HEALTH AND WELLBEING BOARD

30 JUNE 2015

HEALTH CARE FOR THE ARMED FORCES

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Summary

This report is provided for information regarding the commissioning of health care for the Armed Forces population. It provides information on the NHS England commissioning intentions 2015/16 and Armed Forces Health Operational Plan 2015-17. It also provides details of the Armed Forces Network and how stakeholders can become involved in this.

1. Commissioning Arrangements

1.1 From April 2013 NHS England took over responsibility of some aspects of health care for the Armed Forces population (and their dependents registered with a military GP Practice) in England.

1.2 MOD responsibilities

- MOD provide primary care for this population
- MOD provide extensive primary dental care for their serving population
- MOD provide extensive occupational health services for their serving population
- MOD provide both community and inpatient mental health services for their serving population (except for specialised services which NHS England is responsible for)
- MOD lead on the transition (from military to civilian) process for Armed forces personnel and their families

1.3 NHS England responsibilities

- NHS England commission secondary care services for the registered population
- NHS England have a risk share agreement in place with CCGs for community and community mental health services for the dependent population

- NHS England and Local Authorities commission screening, immunisations and vaccination programmes for the population as part of their local commissioning arrangements

1.4 CCG responsibilities

- CCGs commission all services for veterans with the exception of specialised services (such as the veteran Post Traumatic Stress Disorder service).

2. NHS England commissioning intentions

2.1 The NHS England Armed Forces and their Families Commissioning Intentions 2015/16 and the Armed Forces Health Operational Plan 2015- 17 are attached for information.

2.2 Some Identified priorities for 2015/16 and beyond include:

- The transition process especially for early service leavers and Wounded, Injured and Sick (WIS) personnel
- Identifying vulnerable service leavers and ensuring their safe transition to civilian life
- Raising awareness and of GP system read codes for veterans and reservists (the MOD does not have the authority to compel service leavers to register, service leavers can chose to register (or not) and can choose to disclose their military background (or not) and GPs are not contractually obliged to ask or register this) and encouraging GPs to ask the question.
- Supporting 3rd sector organisations to seek formal accreditation and assurance for their offered services

3. The Armed Forces Networks

3.1 The Armed Forces Networks (AFNs) have, since 2009, enabled and supported the delivery of the Armed Forces Covenant, policy intentions, transition protocols and the Government Mandate to the NHS and its subsequent Operating frameworks in their respective regions.

3.2 The aim of the AFNs is to discuss, debate and develop how each AFN supports and can deliver appropriate care in the **local region** to the Armed Forces community including dependants, reservists, their families and veterans and to share news and upcoming developments relating to this population.

3.3 Armed Forces Networks (AFNs) were held in May 2015 in the South East, South Central and the South West with in excess of 100 attendees over the 3 events. Building on the success from the meetings in Oct/Nov 2014 and taking into account the views and feedback from those attending; the May events focussed on updating attendees on relevant news from both NHS England and the CCGs and included presentations from Alcoholics Anonymous (AA), Community Mental Health and the Defence Medical Welfare Service.

3.4 The key areas/themes from all Networks identified:

- Further funding has been confirmed for mental health service provision for veterans' and reservists
- The stigma relating to mental health, including alcoholism is reducing
- GP system codes for veterans, reservists and their families are embedded in software and 'ready to go'
- NHS Choices will be updated to include more information for those in the Armed Forces and their families (including guidance on what re-basing will mean for them)

3.5 Suggested themes/presentations to be incorporated into future AFN events:

- Transitional issues affecting those serving as well as veterans'
- The role of PROs (Personal Rehabilitation Officers)
- Early Service Leavers
- Royal British Legion
- Update on Veterans Council (including LIBOR funding)
- Bath University

3.6 The next AFN events will be held during October/November 2015. Any stakeholders who would like to be included in the circulation for future events, or have proposed agenda items/proposed guest speakers they would like included in future events can email ENGLAND.south-armedforces@nhs.net.

4. Risk Management

4.1 There are no direct risk management implications of this report.

5. Financial and legal Implications

5.1 There are no direct legal and financial implications of this report

6. Recommendation

6.1 The Board is asked to note this report and identify issues for further discussion at a future meeting.

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Background Papers

None

Appendices

Appendix 1 – Armed Forces and their Families Commissioning Intentions 2015/16
Appendix 2 – Armed Forces Health Operational Plan 2015-2017

Appendix 1

NHS England

Armed Forces and their Families Commissioning Intentions

2015/16

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Description	These Commissioning Intentions serve as formal notice to providers of NHS England's plans in respect of secondary care services commissioned on behalf of Armed Forces personnel and their families registered with Defence Medical Services practice for 2015/16. They reflect the central challenge of improving patient outcomes whilst constraining levels of spend to match available resources. For NHS England and its providers, collaborating to adopt the most efficient service models through delivering change is a key priority.
Cross Reference	• The NHS Constitution - http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution • The NHS Mandate - http://mandate.dh.gov.uk/ • Everyone Counts – NHS England Planning Guidance - http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf • NHS England Business Plan - http://www.england.nhs.uk/wp-content/uploads/2014/04/ppf-1415-1617-wa.pdf • Securing Excellence in commissioning for Armed Forces - http://www.england.nhs.uk/wp-content/uploads/2013/03/armed-forces-commissioning.pdf • The Armed Forces Covenant – https://www.gov.uk/the-armed-forces-covenant; • The Armed Forces Community Covenant
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Contact Details for further information	Direct Commissioning Operations, Armed Forces Central Team Skipton House, 80 London Road London SE1 6LH

Document Status

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Equality Statement

Promoting equality and addressing health inequalities are at the heart of NHS England's values. Throughout the development of the policies and processes cited in this document, we have:

Given due regard to the need to eliminate discrimination, harassment and victimisation, to advance equality of opportunity, and to foster good relations between people who share a relevant protected characteristic (as cited under the Equality Act 2010) and those who do not share it;

Given due regard to the need to reduce inequalities between patients in access to, and outcomes from, healthcare services and in securing that services are provided in an integrated way where this might reduce health inequalities

The Equality Delivery System (EDS) for the NHS helps all NHS organisations, in discussion with local partners including patients, to review and improve their performance for people with characteristics protected under the Equality Act. By using the EDS, NHS organisations can also be helped to deliver on the public sector Equality Duty.

If you have any questions in relation to equality or health inequalities please contact england.eandhi@nhs.net

1. Introduction

Since 01 April 2013 NHS England has had the responsibility of commissioning services for serving personnel and those families registered with a Defence Medical Service (DMS) practice in England. This document should be read in conjunction with the armed forces commissioning documents described in Appendix 1.

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.

These commissioning intentions serve as formal notice to providers of NHS England's plans in respect of secondary care services commissioned on behalf of Armed Forces personnel and their families registered with Defence Medical Services practice for 2015/16. They reflect the central challenge of improving patient outcomes whilst constraining levels of spend to match available resources.

The **prioritisation round** which began in December will consider investment and disinvestment to achieve best outcomes for patients within available resources. Providers should not initiate service developments unless these are required as a result of prioritisation.

NHS England will monitor service specification KPIs and **quality dashboards** through core quality standards. CQUIN will continue to be used to improve quality and efficiency.

NHS England will only make payment where treatment complies with policies so providers need to ensure monitoring systems are in place. **Coding and counting changes** for nationally priced services will be subject to national notification and standard template reporting.

For nationally priced services, payments above **mandatory tariffs** will not be made except through local tariff modification applications supported by Monitor.

The **NHS standard contract** will be used, with a uniform standard price/activity matrix and local price list format to improve transparency and benchmarking capability.

2. Purpose

This document sets out to healthcare providers' notice of NHS England's Commissioning Intentions for Armed Forces and their Families registered with Defence Medical Services (DMS).

It should be read in conjunction with other Armed Forces Commissioning Documents described in Appendix 1.

The commissioning intentions provide the context for constructive engagement with providers, with a view to achieving the shared goal of improved patient outcomes; patient centred care and reduced health inequalities as enshrined in the Health and Social Care Act 2012.

It is the intention of this document to demonstrate to the reader not only the range of services to be commissioned along the care pathway and the reasoning for these, but also the coherent principles which underpin this approach. This document provides a robust level of detailed description to permit the reader to understand the various components, but it should be remembered that these discrete units are part of an integrated system in which service users may be receiving services from multiple providers concurrently.

This document is compliant with the NHS Constitution and the Human Rights Act 1998. This applies to all activities it is responsible for, including policy development, review and implementation.

NHS England is committed to securing alignment across all aspects of NHS commissioning and will work with CCGs, partner NHS oversight bodies and local government to secure the best possible outcome for patients and service users within available resources.

3. Context

This is the second year of producing Commissioning Intentions for Armed Forces and their Families Direct Commissioning. This year's document builds on work completed in 2014/15 as well as looking at the context of future ambitions for 2016/17 and the Five Year Forward View. It within the overall strategic framework and priorities set out by NHS England within "*Everyone Counts- Business Planning Guidance" and 'Securing Excellence in Commissioning for Armed Forces 2013".*

On 01 April 2013, NHS England, as part of its portfolio of directly commissioned services, became responsible for the commissioning some health services for those individuals who are registered with, and entitled to receive primary care from Defence Medical Services (DMS). This includes Serving Personnel, mobilised Reservists and some armed forces (AF) families.

The Royal British Legion estimates there are currently 2.32 million veterans in the England, 46% of who are over 75 years of age. However there were over 800 very

seriously or seriously injured personnel from recent conflicts (such as Afghanistan and Iraq) and over 10,000 aero-medical evacuations over the coming years these may present an evolving healthcare challenge. Most services for veterans are commissioned locally by CCGs.

The following services are normally commissioned by the NHS England Armed forces commissioning team for the DMS registered population (including DMS registered families) in England:

- community services.
- secondary care services, including emergency care.
- mental health services (only for families registered with DMS).

DMS commissions or provides the following services in England:

- Occupational Health for military personnel.
- Primary Care for Serving personnel and GP services for DMS registered families.
- All Health Care when on active operations and prior to return to UK.
- Rehabilitation Services for Musculoskeletal (MSK) and some neurological patients for serving personnel.
- Mental health in community and inpatient for serving personnel (i.e. not families, see above).

The following services are commissioned for the armed forces community by other parts of NHS England:

- Primary Care for families registered with NHS practices
- Dental, Pharmacy and Optometry services for families
- Specialised Services
- Public Health services covered by Section 7A

NHS England has specific duties and separate funding to provide the following:

- A small number of veterans' mental health services, including on line and Specialised residential services and veteran specific Psychological therapies in response to "Fighting Fit".
- Veterans' prosthetic services including the Veterans' Prosthetics Panel (VPP) in response to "A Better Deal for Military Amputees".
- Assisted conception services for those in receipt of compensation for loss of fertility.
- On line psychological support services for veterans and families
- Inpatient PTSD services for veterans

- It is expected that some additional duties around wheelchair provision, hearing aids and rehabilitation for veterans may be added to the commissioned services above.
- NHS England may also provide lead commissioner or other support arrangements for other services such as cervical screening for those DMS registered patients overseas.

Armed Forces personnel and families returning from overseas for treatment in the UK are covered by Overseas Visitor (OSV) regulations and are the responsibility of the local clinical commissioning group (CCG) in which the provider of the care that they receive is located.

4. National Commissioning Framework

NHS England's commissioning of health services for the armed forces is carried out through a single operating model, providing a national approach to strategic planning and oversight and commissioning and contracting will be delivered via a nationally integrated armed forces commissioning team.

In developing this model, it is the objective of NHS England to ensure that the commissioning of services is organised in such a way as to provide the best possible patient outcomes and avoid any geographical or organisational variation that may have existed previously, whilst maintaining essential stakeholder relationships.

The model outlined above will support commissioners and providers of services to:

- Improve patient access
- Encourage transparency and choice
- Ensure patient involvement and participation
- Identify better data to drive improved outcomes and better commissioning
- Deliver higher standards and safer care
- Provide services within financial constraints.

NHS England's commissioning policies for the populations that it commissions for are clinically led. An armed forces Clinical Reference Group (CRG) has been created to advise commissioners on their commissioning policies. The CRG's membership consists of both NHS and DMS clinicians with input from lay members, professional bodies and other stakeholders. Its role is to provide expert clinical advice to enhance the care provided, enable equitable decisions to be made (based on clinical need) and to improve the integration of care across the NHS.

The national delivery framework and commissioning intentions have been developed by NHS England, with input from Ministry of Defence (DMS, Personnel and

Recovery). CCGs have had opportunity to input and comment through the Clinical Reference Group. It is our intention to work in partnership with DMS and the wider Ministry of Defence in respect of commissioning health care as per the armed forces National Partnership Agreement agreed in 2014/15.

NHS England will monitor service specification KPIs and **quality dashboards** through core quality standards. CQUIN will continue to be used to improve quality and efficiency.

NHS England will only make payment where treatment complies with policies so providers need to ensure monitoring systems are in place. **Coding and counting changes** for nationally priced services will be subject to national notification and standard template reporting.

For nationally priced services, payments above **mandatory tariffs** will not be made except through local tariff modification applications supported by Monitor.

The **NHS standard contract** will be used, with a uniform standard price/activity matrix and local price list format to improve transparency and benchmarking capability.

5. Public and Patient Involvement

In upholding the NHS Constitution, NHS England is committed to ensuring that patients are at the centre of every decision that NHS England makes. Putting patients first needs to be a shared principle in all that we do. NHS England will ensure that this is demonstrated in the way care is provided and monitored through our formal contracting process with providers.

We expect all providers to demonstrate real and effective patient participation, both in terms of an individual's treatment and care, and on a more collective level through patient groups/forums; particularly in areas such as service improvement and redesign.

It is essential that all providers of services to armed forces personnel and their families demonstrate the principles of transparency and participation and offer their patients the right information at the right time to support informed decision making about their treatment and care.

Providers of services to armed forces personnel and their families should look to provide accessible means for patients to be able to express their views about and their experiences of services, making best use of the latest available technology and social media as well as conventional methods.

As well as capturing patient experience feedback from a range of insight sources, providers should demonstrate robust systems for analysing and responding to that feedback.

Outcomes for Patients in 2015/16

The following are priorities for services commissioned for armed forces personnel and their families;

- Choice of providers for armed forces personnel and their families.
- Improved access to screening services.
- Improved transition of care for Wounded, Injured and Sick personnel leaving the armed forces, especially to continuing healthcare
- Improved prosthetic care for veterans
- Consistent access to IVF treatment.
- Continue to ensure consistent and fair commissioning policies for those services commissioned.
- Improved data recording by specialist veterans' mental health services, in order to support improvements in services

6. Improved pathways of care

We will work closely with partners, such as local authorities, welfare organisations and charities to develop improved pathways of care, which would particularly support Armed forces personnel and also support DMS in making appropriate links with partners. This work will focus on:

- Improving access to alcohol misuse service, where DMS will be supported in linking in with Local Authorities;
- Improving access to services which support families and dependents by linking with CCGs;
- Improving Discharge and Transition Management;
- Redesign of spinal and musculoskeletal care pathways;
- Review and redesign of neuro-rehabilitation;
- Improving audiology transition pathways.

7. Changes in 2015/16 and beyond

NHS England has agreed that the following services should no longer be commissioned by Specialised Commissioning and should therefore be reflected in both the CCG contracts for the general population and in Armed forces contracts for Armed forces personnel and families registered with DMS from April 2015:

- specialised wheelchair services;
- outpatient neurology referrals made by GPs to Adult Neurosciences Centres;
- outpatient neurology referrals made by GPs to Adult Neurology Centres.

NHS England has also agreed that the following services will no longer be commissioned by the armed forces commissioning team for serving personnel and DMS registered families, but will be included within the specialised commissioning team's element of the contract from April 2015:

- some highly specialised adult male urological procedures

- some adult oesophageal procedures
- services for patients with homozygous familial hypercholesterolemia
- some adult specialist haematology services

Any change in responsible commissioners will be reflected within Specialised Commissioning, Armed forces and Health and Justice contracts with providers.

Budgets will be adjusted to ensure adequate funds are transferred within NHS England to reflect the change in commitments.

8. Services Prioritised for Review in 2015/16

The armed forces interim commissioning policies will be formally ratified before the start of the 2015/16 financial year and will comply with the generic commissioning policies of NHS England. The Armed forces Clinical Reference Group plan will commence a programme of reviews of all policies and have agreed the following priorities:

The services prioritised with partners for review in 2015/16 are:

- Wisdom Teeth Extraction with NHS England Primary Care (dental).
- Continuing Health Care (CHC) and Personalised Health Budgets.
- Musculoskeletal Pathways (MSK).
- Dermatology referral and pathways.
- Spinal Pathways.
- Out of Hours Contracts transfer from DMS to CCGs.
- Review, health needs assessment, and commissioning options evaluation for mental healthcare for veterans (for implementation in April 2016):
    i. On-line services
    ii. Specialised inpatient services
    iii. Regional specialist psychological services

9. Service development and reinvestment

As outlined in its previous Commissioning Intentions, NHS England is developing a transparent prioritisation framework to guide the work of Clinical Reference Groups and Specialised Programmes of Care to enable decisions to be made about investment and disinvestment in services to best meet need within the resources available. These proposals are assessed by the national Clinical Priorities Advisory Group, which advises NHS England on all directly commissioned services.

Investment in new services and interventions will be prioritised using the prioritisation framework. This will ensure that the range of services and interventions are optimised to best meet the needs of patients.

Service developments with a financial impact for existing providers of a given service will only be approved where they were initiated with NHS England's formal agreement.

They will need to demonstrate measurable outcome and value improvements and will need to be agreed as part of the national prioritisation process and where resources have been released from elsewhere within an achievable balanced national financial plan. Where development or changes to the clinical eligibility policy for a treatment would warrant new provider entry or revisiting the assessment of existing providers as the most capable to provide a significantly changed service, this will be managed through the service and commissioning review process with existing and potential providers considered for procurement.

The prioritisation round for 2015/16 took place in December 2014 with decisions ratified in January. Where required, contractual notice periods will be observed for any changes except where, by mutual agreement, more rapid implementation is jointly agreed.

For the avoidance of doubt, NHS England is unable to give support to cost increasing business case proposals outside of the national process. Providers should not initiate in-year service developments unless formally requested by commissioners as a result of the national prioritisation process.

10. Capacity planning and engagement

The 2015/16 contract requires all activity plans and local price lists to be in a mandatory common format. Capacity planning to inform contract discussions will take place in the autumn and should start from a 'no intervention' basis.

NHS England and providers will have early discussions to inform the affordable contract envelope for services, and develop solutions to ensure continued delivery of care within available resources.

11. Contracting

There are no direct 'standalone' contracts for armed forces health care with major NHS providers as we share contracts with other parts of NHS England using the schedules in the NHS Standard Contract.

NHS England commissions according to agreed policies and service specifications, which identify which treatments, devices and services, are routinely commissioned. It should be noted that armed forces policies, are published on the NHS England web site. In line with the other NHS England policies, those policies that specify treatment thresholds and criteria act within the NHS contract as group prior approvals for treatment. In some cases, additional audit requirements may be required with regard to individual prior approval by commissioners. Where policies and specifications make clear that treatments, devices and services are not routinely commissioned or where treatment thresholds and criteria have not been adhered to interventions will not be funded. Where procedures are defined as low priority, these will not be routinely funded although an Individual Funding Request can be made.

12. Individual Funding Requests

An Individual Funding Request (IFR) applies if the referrer believes that their patient is a clinical exception. Should this be the case, and you wish to put in an IFR for approval; it is recommended that the referring clinician familiarises themselves with the process and criterion thresholds. Further information can be found at:

- Interim Individual Funding Request Guidance _[on line at: http://www.england.nhs.uk/wp-content/uploads/2013/04/cp-03.pdf}
- IFR Application Form.doc

All IFR requests are to be directed to the appropriate NHS Regional Office for your area. Generic mail boxes listed below:

- england.ifrsouth@nhs.net (South of England)
- lonhscb.ifr@nhs.net (London)
- england.ifrme@nhs.net (Midlands & East)
- england.ifrnorth@nhs.net (North of England)

Referrers of armed forces personnel will be required to move on to e-booking as it is developed to:

- Support informed patient choice (where desired for serving personnel by DMS).
- Achieve shorter waiting times.
- Access more geographically convenient services.
- Select providers with higher quality indicators that understand the occupational environment that armed forces personnel operate in.
- Increase the use of out of hospital services, where appropriate.

We will continue to build on the work from 2014/15 and seek to make further improvements in contracting arrangements to:

- Increase the proportion and accuracy of volume based contracts, the risks of which are covered by risk sharing agreements with CCGs.
- Make suitable use of contracts of nil guaranteed volume.
- Develop improved risk assessment processes.
- Develop protocols for changing from one contract type to another (e.g. from one of nil guaranteed value to one with a value).

We will work with our providers to share responsibility for managing the care of patients in the most appropriate setting. We will agree a policy and process, in line with the National Tariff Payment System on the reimbursement arrangements for emergency readmissions within 30 days of avoidable unplanned hospital stays.

We will work to ensure the first to follow-up outpatient ratios that reflects national guidance or regional benchmarking (e.g. medium acute trusts or acute teaching hospitals England). For those specialities where the Trust's performance is better than the benchmark, the Trust will be expected to maintain its level of performance.

This performance measure will be applied on an annual basis using the most recent national performance matrices.

The Commissioner will not pay more for same services, brought about by technical changes such as movement from block to cost and volume, or changes to recording currencies.

The commissioners will initially review contracts annually and refresh contracts as appropriate. The intention for 2015/16 is that NHS England will hold (or be party to) one NHS Standard Contract with any provider and, where appropriate, will work with co-commissioners including CCGs to identify services and standards which require clinical review and redesign for armed forces across individual providers, Changes to any contracts will be consistent with the Guidance on the use of mandatory contract provisions. Clauses (where permitted by law) will be incorporated into contracts to ensure that amendments can be made; thereby ensuring a process of continuous improvement can be implemented.

13. CQUINs

As above, there are no direct 'standalone' contracts for armed forces health care with major NHS providers as we share contracts with other parts of NHS England and CCGs. However where possible NHS England will seek to include a set of CQUINS which are relevant and meaningful for the armed forces for this population.

14. Quality, Innovation, Productivity and Prevention QIPP

NHS England will be intending to secure a 3% Quality, Innovation, Productivity and Prevention (QIPP) saving. . The QIPP aspiration and aspects will be (i) transactional QIPP schemes delivered through the contracting round; (ii) considering benefits of locally developed CCG QIPP schemes that impact on AF case-mix; (iii) additional transformational schemes (e.g. specific work on first to follow up ratios for AF patients; pathway streamlining). In recognition of the overall size of the budget / patient cohort QIPP will be challenging; however this approach affirms the commitment to achievement in order to maximise the overall health utility.

As co-commissioners to all of our contracts, delivering QIPP within local providers is likely to be through local QIPP plans with the main commissioner (CCG or other parts of NHS England). However we will seek to work with other partners e.g. DMS to deliver QIPP benefits.

We will look at pathway changes that work across DMS and NHS Services that lead to savings though the following:

- Implementation of commissioning policies
- Repatriation/Movement of services to out of hospital settings (in agreement with Defence Dental Services and DMS) such as:

    - Wisdom tooth extraction
    - Vasectomies
- Reduction in did not attend (DNA) rates
- Reduction in the ratio of follow ups to new out-patient appointments where appropriate
- Increased work up/access to care in primary care settings to prevent hospital referral
- Direct access for diagnostic testing
- Improved Immunisation and screening take up and recording

15. Quality Assurance

Providers will be expected to participate fully in national assurance processes and respond in a timely manner to recommendations made. Quality monitoring will be undertaken by NHS England working closely with co-commissioners to support the monitoring of quality performance for a range of providers in their location. This will be done in conjunction with the requirements of NHS England's assurance framework. NHS England will expect providers to:

- Take account of the results of any Care Quality Commission regulatory activity and implement any actions required.
- Provide evidence of appropriate safeguarding policies and appropriate escalation and actions required.
- Share their annual review and response to the quality account
- Identify and share details of any issues requiring improvement by the provider.
- Carry out deep dives and provide reports where serious quality concerns are identified.

NHS England has produced a revised framework for serious incidents requiring investigation. These measures protect patients and ensure that robust investigations are carried out, which result in organisations learning from serious incidents to minimise the risk of the incident happening again. When an incident occurs it must be reported to all relevant bodies.

This revised framework has been developed by NHS England in partnership with commissioners, regulators and experts and explains the responsibilities and actions for dealing with serious incidents and the tools available to help commissioners. It is relevant to all NHS-funded care in the primary, secondary and tertiary sectors.

16. Coding and counting

NHS England recognises the benefits of improvements in the accuracy of coding in the context of an overall reduction in spending within financial resources available.

Change in counting can lead to increased expenditure without additional clinical benefit, which could lead to disinvestment in other services and reduced access to services by patients. It is therefore important that all change proposals are robustly

evidenced so that a national assessment of the wider system impact of proposal can be made.

Commissioners are mindful that consideration is being given to a moratorium on coding and counting changes to ensure service stability. For the coming year:

- Notice for coding and counting change proposals for services with a national price must be submitted using the standard documentation template and email address, which was issued in August 2014 by circular via local team commissioners. Submissions were requested by 30 September 2014 in line with the requirements in national contract provisions.

- Additional backing information will be worked through with local NHS England commissioners who will also provide to the national team an initial assessment of validity of proposals that are likely to be supportable should a decision be made to accept such changes for 2015/16.

- NHS England will liaise with co-commissioners to understand the impact if any, of coding changes on the case mix of services commissioned.

- Providers should not consider the acceptance of a coding change by another commissioner, in any way, as the acceptance of the same change by NHS England without our explicit consent.

17. Drugs and Devices

Non-excluded drugs prescribed concurrently with the excluded drugs are not chargeable as these are covered within national tariff. No additional charges above cost will be accepted unless specifically identified in 2015/16 national tariff guidelines, explicitly agreed with NHS England and specifically in advance within the contract

Drugs as detailed in the current NHS England excluded drug list will be commissioned in line with NHS England commissioning policies and National Institute of Clinical Excellence (NICE) Technology Appraisals (TAs). NICE approved drugs/ devices recommended within a NICE TA that are excluded from tariff will be automatically funded from day 90 of publication. Some approved drugs and devices may be funded before this time at the discretion of NHS England. Trusts are expected to meet the requirements of NICE TAs and be able to demonstrate compliance through completion of innovation scorecard returns.

Those excluded drugs and devices that are not NICE approved or endorsed within a national clinical commissioning policy can be considered via an individual funding request, if there is evidence that the patient has clinically exceptional circumstances in comparison with other patients with the same condition presenting at the same stage of the disease and there is an exceptional ability to gain clinical benefit from the treatment.

Excluded drugs/devices recommended within a NICE Interventional Procedures Guidance and/or guideline will not be routinely funded unless endorsed within a national clinical commissioning policy

An updated policy covering requests for excess treatment costs for research will be published later this year.

18. Service Specifications

During 2015/16 NHS England will refine and finalise the suite of service specifications for services commissioned through the use of the Murrison funding for Veterans Mental Health. NHS England will performance manage the delivery of contracts and service specifications using routine contract management mechanisms. This approach is relevant to those contracts which were in place prior to establishment of NHS England. NHS England will utilise contract sanctions where there is significant and persistent underperformance against these plans.

19. Procurement

In line with the National Health Service (Procurement, Patient Choice and Competition) (No 2) Regulations 2013, and guidance issued by Monitor entitled 'Substantive guidance on the Procurement, Patient Choice and Competition Regulations', NHS England is committed to ensuring that when it procures health care services it satisfies the procurement objectives laid down in the regulations, namely to act with a view to: securing the needs of the people who use the services; improving the quality of the services; and improving the efficiency in the provision of services.

20. Conclusion

The 2015/16 Commissioning Intentions for services for armed forces personnel and their Families are designed to support effective commissioning and delivery of high quality services across for armed forces personnel and their families to ensure **"high quality care for all, now and future generations".**

These Commissioning Intentions reflect the ambitions of NHS England and its partners to drive greater quality of healthcare provision this group of service users.

Much of what is being proposed is building on existing and established programmes of care, some of which are being refined in the light of further evidence and the experience of practitioners and service users. Other services are new to the commissioning portfolio, and represent an exciting opportunity to integrate new and innovative solutions into the care pathway, to intervene at more appropriate points, thereby enabling better outcomes for service users.

Appendix 1:

Key Documents for Armed Forces Commissioning

- The NHS Constitution - http://www.nhs.uk/choiceintheNHS/Rightsandpledges/NHSConstitution
- The NHS Mandate - http://mandate.dh.gov.uk/
- Everyone Counts – NHS England Planning Guidance - http://www.england.nhs.uk/wp-content/uploads/2013/12/5yr-strat-plann-guid-wa.pdf
- NHS England Business Plan - http://www.england.nhs.uk/wp-content/uploads/2014/04/ppf-1415-1617-wa.pdf
- Securing Excellence in commissioning for Armed Forces - http://www.england.nhs.uk/wp-content/uploads/2013/03/armed-forces-commissioning.pdf
- The Armed Forces Covenant – https://www.gov.uk/the-armed-forces-covenant;
- The Armed Forces Community Covenant https://www.gov.uk/government/policies/fulfilling-the-commitments-of-the-armed-forces-covenant/supporting-pages/armed-forces-community-covenant
- Partnership Agreement https://nhsengland.sharepoint.com/teams/ops/armedforces/Shared%20Documents/20140430%20Partnership%20Agreement.pdf
- Commissioning Hierarchy (Draft 9 as at September 2014)
- NHS England; The Quality Assurance Framework http://www.england.nhs.uk/revalidation/wp-content/uploads/sites/10/2014/04/fqa.pdf
- NHS England ;The Serious Incident Framework http://www.england.nhs.uk/wp-content/uploads/2013/03/sif-guide.pdf

Appendix 2: **Key Contacts**

Key Contact Information for NHS England Armed Forces and their Families

Regional Teams

North Region
england.nyh-armedforces@nhs.net

Midlands & East of England Region
england.midlandsarmedforces@nhs.net

South and London Regions

england.south-armedforces@nhs.uk

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Appendix 3:

The Responsible Commissioner Matrix

	Serving AF Mobilised Reservists	Families with DMS	Families not with DMS	Non Mobilised Reservists	Veterans
Primary Medical Care	DMS	DMS	NHS - 1° care	NHS - 1° care	NHS - 1° care
OOH	DMS	DMS	CCG	CCG	CCG
Primary Dental Care	DMS	NHS - Dental	NHS - Dental	NHS - Dental	NHS - Dental
Operational Care (anywhere)	DMS				
Primary Medical Care - Overseas	DMS	DMS			
Primary Dental Care - Overseas	DMS	DMS			
Blue Light ambulance	CCG	CCG	CCG	CCG	CCG
Emergency care	NHS - AF	NHS - AF	CCG	CCG	CCG
Emergency care – overseas	DMS	DMS			
Secondary care – dental	NHS - Dental	NHS - Dental	NHS - Dental	NHS - Dental	NHS - Dental
Secondary Care (non-specialised)	NHS - AF	NHS - AF	CCG	CCG	CCG
Secondary Care (specialised)	NHS - Spec	NHS - Spec	NHS - Spec	NHS - Spec	NHS - Spec
Secondary Care - delivered overseas	DMS	DMS			
Secondary care - overseas returned to England	CCG	CCG			
Community care	DMS & NHS - AF	NHS - AF	CCG	CCG	CCG
Community care - delivered overseas	DMS	DMS			
mental health (non-specialised)	DMS & NHS - AF	NHS - AF	CCG	CCG	CCG
mental health - delivered overseas	DMS	DMS			
mental health (specialised)	NHS - Spec	NHS - Spec	NHS - Spec	NHS - Spec	NHS - Spec
Rehab - post injury	DMS provision				
IVF - WIS cohort	NHS AF & DH			CCG & DH	CCG & DH
IVF	NHS AF	NHS AF	NHS AF	CCG	CCG
Continuing Healthcare (CHC)	NHS AF	NHS AF	CCG	CCG	CCG
Public Health (Screening & Immunisations)	NHS - PH	NHS - PH	NHS - PH	NHS - PH	NHS - PH

Public Health (0-5)		NHS - PH	NHS - PH		
Occupational Health	DMS				
Prosthetics	DMS & NHS - VPP	NHS - Spec	NHS - Spec	NHS - VPP	NHS - VPP
Wheelchairs	DMS & NHS - AF	NHS - AF	CCG	CCG	CCG
wheelchairs (specialised)	DMS & NHS - Spec	NHS - Spec	NHS - Spec	NHS - Spec	NHS - Spec

Appendix 4:

Commissioning Framework (Population, Partnership and Processes)
NHS England commissions for:

- All community and secondary acute and mental healthcare for families registered with a DMS GP, in line with the principles of a common commissioning policy for NHS England (and includes Continuing Health Care (CHC).
- All non-combat related community and secondary healthcare for Serving Personnel, Mobilised Reservists and Families registered with DMS GPs. In line with the principles of no disadvantage and a common commissioning policy for NHS England, with the exception of services normally commissioned by or provided by DMS including:
    i. In Patient Mental Health is normally commissioned by DMS from a NHS consortium led by South Staffordshire and Shropshire FT
    ii. Community Mental Health – normally commissioned and provided by DMS
    iii. Community musculoskeletal and neuro rehabilitation
- Services are commissioned in line with the requirements of the armed forces covenant for veterans:
    i. Prosthetics
    ii. IVF for those with infertility as a result of injuries on operations
    iii. Mental Health
        1. Specialised Psychological therapies
        2. On line Psychological support
        3. Specialised inpatient treatment

The Commissioning Processes

Armed forces healthcare will be commissioned within a single framework which will include the following elements.

- Joint-commissioning arrangements with MoD, Other parts of NHS England and CCGs
- Assessment of health needs and links into Health and Wellbeing Boards and Joint Strategic Needs Assessments
- Parity of Esteem
- Equality and Diversity requirements
- Patient engagement
- Commissioning principles
- Standardised outcome measures
- Delegated commissioning model, (NHS England uses local commissioning arrangements) where this can be used and the safeguards are required
- Standardised contracting arrangements
- Whether any deviation from the National Contract is appropriate

- Standardised contract term
- Prime provider model, or other appropriate vehicles
- Delegated authority approvals and limits
- Associate commissioner models with NHS England
- Monitoring, evaluation and quality assurance systems
- Information and information governance

Appendix 5:

Glossary of Terms

AF	Armed Forces
AFC	Armed Forces Community
AFN	Armed Forces Network
AT	Area Team
CCG	Clinical Commissioning Group
CoC	Chain of Command
CPAG	Clinical Priorities Advisory Group
CRG	Clinical Reference Group
CSU	Commissioning Support Unit
DA	Devolved Administrations
DCMH	Defence Community Mental Health
DH	Department of Health
DMS	Defence Medical Services
DoN	Director of Nursing
D&N	Derbyshire and Nottinghamshire
DPHC	Defence Primary Health Care
DSC	Disablement Services Centre
DTSG	Defence Transition Steering Group
HSCIC	Health and Social Care Information Centre
IFR	Individual Funding Request
IG	Inspector General
IM&T	Information Management and Technology
Info Gov	Information Governance
IVF	In vitro fertilisation
KPI	Key Performance Indicator
LAs	Local Authorities
MH	Mental Health
MoD	Ministry of Defence
NHAIS	National Health Applications and Infrastructure Service
NST/C	National Support Centre/ Team
NY&H	North Yorkshire and Humber
OH	Occupational Health
PbR	Payment by Results
PH	Public Health
PHE	Public Health England
PRU	Personnel Recovery Unit
QA	Quality Assurance
QIPP	Quality, Innovation, Productivity and Prevention

RAF	Royal Air Force
RN	Royal Navy
SG	Surgeon General
ToR	Terms of Reference
WIS	Wounded Injured and Sick

Appendix 2

NHS England

Armed Forces Health Operational Plan 2015-2017

Information Reader Box (IRB) to be inserted on inside front cover for documents of 6 pages and over, with Publications Gateway Reference number assigned after it has been cleared by the Publications Gateway Team. Publications Gateway guidance and the IRB can be found on the Intranet.

Armed Forces Health Operation Plan 2015 - 2017

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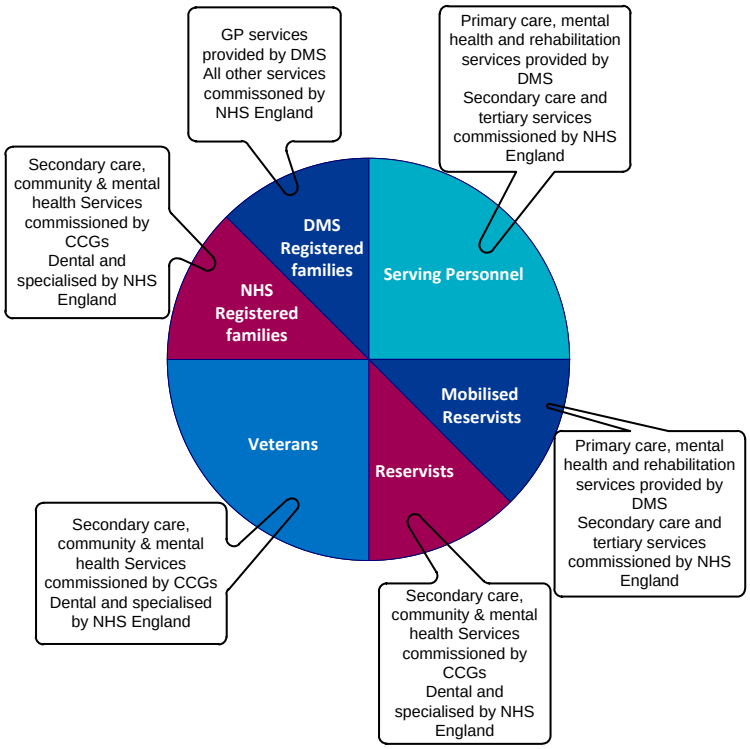
1 Executive Summary

Since 1st April 2013 NHS England has commissioned services for serving personnel and those families registered with a Defence Medical Service (DMS) practice in England. This document is the first version of the 2015/16 Two year operational plan refresh following publication of the *Five Year Forward View* by NHS England.

This document is based upon the fundament elements of operational plans as set out in the planning guidance document *Supplementary information for commissioner planning.* [1]

The main focus of the plan is on the population that NHS England directly commissions for, that is to say, patients registered with a Defence Medical Services practice. It should, however be noted there are other cohorts within the Armed Forces community such as Veterans, Reservists and families registered with an NHS practice, the graphic below shows the various sections of the Armed Forces Community and who is their responsible commissioner.



1.1 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.

[1] http://www.england.nhs.uk/ourwork/forward-view/

1.1.1 Our values and principles

To achieve our vision we will:

- 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 who are injured or become ill as a consequence of their service as a proper return for their sacrifice
- Listen to and learn from patient experiences
- 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

Objectives

Underpinning the vision, values and principles are four key objectives, these are:

1. Services for the armed forces are commissioned to achieve the best health outcomes, in line with the commitments of the Armed Forces Covenant
2. We work in partnership with the MoD to commissioning healthcare in line with the partnership agreement and in support of DMS's objective to promote, protect and restore the health of the Defence population in order to maximise fitness for role.
3. We will work with the MoD and CCGs to improve the model of integrated care that service leavers with mental health or complex physical health needs receive
4. We will collaborate with CCGs and Health and Wellbeing Boards to develop and embed strong Armed Forces Networks to ensure that the armed forces community receives appropriate care regardless of commissioner

These, together with our improvement interventions are summarised in our plan on a page which is shown overleaf.

1.2 Sign off

This document was been received by the Armed Forces Oversight Group in March 2015.

2 Plan on a Page

Armed Forces Health Commissioning (2015-2017)

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.

System Values

To achieve our vision we will:

- 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
- Listen to and learn from patient experiences
- Work together with Defence Medical Services to ***promote, protect*** and ***restore*** 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

Objectives

System Objective One

Services for the armed forces are commissioned to achieve the best health outcomes, in line with the commitments of the Armed Forces Covenant

System Objective Two

We work in partnership with the MoD to commissioning healthcare in line with the partnership agreement and in support of DMS's objective to promote, protect and restore the health of the Defence population in order to maximise fitness for role.

System Objective Three

We will work with the MoD and CCGs to improve the model of integrated care that service leavers with mental health or complex physical health needs receive

System Objective Four

We will collaborate with CCGs and Health and Wellbeing Boards to develop and embed strong armed forces Networks to ensure that the armed forces community receives appropriate care regardless of commissioner

Interventions

Delivering better care through the digital revolution

(a) increase use of E-referrals, including advice and guidance functionality, within DPHC
(b) increase the use of telemedicine as an alternative to face to face care where appropriate;
(c) increase access to national screening programmes
(d) link DMS systems to Child Health Information Systems

Co-ordinated access to musculoskeletal pathway

(a) Improved use of E-referrals and its functionality within DPHC for access to secondary / tertiary referral for MSK conditions
(b) re-design MSK pathways to make best use of recognised good practice in rehabilitation

Improved access to mental health services

(a) Improve care co-ordination on service discharge
(b) Improve signposting to appropriate mental health services including crisis services
(c) Improve choice of recognised good practice and evidence based services for mental health

WIS leavers to have an agreed health plan

Work with the MoD to ensure that all WIS service leavers leave with a personal health plan; designed to empower patients to take to take more control of their long term health and direct them to the most appropriate professional under the primary care team to manage their routine needs.

Overseen through following governance arrangements

- Area Team internal meetings
- Armed Forces Operational Group
- Joint Commissioning Group
- Armed Forces Oversight Group

Measurement

- Increased referrals made electronically
- Sustained RTT performance
- Co-produced workforce measures
- Access to screening programmes
- Number & % of agreed health plans
- Register of Armed forces champions
- Mental Health services directory

Sustainability

- We will consider sustainability and affordability in our approach to decision making.
- We will work with DMS to, where possible, standardise the approach to state funded items to help deliver affordability and sustainability.

3 Context

This document provides information about NHS England's Armed Forces Health commissioning plans for 2015/16 to 2016/17.

NHS England is an independent organisation that operates across England, at arms-length from government. Through its 4 regions and the directorate of Commissioning Operations, NHS England is responsible for directly commissioning:

- Some healthcare services for the armed forces and those families registered with a Defence Medical Services (DMS) practice, which is delivered through one commissioning operations team and a central team.
- Primary care services (GP services, dental services, optometry and pharmacy services)
- Secondary care dental services
- Specialised healthcare services
- Healthcare services for offenders and those within the justice system

The focus in direct commissioning, for the armed forces and those families registered with a DMS practice, is on improving health outcomes, value for money and ensuring equity and consistency in the provision of health services.

NHS England also works closely with local clinical commissioning groups (CCGs); 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 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.

3.1 The national context

Each year the Government publishes the NHS mandate setting out ambitions for the NHS and the outcomes the NHS should achieve for patients. The mandate is available at https://www.gov.uk/government/publications/nhs-mandate-2015-to-2016

NHS England has published the Five Year Forward View[2], in October 2014, which sets out a vision for the future of the NHS. The Five Year Forward View articulates why change is needed, what that change might look like and how we can achieve it. It describes various models of care which could be provided in the future, defining the actions required at local and national level to support delivery

[2] http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf

4 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 136,000 people, all of whom are registered with Defence Medical Services (DMS) Medical Centres in England. 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 15,000 are registered with DMS Medical Centres in England and are the responsibility of NHS England.
- **Veterans** – A Veteran is defined, in the Armed Forces Covenant, as anyone who has been a member of the serving Armed Forces for a day or more. The Royal British Legion's 2014 Household Survey estimates that there are approximately 2.8[3] million veterans in the UK .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. DMS remain responsible for the local provision of services in overseas bases.
- **Devolved Administrations** – 'Devolved Administrations' mean Scotland, Wales and Northern Ireland. The 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.

A brief high level summary of commissioning responsibility for these populations is shown in Table 1. A more detailed table can be found in

[3] http://www.britishlegion.org.uk/about-us/campaigns/household-survey-2014

Appendix 1 – Commissioning Responsibilities

Table 1 - High level commissioning responsibilities

Population	Responsible Commissioner
Serving personnel Mobilised Reservists	NHS England
Families – with a DMS practice	NHS England
Families – with an NHS practice	CCGs
Reservists – not mobilised	CCGs
Veterans	CCGs

4.1 Health needs of serving personnel

Summary Demographic Details[4]

- 50% of the Armed Forces population is aged under 30 this is in comparison with 35% of the England population. 81% of the Armed Forces population is aged under 40, compared with 47% of the England population. 17% of the England population is aged 65 or over, by comparison, none of the reported DMS population is aged more than 65.
- 9.9% of the serving population is female[5], when dependents are included in the commissioning population this rises to 16.6%
- 54% of the serving population is in the Army, 22% in the Royal Navy or Royal Marines and 24% in the RAF
- In England, 18.6% of the serving population are officers (15.2% Army to 22.7% Naval Services); 81.4% other ranks (77.3% Naval Services to 84.8% Army) [6]
- Overall 7.1% of the serving population are from a BME group (2.4% of officers, 8.1% of other ranks)[7]; by comparison 13% of the England population is from a BME group.

4.2 Physical Health needs of Serving Personnel

- Armed Forces personnel 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.
- Due to the nature of the role, there are a number of medical conditions that preclude enlistment; these include a number of long term conditions such as those associated with cardiovascular disease, diabetes and respiratory conditions[8].
- The greater investigation of the population, to meet occupational requirements, may give rise to asymptomatic but unmet health needs.
- Armed Forces personnel 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 2013 report include:
    - Health promotion – smoking cessation, oral health and alcohol misuse
    - Musculoskeletal problems
    - Mental health

4.3 Mental Health needs of the Armed Forces

The Ministry of Defence (MoD) commission bespoke inpatient and community mental health services for their service personnel. NHS England commission prescribed

[4] https://www.gov.uk/government/publications/defence-personnel-nhs-commissioning-quarterly-statistics-financial-year-201415 April 2014 figures
[5] https://www.gov.uk/government/publications/mod-diversity-dashboard-2014 1 April 2014
[6] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/312590/qls_april_14.pdf
[7] https://www.gov.uk/government/publications/mod-diversity-dashboard-2014 1 April 2014
[8] Example RN standards http://www.royalnavy.mod.uk/~/media/files/cnr-pdfs/eligibility_form_online_version.pdf :

specialised mental health services[9] for the population in England, including serving personnel. As with physical heath there are a number of mental conditions that preclude enlistment, these include ongoing psychiatric illness, schizophrenia, personality disorder and substance dependence[10].

They publish an annual mental health report[11], providing statistical information on mental health in the Armed Forces, based on information and data available to Defence Statistics. Key points are:

- Of the 6,804 new episodes of care at Department of Community Mental Health (DCMH), a DMS provider, in 2013/14, 5,351 (79%) were assessed as having a mental disorder, representing a rate of 30.4 per 1,000 at strength. This is higher than the rate within the UK general population (20.4 per 1000) and may be due to a lower referral threshold to specialist psychiatric care in the Armed Forces compared with GPs in the general population.
- Conversely, rates of in-patient admission within the UK Armed Forces were lower than the general population (1.8 and 6.0 per 1000 respectively).
- The rigorous selection of fit people into the Armed Forces may help to prevent those with more serious mental health disorders joining the Services and Armed Forces personnel who have a mental health disorder which prevents continued service may be considered for medical discharge, thus more severe cases of mental health disorders may not remain in the Armed Forces population.

4.4 Health needs of Families

- Most families (spouses/ partners and children) 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.
- It is critical to note that whilst the families and dependants of serving Armed Forces personnel have health needs typical of their age and gender there a number of underlying elements to daily lives of this population which could impact their health such as; geographic and social isolation and impact on mental health the potential upheaval of mobility due to moves and possible issues with access to services as a result[12].
- The needs of military families must be referenced and planned for where large numbers exist in a community, for example maternity and children services will need focus where a regular population of young families reside due to their circumstances

4.5 Health Needs of Veterans

- On leaving the Armed Forces, Service personnel register with an NHS GP practice and become the responsibility of Clinical Commissioning Groups (CCGs)

[9] http://www.england.nhs.uk/ourwork/commissioning/spec-services/
[10] Examples : http://www.royalnavy.mod.uk/~/media/files/cnr-pdfs/eligibility_form_online_version.pdf
[11] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/338212/20140729_Annual_Mental_Health_report_2013_14.pdf
[12] The Overlooked Casualties of Conflict, Royal Navy and Royal Marines Children's Fund, November 2009

- Under certain circumstances, veterans are entitled to priority treatment within the NHS, where their condition is related to their military service and subject to the clinical priorities of other patients.
- Though military Service is often seen as a job for life, less than one fifth of personnel actually serve for a full career of 22 years. Of those leaving in 2011/12, nearly half had served less than six years[13], including a significant number of Early Service Leavers who depart before they complete training. The average length of Service, for those that do complete training, is nine years.
- The Royal British Legion's 2014 Household survey of the UK's ex-service community[14] found the following:
    - There are estimated to be 2.8m veterans in the UK
    - They, and the wider ex-service community, are elderly and declining in size – 64% are over 65 and 46% are over 75. By comparison with the adult (over 20 years old) population 22% are over 65 and 10% over 75 years
        - Issues with their health included depression; hearing problems and back pain

4.6 Strategic Issues affecting our population

4.6.1 Planned changes which impact on the population

During the lifetime of this plan we know that the population we are responsible or its needs for will change. There are a number of influences:

- Strategic Defence & Security Review 2015
- Rebasing[15] - within the timescale of this two year plan troops currently based in Germany are also returning to the UK and will be integrated into existing UK based Garrisons and Barracks. Troops will start to return from Germany this year.
- FR20 - Reserves in the Future Force 2020: Valuable and Valued [16]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, if which 19,090 were in the Army

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

[13] http://www.dasa.mod.uk/publications/health/veterans/career-transition-partnership/financial-year-2012-13-q2/2009-10-to-2012-13-q2-revised.pdf
[14] http://www.britishlegion.org.uk/about-us/campaigns/household-survey-2014
[15] http://www.army.mod.uk/structure/33834.aspx
[16] Reserves in the Future Force 2020: Valuable and Valued Cm 8655 July 2013

5 Outcomes

5.1 Improving health outcomes aligned 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 five domains and seven outcomes ambitions have limited applicability to the Armed Forces population; our main aim is 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.

Actions to improve outcomes

Although it is recognised that for the armed forces population there is limited applicability to the national measures, there are still actions that NHS England and the MoD can undertake to influence outcomes.

These include:

- Improving access to screening and immunisation programmes
- Undertaking a health needs assessment to understand how to address alcohol culture issues
- Plans for smoking bans

5.2 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. This means that only a very small percentage are within the powers of NHS England to affect but we will seek additional years of life for these; although this metric has limited applicability we will:

- Work with the MoD to look at the preventative medicine agenda on for example lifestyle issues that influence long term health.
- Work with the MoD to support the earlier diagnosis of cancer, in for example, targeted campaigns
- 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;

5.3 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 statistically meaningless. Although this metric 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 e.g. EQ5D scores for individuals who identify themselves having a LTC.
- Work with DMS to 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

5.4 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.

5.5 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 the 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 1000 patients
- Look at quality of effect (did the services received make a difference to your health problem) and quality of effort (how did we treat you) measures

Outcome ambition 6 – positive experience of care outside of hospital

We will work with DPHC to:

- Reduce poor patient experience of primary care services (GP and OOH) where the NHS is in a position to influence patient experience; measured by rate of responses of a fairly poor or very poor experience across GP and OOH services per 1000 patients
- Look at quality of effect (did the services received make a difference to your health problem) and quality of effort (how did we treat you) measures, where the NHS is in a position to influence the care delivered.

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

Outcome ambition 7

We will work with co- commissioners to make significant progress towards eliminating avoidable deaths in our hospitals caused by problems in care. Care for our population is delivered in a large number of organisations which may make information and trends statistically irrelevant; this outcome will be monitored through serious incident reporting.

5.7 Improving Health

We will be working with DMS, Health and Well-being boards, Local Authorities and colleagues in Public Health, both Public Health England and within NHS England to take the necessary steps recommended in the Commissioning for Prevention.
Our key priorities are:

- Improved access to immunisations and 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

5.8 Reducing Health Inequalities

5.8.1 Identification of groups of people

NHS England has commissioned Community Innovations Enterprise (CIE) to look at inequality within the armed forces. In particular the review will identify the particular health needs of minority groups in order to improve outcomes. We have also commissioned needs assessment reviews in relation to mental health and musculoskeletal services which will also consider needs across all groups of people. Non-freezing cold injury has been shown to be an issue in some groups of people and further research has been commissioned into this

Studies of early service leavers have demonstrated that the socio-economic background of service personnel has an influence on health outcomes, and that a poorly managed transition from service life can have a detrimental impact on long term health outcomes.

5.8.2 Five most cost effective high impact interventions

As the five most cost effective high impact interventions relate primarily to prescribing and management of diabetes we will need to work with Defence Primary Health care to influence this. Another of the high impact interventions relates to smoking cessation and DMS already have plans to reduce smoking as part of their health strategy.

5.8.3 Implementing EDS2

In its role as a system leader, and as an NHS organisation subject to the Public Sector Equality Duty of the Equality Act 2010 in its own right, NHS England has committed to implement *EDS2*. This commitment is reflected in NHS England's corporate Equality Objectives for 2014/15 to 2018/19.

Within NHS England an EDS2 Implementation Group is being established which will lead on the organisation's implementation of EDS2. This group will help to identify equality priorities and actions for NHS England, track organisational progress and facilitate stakeholder engagement.

As part of the work to advance this, there is a requirement, in the standard contract for 2015/16, for NHS Trusts and NHS Foundation Trusts to implementation EDS2. We will, therefore, be working with our coordinating commissioner colleagues to ensure that our providers implement them.

5.8.4 Workforce race equality standard

The workforce race equality standard requires organisations to demonstrate progress against a number of indicators of workforce equality, including a specific indicator to address the low levels of BME Board representation.

As with EDS2, implementing the national workforce race equality standard, is part of the standard contract for 2015/16, and we will work with our commissioning

colleagues to ensure that annual reports are received from providers on their implantation progress.

The MoD produces the Diversity Dashboard which is published biannually; the report was created to meet the MoD's obligations under the Public Sector Equality Duty to provide information on its workforce in relation to the protected characteristics identified by the Equality Act 2010. Key points in relation to ethnicity include:

- Black, Asian Minority and Ethnic (BME) personnel comprised 7.1 per cent of the UK Regular Forces, remaining relatively constant since 1 October 2012. This representation differs for officers (2.3 per cent) and other ranks (8.1 per cent).
- At 1 October 2014 the proportion of BME personnel in the RN/RM was 3.5 per cent, the Army was 10.2 per cent and the RAF was 2.1 per cent.

5.9 Parity of Esteem

The majority of mental health services for members of the armed forces are provided by and / or commissioned by the MoD. There are 16 Departments of Community Mental Health, with approximately 250 mental healthcare professionals across the service, providing outpatient mental health services. This is estimated, by the MoD, to be approximately twice the level of resources compared to NHS provision although comparisons are imprecise as the inputs and outputs are not the same. Inpatient care is provided by bespoke contract with South Staffordshire and Shropshire NHS Foundation Trust, as lead provider and seven other NHS Trusts across the UK.

Due to historic identification issues, and the types of contract in place for mental health services, a risk share is in place, between NHS England and CCGs, for mental health commissioning. Under the risk share, the CCGs have retained both the budget and commissioning responsibility for NHS commissioned mental health services for the armed forces and eligible civilians. As the commissioning has remained with the CCGs, we will need to work with the CCGs to ensure that our population is able to access appropriate services

In addition to commissioning activities associated with parity of esteem the MoD have undertaken a number of education programmes for Military GPs on mental healthcare and the policy on transition arrangements for those leaving the armed forces reflect the requirements on parity of esteem.

5.9.1 Younger People with mental health problems.

We have a disproportionately small population of patients aged 19 years or under (10% compared to 23% for England); this is a reflection of the small numbers of dependents that are registered with DMS practices.

Within our population there are just over 5000 service personnel who are aged 19 years or under; these service personnel would be eligible to access both NHS & MoD commissioned services as appropriate to their needs, whilst for dependents, services such as CAMHS would be accessible via the services commissioned by NHS England and CCGs.

In addition to the traditional mental health services members of the armed forces community are able to access Big White Wall[17] an online early intervention service for people in psychological distress. Big White Wall offers a range of therapeutic interventions including: talking therapies in groups and on a one-to-one basis; guided groups informed by recognised therapies such as cognitive behaviour and interpersonal therapies; peer support and networking; and live therapy – one to one therapy via webcam, audio or instant messaging.

5.9.2 Severe Mental Illness

NHS England and the MoD have a limited ability to influence the life expectancy gap for those with severe mental illness; this is because severe mental illness would prevent someone from serving with the Armed Forces. Recent data[18] suggests that 12.7% of medical discharges(n=2714) had a mental health diagnosis as the principal cause of medical discharge, and only 4.7% of all medical discharges (n=2714) suffered from PTSD.

Those personnel being discharged from the Armed Forces due to a health issue would be managed as part of the agreed transition protocol between the MoD and the NHS; this helps to ensure that patients care is uninterrupted during their transition from service to civilian life. This managed transition process would be expected to make a positive impact to health.

Once discharged from service, in addition to the services commissioned by CCGs the patient, as a veteran, would also be able to access bespoke veterans' services, such as Hidden Wounds; the Combat Stress inpatient PTSD programme and a range of welfare offers which impact positively on health.

5.9.3 Spending on Mental Health services

As previously noted, there is a risk share in place between NHS England and CCGs for mental health commissioning; the impact of this is that any increase in CCG expenditure on mental health will also have an impact on the serving community.

The majority of mental health services for members of the armed forces are provided by and / or commissioned by the MoD. There are 16 Departments of Community Mental Health, with approximately 250 mental healthcare professionals across the service, providing outpatient mental health services. This is estimated, by the MoD, to be approximately twice the level of resources compared to NHS provision although comparisons are imprecise as the inputs and outputs are not the same. Inpatient care is provided by bespoke contract with South Staffordshire and Shropshire NHS Foundation Trust, as lead provider and seven other NHS Trusts across the UK. MoD spend on in house mental health services per head is expected to increase with time, as the reducing numbers in the overall serving personnel population have not fed through to mental health services, implying an real increase in provision.

[17] www.bigwhitewall.co.uk

[18] https://www.gov.uk/government/statistics/uk-service-personnel-medical-discharges-financial-year-201314

6 Access

6.1 Convenient Access for Everyone

Primary Care

Primary care for service personnel is provided by Defence Primary Healthcare (DPHC), with weekday access usually on a same day basis. There are, however, opportunities to improve services and 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.

During 15/16 we will be supporting the transfer of out of hours care from MoD contracted services to CCG commissioned services; this will ensure that serving personnel are able to access the same level of service as their local population.

Mental Health

DMS provide or commission most of their own mental health services, on an occupational health basis for the serving population. The Departments of Community Mental Health aim to see, assess and develop treatment plans for all GP routine referrals within 20 working days (four weeks); urgent cases can be seen within one working day. They do not provide 24 hour crisis care nor care for families registered with a DMS practice; these services are provided through services commissioned by CCGs. We will therefore:

- Continue to work with the MoD to identify potential gaps in service provision
- Work jointly to ensure that the principles of Parity of Esteem and Closing the Gap are applied equally to the Armed Forces population and any services commissioned for this population;
- Improve, in line with the Crisis Concordat and through CCG commissioning, the access of service personnel to crisis support;
- Ensure that families registered with a DMS practice are able to access their choice of mental health provider.

Community Care

DMS provides a significant amount of services that the NHS would consider to be a ‘community service’ – for example DMS provide a comprehensive rehabilitation service ranging from local services through to the specialist services at DMRC Headley Court.

In addition to the DMS provided services, service personnel and registered families are able to access services commissioned by CCGs.

There are issues of activity identification with community services and we will be working with CCGs and the MoD to:

- To identify potential gaps in service provision
- Ensure that families registered with a DMS practice are able to access appropriate services

Secondary Care

Secondary care services are co-commissioned with specialised commissioning; in this year's contract there are general provisions to ensure that individuals are able to access a choice of service even where there is no contract in place between the responsible commissioner and the provider. We have also included a requirement to report waiting time information in the information schedule.

We will work with colleagues to ensure that NHS Choices is kept up to date and relevant as a first point of information on NHS services for service personnel, their families and those transitioning to civilian life.

Early Cancer Diagnosis

We will work with Defence Primary Health Care (DPHC) to raise awareness of cancer referral criteria. As evidence indicates that early detection is related to better outcomes, we will link DMS practices with local Public Health teams and CCGs who are commissioning awareness campaigns, such as Cancer Activists in the community and *'Get to know cancer'* pop-up shops, to raise awareness of symptoms and encourage early diagnosis.

We will continue to ensure that people registered with DMS practices are recognised and incorporated into NHS cancer screening programmes.

We will collaborate with CCGs to improve local hospital performance, such as following best practice on lung cancer and bowel cancer to reduce variations and promote adoption of Royal College recommendations on waiting and reporting times for diagnostic tests.

6.2 Meeting the NHS Constitution Standards

Commissioning Sufficient Services

We will be working with our co-commissioning colleagues in specialised commissioning and in CCGs to ensure that sufficient capacity is commissioned from NHS and IS providers.

Mental Health Access Standards

DMS provide or commission most of their own mental health services, on an occupational health basis for the serving population. The Departments of Community Mental Health aim to see, assess and develop treatment plans for all GP routine referrals within 20 working days (four weeks); urgent cases can be seen within one working day. We will work with DCMH to ensure that their treatment plans meet the new national waiting times standards.

Services for families and those that aren't provided by the DCMH are commissioned by CCGs as part of an agreed risk share, as the population cannot, currently, be separately identified. We will be working with CCGS to ensure that service development plans (SDIP) in contracts reflect the need to meet access targets.

7 Quality

7.1 Responses to Francis, Berwick and Winterbourne View

Some of the themes raised in the Berwick and Francis reports are now becoming embedded into the national standard contract, however, we need to continue to make sure that good practice in relation to patient safety and transparency, for example, continues. As we are not the lead commissioner we will need to link with the local quality system, e.g. QSGs to obtain our assurances.

Although the nature of service life means it is unlikely that any of our patients will have a learning disability and be care for in an inpatient setting, there may be a small number of dependents who fall into this category. In addition, the principles associated with the Winterbourne View report, around personalised care services and local home based support should apply to those patients, on transition pathways, with a traumatic brain injury leading to cognitive impairment and potentially challenging behaviour. We will need to work with the MoD, and predominantly the Personnel Recovery Units to make sure that the applicable recommendations of Winterbourne View are reflected in care planning.

7.2 Patient Safety

7.2.1 Sepsis and Acute Kidney Injury

We will work with our co-commissioning colleagues to ensure that the CQUINs for sepsis and acute kidney injury are including in contracts
We will also work with DPHC to understand the contribution that primary health care plays in these two patient safety issues

7.2.2 Antibiotic prescribing

We will work with providers and commissioning colleagues to look at antibiotic prescribing in secondary care. We will also be encouraging DPHC colleagues to review their antibiotic prescribing approach and whether there is any good practice in relation to antibiotic prescribing that could be shared between the NHS and DMS.

7.3 Patient Experience

7.3.1 Ensuring NHS Constitution rights and commitments are met

Due to the way national reporting arrangements were established it has not been possible to have armed forces specific waiting times reporting. This means that we have not been able to assure ourselves that armed forces patients are being treated within the specified timeframes. To address this, we have specified in this year's information schedule, to the standard contract, a requirement for providers to supply NHS England's CSUs with a waiting times minimum data set; this, will enable us to monitor waiting times and confirm that out patients are not having their waiting times disadvantaged as a consequence of moves around the country.

7.3.2 Reducing poor experience of inpatient care and in general practice

Primary care services for members of the armed forces are commissioned by the MoD and provided by Defence Primary Health care (DPHC). A new patient experience survey has been commissioned by Defence Medical Services (DMS) and

this includes the Friends and Family test (FFT). Results from the survey will be available later this year which will provide baseline from which improvements can be made.

We will work with colleagues in CCGs, other commissioners in NHS England and our providers to set measurable ambitions to improve patient experience in inpatient care services

7.3.3 Assessing and improving the quality of care experienced by vulnerable patients

Assessing the quality of care experienced by vulnerable patients can be difficult; we are fortunate that in addition to the mechanisms put in place by providers and CCGs, the armed forces community have an number of organisations providing welfare support who are also able to make an assessment of the quality of care, feedback to commissioner and act as a patient advocate if necessary.

7.3.4 Demonstrate improvements from FFT, complaints and other feedback

As a small commissioner to most contracts it can be difficult to influence providers, however, in the area of patient complaints and other feedback, the profile of the armed forces community offers a powerful lever. NHS England is contacted by a number of stakeholders about patient experience and is able to feedback directly to users and patient advocate groups about what has happened as a result of their experience. We will also inform that other commissioners of the service are aware of the issues faced by our patients to ensure that they are captured in any thematic analysis undertaken.

7.3.5 Meeting the recommendations of the Caldicott review that are relevant to patient experience

In all our work related to understanding members of the armed forces experiences of NHS services by members of the Armed Forces we will endeavour to ensure comments are fully anonymised and that it is not possible to attribute comments to individuals. Where feedback is received that requires follow up and the only way to deal with the matter is to identify the person in question then full agreement and sign off by the individual is obtained before their personal details and comments are shared.

7.4 Compassion in Practice

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 DPHC are 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 HCAIs 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.

7.5 Staff Satisfaction

The armed forces population is based throughout England and accesses services from a wide range of providers. We will, therefore, need to work with our co-commissioning colleagues in CCGs and specialised commissioning to understand the factors affecting staff satisfaction in each area.

In addition to this, the Headquarters Surgeon General (HQ SG) conducts a Continuous Attitude Survey (CAS) across both regular and reserve DMS personnel employed within the MOD; many of these staff will also work in NHS providers. Although the responses from all questionnaires are anonymous, they have the potential to offer a comparator to the NHS on issues such as staff morale. The CAS also uses a number of free-response questions which may provide a focus from which to further investigate issues by follow up focus groups.

We also need to recognise that staff experience is an influencer on patient experience and that this may affect DMS provided services. The ability to offer a comparator, either nationally or locally, may enable greater understanding of the issues affecting staff.

7.6 Seven Day services

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

- Ensure that the standards relating to seven day services are covered in our contracts with providers
- 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 the Directory of Services (DOS) which is accessed by NHS 111, and maintained by CCGs.
- 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.

7.7 Safeguarding

7.7.1 Protecting Vulnerable People

All DPHC GPs are required to have or be working towards Level 3 Safeguarding training which requires local training and awareness of local resources and processes. In addition, all mental health professionals have been trained in Child Safeguarding awareness.

Within the North region the boundaries for the local NHS England team responsibility and the DPHC region are co-terminus. This has enabled the local team to work far more closely with the Regional DPHC Team and establish close links, particularly around the quality agenda. The senior nurse for DPHC North now has a standing invitation to attend the local team QSG plus a number of additional local quality related meetings. This has enabled her to get to know the nursing team at the local team and create a peer support network for herself. It is hoped that this model can be replicated across all DPHC regions.

7.7.2 Mental Capacity Act

The Mental Capacity Act (MCA) is designed to protect and empower individuals who may lack the mental capacity to make their own decisions about their care and treatment. It is a law that applies to individuals aged 16 and over. Examples of people who may lack capacity, who are likely to be the armed forces include those with a brain injury, a mental health condition or those who have had a stroke or unconsciousness caused by an anaesthetic or sudden accident

Within the MoD the use of the MCA is largely limited to DMRC Headley Court for patients with acquired head pathology and there is a defined protocol in place in

relation to circumstances which may be defined as a deprivation of liberty. The MCA is not applied within the Departments of Community Mental Health (DCMH)

Wounded Injured and Sick (WIS) patients may also be subject to the MCA due to the nature of their injury. Training for Personnel Recovery Officers (PROs), who manage the transition from service to civilian life, covers the MCA to ensure that decisions are made in the best interest of the patient.

Finally, all staff working in the NHS and in social care are expected to have an understanding of the act as it relates to their own responsibilities; we are working with our co-commissioning colleagues to ensure that our providers

7.7.3 Prevent

The *Prevent* strategy forms one of the four strands of the Government's counter-terrorism strategy *CONTEST*[19]. *Prevent* requires healthcare organisations to work with partners to contribute to the prevention of terrorism by safeguarding and protecting vulnerable individuals who may be at greater risk of radicalisation. From the perspective of the Armed Forces there are a number of aspects to this:

- NHS England's role as a commissioner of services and ensuring that our providers comply with their contractual requirements in relation to *Prevent*
- Ensuring linkages between local safeguarding forums, who have an oversight role in *Prevent*, and the MoD
- The MoD's own role in *CONTEST,* including the application of the MoD's personnel security policy, which is based on the national security and vetting policy. The policy covers the national security vetting carried out by the Defence Business Services National Security Vetting as the main provider of national security vetting in the UK.

8 Innovation

NHS England has commissioned a number of pieces of research related to the Armed Forces Community; these including literature reviews of non-freezing cold injury; Noise induced hearing loss and mental health and musculoskeletal needs assessments.

In addition to this, in recent years the healthcare associated with combat injuries and the ongoing recovery has led to healthcare innovation that is now being adopted by the NHS – we need to work with Academic Health Science Networks to understand how this can continue.

[19] https://www.gov.uk/government/publications/counter-terrorism-strategy-contest

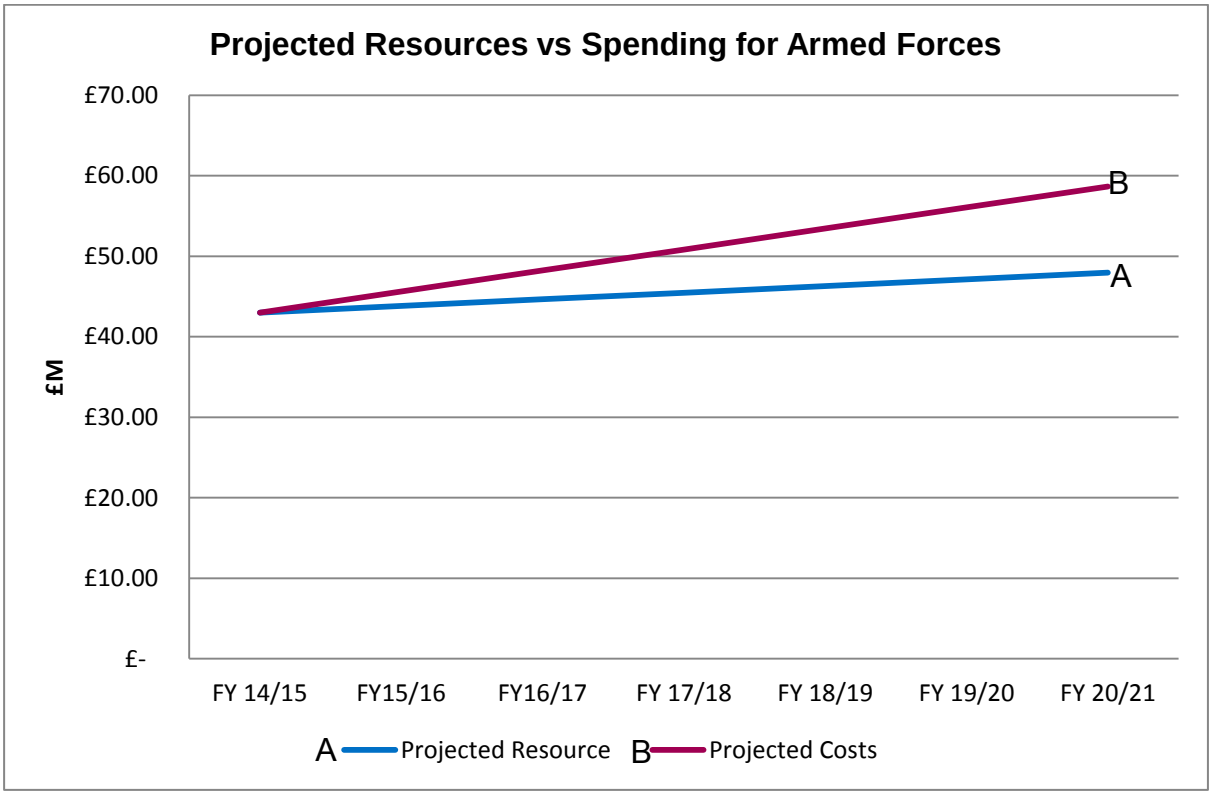
9 Delivering Value

9.1 The financial challenge

Nationally there is a forecast national financial gap of circa £30 billion by 2020/21, across all commissioners, 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 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. The Armed Force Health projected gap is shown in Figure 1 – Projected Financial Gap below, based on our current known expenditure levels and assuming the same rising demand and cost levels.

Figure 1 – Projected Financial Gap



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, which will have an impact on Armed Forces Health as our co-commissioning CCGs redesign services to help meet the challenge.

9.2 Delivering an affordable NHS for future generations

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 conflict in Afghanistan with particular regard to the cessation of additional HM Treasury funding (NACMO). The long term impact of Operation TELIC and Operation 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 start to impact from 2016 as the warranties on the knee start to expire.

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 affordable.

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.

9.3 Current position – expenditure on secondary care

The 2014/15 forecast outturn position for Armed Forces is to deliver the planned surplus of £0.4m.

Each Area Team agreed a risk sharing arrangement with CCGs specifically covering community and mental health services. The risk sharing arrangement confirms that CCGs will continue to fund these services as PCT financial baselines did not identify the associated funding when PCTs were identifying the Armed Forces financial resource to transfer across to NHS England.

Appendix H: **2014/15 - Month 9**

Executive Summary - Direct Commissioning - Armed Forces - Surplus

Year to Date Surplus				Area Team	Allocation £m	Forecast Surplus				Forecast % of allocation	Change in Forecast £m	QIPP	
Plan £m	Actual £m	Var £m	Var % of allocation			Plan £m	Forecast £m	Var £m	Var % of allocation			YTD variance £m	FOT variance £m
0.0	0.0	0.0	0.0 %	Bath Glos Swindon & Wiltshire	27.2	0.0	0.0	0.0	0.0 %	0.0%	0.0	0.0	0.0
0.2	0.2	(0.0)	(0.1%)	Derbyshire & Nottinghamshire	13.0	0.3	0.3	0.0	0.0 %	1.9%	0.0	0.0	0.0
0.1	0.2	0.1	1.1 %	North Yorkshire & Humber	6.3	0.2	0.2	0.0	0.3 %	3.0%	0.0	0.0	0.0
0.3	**0.4**	**0.0**	**0.1 %**	**Total Surplus**	**46.5**	**0.4**	**0.4**	**0.0**	**0.0 %**	**0.9%**	**0.0**	**0.0**	**0.0**

Potential Risk Value	0.9		
Expected Mitigation Value	1.0		
Net (Risk) / Headroom	0.1		
Risk Adjusted Surplus	**0.6**	**0.1**	**0.3 %**

9.4 Current position – expenditure against programme budgets

The programme budgets in 2014/15 were:

- Veterans' prosthetics - £7.3m
- 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.

9.5 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 Operation TELIC and Operation HERRICK and prosthetics.

9.6 Overall Financial Plan

A summary of the initial financial plans, submitted as part of the 2014/15 planning round, is shown in the table below:

Area Team 2014/15 Financial Plans	Allocation £k	Planned Spend £k	Planned Surplus / (Deficit) £k	Planned Surplus / (Deficit) %	Net (Risk) / Headroom £k	Contingency %	Non Recurrent %	QIPP %
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 £k	Planned Spend £k	Planned Surplus / (Deficit) £k	Planned Surplus / (Deficit) %	Net (Risk) / Headroom £k	Contingency %	Non Recurrent %	QIPP %
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%

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 was not met.

The 2015/16 plan is currently being refreshed. It is anticipated that the requirements to deliver a 1% surplus and 0.5% contingency will be met. This document will be updated to reflect the revised financial plan which is being submitted separately.

9.7 Programme Funding

The following central programme budgets for 2015/16 are confirmed.

- Veterans' prosthetics - £6m, which will fund the recurrent (staffing) cost of grant aid investment in the nine Disablement Service Centres (DSCs), and high tech' prosthetics through the Veterans' Prosthetics Panel to meet the recommendations in "*A better deal for military amputees*"
- Veterans' mental health – NHS England currently delivers its Mandate commitment through two programmes and are set to consider a third next year:
    - Ten regionally based community veterans' mental health services (£150k each) and one central fund of £03.m
    - The specialised commissioning contract for inpatient PTSD services (£3.2m)
    - An online veterans' mental health service provided by Big White Wall, which is currently funded by the Department of Health

9.8 QIPP

There are a number of strands to our approach to QIPP. These are:

- Ensuring we spend our resource in the most effective way
- Working with our CCGs to design and implement QIPP schemes that impact on the services we co-commission and ensuring that the elements of savings accrued from acute trust based QIPP schemes agreed with co-commissioners of the service are drawn down proportionate to the caseload.
- Working with the MoD to ensure that there is a tax payer benefit to our actions for example commissioning services to increase deployability

9.9 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. NHS England has agreed a similar approach to risk sharing in 2015/16. This will involve:

- A focus on acute activity for 2015/16. All acute activity to be commissioned by local NHS England teams in 2015/16, 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;
- Confirming that mental health and community activity remain with CCGs (as in 2014/15), to be moved at an appropriate future date; and
- In year agreements to transfer funds from CCGs to local NHS England 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.

	Risk	Mitigating actions
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 1st April 2014
2	Weaknesses in invoice validation processes result in inappropriate payments or delays in payments and uncertainties over liabilities	s.251 exemption has improved availability of data to CSUs to enable NHS England to carry out invoice validation Longer term solution being supported by Activity Reporting Programme and new CSU SLA
3	Clarification of commissioning and funding responsibilities, specifically including Continuing Health Care	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 personnel and their families returning from overseas 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

10 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.

10.1 Streamlined / co-ordinated access to musculoskeletal 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 musculoskeletal (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.
(c) Reduce the morbidity from MSK injuries

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
2015/16 for E-referral uptake
2015 and beyond for implementing pathway redesign

Enablers
Engagement of DMS Regional Rehabilitation Units

10.2 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 and evidence based 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.

We will work with DCMH, NHS providers and the third sector to pilot joint mental health clinics that can see both service personnel and veterans.

We will support and promote delivery, via the Veterans' Council, of a managed website for accredited providers of veterans' 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

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10.3 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 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
- Agree other agencies required to support health and wellbeing, e.g. local authorities and support from veterans' charities

Investment costs
Financial – limited

Non-financial – workforce change within DPHC for service leavers

Implementation timeline
2015 – Agree content of plans with Defence Transition and NHS GPs currently managing WIS patients
2015/16 – Roll out across Recovery capability

Enablers
Engagement with Defence Transition
Engagement with Personnel Recovery Units

Barriers to success

DMS workforce change

10.4 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 and evidence demonstrates the utility of a telemedicine approach; 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. This will need to be funded from running cost allocations
- CHIS – national solution being worked upon

Non-financial – workforce change

Implementation timeline
2015/16 for E-referral (Choose and Book) uptake
2015 and beyond for access to screening
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
Lack of evidence to support the utility of telehealth / telemedicine
Absence of national solution to support CHIS integration

11 Glossary

Abbreviation	Meaning
BLESMA	British Limbless Ex-Service Men's Association
BME	Black or Minority Ethnic
CCG	Clinical Commissioning Group
CHIS	Child Health Information Systems
COPD	Chronic Obstructive Pulmonary Disease
CQC	Care Quality Commission
CRG	Clinical Reference Group
DCMH	Department of Community Mental Health
DH	Department of Health
DMICP	Defence Medical Information Capability Programme
DMRC	Defence Medical Rehabilitation Centre
DMS	Defence Medical Services
DOS	Directory of Services
DPHC	Defence Primary Health care
DSC	Disablement Service Centre
GP	General Practitioner
HSCIC	Health and Social Care Information Centre
IS	Independent Sector
KCMHR	Kings Centre for Military Health Research
LTC	Long term condition
MDS	Minimum Data Set
MDT	Multi-disciplinary team
MoD	Ministry of Defence
MSK	Musculoskeletal
NACMO	Net Additional Costs of Military Operations
NHAIS	National Health Authority Information Systems
NOTICAS	Notification of Casualty
ONS	Office of National Statistics
OOH	Out of Hours
PAR	Population at Risk
PCT	Primary Care Trust
PPV	Patient and Public Voice
PTSD	Post-Traumatic Stress Disorder
PYLL	Potential Years of Life Lost
RAF	Royal Air Force
RAF	Royal Air Force
RRU	Regional Rehabilitation Units
RTT	Referral to treatment time
SG	Surgeon General
SI	Seriously injured
VPP	Veterans' Prosthetics Panel
VSI	Very seriously injured
WIS	Wounded, injured or sick

Appendix 1 – Commissioning Responsibilities

	Serving AF Mobilised Reservists	Families with DMS	Families not with DMS	Non Mobilised Reservists	Veterans
Primary Medical Care	DMS	DMS	NHS - 1° care	NHS - 1° care	NHS - 1° care
OOH	DMS	DMS	CCG	CCG	CCG
Primary Dental Care	DMS	NHS - Dental	NHS - Dental	NHS - Dental	NHS - Dental
Operational Care (anywhere)	DMS				
Primary Medical Care - Overseas	DMS	DMS			
Primary Dental Care - Overseas	DMS	DMS			
Blue Light ambulance	CCG	CCG	CCG	CCG	CCG
Emergency care	NHS - AF	NHS - AF	CCG	CCG	CCG
Emergency care - overseas	DMS	DMS			
Secondary care - dental	NHS - Dental	NHS - Dental	NHS - Dental	NHS - Dental	NHS - Dental
Secondary Care (non-specialised)	NHS - AF	NHS - AF	CCG	CCG	CCG
Secondary Care (specialised)	NHS - Spec	NHS - Spec	NHS - Spec	NHS - Spec	NHS - Spec
Secondary Care - delivered overseas	DMS	DMS			
Secondary care - overseas returned to England	NHS	NHS			
Community care	DMS & NHS - AF	NHS - AF	CCG	CCG	CCG
Community care - delivered overseas	DMS	DMS			
Mental health (non-specialised)	DMS	NHS - AF	CCG	CCG	CCG
Mental health - delivered overseas	DMS	DMS			
Mental health (specialised)	NHS - Spec	NHS - Spec	NHS - Spec	NHS - Spec	NHS - Spec
Rehab - post injury	DMS provision				
IVF - WIS cohort	NHS AF & DH	NHS AF & DH	CCG & DH	CCG & DH	CCG & DH
IVF	NHS AF	NHS AF	NHS AF	CCG	CCG
Continuing Healthcare (CHC)	NHS AF	NHS AF	CCG	CCG	CCG

Public Health (Screening & Imms)	NHS - PH	NHS - PH	NHS - PH	NHS - PH	NHS - PH
Public Health (0-5)		NHS - PH	NHS - PH	NHS - PH	NHS - PH
Occupational Health	DMS				
Prosthetics	DMS & NHS - VPP	NHS - Spec	NHS - Spec	NHS - VPP	NHS - VPP
Wheelchairs	DMS & NHS - AF	NHS - AF	CCG	CCG	CCG
wheelchairs (specialised)	DMS & NHS - Spec	NHS - Spec	NHS - Spec	NHS - Spec	NHS - Spec