse problem.
- Less than 1 per cent of ex-offenders living in the community are referred for mental health treatment.
- In prisons, the smoking rate is as high as 80 per cent – almost four times higher than the general population.
- 63 per cent of male prisoners and 39 per cent of female prisoners are hazardous drinkers.
- Before being in custody, 58 per cent of prisoners are unemployed and 47 per cent are in debt.

Sources:
Department of Health, Department for Children, Schools and Families, Ministry of Justice, Home Office (2009) *Healthy children, safer communities – a strategy to promote the health and well-being of children and young people in contact with the youth justice system.*
Ministry of Justice (2010, 2011, 2012) *Compendium of reoffending statistics and analysis.*

commissioning. Primary care trusts (PCTs) are being abolished and, from April 2013, responsibility for commissioning health services will be transferred to clinical commissioning groups (CCGs) and the NHS Commissioning Board (NHSCB), with local authorities having responsibility for public health. Commissioning responsibilities for criminal justice-related health and care services under this reformed system are detailed on page 6.

It is a requirement of the Health and Social Care Act that a health and wellbeing board be established for every single and upper tier local authority from April 2013. There is a prescribed core statutory

Criminal justice system agencies and their health and wellbeing responsibilities

CJS agencies include a range of statutory and non-statutory organisations that provide custodial and non-custodial services. They include:

- the police (police forces and Police and Crime Commissioners (PCCs))
- the Crown Prosecution Service
- HM Prison Service
- probation trusts
- Juvenile and Young Offender Secure Estate
- community safety partnerships (CSPs)
- the youth justice system
- Courts Service
- Independent Monitoring Board
- private sector companies and voluntary, community and social enterprise organisations.

CJS agencies employ and work with highly trained staff engaged in a wide range of health, mental health, substance misuse and social care activities to support and help offenders. For example:

- dedicated substance misuse teams in prisons design and run programmes to support offenders dealing with drug and alcohol dependency
- drug workers in police custody suites and courts
- mental health trainers working with youth offending teams
- probation trusts implement a range of community sentences, including drug rehabilitation requirements and substance abuse programmes
- youth justice liaison and diversion at the point of arrest provides an opportunity to identify health and care needs early on and to link young people and their families with the support they need.

Many offenders live chaotic and disordered lives, are not registered with a GP practice, and can over-depend on local A&E services to address their health needs. CJS agencies can therefore act as a gateway for offenders into health services.

As well as supporting the health needs of offenders and ex-offenders, CJS agencies respond to the health needs of victims of crime, witnesses and families of offenders.

CJS agencies also undertake significant multi-agency partnership work to prevent and reduce violence, and promote community safety.

CJS agencies play an active role on CSPs which, under the terms of the Crime and Disorder Act 1998, as amended, have a statutory duty to prepare strategies for reducing crime and disorder, re-offending and substance use. From April 2013, CCGs will replace PCTs as responsible authorities on CSPs. Local authorities are also represented. CSPs offer a forum for all partners to focus on improving offender health and wellbeing outcomes that will contribute to reduced crime rates. When PCCs are appointed in November 2012, they will take responsibility for a new community safety fund from which CSPs can be funded.

Police and crime commissioners (PCCs)

From November 2012, directly elected PCCs in England and Wales, outside London, will have responsibility to ensure local police force activity is held to account by the local community it serves.

PCCs will have a remit to cut crime, along with the commissioning powers and funding to enable them to deliver on this.

Their key duties are to:

- appoint the Chief Constable and hold them to account
- set out a five-year Police and Crime Plan based on local priorities
- set the annual local precept and force budget
- make grants to organisations aside from the police, including but not limited to CSPs.

These statutory functions are intentionally broad and flexible to allow working arrangements to develop in ways that are most effective and meaningful locally, and to allow scope for innovation.

Given the significant health inequities among offenders and ex-offenders, PCCs are likely to have particular interest in working with local health and care agencies.

Health and wellbeing boards will be key partners given their responsibility for JSNAs and JHWSs that will inform the commissioning of local health and care services. Since PCCs will be commissioning services to cut crime, they may wish to align the needs and strategic priorities in the Police and Crime Plan with JSNAs and JHWSs in their local area.

For more information, see:
www.homeoffice.gov.uk/police/police-crime-commissioners/partners/partnership-working/health-and-care-sector

www.homeoffice.gov.uk/publications/police/pcc/working-with-others

membership of the board of at least one elected representative; a representative from each local CCG whose area falls within or coincides with the local authority area; the local authority directors of adult social services, children's services, and public health; and a representative from local Healthwatch.

The local authority can appoint to the health and wellbeing board additional non-statutory members it considers appropriate and who would support the work of the board, such as CJS agencies.

JSNAs and JHWSs

Local authorities and CCGs have a shared responsibility to undertake JSNAs and develop JHWSs through the health and wellbeing board. Together, they will drive local commissioning policies and practice. They are the key mechanism by which health and wellbeing boards will engage with their local partners.

JSNAs are local assessments of current and future health and social care needs, including mental health, health protection and prevention. In developing JSNAs, each board should give attention to the needs of the whole local community, including:

- vulnerable groups experiencing health inequalities, such as offenders and ex-offenders
- wider social and economic factors that impact on health and wellbeing
- what health and social care information the local community needs.

They should also consider what local communities can offer in resource terms to meet these needs. As a result, JSNAs should engender a shared understanding across all local partners of what the local communities' needs and assets are and where key inequalities exist.

JHWSs are strategies to meet the needs identified in JSNAs. They should not seek to cover everything, but

prioritise areas where health and wellbeing board members can take collective action and make the biggest impact. Local commissioning plans for health and social care services must take JSNAs and JHWSs into account – seeking to address both the agreed local priorities in JHWSs and the wider needs identified in JSNAs relevant to those service areas. JHWSs should also be used to influence other local services that impact on health and wellbeing outcomes – including for offenders, ex-offenders and victims of crime.

The health and wellbeing board must involve local Healthwatch and the wider local community throughout the JSNA and JHWS process. Local Healthwatch organisations will be commissioned by local authorities, replacing local involvement networks (LINks).

Every health and wellbeing board will need to consider inclusive ways of engaging people from different parts of the community; recognising the value of engaging with socially excluded and vulnerable groups, such as offenders, ex-offenders and victims of crime, if their health and care needs are to be successfully addressed by commissioners. Health and wellbeing boards will therefore benefit from working closely with other partners, such as CJS agencies, PCCs, CSPs, youth justice services and troubled families coordinators, to reach a thorough understanding of local needs and how to address them.

Guidance on JSNAs and JHWSs is being developed by the Department of Health and will be available before the end of 2012, and operating principles for building success for JSNAs and JHWSs can be found at **www.nhsconfed.org/HWB**

Key reasons why every health and wellbeing board should take account of the health and care needs of people in contact with the CJS

Significant health inequalities are experienced by offenders, ex-offenders and those at risk of offending, in comparison with the general population. Research evidence shows they are more likely to smoke, misuse drugs and/or alcohol, suffer mental and physical health problems, report having a disability, self-harm, attempt suicide and die prematurely. Yet despite facing greater need, many offenders, ex-offenders and those at risk of offending, as well as victims, face difficulties accessing mainstream health and care services or use them erratically.

Since there is an identifiable link between health inequalities and offending behaviour, improving their health outcomes can markedly reduce re-offending rates. For example, drug users are responsible for between a third and a half of all acquisitive crime, yet effective support and treatment can cut the level of crime they commit by half. In turn, a reduction in

Case study: Incorporating the health and care needs of prisoners into a JSNA

Wiltshire Health and Wellbeing Board has incorporated the health and care needs of prisoners and ex-prisoners from HMP Erlestoke – an adult male, category 'C', closed training prison – into its JSNA. These needs were identified through a health needs assessment carried out for the prison in 2011, and include sexual health, infectious diseases, mental health and substance misuse.

The JSNA also provides information on several programmes shown to effectively work locally in addressing some of the needs. One of these is the NHS Health Trainer programme for prisoners who, after completion of training, work on a one-to-one basis with fellow offenders to support behaviour change to improve health. Since July 2009, more than 20 prisoners have successfully qualified as health trainers. An evaluation of the programme reported that, of 117 personal health plan goals agreed with the prisoner clients of health trainers, more than 80 per cent were partly or fully achieved. Diet-related goals, including 'diet change' and 'increase in fruit and vegetable intake', accounted for four out of ten of these health goals.

Commissioning functions in the reformed health and care system

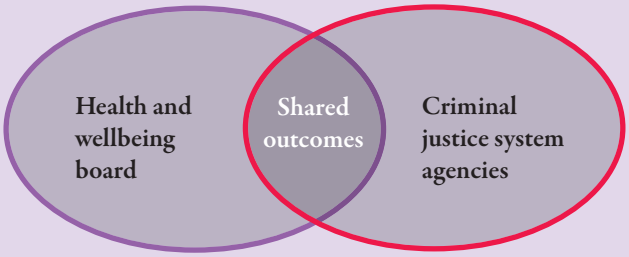
Clinical commissioning groups (CCGs)	NHS Commissioning Board (NHSCB)	Local authorities
Responsible for commissioning: • health services for adults and young offenders serving community sentences or completing custodial sentences on licence, supervised by the local probation trust • emergency care, including 111, A&E and ambulance services, for prisoners and detainees • mental health services, including assessment at arrest and advice to courts (as well as psychological therapies) • treatment services for children, including child and adolescent mental health services (CAMHS) • treatment for mental ill health, including community sentences with a mental health treatment requirement • alcohol health workers in a variety of healthcare settings • promoting early diagnosis, as part of community health services and outpatient services • drug misuse advice and treatment in the community, which may form part of other healthcare contacts.	Responsible for commissioning: • primary care, including mental health, secondary care, drug and alcohol treatment services • health services (excluding emergency care) and public health services for people in prisons and other custodial settings (adult prisons, young offender institutions, juvenile prisons, secure children's homes, secure training centres, immigration removal centres, police custody suites) • public healthcare for people in prison and other places of detention • sexual assault referral services (SARCs) • mental health interventions provided under GP contract • some specialised mental health services • secure psychiatric services • brief drug, alcohol misuse and tobacco control interventions in primary care.	Responsible for commissioning: • drug misuse services, prevention and treatment • alcohol misuse services, prevention and treatment • local tobacco control activity, including stop smoking services, prevention activity, enforcement and communications • sexual health advice, prevention and promotion • mental health promotion, mental illness prevention and suicide prevention • local programmes to address inactivity and other interventions to promote physical activity • adult and young people's social care services • vulnerable adult accommodation services.

re-offending is likely to bring health and wellbeing benefits to a wider local population as a result of improved community safety.

There is an ideal opportunity to tackle the health and care needs of people whilst they are in contact with their local CJS agencies. CJS agencies have the local knowledge, experience and evidence base of what works in delivering improved health outcomes. Most people in contact with the CJS are not in prison or another place of detention. All commissioners and providers of local health and care services will have an offender and ex-offender population within their community whether or not they have a prison in their local area, as well as victims of crime and those at risk of offending. Commissioning of health, drug, alcohol and mental health services in the community will support the courts in using all available sentencing options. This may involve specified treatments for people as part of community orders which support both health and justice outcomes.

Furthermore, considerable cost savings for the NHS and care agencies can be achieved locally as a result of

Potential shared outcomes across the Outcomes Frameworks



NHS Outcomes Framework 2012/13

- Improving experience of healthcare for people with mental illness

Adult Social Care Outcomes Framework 2012/13

- The proportion of adults in contact with secondary mental health services in paid employment
- The proportion of adults with learning disabilities in paid employment

Public Health Outcomes Framework 2012/13

- People with mental illness and/or disability in settled accommodation
- Suicide
- Domestic abuse
- Violent crime (including sexual violence)
- Re-offending
- Statutory homelessness
- Hospital admission as a result of self-harm
- Smoking prevalence – adults (over 18)
- Successful completion of drug treatment
- People entering prison with substance dependency issues who are previously not known to community treatment
- Alcohol related admissions to hospital

Outcomes aimed at children and young people

- Hospital admissions caused by unintentional and deliberate injuries in under 18s
- First-time entrants to the youth justice system
- Emotional well-being of looked after children
- Smoking prevalence – 15-year olds

For more information see: *Integrating the outcomes frameworks* (2012) **www.nhsconfed.org/Publications/Pages/lresources-health-wellbeing-boards.aspx**

Report of the Children and Young People's Health Outcomes Forum (2012) **www.dh.gov.uk/health/files/2012/07/CYP-report.pdf**

interventions that help reduce smoking, alcohol and drug dependency, all of which have higher prevalence among people in contact with CJS agencies. For example, evidence suggests that the community benefits by £2.50 for every £1 spent on drug treatment. (Jones et al (2009) *Drug treatment outcomes research study: final outcomes report*. The Home Office.)

The 2012/13 NHS, Public Health, and Adult Social Care Outcomes Frameworks include a number of potential shared health and wellbeing outcomes linked to reducing violence, offending and re-offending behaviour and support of victims of crime. These are useful tools to underpin and support local joint working between health and wellbeing boards and CJS agencies.

Top tips for health and wellbeing boards on building positive partnership working with CJS agencies

- Understand that better access to continuity of care through the offender journey, and integrated delivery of services, can help reduce offending and re-offending, benefiting the health and wellbeing of the wider local community.
- Build on relationships that already exist at a local level between health and wellbeing board member organisations and CJS agencies, including shared membership of CSPs and of local criminal justice boards.
- Recognise that CJS agencies and professionals often have detailed insight into the individual health and social care needs of people in contact with the CJS.
- Utilise the knowledge that CJS agencies have of evidence-based interventions that produce the most effective and cost-effective health and wellbeing outcomes for offenders and those at risk of offending or re-offending at the local population level.
- Consider that CJS agencies, such as prisons, probation trusts and youth offending teams, have highly trained and experienced staff actively involved in a wide range of physical and mental health, substance misuse and social care work; for example, teams of psychologists and mental health trainers who design and deliver interventions to improve offender skills in managing their physical and mental health, social care and relationships.

Case study: Integrated working between CJS agencies and health and social care services

The Warrington New Directions programme provides early intervention integrated working across more than 25 local CJS agencies and health and social care services, to meet the needs of adults in contact with the police and perceived to have mild/moderate mental health problems. Beneficiaries of the service, operating since 2008, may be offenders, victims or those deemed to be at risk or in distress. Many have multiple and complex needs, but are unable to advocate for themselves, and would not normally be helped until their condition deteriorates further.

Social workers linked to the criminal justice liaison team repeatedly attempt, over a month, to contact those identified, to offer a holistic needs assessment, including physical health, social networks, housing and benefits, as well as mental health. The social workers provide brief interventions as well as support to make and keep appointments with appropriate organisations to address the identified issues impacting on their mental health.

An evaluation of the service revealed that 74 per cent of those assessed had experienced mental health problems. Many were also found to suffer from housing issues (50 per cent), alcohol misuse (45 per cent), financial problems (45 per cent), and self-harm (42 per cent). Significantly more than 60 per cent of referrals have an offender history.

Top tips for CJS agencies on engaging with health and wellbeing boards

- Be proactive in engaging with health and wellbeing boards, since the boards are mostly newly formed bodies attempting to work in new and different ways with partners.
- Utilise existing local partnership arrangements between CJS agencies and local authorities, for example, CSPs and local criminal justice boards, to inform JSNAs and JHWSs.
- Identify potential areas for shared outcomes on health and criminal justice, for example, getting offenders and ex-offenders off drugs for good and tackling offender alcohol dependency with a focus on recovery.
- Marshal the evidence base and cost effectiveness of current offender and ex-offender health programmes and initiatives that can support commissioning decisions.
- Recognise the benefits of sharing knowledge and experience with the health and wellbeing board of 'what works' in relation to health and social care treatments and interventions for people in contact with the CJS.
- Develop structured partnership links with emerging local Healthwatch to ensure there is active engagement with the different local communities in contact with the CJS, including offenders, those at risk of offending or re-offending and victims of crime, and encourage their engagement with local Healthwatch.

Ten questions every health and wellbeing board should ask about working in partnership with CJS agencies

1. Do board members have an awareness and understanding of the positive local health outcomes linked to improving the health of people in contact with the CJS, including offenders and those at risk of offending or re-offending as well as victims?
2. Does the board have a good understanding of how current investment in the health of people in contact with the CJS is deployed, and the levels of access this provides?
3. Is there a local needs assessment incorporated into JSNAs that identifies the health and social care needs of people in contact with the CJS?
4. Do local commissioning plans explicitly recognise the service needs of offenders and ex-offenders including health and re-offending prevention services?
5. Is there a coherent and agreed partnership strategy with CJS agencies for offender and ex-offender health?
6. Do health and wellbeing board members recognise that new ways of partnership working are required and has consideration been given to how partnership links with local CJS agencies can be strengthened?
7. Is integrated care for people in contact with the CJS commissioned through providers and other organisations with clear shared priorities and vision?
8. Are primary care services aware of the wider needs of people in contact with the CJS and are they able to signpost and refer for example, for housing, employment, benefits etc.
9. Are offenders supported to maintain continuity of health and social care from prison to community?
10. Is there active engagement with the different local community groups in contact with the CJS, including offenders and those at risk of offending or re-offending as well as victims, through local Healthwatch and other agencies?

Ten questions CJS agencies should ask about working in partnership with health and wellbeing boards

1. Do you understand how JSNAs and JHWSs and commissioning plans fit together in the new local health and care system?

2. Do you know how to input into and influence JSNAs and JHWSs?
3. Has the health and wellbeing board been made aware of the responsibilities across the local CJS for delivery of local offender and ex-offender health outcomes?
4. Is key evidence (including quantitative data and analysis, and qualitative information) on health and health inequalities among people in contact with the CJS, shared with the health and wellbeing board and member organisations?
5. Do CJS agencies share an awareness and acceptance of the benefits of integrated planning, commissioning and delivery of health and care services across the CJS?
6. Is there a coherent and agreed partnership vision across local CJS agencies for offender and ex-offender health priorities and outcomes that can be shared with the health and wellbeing board?
7. Are all CJS partners open and willing to explore new ways of partnership working?
8. Are local CJS leaders clear about their roles and responsibilities in terms of fostering joint working between CJS agencies and the health and care system at local level?
9. Are CJS agencies willing and able to align their priorities for delivering improved health outcomes in the CJS with those of JHWSs?
10. Is there recognition of the benefits from strong and effective leadership, able to influence and motivate across organisational boundaries to translate locally agreed health and wellbeing priorities into action?

Case study: A multi-agency approach in North Somerset

In North Somerset an intensive multi-agency approach is being used to address the interrelated health and care needs of the offender population. The North Somerset Reducing Reoffending Board gives particular emphasis to early intervention strategies, overseeing a body of projects developed along eight pathways out of re-offending: accommodation; employment, learning and skills; mental and physical health; drugs; alcohol; finance, benefits and debt; children and families; attitudes, thinking and behaviour.

The Integrated Offender Management Scheme, IMPACT, is a core part of the overall programme. This multi-agency model has been developed on a cost neutral basis by bringing together professional resources already involved with offender care, wherever possible being co-located, to jointly manage the needs and interventions for offenders.

Established in 2011, IMPACT is already evidencing positive early impacts in terms of reductions in offending.

Further information/resources

Department of Health resources on offender health:
www.dh.gov.uk/health/search?q=offender%20health

Department of Health draft guidance for JSNAs and JHWSs:
www.dh.gov.uk/health/2012/07/consultation-jsna/

Information on commissioning and delivery of health and wellbeing services across the youth justice system:
www.chimat.org.uk/youthjustice

APACE (2012) *Cutting crime and building safer communities. An introduction to becoming a commissioning organisation*.
www.academyforjusticecommissioning.org.uk/document.php?doctype[]=53

Department of Health (2011) *Joint Strategic Needs Assessments and joint health and wellbeing strategies explained*.
www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131733.pdf

Department of Health (2012) *Local Healthwatch: a strong voice for people – the policy explained*.
www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_132922

Local Government Association (2011) *Police and crime commissioners: a guide for councils*.
www.local.gov.uk/c/document_library/get_file?uuid=c0cc4372-f588-4685-88fd-b3b380c4a77a&groupId=10171

Ministry of Justice (2010) *Breaking the cycle: effective punishment, rehabilitation and sentencing of offenders*.
www.justice.gov.uk/consultations/consultation-040311

National Offender Management Service (2012) *NOMS commissioning intentions for 2012–14. Discussion document*.
www.justice.gov.uk/downloads/about/noms/commissioning-intentions-2013-14.pdf

NHS Commissioning Board (2012) *Developing commissioning support: towards excellent service*.
www.commissioningboard.nhs.uk/files/2012/01/NHSCBA-02-2012-8-Guidance-Developing-commissioning-support-Towards-service-excellence.pdf

NHS Confederation (2011) *Operating principles for health and wellbeing boards*.
www.nhsconfed.org/Publications/reports/Pages/Operating-principles.aspx

National Treatment Agency for Substance Misuse (2012) *JSNA support pack for commissioners*.
www.nta.nhs.uk/uploads/commissionersjsna.pdf

National Treatment Agency for Substance Misuse (2012) *Treat addiction – cut crime*.
www.nta.nhs.uk/news-2012-cutcrime.aspx

This document was developed as part of the National Learning Network for health and wellbeing boards, a programme funded by the Department of Health and supported by the NHS Confederation, the Local Government Association and the NHS Institute for Innovation and Improvement. Each health and wellbeing board learning set has focused on a theme that early implementers have said is of most interest and importance.

It aims to provide health and wellbeing board members with an accessible and helpful resource and does not necessarily showcase best practice but represents key learning on the issues. For further information, or to comment, please email **hwb@nhsconfed.org**

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