

DRAFT FOR ENGAGEMENT

Armed Forces Health - Strategy



NHS England Armed Forces Health Strategy

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1. Executive Summary

This document is the first version of the 2014/15 Strategic Plan for Armed Forces Health commissioning within NHS England. The document sets out the current position for armed forces health commissioning in the context of the first year of explicitly commissioning services for this population and describes our ambitions for the next five years.

This version of the Strategy begins to consider the ambitions for the community in 2014/15 and beyond in the context of our current position and what is known about national expectations. The plan has been refreshed from the key lines of enquiry submitted earlier in 2014 to reflect the requirements of the NHS England Business Plan 2014/15 – 2016/17 and to reflect the feedback received from stakeholders as part of the consultation process and colleagues as part of the assurance process undertaken within NHS England.

1.1 Long Term Vision

Our vision is to obtain the best health benefit from the available resources by commissioning high quality, safe and effective care for Armed Forces personnel and their families, in accordance with the Armed Forces Covenant and the NHS Constitution.

Our values and principles

To achieve our vision we will:

- Work with Defence Medical Services to support them in their task of ***promoting, protecting*** and ***restoring*** the health of the Defence population in order to maximise fitness for role. We will achieve this by commissioning a comprehensive core service.
- Make evidence based decisions
- Listen to and learn from patient experiences
- Ensure that Armed Forces personnel are not disadvantaged in their access to healthcare be that offer, access or outcome
- Ensure that special consideration is given to those injured as a proper return for their sacrifice

1.2 Sign off

2. Introduction

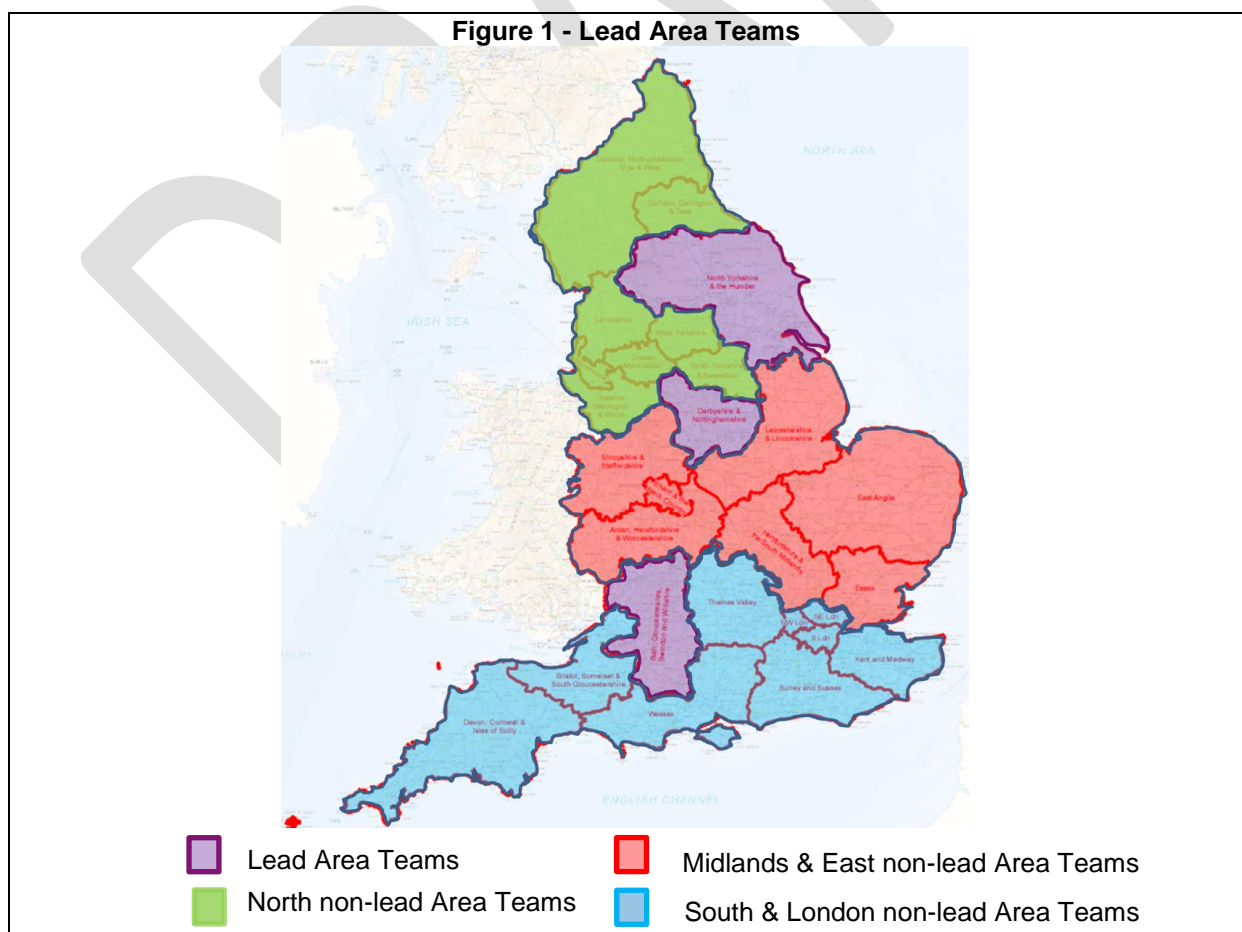
This document provides information about NHS England's Armed Forces Health commissioning plans for 2014/15 to 2018/19

NHS England (known legally as the NHS Commissioning Board) is an independent organisation that operates across England, at arms-length from government. Through its 27 local area teams, NHS England is responsible for directly commissioning:

- Primary care services (including GP services, dental services and pharmacy services)
- Secondary care dental services
- Specialised healthcare services
- Healthcare services for offenders and those within the justice system
- Some healthcare services for the armed forces and those families registered with a Defence Medical Services (DMS) practice.

NHS England Armed Forces delivers the last of these through three Area Teams and a National support team.

Our three Area Teams cover the four regions of NHS England and are shown in Figure 1



- North Yorkshire and Humber Area Team covering the North Region
- Derbyshire and Nottinghamshire Area Team covering the Midlands and East Region
- Bath, Gloucestershire, Swindon and Wiltshire Area Team covering London and the South Regions

Our focus in direct commissioning is on improving health outcomes for patients and ensuring equity and consistency in the provision of health services, but with services tailored to meet local need. This includes establishing national service specifications and commissioning intentions, which are then tailored locally.

NHS England also works closely with local Clinical Commissioning Groups (CCGs) to support them to use their local knowledge and understanding of the needs of local patients to commission a wide range of other community and hospital services.

CCGs have specific duties for the commissioning for Reservists when not mobilised, Veterans and Armed Forces Families except the few registered with DMS practices. CCGs will also need to consider the needs of serving personnel transitioning out of the Armed Forces, particularly when they have been wounded, injured, or are sick.

CCGs are also developing their five year plans and we will need to ensure that CCGs are aware of our strategic direction as this will influence service that CCGs may wish to commission for Reservists, families and veterans. Our plan on a page was shared with CCGs as part of the engagement process.

2.1 The national context

Each year the Government publishes the NHS mandate setting out ambitions for the National Health Service. This can be viewed at <https://www.gov.uk/government/publications/nhs-mandate-2014-to-2015>. The mandate details the outcomes that the Government wants the NHS to achieve for patients but gives clinical commissioning groups (CCGs) and NHS England (through its direct commissioning role) flexibility on how these are delivered.

Much of the basis for the Government's mandate originates in the NHS Outcomes Framework which describes the five main categories of better outcomes we want to see within the health service:

- a. We want to **prevent people from dying prematurely**, with an increase in life expectancy for all sections of society.
- b. We want to make sure that those people with long-term conditions, including those with mental illnesses, get the **best possible quality of life**.
- c. We want to ensure patients are able to **recover quickly and successfully** from episodes of ill-health or following an injury.
- d. We want to ensure patients have a **great experience** of all their care.
- e. We want to ensure that patients in our care are **kept safe** and protected from all avoidable harm.

Delivering these identified long-term ambitions will require transformational change across health and care systems and in the way health services are delivered. That is why in July 2013 NHS England (along with our national partners) launched *A Call to Action* which set out the challenges and opportunities faced by the health and care systems across the country over the next five to ten years. We need to find ways to raise the quality of care for all in our communities to the best international standards, while closing a potential funding gap of around £30 billion by 2020/21.

On the 20th December NHS England issued planning guidance to CCGs and NHS England direct commissioners titled *Everyone Counts: Planning for Patients 2014/15 to 2018/19*. This sets out how it is proposed to invest the NHS budget so as to drive continuous improvement and to **make high quality care for all, now and for future generations** into a reality. The planning guidance can be viewed at <http://www.england.nhs.uk/2013/12/20/planning-guidance/> and will be used to inform the development of local health services for the Armed Forces.

Change will need to be achieved through:

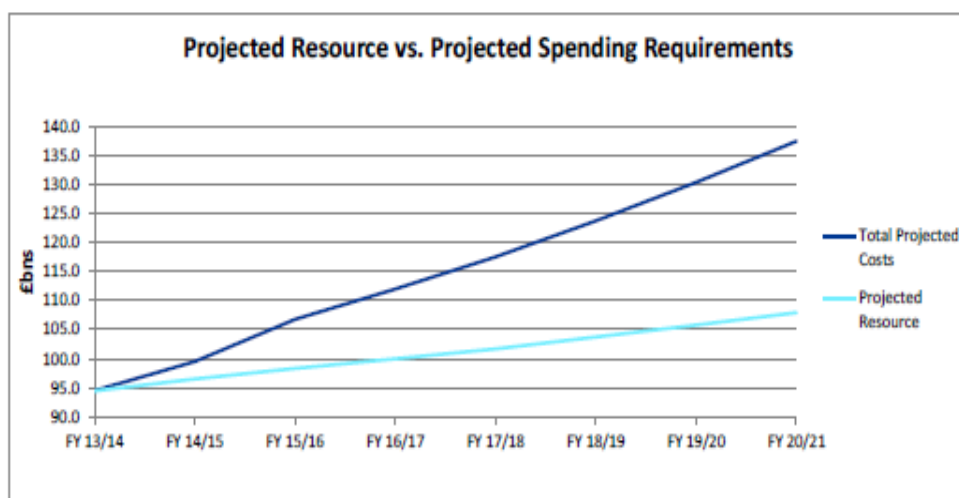
- Listening to patient views
- Delivering better care by realising the benefits of the digital revolution
- Transparency and sharing data about local health services
- Transforming services
- Ensuring tailored care for vulnerable people
- Delivering care in a way that is integrated around the individual patient
- Ensuring access to the highest quality urgent and emergency care
- A step change in the quality of elective care
- Providing specialised services concentrated in centres of excellence
- Improving access to services (e.g. moving to seven day service provision)
- Supporting research and innovation
- Developing an integrated training model

NHS England is focused on ensuring equity and consistency of provision but with services tailored to meet local need. This includes establishing national service specifications and commissioning intentions, which are then tailored locally. The following sections provide information on the development of commissioning plans and intentions for those services that NHS England directly commissions for the Armed Forces, taking account of the national planning guidance and commissioning intentions.

2.2 The financial challenge

Nationally there is a forecast national financial gap of circa £30 billion by 2020/21, across all commissioners. This is shown on the graph below. This is based on projections on the rising costs of healthcare, largely due to an ageing population and

the current projected funding available to meet these costs.



The affordability challenges (or more accurately the demand challenges) in 2014/15 and 2015/16 are real and urgent. The prospect of resources being outstripped by demand, driven largely by an ageing population and an increasing prevalence of chronic diseases, presents a significant challenge to the way the NHS currently commissions and provides care.

The Armed Forces population is a small percentage of the national population and with a necessarily fit and healthy population is arguably facing less of an impact from demographic demand changes. However, demography is not the only driver of cost, and others such as pace of change of healthcare technology will have a greater impact on this population. Regardless of the drivers we will have a 'part to play' in delivering the financial challenge and the armed forces population will see an impact as our co-commissioning CCGs redesign services to help meet the challenge.

3. Our Population

Serving members of the Armed Forces, Reservists, Veterans and all of their families form part of a larger 'Armed Forces Community'

- **Serving Armed Forces** – Approximately 140,000 people, all of whom are registered with Defence Medical Services (DMS) Medical Centres in England. (Northern Ireland, Scotland and Wales have approximately 20,000 serving Armed Forces and registered dependants which are *outside* the scope of the NHS in England and some are based overseas under DMS or other arrangements). Approximately half of the England DMS-registered population is concentrated in four areas (Devon, Hampshire, Wiltshire and North Yorkshire).
- **Their families** – i.e. spouses / partners and dependent children and adults. Most are registered with NHS GP Practices and are the responsibility of CCGs. Approximately 20,000 are registered with DMS Medical Centres in England and are the responsibility of NHS England.
- **Veterans** – A Veteran is defined as anyone who has been a member of the serving Armed Forces for a day or more. There are approximately 4.8 million

veterans in the UK (4 million in England). All should be registered with NHS GP Practices and are the responsibility of CCGs

- **Reservists** – Reservists are civilians who are called in to the serving Armed Forces from time to time for particular tours of duty. Reservists are regarded as members of the Armed Forces while mobilised. When not mobilised, reservists should be regarded as veterans when accessing NHS care.
- **Overseas** – In addition to the England-based population, there are 36,000 serving Armed Forces and dependants in Germany, and 17,000 on other overseas operations / postings. All have a right of return to receive NHS secondary and community care in the UK. However DMS remain responsible for the local provision of services in overseas bases.
- **Devolved Administrations** – ‘Devolved Administrations’ mean Scotland, Wales and Northern Ireland. The normal rules of NHS commissioning responsibility apply. NHS England has responsibility only for commissioning health services for members of the Armed Forces and their families registered with DMS practices in England or, for those posted Overseas, who choose to return to use NHS services in England. Devolved Administrations are responsible for commissioning care for members of the Armed Forces and their families registered in their countries or who return from Overseas to use services located in Devolved Administrations.

Commissioning responsibility for these populations is shown in the table

Demographic Details

- 51% of the Armed Forces population is aged under 30
- 82% is aged under 40
- 9.7% of the serving population is female
- 58% of the serving population is in the Army, 20% in the Navy or Royal Marines and 22% in the RAF.
- 17% of the serving population are officers (14% Army to 22% RAF); 83% other ranks (78% RAF to 86% Army)
- Overall 7.1% of the serving population are from a BME group (2.4% of officers, 8.1% of other ranks)

3.1 Physical Health needs of the Armed Forces

- Members of the Armed Forces are typically younger and fitter than the general population. As such, there is low prevalence of long-term conditions but higher incidence of musculoskeletal injury. Combat-related injuries aside, Armed Forces healthcare needs can usually be met by standard NHS services.
- The greater investigation of the population, to meet occupational requirements, may give rise to asymptomatic but unmet health needs.
- The families and dependants of serving Armed Forces members have health needs typical of their age and gender. Maternity services and children’s health services in particular must be planned and commissioned with the needs of military families in mind where they are present in large numbers in a community.
- Members of the Armed Forces may also have specific Health needs that relate to their occupation or employment and have extensive occupational health support. Where the services needed for occupational health exceed the normal NHS

services or standards, they will remain the responsibility of DMS to commission, pay for or deliver.

- The MoD produces an annual report on the Health of the Armed Forces, key themes from the report include:
 - Health promotion – smoking cessation, oral health and alcohol misuse
 - Musculoskeletal problems
 - Mental health
- It is recognised that military personnel put themselves in harm's way in the service of their country, risking risk injury or death in the course of their duty. Successive governments have recognised the debt society owes to its Armed Forces, their families and veterans, and most recently Society's obligations were recently set out in the *Armed Forces Covenant*, a framework for the duty of care Britain owes its Armed Forces. In terms of healthcare, the key principle is that they experience no disadvantage in accessing timely, comprehensive and effective healthcare. They will also receive bespoke services in some agreed areas for their particular needs or combat-related conditions including, for instance, specialist limb prostheses and rehabilitation.
- DASA provide statistical information on patients that were very seriously injured (VSI) or seriously injured (SI) on Operation HERRICK (Afghanistan) between 8 October 2007 and 31 March 2013 based on the NOTICAS signal data. Key points are:
 - 512 casualties had survived, of these, 207 are amputees,
 - 123 of the 512 have been discharged from the armed forces and are now veterans;
 - 126 of the total NOTICAS reported VSI or SI have been assessed as having a mental disorder. Of which, 33 were assessed as having Post Traumatic Stress Disorder (PTSD). It should be noted that the assessment of a mental disorder may not be related to the VSI/SI injury sustained on Op HERRICK.
 - 320 personnel who had an initial NOTICAS classification of VSI or SI on Operation HERRICK between 8 October 2007 and 31 March 2013 had survived their injuries and had closed care pathways, indicating that no further specialist care was required. On average (median) the length of the closed pathways were 614 days. 45 personnel returned to the UK for treatment and subsequently redeployed after their care pathway closure date.
 - As at 1 June 2013, 136 personnel who had suffered a VSI or SI on Operation HERRICK between 8 October 2007 and 31 March 2013 were still in Service with a closed pathway.

3.2 Mental Health needs of the Armed Forces

There is a public perception that the Armed Forces community have a range of mental health problems and in particular suffer from Post-Traumatic Stress Disorder (PTSD). In 2009 the Academic Centre for Defence Mental Health undertook a useful review of evidence on the health and social outcomes - and the health service experiences - of UK ex-service personnel. Their findings highlighted that:

- The ex-service population has comparable health to the general population and a broadly similar prevalence of mental health-related conditions.

- Current UK military personnel have higher rates of heavy drinking than the general population.
- The most common mental health issues experienced by ex-service personnel are alcohol misuse, depression and anxiety disorders.
- Military personnel with mental health problems are more likely to leave the armed forces and are at increased risk of adverse outcomes in post-service life.
- The minority who leave the military with psychiatric problems are at increased risk of social exclusion and ongoing ill health.
- The overall rate of suicide is no higher than for the general UK population, with the exception of male veterans aged 24 or younger who are at increased risk compared to their general population counterparts.
- Early service leavers are more likely to have adverse outcomes and carry out risk taking behaviours than longer serving veterans.
- Deployment to Iraq or Afghanistan is associated with adverse mental health outcomes for some groups, particularly those with pre-service vulnerabilities, those who experience a high level of combat and reservists.

The Ministry of Defence (MoD) publishes an annual mental health report, providing statistical information on mental health in the Armed Forces. Key points are:

- Of the 6,700 new episodes of care at Department of Community Mental Health (DCMH), a DMS provider, in 2012/13, 5,058 (75%) were assessed as having a mental disorder, representing a rate of 27.1 per 1,000 at strength.
- The populations at risk for new episodes of mental health disorders in the UK Armed Forces between 2007/08 and 2012/13 were :
 - Army and RAF personnel (Lower rates of mental disorder among Royal Marines may be due to the recruitment selection process and support received as a result of tight unit cohesion);
 - Females (this is replicated in the UK civilian population and may be a result of females being more likely to report mental health problems than males);
 - Other Ranks (Higher educational attainment and socio-economic background are associated with lower levels of mental health disorder and this may explain differences in the rates between officers and other ranks)
 - Personnel aged between 20 and 39 years.
- Previous deployment to Iraq/Afghanistan was not a predictor for being seen at a DCMH for a mental health condition for the Armed Forces as a whole.
- Neurotic disorders were the most prevalent disorder throughout the six year period and had a significantly higher rate than all other mental health disorders over all years presented. Adjustment disorder accounted for the majority of all neurotic disorders (61%, n=8,679), whilst PTSD remained a rare condition and only accounted for 10% of all neurotic disorders (n=1,369) over the six year time period.
- Depressive episodes accounted for around 80-90% of all mood disorders year on year since 2007/08. The most likely explanation is that the other types of mood disorder (manic episode, bipolar affective disorder and persistent mood disorder) are rare in a fit young population which typifies the UK Armed Forces.

3.3 Strategic Issues affecting our population

Planned changes to the population

During the lifetime of this strategy we know that the population we are responsible for will change. There are three main influences:

- A general change in demography with more females in the armed forces, and a change in female roles in the services, e.g. female submariners
- FR20 - The White Paper Future Reserves 2020 indicated that MoD planned to enhance role of Reservists and with that to raise the healthcare offered to them to the same level as those of regular service personnel (especially in rehabilitation). This will include enhanced occupational health and hence more illness and disease is likely to be identified. The recommendation of the 2011 Independent Commission Reviewing the UK Reserve Forces was that by April 2020 the trained Volunteer Reserves should increase to 34,900, including 30,000 in the Army Reserves. The current FR20 population of trained personnel was 21,870 as at October 2013, of which 19,090 were in the Army
- Rebasing - within the timescale of this Strategic Plan troops currently based in Germany are also returning to the UK and will be integrated into existing UK based Garrisons and Barracks.

These changes will impact on both NHS England, as numbers of service personnel change and CCGs as the number of reservists and families change.

3.4 Current position

Until April 2013 serving personnel were not discretely identifiable within NHS systems, with any historic activity forming part of a PCT's data set. From April 2013, NHS systems have been able to identify this population from a hospital based activity perspective but there remains limited outcomes data on this population – for example, the friends and family test does not report at commissioned population level nor do outcome measures such as RTT wait times.

The Defence Analytical Services Agency (DASA), are the official source of defence and national statistics for the MoD and produce a number of reports that have informed this plan, although there are known issues with the commissioning population data which has informed this document . Each of the single Services produces an Annual Report on the Health of their Population and these together with the Defence Medical Services Annual Report have influenced our ambitions.

Needs Assessments for the Armed Forces Community exist at two levels – national assessments undertaken by the each of the single services as part of their annual reports process covering service personnel and at a local level undertaken by CCGs and Health and Wellbeing Boards to reflect their needs of their populations.

National emergent themes include smoking, alcohol and access to services; whilst local themes include access to services particularly for families and veterans and mental health services for veterans.

Through the Armed Forces Networks we will be working with CCGs, Local Authorities health and well-being boards to finalise our plans.

4. Our planning approach including engagement & prioritisation

4.1 Engagement & Prioritisation

Through 'Putting Patients First: The NHS England Business Plan for 13/14 – 15/16' NHS England has an on-going commitment to transparency and increasing the patients' voice in improving patient care. The plan describes an 11 point scorecard which NHS England will introduce for measuring performance of key priorities, focused on receiving direct feedback from patients, their families and NHS staff. This plan supports 3 of the 11:

- Priority 6 – Outcomes Framework – Domain 4 'Ensuring that people have a positive experience of care
- Priority 9 – NHS Constitution rights and pledges, including delivery of key service standards
- Priority 10 – Becoming an excellent organisation

In Armed Forces the Area Teams will work closely with the CCGs and focus on the assets in the local communities where Armed Forces serving personnel and their families are based, working in co-production with patients, families and carers and collaborating to improve outcomes. Working across boundaries and across organisations our ambitious plan aims to:

- scope the current level and quality of PPV in Armed Forces
- jointly agree and develop toolkits to enable improved patient participation for Armed Forces personnel and their families
- with CCGs link to existing patient leadership programme
- ensure that PPV is a central focus of the Armed Forces network programme and is fully embedded into CCG and Health & Wellbeing Board plans
- devise mechanisms to ensure patient participation is integrated into the Armed Forces assurance/ commissioning cycle

Commissioning decisions are better supported when people are involved in identifying problems and designing solutions that work. In building partnerships we will:

- Work with stakeholder groups to look at their sources of feedback and how we can ensure we maximise opportunities to learn from this rich source, as a catalyst, to proactively influence change and drive improvements for patients
- Establish a network of key stakeholders, including patient organisations, to agree a standard definition of "vulnerable" for the purposes of this action. Give consideration to equality and diversity issues faced by vulnerable groups
- Carry out an evaluation exercise on what information provider organisations are currently capturing and how they use it and undertake a gap analysis
- Decide how best to share this information with other health and social care organisations as appropriate and make recommendations for sharing good practice and supporting local organisations as necessary.

Insight gathered from the public helps to improve services and outcomes as well as potentially helping to spot failures. Listening to and using the voice of patients and the public were never more forcefully presented than in the Francis Report.

The use of patient and staff focus groups in the Keogh review and now the Care Quality Commission inspections of health and social care are probably the single most powerful aspect of these review processes, ensuring a cultural assessment, not just a technical one is made. There are many groups, structures and organisations who are already gathering and communicating 'patient voice' and participation really well but the overall impression that the participants in this process have is that the overall system may not be working as well as it could – we need to connect these conversations together and make the voice of the citizen (or patient or even service user) an integral part of strategy, commissioning or structural reform of the NHS.

The aim of creating a national Citizens Assembly for Armed Forces personnel and their families and Veterans will be:

- To create patient leaders for the future
- To give citizens and organisations a direct transparent route for their voices to reach the heart of the NHS England Area Team decision making process, in a way that cannot be ignored.
- To give all local commissioners and others a new source of evidence and opinion on Armed Forces health care now and future.
- To give an open and robust accountability mechanism for the work of NHS England, and opportunities to participate in every aspect of the organisation's work.
- Leads to action, quickly

Without knowing what the Armed Forces Citizen Assembly will look like in detail, as this needs to be designed with the stakeholders, it would however need to consider certain 'tests' to 'feel' successful. Some of these tests are more measureable than others but we wanted to reflect the full range here. The tests are:

Influence

- The Armed Forces Citizens Assembly supports Armed Forces commissioning plans and those of the CCG and health and Wellbeing plans and is an is part of the AF network
- Develop clear indicators from patient experience that commissioners can use
- Enable questions to be used widely and wisely in commissioning conversations alongside other measures, such as service redesign and financial allocations

A trusted process

- The way in which the Citizens Assembly for Armed Forces holds NHS England to account is transparent and seen to be fair
- Decisions should be respected even if not agreed with because we have established trust in the system

No issue is left behind

- No question/issue raised through the Discovery/discuss process will get lost

- Even if it's not a question for NHS England the process should signpost to the right organisation, whether that's the trust next door, social care or another organisation

The difference can be seen

- Patient leaders will support the Armed Forces Citizens Assembly
- Participants will be in the constant loop of feedback
- The conversations will be public
- There will be clear successes to celebrate and failures to genuinely be learned from

Cultural change is part of success

- It must galvanise people by reaching hearts and minds of staff, patients and the wider public
- Consider the recommendations in the Clwyd Review regarding the handling of complaints

No single point of failure

- There will be no single point of failure: one bad experience doesn't bring down the whole process

Issues are looked at from many perspectives

- The issues that are brought to the surface will be widened out by looking at them from different perspectives,
- Discussions will involve a wider range of people and topics than is currently seen – un-usual suspects
- The Armed Forces Citizen Assembly should be listening to the widest possible range of conversations about health: right down to a group of people talking about their experiences while playing dominos

Each of these deliverables is capable of objective evaluation.

4.1.1 Key Stakeholder Engagement

We will be working the MoD to ensure that our strategic vision is signed up at the highest levels, within Surgeon General's Health and Personnel Departments. We will also work with the Health Partnership Forum with Service Charities at a national level

Through the Armed Forces Networks we will work with CCGs and Health & Wellbeing Boards to develop further iterations of our plan, especially the longer term elements. These will include Local Authorities and the armed forces and charities at a local level.

One of the key elements will be Defence Medical Welfare Services, whose mission in support of Armed Forces personnel in hospitals forms a natural group who can reflect the patient experience of armed forces service users.

4.1.2 Clinical Engagement

We have a number of approaches:

At a national level we recognise that clinical leadership and engagement is crucial and this year we established an Armed Forces Clinical Reference Group (CRG) to provide that leadership. The main focus of the CRG in 2014 has been the development of interim commissioning policies to support secondary care activity and ensure consistency of access across England.

The immediate task of the CRG in the coming months will be the development of a framework for prioritisation and to ratify the ambitions set out in this plan.

We have armed forces expertise, from both Regular and Reserves services, on other specialised commissioning CRGs, for example Rehabilitation, Major Trauma and prosthetics; this helps to ensure that the current needs of the armed forces community can be reflected in the general discussions on clinical need and enable knowledge & best practice transfer between Defence Medical Services and the NHS.

We also have clinical representation from the MoD (DPHC and Public Health) on the joint commissioning group, which will oversee the implementation of this strategic plan.

We also are able to access the expertise of the service charities through the Health Partnership Working Group, a collaboration of key service charities including Combat Stress, SSAFA and the Royal British Legion. The service charities are able to provide advice to the NHS on matters that affect the Armed Forces Community and act as an advocate for those communities.

Finally, at a local level we are looking to develop focus groups to seek feedback from a range of groups, including referrers and other clinicians, families and services personnel.

4.1.3 Call to Action

NHS England recognises the significant cultural differences between the civilian world and that of the Armed Forces, the potential challenge that this may pose in engaging with members of the Armed Forces community and that historically systematic engagement with the armed forces community has not occurred.

However in partnership with the MOD, Defence Medical Services and the Personnel & Welfare branches of the Armed services we are committed to undertaking a systematic engagement exercise taking into account all ranks of service personnel, families and children of those serving, reservists and those Defence Medical Services providers and referrers who work on a daily basis with the NHS. By asking these groups their view on their own care and what needs to be better, this will enable us to build a model of participation in whatever (or many) forms e.g. forums, workshops, online discussions or anonymous feedback. We are working in conjunction with our Nursing and Patient & Information directorates.

Clinical leadership and engagement is crucial – this year the Armed Forces Clinical Reference Group has been established and will deliver on its programme of work to inform commissioning plans and ensure any decision making has clinical foundation and rigour.

At a more local level, NHS England hosts the Armed Forces Networks across England. This set of networks ensure local issues for serving personnel and veterans' health are managed through partnerships able to ensure that professionals from across many differing part of health, local authorities, charity and MoD and pathways are kept connected by offering advice and support to those that are transitioning out of service or require assistance in any form.

The Veterans Mental Health Network recognises the specific needs of service veterans and addresses this by establishing on a regional basis, networks of expertise in armed forces mental health to provide specialist assessment and treatment in a culturally sensitive setting.

All these elements will be brought together to establish a Stakeholder Forum within the governance structure of NHS England which will be a representative body of service users across both serving personnel and veterans to review the engagement work undertaken by the programme, and to act on their themes. This forum (alongside the CRG, Armed Forces Network and Veterans Mental Health Network) will report directly to the Armed Forces Oversight Group.

We have started the process of specific Call to Action engagement with an article in the Families Federation Newsletter. To date we have received limited feedback. Local CCGs have also undertaken call to action feedback, and this will have included the views of families, reservists and veterans. Key themes that have emerged are:

- Information
- Education for patients and staff
- Integrated Care/integration of services
- Supporting people to self-care
- Mental Health
- Better use of technology

We will be working with our key stakeholder forums and Armed Forces Networks to feedback on “you said, we did”.

An example of this is the ongoing discussions with the Patients and Public Voice (PPV) team about a specific Armed Forces PPV group and how this would relate to the Armed Forces Oversight group. A suggestion for membership is to ask the Armed Forces Networks to nominate members

5. Enabling Change

5.1 Empowered Citizens

Listening to Patient Views

We will be building upon the engagement work that commenced as part of the 'Call to Action' both locally and nationally as a way of securing views of our population. We know that this community is an enthusiastic user of social media as a method of communicating and providing feedback and we will be working with our patient experience leads to take this forward.

Delivering better care through the digital revolution

During 2012/13 significant progress was made to ensure that all Armed Forces patients were recorded on the NHAIS system, which links to the national spine. In addition to ensuring that NHS systems recognised the NHS number identifier of armed force patients, Defence Medical Services (DMS) implemented choose and book, allowing referrers to view both national and local choice menus and increase the availability of choice to the armed forces community.

From 2014 we will be working with DMS to achieve the full benefits of NHAIS and access to NHS systems, in particular:

- Increasing the uptake of E-referrals (previously choose and book)
- Call, recall and result notification for screening and immunisation services to be at NHS average by April 2015
- Integration of Children's records, especially for the under 5 year olds by April 2015
- Support the mobilisation and demobilisation of Reservists by April 2016
- Enable enhanced transition of service leavers (especially the wounded injured and sick) to civilian medical care by April 2015.

We will also be working with the Patients and Information Directorate and HSCIC in supporting DMS to deliver the CORTISONE programme by 2016. The purpose of the CORTISONE programme is to *"to provide a health and healthcare information capability that delivers the right information to the right people, at the right time and in the right format, in order to enable effective delivery of health and healthcare advice, health and healthcare services and medical operational capability, and thus support the aim of the Defence Medical Services"*

We will be working with DMS over the next 5 years to increase the appropriate use of telehealth and telecare both within DMS and to NHS providers, recognising that the appropriate use of telemedicine offers productivity benefits.

Transparency and data sharing.

We will work with our providers, DMS and the MoD to ensure that:

- There is consultant level activity data by September 2015 for the armed forces population
- There are patient outcomes identifiable for the armed forces population by 2016.
- There is an increase in the adoption of NHS number as the sole identifier, measured by identifying 25% of providers in the bottom quartile and secure improvements through the contract by March 2015.

- Where appropriate patients can have on line access to their medical records, book appointments and manage repeat prescriptions by 2018

We can work with and make use of the care.data programme, recognising that the primary care data is held by the MoD and not the NHS.

5.2 Wider Primary Care

Primary care for service personnel is provided by Defence Primary Healthcare (DPHC), we will, therefore, work with the MoD and DPHC to:

- Understand the changes in NHS primary care and how and whether these should be reflected within DPHC.
- Consider whether there are further collaborations between DPHC and community services including those provided by DMS that could ensure more patients with mild to moderate mental or physical illness access more of their care and support they need in a primary care setting.
- Look at pathway redesign as a means of improving values, quality and outcomes.

5.3 A Modern Model of Integrated Care

We will work with the MoD, DMS, CCGs, service charities and providers to improve the model of integrated care that service personnel and their families receive.

Our particular focus will be on those patients with the most complex care needs. We will work to ensure that:

- The date of discharge from the Armed Forces has no impact on the care decisions made, regardless of how far in the future the date may be.
- Area teams facilitate and support a Multi-Disciplinary team (MDT) approaches for those service leavers that have complex health needs or are considered to be a seriously Wounded Injured or Sick (WIS) individual. This may include organising for continuing health care assessments to be made
- WIS individuals have an agreed personal health plan prior to service discharge and are clear as to the NHS offer and their rights and responsibilities.
- CCGs understand the needs of WIS individuals and their rights under the Armed Forces Covenant.
- The CRG are keen to be in the lead of working with commissioning for outcomes and making use of pooled budgets

For those service personnel with a mental health need we will work to ensure that there is no cliff edge in their transition from Defence Community Mental Health to NHS commissioned services; specifically we will improve continuity of care through the use of personalised transition plans.

5.4 Access to the highest quality urgent and emergency care

We will work with DMS, Clinical Networks and local CCGs and providers to:

- Ensure that the armed forces community is able to access appropriate services and cost effective out of hours primary care services

- Ensure that the armed forces community is able to access appropriate services for those in mental health crisis.
- Ensure that appropriate services are included in NHS 111 directories.
- Ensure that the views and needs of DPHC are represented at Urgent Care Working Groups, where there is a sizeable population at risk (PAR) within the community.
- Ensure that where there is a sizeable PAR their needs are reflected in the plans that CCGs and Health & Wellbeing Boards agree for the Better Care Fund.
- Ensure that the redesign of emergency care systems where there is an associated movement of DMS staff does not result in a destabilisation of providers.

5.5 Productive Elective Care

We will work with DMS, our clinical reference group, local CCGs and providers to:

- Ensure that providers we commission elective services from deliver high quality and safe treatment using the most modern technology and equipment available.
- Identify and support service changes to achieve better outcomes alongside a 20% productivity improvement
- Access innovation funds to ensure the development of best practice within new models of care.
- Look at a more productive use of outpatient appointments to reduce duplication, inappropriate referral and control consultant to consultant referrals.

5.6 Mental Health Services for Serving Personnel and in Transition.

DMS provide or commission most of their own mental health services for the serving population however they do not provide 24 hour crisis care nor care for service families. We will therefore:

- work to get a more precise definition of the areas that are not commissioned or provided by DMS
- Ensure the details of Parity of Esteem and Closing the Gap are applied equally to the Armed Forces population
- Improve (in line with the Crisis Concordat and with CCG commissioning) the access of service personnel to crisis support.

5.7 Specialised Services concentrated in centres of excellence

NHS England specialised team are currently carrying out an assessment of services provided by acute and tertiary care providers to establish whether the specialised services they provide meet the standards of the national service specifications.

Where providers do not meet the standards a derogation process has been applied. The aim of the derogation policy is to ensure an open and objective dialogue between commissioners and providers, to support clear communication to stakeholders on any agreed variation to national requirements.

We will work with Specialised Commissioning and providers to ensure that the any impact on services as a result of the derogation process are taken into account in the

2 and 5 year plan in order to maximise patient safety and experience and to ensure actions are in place to meet key service standards with the minimum delay.

We will continue to work with BLESMA and the 9 Disablement Services Centres (DSC) to implement the recommendations of Dr Murrison's report "*A better deal for military amputees*". This is a two-year investment programme funded by Department of Health grant aid monies to ensure that veterans have access to similar prosthetics and rehabilitation services to those available to wounded service personnel at DMRC Headley Court. We will work closely with the Prosthetics CRG, a sub-group of the Complex Disability CRG and the responsible commissioner for prosthetics on this work programme as there is a common aim to improve prosthetics services.

We will work with DMS, CRGs and Clinical Networks on:

- The evaluation of the need and options for a National Rehabilitation Centre and its possible collocation with a National Defence Rehabilitation Centre.

Any redesign of specialist care to ensure that that any redistribution of DMS workforce is planned well in advance and does not destabilise local providers

6. Improving Quality & Outcomes

6.1 Improving health outcomes in alignment with the seven ambitions

The MoD publishes an annual document about health in the Armed Forces. It is clear from this that the health of the Armed Forces is directly affected by the personnel and welfare policies of MoD, as well as the effects of operational policies (e.g. how people are trained) and active combat operations. The influence of health care is likewise affected by the activities of Defence Medical Services (DMS): Defence Public Health, Primary Health Care (DPHC), Rehabilitation Services, Community Mental Health (DCMH) services, Operational healthcare and a variety of contracts including for inpatient Mental Health.

The population covered is generally younger, physically fitter with a higher percentage of males than the general population and therefore the domains and seven ambitions have limited applicability to the armed forces population; our main aim for the next 5 years will be to develop meaningful outcome data and benchmark this against the best NHS practice, however, where possible we will look to develop metrics and improvement trajectories in line with the spirit of the ambitions.

6.2 Preventing people from dying prematurely

Outcome ambition 1

Mortality of the armed forces population is currently split (roughly equally) between operational casualties, accidents and other illnesses. Therefore only a very small percentage are within the powers of NHS England to affect – but we will seek additional years of life for these. This has limited applicability but we will:

- Work with the MoD to increase screening and immunisation coverage
- Work with Public Health England and MoD to secure baseline and comparable data to identify Potential Years of Life Lost (PYLL) data to look at PYLL rates:
 - from causes considered amenable to healthcare (adults and children)
 - the rate per 100,000 population

6.3 Enhancing quality of life for people with long term conditions

Outcome ambition 2

Given the nature of the role of the armed forces and the need to be medically deployable there are very few in the armed forces population who have long term conditions (LTCs). Any measures are likely to be statically meaningless. Although this has limited applicability NHS England will:

- Seek to work with Public Health England and MoD to secure baseline and comparable data to identify average health status (EQ5D) score for individuals who identify themselves having a LTC.
- Ensure easy & rapid access to appropriate mental health services

- Work with DMS to (reduce the impact of transition from service life to civilian life and avoid discontinuity of care issues for those with a mental health problem

6.4 Helping people to recover from episodes of ill health or following injury

Outcome ambition 3

Reducing the amount of time people spend avoidably in hospital through better and more integrated care in the community, outside of hospital, in for example Regional Rehabilitation Units (RRUs)

NHS England will seek to:

- Work with Public Health England and MoD to secure baseline and comparable data to :
 - identify emergency admissions for acute conditions that should not usually require hospital admission
 - Emergency admissions for children with lower respiratory tract infections
 - Rates per 100,000 population

Outcome ambition 4

Increasing the proportion of older people living independently at home following discharge from hospital; given our population this is not applicable as a measure but NHS England will work with the MoD to develop an alternative measure around discharge of veterans.

6.5 Ensuring that people have a positive experience of care

Outcome ambition 5 – positive experience of hospital care

Delivery of the NHS Constitution standards will help to ensure that our patients access timely care, which will influence their experience. We will ensure delivery of the NHS Constitution standards through our contracts with providers and have in place monitoring systems to ensure performance of providers is monitored to enable contractual performance discussions to be held with providers and co-commissioners where concerns are identified.

The Armed Forces health team will work with Nursing Directorate and Patients and Information to:

- Develop measures and baseline for AF population with a view to benchmarking against CCG patients.
- Link to 15 questions from the national inpatient survey and look at the rate of responses of a poor experience of inpatient care per 100 patients

Outcome ambition 6 – positive experience of care outside of hospital

We will work with DPHC to:

- Reduce poor patient experience of primary care (GP and OOH services) where the NHS is in a position to influence patient experience
- Rate of responses of a fairly poor or very poor experience across GP and OOH services per 100 patients

6.6 Treating & caring for people in a safe environment and protecting them from avoidable harm

Outcome ambition 7

Working with co-commissioners in making significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care. However due to the small dispersed population which may make information and trends statistically irrelevant these outcomes will be monitored through SI reports

6.6.1 Compassion in Practice

Compassion in practice presents a challenge for commissioners; commissioners working in isolation will not give the paradigm shift in care that is required in the Call to Action. The shift in nursing/Allied health professional culture and models of working will be ambitious and radical in order to provide the transformation required in primary and community nursing to enable visionary transformation over the next 5 years.

We will support and work in partnership with CCGs in planning and delivering our vision for our directly commissioned services. We will need to ensure that defence primary care is enabled to play a stronger role as the key to an integrated system of community-based services in improving quality, safety and outcomes for our patients when they access these services.

We will work in partnership with DMS, CCGs, providers and Local Education and Training Boards to develop new models of care ensuring that the nursing/professions allied to nursing workforce is able to deliver the future vision embedding the 6 Cs:

- Reducing the artificial divide between DMS practice and NHS community nursing
- Supporting the development of federated models of care and integration of nursing across organisational and health system boundaries including specialised nursing to fit the patient pathway.
- Ensuring measurable competence across pathways
- Delivering innovative models that are focused on the patient/community not the provider in order to improve care for patients with long term conditions or other vulnerable groups such as those Wounded Injured or Sick personnel in transition.

Safety of patients is of paramount importance especially during radical transformation and wide system change. We will work in partnership with all stakeholders to ensure improvements in safety and reduce avoidable harm:

- Area Team Quality Surveillance Group to provide a wealth of evidence and intelligence to support early intervention when issues develop.
- Ongoing focus on HCAs in the community setting and across organisational and departmental borders.
- Lead on the development of an open safety culture in commissioned services including the improvement of reporting of incidents and sharing of information and learning
- Embed work on culture and human factors affecting safety

- Ensure openness and transparency through publishing meaningful data learning from transparency work already undertaken in the acute settings.
- Work collaboratively with the CQC sharing quality risk issues to aid improvement
- As part of the transition of Health Visiting and School nursing to the Local Authority ensure effective Clinical governance systems are maintained

We will build and strengthen leadership to ensure future models are robust at implementation but also sustainable and flexible for future changes.

We will develop a positive culture and support positive staff experience to ensure there is a positive impact on patient experience.

Compassion in practice implementation plans will be reflected in the services we commission.

6.7 Reducing health inequalities

We will be working with DMS, local authorities and colleagues in Public Health, both Public Health England and within NHS England on the health inequalities agenda. Specific areas of focus are:

- Access to national screening programmes
- Access to the child health information system
- Smoking cessation
- Alcohol misuse
- Maternity - vulnerable & disadvantaged families
- Sexual health services
- Access to mental health services during and after transition

7. Improvement Interventions

There are a number of material transformational interventions required to move from the current state to the desired long term vision. These are set out below and detail the aims of the intervention; the expected outcomes, the costs and timescale for implementation and the enablers and barriers to success.

7.1 Delivering better care through the digital revolution

We will work with DMS to:

- (a) Increase use of E-referrals (previously Choose & Book) building on NHS experience to support the development of users' confidence and expertise, and maximising the benefits to patients and referrers. This will include supporting further development of the advice and guidance functionality, within DPHC
- (b) Increase the use of telemedicine as an alternative to face to face care where appropriate; the demographic of our population lends itself to being early participants in dynamic developments of telehealth delivery.
- (c) Increase access / coverage of national screening programmes.
- (d) Link DMS systems to Child Health Information Systems.

These interventions support the care delivery through the digital revolution. The expected outcomes are:

- Sustained delivery of 18 weeks RTT, with recognition and delivery of the commitments within the Armed Forces Covenant.
- increased care closer to home through the use of E-referral, through provider locator and advice and guidance functionality, and technology developments
- Reduction in numbers defined as medically not deployable / medically limited deployability through joint identification and focus within MoD.
- reduction in travel and subsistence costs to the MoD
- increased access to the screening programmes and a reduction in late diagnosis
- reduction in inequitable access to childhood health programmes

Investment costs

Financial

- E-referral - limited – use of existing structures and systems
- telemedicine – possible deployment cost – expect a reduction in cost of attendances
- screening - £250k to amend national system plus increased screening costs as update increases
- CHIS – national solution being worked upon

Non-financial – workforce change

Implementation timeline

2014/15 for E-referral (Choose and Book) uptake

2014/15 and beyond for access to screening

2014/15 CHIS solution

After 2015 for telemedicine

Enablers

Presence of suitable telehealth / telemedicine schemes

Barriers to success

DMS workforce change

Lack of engagement with providers / enthusiasm to support telehealth / telemedicine

Absence of national solution to support CHIS integration

7.2 Streamlined / co-ordinated access to Musculoskeletal (MSK) services

We will work with DMS to:

- (a) increase use of E-referral, including further development and use of the advice and guidance functionality, within DPHC for access to secondary / tertiary referral for MSK conditions
- (b) Develop existing MSK pathways to make best use of recognised good practice in rehabilitation. We will engage with CCG colleagues to support existing and future work on aligning MoD and NHS outcome requirements.

These interventions support domain 2 – ensure patients are able to recover quickly and successfully from injury. The expected outcomes are:

- sustained delivery of the 18 weeks RTT performance
- increased care closer to home through the use of E-referral provider locator and advice and guidance functionality and technology developments
- reduction in numbers defined as medically not deployable / medically limited deployability through joint identification and focus with MoD
- reduction in travel and subsistence costs to the MoD

Investment costs

Financial – E-referral -limited – use of existing structures and systems

Non-financial – workforce change

Implementation timeline

2014/15 for E-referral uptake

2015 and beyond for implementing pathway redesign

Enablers

Engagement of DMS Regional Rehabilitation Units

Barriers to success

DMS workforce change

7.3 Improved access to mental health services in transition

We will work with DMS (Department of Community Mental Health (DCMH)), CCGs, providers and the third sector to improve access to appropriate mental health services for armed forces personnel and those leaving the armed forces, recognising the potential for service users to become disengaged and drop through the care gap as they move from DMS to NHS provided services.

Will support and promote delivery, via the Veterans' Council, of a managed website for accredited providers of veteran's mental health services to aid both veterans and GPs in identifying services available across England.

Expected outcomes:

- Reduction in late presentation, through veterans and their GPs being aware of available services.
- Reduction in discontinuity of care for those who leave with a mental health issue requiring on-going care.

Investment Costs

Continued investments in nationally funded veterans mental health programmes such as the 24 hour helpline and online counselling service

Enablers

National Veterans' Mental health network

Barriers to success

CCGs may not recognise this as a priority and therefore may not engage or invest in services for veterans.

7.4 WIS leavers to have an agreed targeted health plan

We will be working with the MoD to jointly ensure that all Wounded Injured or Sick (WIS) service leavers, including those with a mental health diagnosis, are discharged with a personal health plan. NHS England will ensure that this plan identifies and engages with the receiving NHS GP so that potential gaps are identified and resolved.

The personal health plan will be designed to empower patients to take more control of their long term health where they are in a position to do so and direct them to the most appropriate professional under the primary care team to manage their routine care needs.

Expected outcomes for personal health plans include:

- Agreed interventions required to maintain and improve health
- Establish review dates and how and where to access care appropriately, e.g. GP, Nursing team, pharmacy
- Provide technology solutions
- Agree self-management plans
- Confirm arrangements for any hospital care to ensure this is appropriate and does not result in delayed discharge, including why specialist centres are the best choice for certain conditions
- Provide a public health activity plan
- Agree other agencies required to support health and wellbeing, e.g. support from veterans' charities

Investment costs

Financial – limited

Non-financial – workforce change within DPHC for service leavers

Implementation timeline

2014 – Agree content of plans with Defence Transition and NHS GPs currently managing WIS patients

2015 – Roll out across Recovery capability

Enablers

Engagement with Defence Transition

Engagement with Personnel Recovery Units

Barriers to success

DMS workforce change

8. Sustainability

8.1 Delivering a sustainable NHS for future generations?

The financial template builds upon the first year of explicit commissioning for the armed forces community, a period which has seen uncertainty in terms of the baseline budget.

In addition to the emergent position regarding healthcare expenditure for the armed forces an attempt has been made to model the future year impact of the current conflict in Afghanistan with particular regard to the cessation of additional HM Treasury funding (NACMO). The long term impact Op HERRICK will be particularly felt in areas such as mental health and prosthetics, a nationally commissioned service, where currently service personnel and veterans are able to access the latest technology such as next generation micro-processor knees. The funding impact of this will be at least £6.5M and will impact in between 3 and 6 years' time.

Overall, the plan assumes a steady state from a Defence perspective.

As the majority of our commissioning activities are as a co-commissioner we will be working with DMS, other direct commissioning functions within NHS England and CCGs to make sure that our actions are sustainable.

Where Armed Forces Health leads on work, particularly around Wounded Injured or Sick (WIS), which has the potential to impact on CCGs we will endeavour to consider sustainability and affordability in our approach to decision making.

We will also be working with DMS to, where possible, standardise the approach to state funded items to help deliver affordability and sustainability.

8.2 Current position – expenditure on secondary care

During 2013/14 there were recognised difficulties in setting and agreeing the baseline position for secondary, community and mental health care spend for this population and as a consequence Area Teams entered into a number of risk sharing arrangements with CCGs.

The three Area Teams have reported a combined full year surplus of £1.3m. This is subject to audit. This is shown in the table below

Month 12 Outturn						Outturn % of allocation	Change from M11 FOT		QIPP Outturn variance £m
Plan £m	Actual £m	Var £m	Var % of allocation	RAG			Previous Month £m	Change £m	
(0.0)	(1.0)	(1.0)	(3.6%)	R	Bath Glos Swindon & Wiltshire	(3.6%)	(1.2)	0.3	0.0
0.0	2.2	2.2	32.0%	G	Derbyshire & Nottinghamshire	32.0%	2.2	0.0	0.0
0.0	0.0	0.0	0.2%	G	North Yorkshire & Humber	0.2%	0.1	(0.1)	0.0
0.0	1.3	1.3	3.2%	G	Total Armed Forces Surplus	3.2%	1.1	0.2	0.0

At the year end, Armed Forces commissioners are reporting an overall surplus against a breakeven plan.

Bath, Gloucestershire, Swindon & Wiltshire Area Team's overspend of £1.0m has resulted from providers identifying more activity to recharge than PCTs had identified in their baseline returns. The position improved from month 9 following ongoing validation of activity and financial reporting of providers by the CSU. Some of the improvement is because activity has been charged to Armed Forces and should have been charged to Specialised Commissioning and as such has not affected the overall NHS England position.

Derbyshire & Nottinghamshire Area Team is reporting a surplus position. This is a result of a non-recurrent underspend against the MDHU funding allocated to the Area Team. Agreement was reached across the Midlands and East Area Teams and CCGs that for 13/14 the allocations and expenditure for Secondary Care Armed Forces activity would remain with the CCGs.

The North Yorkshire and Humber Area Team, as Armed Forces commissioner for the North of England, continues to reflect no significant financial concerns in this area of their budget, and in fact agreed the return of £1.3m risk share funding to the CCGs from which it was originally levied.

8.3 Current position – expenditure against programme budgets

The programme budgets in 2013/14 were:

- Armed forces prosthetics - £3.7m
- Veterans' mental health - £1.8m, of which £1.5m has been transferred to ten veterans' mental health networks, the remaining £0.3m has been held centrally.

At the year end, the Armed Forces prosthetics budget was £562k underspent, although spend on developing the nine centres and commitment by the Veterans Prosthetics Panel was in line with the annual plan. The underspend was the result of the timings of the prosthetic panels and Providers not being able to see and fit limbs before the end of the financial year. This underspend cannot be carried forward and will impact on spend in future years.

Unbudgeted IT costs of £0.4m have been incurred to maintain links between the DMS and NHS IT systems. Maintenance of these links has helped to reduce the level of dual registrations, so avoiding dual payments to GPs. The benefits of this will have been savings in the DMS and NHS England's primary care commissioning. These costs were covered by underspends elsewhere in the Operations Directorate programme budgets. A £0.7m bid programme budget has been agreed to avoid a similar unbudgeted cost to Armed Forces in 2014/15.

8.4 QIPP

8.5 Planning Assumptions

The Armed Forces Oversight Group has established a financial group to work in conjunction with the national data flows project to review the position and make a recommendation for national consideration. In particular the financial sub group are looking at the long term financial model for Armed Forces health recognising the known challenges that lie ahead including cessation of NACMO funding, draw down of troops / re basing, long term care costs resulting from op HERRICK and prosthetics.

In 2014/15, Armed Forces commissioners are planning a £428k (1.0% of allocation) surplus which is in line with the NHS England business rules. However, the requirement for 2.5% non-recurrent spend has not been met.

In 2015/16, Armed Forces commissioners are planning a £326k (0.7% of allocation) surplus and so, are not achieving the 1.0% surplus requirement.

8.6 Overall Financial Plan

A summary of the financial plans is shown in the table below:

Area Team 2014/15 Financial Plans	Allocation	Planned Spend	Planned Surplus / (Deficit)	Planned Surplus / (Deficit)	Net (Risk) / Headroom	Contingency	Non Recurrent	QIPP
	£k	£k	£k	%	£k	%	%	%
Bath, Glos, Swindon & Wiltshire	27,646	27,646	0	0.0%	-3	0.5%	0.0%	0.0%
Derbyshire & Nottinghamshire	9,103	8,849	254	2.8%	-9	0.5%	0.7%	0.0%
North Yorkshire & Humber	6,252	6,078	174	2.8%	40	0.5%	0.7%	0.0%
Central	0	0	0	0.0%	0	0.0%	0.0%	0.0%
TOTAL AF PLANS	43,001	42,573	428	1.0%	28	0.5%	0.3%	0.0%

Area Team 2015/16 Financial Plans	Allocation	Planned Spend	Planned Surplus / (Deficit)	Planned Surplus / (Deficit)	Net (Risk) / Headroom	Contingency	Non Recurrent	QIPP
	£k	£k	£k	%	£k	%	%	%
Bath, Glos, Swindon & Wiltshire	27,646	28,548	-902	-3.3%	902	0.5%	0.0%	-2.0%
Derbyshire & Nottinghamshire	9,357	9,103	254	2.7%	-9	0.5%	0.7%	0.0%
North Yorkshire & Humber	6,426	6,252	174	2.7%	87	0.5%	0.2%	0.0%
Central	800	0	800	100.0%	0	0.0%	0.0%	0.0%
TOTAL AF PLANS	44,229	43,903	326	0.7%	980	0.5%	0.2%	-1.3%

8.7 Approach to Risk Management

The most significant issue for planning is the risk that additional activity may be identified as relating to armed forces and their families. All Area Teams have agreed a similar approach to risk sharing in 2014/15. This will involve:

- A focus on acute activity for 2014/15. All acute activity to be commissioned by Area Teams in 2014/15, with a transfer of funding from CCGs where it can be evidenced that the funding has not previously transferred to NHS England. Recognising that any allocation adjustments will need to be agreed by the national team to ensure the integrity of the allocation model;
- Proposing that mental health and community activity remain with CCGs (as in 2013/14), to be moved at an appropriate future date; and
- In year agreements to transfer funds from CCGs to Area Teams if additional baseline level activity for armed forces and their dependants is identified above the levels included in PCT baseline returns. NHS England would agree to fund growth as a result of population and demographic changes.

The main financial risks facing Armed Forces and their families and the mitigating actions are shown in the table below.

	<u>Risk</u>	<u>Mitigating actions</u>
1	Better identification of armed forces and their families patients leads to a transfer of costs from CCGs to Area Teams	Common approach to risk sharing with CCGs adopted by all Area Teams from 1 st April 2014
2	Weaknesses in invoice validation processes result in inappropriate payments or delays in payments and uncertainties over liabilities	S251 exemption has improved availability of data to CSUs who carry out invoice validation Longer term solution being supported by Activity Reporting Programme
3	Clarification of commissioning and funding responsibilities, specifically including Continuing Health Care	Commissioning / Ethical workshop held on 23 rd and 24 th January to develop commissioning strategy Ongoing meetings with DMS to clarify boundary between MoD and NHS
4	Changes to England based numbers of armed forces personnel as a result of repatriation may result in additional financial commitments in the medium but not the longer term	Group established to review likely impact of changes in numbers of armed forces personnel

9. Governance

9.1 NHS England Commissioning

NHS England's Armed Forces Commissioning is a part of the Operations Directorate and reports through its Oversight Group to the Directly Commissioned Services Committee. The Oversight Group and the NHS England Clinical Priorities Advisory Committee are advised by the Armed Forces Clinical Reference Group.

NHS England's commissioning responsibilities are discharged across three area teams, using a recognised best practice matrix working approach:

- North Yorkshire & Humber,
- Derbyshire & Nottinghamshire and
- Bath, Gloucestershire, Swindon and Wiltshire

We work collectively with the national support team as a single team to provide consistency of approach when commissioning services for the Armed Forces community.

CCGs have the direct responsibility for the commissioning for Reservists when not mobilised, Veterans and those service families that are registered with NHS GPs.

The presence of three area teams allows us to build local expertise in military healthcare and foster the necessary relationships between:

- NHS England and local providers,
- CCGs,
- Local Authorities and their Health & Wellbeing Boards,
- DMS medical centres and
- Local and National charities.

We will use Armed Forces Networks, to ensure that we engage properly with these partners.

9.2 Partnership Working

There is a Partnership Board which provides strategic guidance and sets the agenda for Department of Health (DH) in England and for the Devolved Administration and is co-chaired by DH and MoD.

There is a Partnership Agreement between NHS England and the Ministry of Defence (Surgeon General) which sets out the strategic intent and commitment of working together. The agreement recognises the respective statutory responsibilities and independence of each party, but agrees an approach of collaboration and cooperation to achieve the aim of ensuring safe and effective care, which deliver value for money and improves health outcomes for the Armed Forces Community and supports the Armed Forces Covenant. The agreement sets out a partnership approach, which enables MoD to work together with their colleagues in the NHS in planning and organising the delivery of healthcare.

We will also seek to work more formally with the Personnel and Health branches of MoD to ensure that care is integrated and meets the wider needs of the MoD.

The effectiveness of the agreement with the MoD is monitored through the structures in the attached organogram, which shows the external and internal governance structures

There is a Joint Commissioning Team that ensures that commissioning between MoD and NHS England is properly coordinated.

As mentioned above the Clinical Reference Group is made up of MoD and NHS clinicians and patient representatives.

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