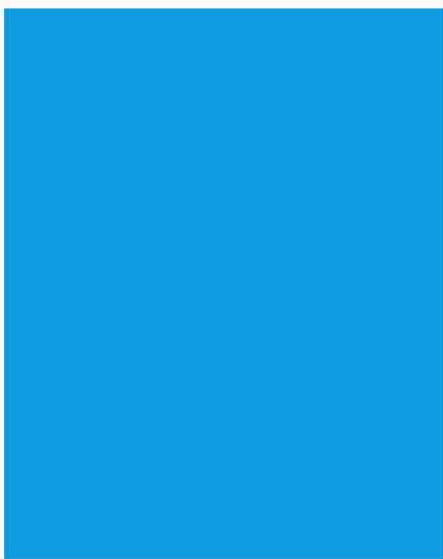


Securing excellence in
commissioning for the
Armed Forces and their
families

March 2013



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Purpose of the document

1. From 1 April 2013, the NHS Commissioning Board (NHS CB) will take up its full duties to ensure that the NHS delivers better outcomes for patients within its available resources and upholds, and promotes the NHS Constitution. As a single national organisation, the NHS CB will be responsible for ensuring that services are commissioned in ways that support consistency not centralisation; consistency in ensuring high standards of quality across the country. The NHS CB will work through its national, regional and area teams to discharge these responsibilities.
2. One of the NHS CB's responsibilities will be to commission directly health services for members of the Armed Forces and their families if registered with Defence Medical Services Medical Centres. This document sets out the operating model through which the NHS CB will secure the best possible health outcomes for this population.
3. The document also sets out where NHS commissioning responsibility lies for all members of the Armed Forces Community, i.e. serving Armed Forces, their families, reservists and veterans.
4. The operating model has been developed collaboratively with stakeholders across the NHS and Armed Forces community, including key contributions from colleagues in the Department of Health, Armed Forces Networks and Joint Medical Command of the Ministry of Defence (MOD). This document is one of a series describing the commissioning arrangements of the NHS CB, which include primary care, specialised services, prison health and those public health services commissioned by the NHS CB (i.e. screening, vaccinations, children's public health for 0-5 year olds and public health for people in prisons).
5. Our ambition is to support commissioners in delivering a consistent, high quality approach to the delivery of services that secure the best outcomes for the Armed Forces and their families. The NHS CB will use the operating model to drive local improvements in quality and outcomes and reduce health inequalities.

Overview

6. Section 15 of the Health and Social Care Act 2012 ¹ gives the Secretary of State the power to require the NHS CB to commission certain services instead of Clinical Commissioning Groups (CCGs). These include ‘services or facilities for members of the Armed Forces or their families.’ Regulations will be laid to allow the NHS CB to assume these powers from April 2013.
7. These regulations will define the scope of responsibility as being for any serving member of the Armed Forces stationed in England and any family dependants who are registered with a Ministry of Defence, Defence Medical Services (DMS) Medical Centre. In addition, reservists who require NHS health services while mobilised will be the commissioning responsibility of the NHS CB. Those stationed overseas who return to England to receive health services will be the responsibility of the NHS CB.
8. The NHS CB will be responsible for ensuring that services are commissioned to support consistently high standards of quality across the country, promote the NHS Constitution, deliver the requirements of the Secretary of State’s Mandate with the NHS CB and are in line with the commitments made by the Government under the Armed Forces Covenant.
9. *Developing the NHS Commissioning Board* ² sets out a number of features that will characterise the culture of the NHS CB. The proposals for commissioning care for the Armed Forces and their families reflect these characteristics and key requirements:
 - a. A clear **sense of purpose** focused on improving quality and outcomes
 - b. A commitment to putting **patients, clinicians and carers** at the heart of decision-making
 - c. An **energised and proactive** organisation, offering leadership and direction
 - d. A **focused and professional** organisation, easy to do business with
 - e. An **objective** culture, using evidence to inform the full range of its activities
 - f. A **flexible** organisation, promoting integration, working across boundaries and performing tasks at the right level, whether national or local

¹ Health and Social Care Act 2012, <http://www.legislation.gov.uk/ukpga/2012/7/contents/enacted>

² ‘Developing the NHS Commissioning Board’, DH, 2011
http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_128118

- g. An organisation committed to **working in partnership** to achieve its goals, in particular by developing an effective and mutually supportive relationship with clinical commissioning groups
- h. An **open and transparent** approach, sharing information freely wherever appropriate
- i. An organisation with clear **accountability arrangements** and a grip on those things for which it will be held to account.

The Armed Forces community

10. Serving members of the Armed Forces, Reservists Veterans and all of their families form part of a larger 'Armed Forces Community'. It is helpful to describe each of these components to clarify the context for how health services will be commissioned for each group in future.
 - a. **Serving Armed Forces** – Approximately 140,000 people, all of whom are registered with Defence Medical Services (DMS) Medical Centres in England. (Northern Ireland, Scotland and Wales have approximately 20,000 serving Armed Forces and registered dependants which are *outside* the scope of the NHS in England). Approximately half of the England DMS-registered population is concentrated in four areas (Devon, Hampshire, Wiltshire and North Yorkshire).
 - b. **Their families** – i.e. spouses / partners and dependent children and adults. Most are registered with NHS GP Practices. Approximately 20,000 are registered with DMS Medical Centres in England
 - c. **Veterans** – Defined as anyone who has been a member of the serving Armed Forces for a day or more. There are approximately 4.8 million veterans in the UK (4 million in England). All should be registered with NHS GP Practices.
 - d. **Reservists** – 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. The numbers of reservists are planned to grow from approximately 15,000 to 30,000.
 - e. **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 UK³.

- f. **Devolved Administrations** – ‘Devolved Administrations’ mean Scotland, Wales and Northern Ireland. The normal rules of NHS commissioning responsibility apply. The NHS CB has responsibility only for commissioning health services for members of the Armed Forces and their families registered with DMS practices in England or, for those posted Overseas, who choose to return to use NHS services in England. Devolved Administrations are responsible for commissioning care for members of the Armed Forces and their families registered in their countries or who return from Overseas to use services located in Devolved Administrations.

Health needs of the Armed Forces

11. Military personnel put themselves in harm’s way in the service of their country. They risk injury or death in the course of their duty and successive governments have recognised the debt society owes to its Armed Forces, their families and veterans. Society’s obligations were recently set out in the *2011 Armed Forces Covenant*⁴, a framework for the duty of care Britain owes its Armed Forces. In terms of healthcare, the key principle is that they experience no disadvantage in accessing timely, comprehensive and effective healthcare and that they receive bespoke services for their particular needs or combat-related conditions including, for instance, specialist limb prostheses and rehabilitation.
12. Members of the Armed Forces are typically younger and fitter than the general population. As such, there is low prevalence of long-term conditions but higher incidence of musculo-skeletal injury. Combat-related injuries aside, Armed Forces healthcare needs can usually be met by standard NHS services. Similarly, the families and dependants of serving Armed Forces members have health needs typical of their age and gender. Maternity services and children’s health services in particular must be planned and commissioned with the needs of military families in mind where they are present in large numbers in a community.

³ The National Health Service (Charges to Overseas Visitors) Regulations 2011 S.I. 1556/2011

⁴ ‘The Armed Forces Covenant’, MOD, 2011
<http://www.mod.uk/DefenceInternet/AboutDefence/CorporatePublications/PersonnelPublications/Welfare/ArmedForcesCovenant/TheArmedForcesCovenantDocuments.htm>

Current and future arrangements for Armed Forces health commissioning

13. Currently, organisations have responsibility for commissioning health services of the Armed Forces Community as follows:
14. **MOD Current**
 - a. The MOD provides primary and occupational healthcare for serving military personnel through its own Defence Medical Services (DMS) medical centres. There are 127 DMS medical centres of which 21 are GP training practices, which also accept registrations of family members. There are 11 Regional Rehabilitation Units, which provide physiotherapy and group rehabilitation for general musculo-skeletal conditions that support rehabilitation delivered in the majority of primary care facilities – Primary Care Rehabilitation Facilities (PCRFs). The Defence Medical Rehabilitation Centre at Headley Court is a national MOD centre of excellence for rehabilitation following injury, caring for 6,500 patients per year. The MOD also has Departments of Community Mental Health (DCMHs) that provide regionally-based occupational psychological support for service personnel.
 - b. DMS medical centres currently refer a significant number of Armed Forces personnel and dependants for NHS treatment and care annually, mainly for elective surgery. The prevalence of long-term conditions, in particular those associated with aging and end of life, are low in the Armed Forces compared to the general community.
 - c. The MOD commissions some additional secondary care services. These MOD-funded pathways include, but are not limited to:
 - i. Access to non-standard treatment, through Ministry of Defence Hospital Units (MHDUs). The MOD has previously commissioned accelerated access to elective secondary care through these contracts.
 - ii. Inpatient mental health care services.
 - iii. Fast-track access to diagnostic imaging and orthopaedic surgery for specified orthopaedic conditions.
 - d. The MOD commissions access to some secondary care services in situ for Armed Forces personnel and their dependants stationed overseas.

15. **NHS Current**

- a. Armed Forces (and other military personnel, including NATO personnel and their dependants) based in the UK are entitled to the full use of NHS secondary and community services on the same basis as civilians. Equally, members of the Armed Forces serving overseas are entitled to return for NHS care. PCTs are responsible for securing the provision of secondary and community care for such personnel. The cost of treatment is the responsibility of the PCT where the patient is resident or, if stationed overseas, the PCT that covers the secondary care unit providing treatment
- b. As specified in NHS (Charges to Overseas Visitors) Regulations 2011 and NHS (Charges to Overseas Visitors) Amendment Regulations 2012, the spouse, civil partner or child of the member of the Armed Forces serving overseas is also entitled to return to the UK and receive full use of NHS hospital facilities without charge. Again, in England their care should be funded by the PCT that covers the secondary care unit providing the treatment.
- c. PCT allocations include funding for secondary and community healthcare for the Armed Forces and those families registered with DMS Medical Centre within their area on an unregistered patient basis.
- d. Veterans receive standard NHS services as any other member of the community and are registered with NHS GP Practices. There are some bespoke services, tailored for the needs of the veterans' community, some of which will be commissioned nationally e.g. specialist limb prostheses and rehabilitation services, and some of which are commissioned locally by PCTs, e.g. veterans' mental health services.

16. After April 2013, commissioning responsibilities will be distributed as follows

17. **MOD Future**

- a. There is no change to the MOD's scope of commissioning responsibility for primary and occupational healthcare, community mental health or rehabilitation services, However, the MOD will no longer to commission accelerated access from MDHUs and most of its existing contracts expire on 31 March 2013. With the exception of specific contracts, such as for mental health inpatient services and fast-track access for specified orthopaedic conditions, all secondary care referrals from DMS medical centres (unless stated otherwise) will be for standard NHS care services, and therefore the commissioning responsibility of the NHS CB.

18. ***NHS Future***

- a. The NHS CB will commission all secondary and community health services required by the Regular Armed Forces and their families where registered with DMS Medical Centres in England, and reservists while mobilised. The NHS CB will also commission health services for these groups stationed overseas who return to England to receive NHS care.
- b. The NHS CB will commission specialised services, including specialist limb prosthesis and rehabilitation services for veterans.
- c. CCGs will commission all secondary and community services required by Armed Forces' families where registered with NHS GP Practices, and services for veterans and reservists when not mobilised. The bespoke services for veterans, such as veterans' mental health services, will be commissioned by CCGs either individually or collectively.
- d. CCGs also have responsibility for commissioning emergency care services on a geographical basis which can be accessed by anyone present in their defined geographical boundary e.g. accident and emergency services, emergency ambulance services and other emergency health services. Serving members of the Armed Forces and their families (where registered with DMS Medical Centres) will have full access to these services.

19. Commissioning responsibilities for the Armed Forces Community after April 2013 are summarised in the table on the following page.

Armed Forces commissioning responsibilities: NHS & DMS post-April 2013

	Serving Armed Forces in England	Serving Armed Forces overseas	Armed Forces Families registered with DMS med centres in England	Armed Forces Families registered with DMS med centres overseas	Armed Forces Families registered with NHS GP Practices	Reservists while mobilised ⁱ	Veterans (inc. reservists when not mobilised)
Primary Care	DMS ⁱⁱ	DMS	DMS	DMS	NHS CB	DMS & NHS CB ^{iv}	NHS CB
Community Mental Health	DMS	DMS	NHS CB	DMS	CCGs	DMS	CCGs
Secondary acute & community care	NHS CB	DMS & NHS CB ^{iv}	NHS CB	DMS & NHS CB ^{iv}	CCGs	DMS & NHS CB ^{iv}	CCGs ⁱⁱⁱ
MOD Enhanced pathways	DMS	DMS	N/A	N/A	N/A	DMS	N/A
	<p>i - Reservists have access to DMS care whilst mobilised</p> <p>ii - Serving personnel can access local GPs on an emergency basis if needing to access care whilst away from the military address</p> <p>iii - The NHS CB will commission specialised services for veterans, e.g. limb prostheses</p> <p>iv - While overseas, serving personnel and families can access DMS-commissioned healthcare where such provision exists, or may be provided with non-DMS healthcare by local Host Nation or other contracted arrangements, or have right of return for NHS CB-commissioned NHS care in England</p>						

The new commissioning landscape

20. The following organisations have roles to play in the commissioning of health care for the Armed Forces Community:
 - a. **Department of Health (DH)** – the DH will set out the Secretary of State’s expectations and requirements of the NHS in the annual Mandate, agreed with the NHS CB, which will accompany the resources allocated by government to the NHS. The Secretary of State retains responsibility for public health services and will enter into agreements for these responsibilities to be discharged by Local Authorities and Public Health England.
 - b. **The NHS Commissioning Board (NHS CB)** – The NHS CB will be responsible for the direct commissioning of secondary and community health services for Armed Forces and families registered with DMS Medical Centres. It will also assume responsibility for commissioning some public health services through a section 7a agreement with the

Secretary of State (see para 20d), which Armed Forces and their families will be able to access.

- c. **Clinical commissioning groups (CCGs)** – CCGs will be responsible for commissioning health services for veterans and families of members of the Armed Forces registered with NHS GP Practices. CCGs will also be responsible for the commissioning of emergency care services for ‘every person present in its area’, which includes for members of the Armed Forces and their families. It is also recommended that hosting of Armed Forces Networks transfer from SHAs by agreement to appropriate lead CCGs to sustain the work of the 10 Armed Forces Networks currently in place. Given the strong focus on veterans and Armed Forces family healthcare, CCGs are well-placed to lead Armed Forces Networks, with support from the NHS CB. Further discussions will be needed with Armed Forces Networks to agree their transition and leadership arrangements for the future.
- d. **Local Authorities (LAs)** – LAs will be responsible for commissioning the majority of public health services for people in their area including members of the Armed Forces, their families and veterans. The exceptions to this are screening services, immunisations, public health services for children aged 0-5 years, public health services for prisoners and other detainees and Sexual Assault Referral Centres (SARCs). These services will be commissioned directly by the NHS CB. Local authorities will also commission open access sexual health clinics and genito-urinary clinics.

Values and principles

- 21. In the House of Commons Public Bill Committee debate on 1 March 2011, the Minister of State for Health stated the Government’s intention to use the power in the Health and Social Care Act:

“Clause 11 allows for regulations to require the NHS commissioning board to commission services for members of the Armed Forces or their families. This is because members of the Armed Forces are able to access NHS secondary care services directly on referral from Defence Medical Services, which makes demand unpredictable. Demand from members of the Armed Forces for those services may also vary according to tours of duty, for example, and have the potential to impact significantly on consortia budgets and commissioning strategies. We therefore think it more appropriate for

the NHS commissioning board to have responsibility for arranging those services, working closely with relevant local consortia.”

22. Ensuring high standards of patient care for commissioned services is one of the core values within the NHS Constitution and therefore places a requirement on all providers to strive to deliver high quality and safe care to patients. In addition, commissioners of health care have an important role in driving quality improvement and gaining assurance around the quality of care delivered by the provider organisations from whom they commission services.
23. The NHS CB is at the heart of an integrated system of organisations and services that are bound together by the value and principles of the NHS Constitution. The NHS CB is committed to joint working relationships with a wide range of organisations at a national and local level to ensure that there are continuous improvements in health and well-being.
24. The vision is that military personnel and their families should receive excellent health care from the NHS, tailored to their particular needs, in accordance with the Armed Forces Covenant.
25. As well as directly commissioning health care for serving members of the Armed Forces and their families where registered with DMS Medical Centres, the NHS CB is responsible for ensuring the wider NHS system is effectively addressing the comprehensive needs of the Armed Forces, their families and veterans.
26. There are particular issues of access and entitlement for military personnel. Armed Forces personnel are excluded from the NHS Constitution⁵ entitlement to Choice of NHS providers. Postings or deployments can interrupt existing treatment and can result in serving military personnel or their families having to re-join waiting lists in new areas. This is one example of ‘disadvantage’ and the Armed Forces Covenant requires that serving members of the Armed Forces and their families should join waiting lists at a comparable waiting time.
27. The ambition of this framework is that patients experience a seamless transition between services, receiving as a minimum the same standards and quality of care that can be expected in the civilian community. The Government’s Mandate to the NHS CB⁶, which sets out the Government’s expectations of the NHS, contains the following reference to military health:

⁵ Though choice of will normally be offered for secondary care through the Choose and Book service

⁶ ‘The Mandate – A Mandate from the Government to the NHS Commissioning Board: April 2013 – March 2016’, DH, 2012, <https://www.wp.dh.gov.uk/publications/files/2012/11/mandate.pdf>

“The NHS and its public sector partners need to work together to help one another to achieve their objectives. This is a core part of what the NHS does and not an optional extra, whether it is working with local councils, schools, job centres, housing associations, universities, prisons, the police or criminal justice agencies such as Police and Crime Commissioners and Community Safety Partnerships. The NHS Commissioning Board’s objective is to make partnership a success. This includes, in particular, demonstrating progress against the Government’s priorities of:

- upholding the Government’s obligations under the Armed Forces Covenant;”

The integrated commissioning model

28. The NHS CB is structured with 4 regions and 27 Area Teams (ATs). For Armed Forces commissioning, the NHS CB will be a single, national commissioner, with common operating procedures and commissioning policies deployed nationwide. This will ensure the NHS CB can deliver its commitment under the Armed Forces Covenant to deliver a consistently high quality health experience for members of the Armed Forces and their families, with no disadvantage as a consequence of their location.
29. National leadership will provide the framework to ensure consistency in commissioning. Drawing on nationwide insight and intelligence, clinical expertise and the Government’s Mandate, there will be a national framework for contracts. Within this framework will be flexibility for lead Area Teams to manage local relationships and performance, support innovation and secure high quality outcomes.
30. Three lead ATS, one in each of the North, Midlands and East, and South (including London) regions have been identified. The Lead ATs will build the expert capacity necessary to undertake the NHS CB’s commissioning role in respect of members of the Armed Forces and families registered with DMS Medical Centres. This will enable local partnership relationships to be developed between the NHS CB, CCGs, Local Authorities, the MOD, third sector organisations and providers, to ensure the services commissioned are delivering effectively.

31. The three lead area teams are:

a) **North Region:** North Yorkshire and Humber

Armed Forces population: 23,008

b) **Midlands and East Region:** Derbyshire and Nottinghamshire

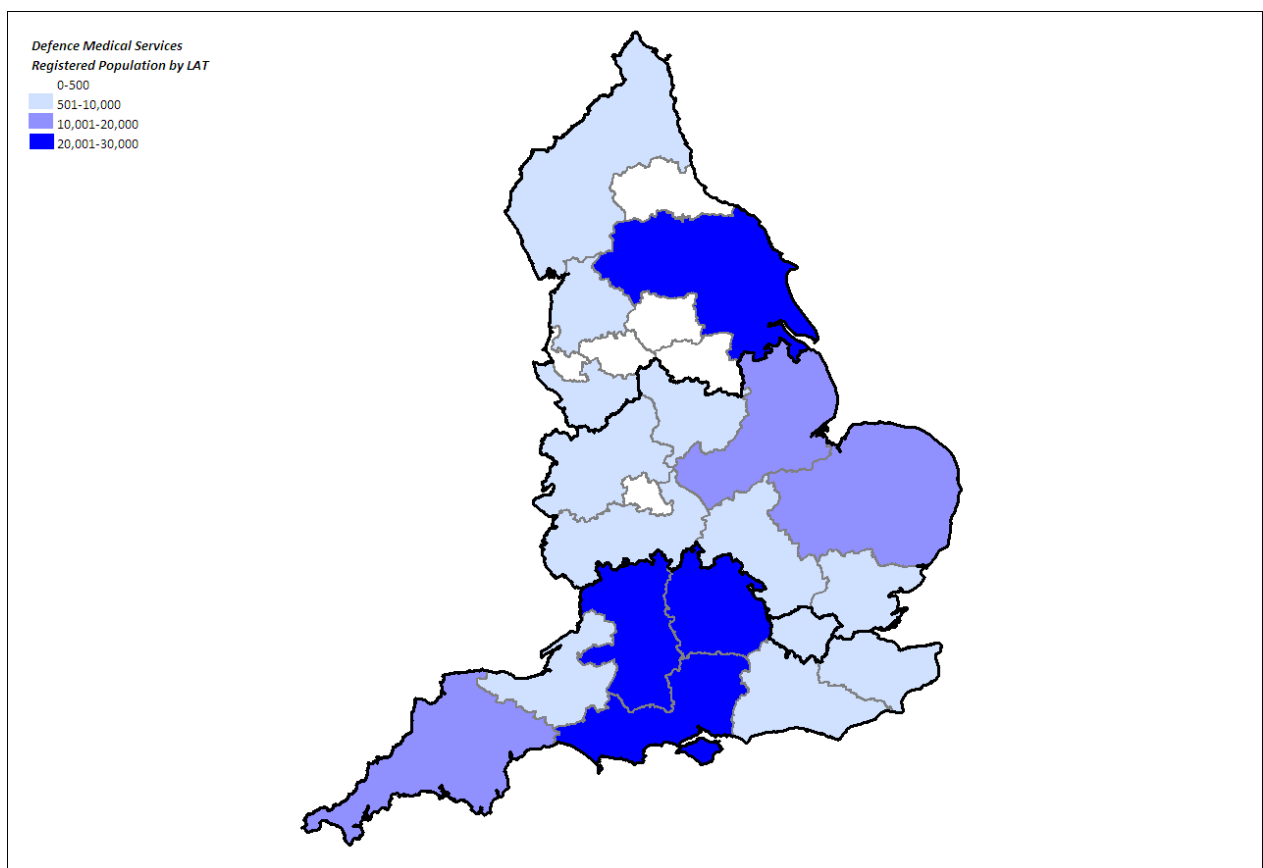
Armed Forces Population: 39,680

c) **South Region (including London):** Bath, Gloucestershire, Swindon and Wiltshire

Armed Forces population: 105,591

32. While there is a heavier distribution of the Armed Forces population in the South of England, the presence of a lead AT in the North and in the Midlands & East regions will ensure Armed Forces health needs can be addressed nationwide.

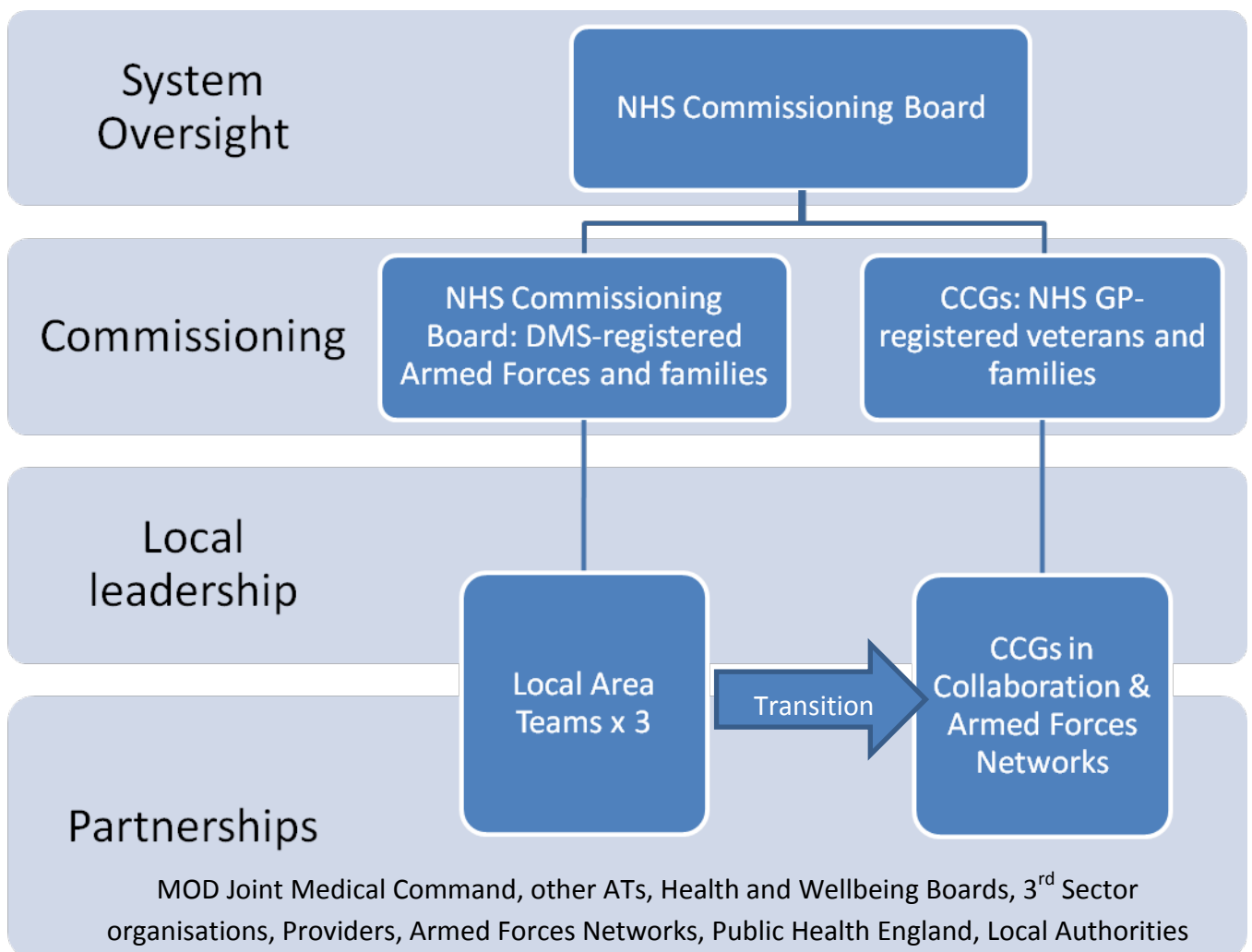
Distribution of Defence Medical Services registered population by area team



33. The three ATs would not necessarily be wholly self-sufficient for all aspects of Armed Forces commissioning within their geographical area. This model would allow flexibility within a task based approach to commissioning, e.g. for a single AT to lead nationwide for particular programmes of care. Furthermore, the developments of focussed commissioning support arrangements are feasible within this model.
34. The advantages of using three ATs to undertake the NHS CB's commissioning for the Armed Forces include the following:
- a. There remains a single, national body commissioning for the serving armed forces with one set of commissioning policies for the Armed Forces, i.e. NHS care and access to it will be nationally defined, not subject to local variation.
 - b. The NHS CB can enter in to standard contracts with providers of NHS care to provide consistency.
 - c. Focusing the work across three ATs will build their expertise in military healthcare and foster the necessary local relationships that have to exist between the NHS CB and local providers, CCGs, Health and Wellbeing Boards, DMS medical centres and Armed Forces Networks, to ensure the NHS CB engages properly with its partners.
 - d. A nationally consistent model for commissioning services for the Armed Forces, wherever it is accessed, with good local links with other agencies (including DMS) to ensure a smooth transition for members of the serving Armed Forces when they leave service.
35. The relationship between the NHS CB, CCGs, local clinicians, local authorities and Joint Medical Command is central to the operating model for the Armed Forces. This will be a new way of working and will require clinical support and expertise along with high quality management and systems.
36. The NHS CB team will be responsible for coordinating needs assessments and service level agreements with key stakeholders from the MOD, third sector, Armed Forces Networks and local authorities. Public Health England will provide public health advice to the NHS CB for its direct commissioning responsibilities throughout the commissioning cycle, including needs assessment, contract arrangements, design of indicators, quality improvement and evaluation.

37. All elements need to work in a coordinated and integrated way to ensure that local activity informs the national strategy and vice versa. To improve outcomes, there must be a strong connection between design and delivery and this requires capacity and capability as well as strategic leadership.
38. The integrated commissioning model for the Armed Forces Community, illustrated below, shows how the arrangements for NHS CB commissioning integrate with CCGs and wider partnerships:

Integrated commissioning model for the Armed Forces community



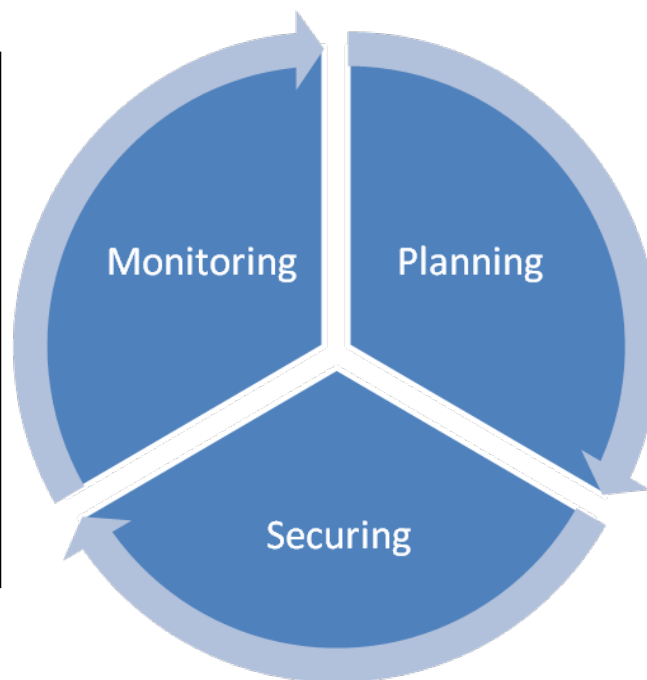
The operating model

Commissioning functions

39. The NHS CB will be responsible for commissioning an agreed set of services for:
- Serving members of the Armed Forces, including those posted overseas
 - Family members registered with DMS Medical Centres
 - Reservists when mobilised
40. The functions which underpin this responsibility are:
- a. **Planning** – Services must meet national standards and local ambitions to ensure that services meet the needs of the population. Key stakeholders are involved in the process including a range of health professionals who contribute to patient care;
 - b. **Securing services**- using relevant data to specify new service requirements and a robust contracting route to deliver best quality and outcomes for Armed Forces and their families that promote continuity of care and integration of services.
 - c. **Monitoring** – assessing and challenging the quality of services; and using this intelligence to design and plan continuously improving services for the future.

National / local relationships

41. These functions will be performed at a national and local level to provide an optimal balance of national consistency with local flexibility to innovate and improve outcomes.
42. All parts of the NHS CB will need to work in a co-ordinated and integrated way to ensure that local commissioning insight informs national strategy and vice versa.



National: Collate, aggregate, analyse information; outcomes in military healthcare; work with area team clinicians and commissioners.
Local: Undertake contract monitoring and performance management within context of national framework; exercise judgement, discretion and proportionate response; quality assure primary care (with CCGs where appropriate).

National: Plan on basis of aggregation of local need, patient insight, DH mandate and NHS CB priorities; develop and agree outcomes frameworks.
Local: Engage with local professionals and patients to identify priority areas for improvements; feed into local assessments; respond to performance; agree commissioning plans locally

National: Develop national contracts; commissioning frameworks; policies, procedures, guidance and processes.
Local: 'custodians of consistency'; expedite fast track adoption and spread of innovation. Use standard framework to secure services and ensure good value for money; facilitate innovation and ideas getting the best return on investment; support providers to ensure optimum delivery.

Financial allocations

- 43. Currently, there are no specific allocations for standard NHS care for the Armed Forces community. Funding is contained within PCT baseline allocations, based upon Office of National Statistics data on the location of Armed Forces and dependants, which adjusts the size of each PCT's responsible population. An audit exercise of PCT clusters conducted in December 2011 identified £23m of current expenditure on serving Armed Forces by the NHS, but this is likely to be a significant underestimate due to a difference in methodologies adopted between PCTs and their clusters.
- 44. It is likely a year of operation of the NHS CB will be needed to validate the correct resource allocation for military health commissioning, to allow for current deficiencies in the modelling of resource usage, such as:
 - a. Ill-defined usage by the DMS-registered population of e.g. community health services
 - b. The recording of significant volumes of military-related activity as 'unregistered', due to patients not having a GP registration record on NHS systems

- c. A lack of distinction between activity historically commissioned by the MOD and that commissioned by PCTs
 - d. The full-year effect of MOD commissioning intentions to rely much more heavily in future on standard NHS-funded services
45. Attention will be paid to the management of in-year financial risk to ensure that risk is distributed fairly between the NHS and MOD and within the NHS CB itself.
46. Other central funding, £15m over four years 2011-2015, has been made available to implement the recommendations of the Murrison Report (“A Better Deal for Military Amputees”) to improve limb prostheses and rehabilitation services for veteran amputees. The NHS CB will be responsible for the on-going management of this programme.

Commissioning support services functions

47. The arrangements for commissioning support services (CSS) are developing as described in *Developing Commissioning Support; Towards Service Excellence*⁷.
48. The NHS CB has identified the functions and activities it requires both at scale for Military Health commissioning and is currently working through more detailed specifications to ensure that these are finalised and Commissioning Support Units (CSU) arrangements agreed. It is expected that the commissioning support will be required in the following areas:

- a. **Business Intelligence** - To enable the NHS CB to track patient care across all settings.

This will include tracking all acute and outpatient care through the Secondary Users Service (SUS) data set and build upon the use of the NHS number, the accuracy and use of which is being improved for Armed Forces personnel.

In terms of the community information data set (CIDS), the dataset has been available from April 2011 to start local collection; it should be possible to develop a proxy of the current position. The national view of

⁷ ‘Developing commissioning support: Towards service excellence’, DH, 2012, http://www.commissioningboard.nhs.uk/files/2012/01/NHS_CBA-02-2012-8-Guidance-Developing-commissioning-support-Towards-service-excellence.pdf

roll out is that providers should be capturing data from April 2012 and suppliers of community systems should ensure that systems are able to capture and/or derive the data items defined within the standard and that systems are fully compliant with this standard by August 2013. All providers MUST be fully compliant with this standard by April 2014. So long as datasets are capturing the NHS number and registered GP Practice code, this should be sufficient to provide relevant commissioning data. As an interim in the absence of robust information CSSs would need to ensure they had the specification in place with key performance indicators that would support monitoring and appropriate assessment of usage of e.g. community health services

- b. **Procurement Support** – to enable the NHS CB to procure new services as required

This arrangement is likely to be secured on a 'call off' arrangement.

Common operating procedures

- 49. In collaboration with Armed Forces Networks and other key stakeholders a series of common operating policies and procedures to support ATs are being developed. These include:
 - a. Standard quality principles and links to the outcomes framework
 - b. Transition issues from MOD to NHS responsibility
 - c. Roll out of limb prosthesis services
 - d. Infertility services
 - e. Application of the 'no disadvantage' requirement of the Armed Forces Covenant
- 50. Standard policies will become available from January 2013 – April 2013.

Indicators

- 51. Indicators will be identified which best measure whether health outcomes and patient experience for serving members of the Armed Forces and their families are improving. These will relate where appropriate to the outcome frameworks that have been published to support the new health system i.e. NHS Outcomes Framework, Public Health Outcomes Framework and Commissioning Outcomes Framework.

52. The NHS CB has limited opportunity to impact on the indicators in these outcome frameworks in respect of the Armed Forces and DMS-registered families because it has no responsibility for primary care services (for which DMS is responsible), is dealing with younger age-profile population for the time they are of serving age only and because the health profile of the Armed Forces is generally fitter than the average population to deliver the level of fitness needed for operations.
53. However, the NHS CB is well-placed to make an impact in the areas where it is commissioning directly for the Armed Forces Community, for instance, limb prosthesis services for Veterans, fertility services and access to care under the principles of the Armed Forces Covenant.
54. These indicators will be developed further over the coming months.

IT and data management

55. IT and data management systems for the Armed Forces patient population are developing quickly. The following issues describe the changes to be expected over the next year.

Pre-2013 state

56. Upon entry to the Armed Forces, patients were removed from their NHS GP list and registered with DMS; this was reflected as being 'unregistered for PHC' on all NHS demographic systems. Military Medical Officers could refer patients into the NHS but neither the patient nor the DMS Medical Centre was recognised on the NHS systems. This means a military patient was either referred to the NHS via a paper referral with it not being possible to identify these referrals, or via an enhanced pathway MDHU contract, which has its own military code for monitoring purposes.
57. For a standard NHS-funded care pathway, the responsibility for payment falls to the PCT hosting the NHS provider trust as the patient is unregistered. Similarly, when a military patient presents for unscheduled care the responsibility for payment falls to the PCT hosting the NHS provider trust as the patient is unregistered.

Future state

58. By 1st October 2012, all standard NHS care pathways through a MDHU host Trust are being funded by PCTs. The MOD may fund additional care in exceptional circumstance.

59. A new National Health Applications and Infrastructure Services (NHAIS) system has been created to administer the military patient population registration within the NHS. This means the demographic data for each military patient will show a GP registration of a DMS Medical Centre on the national NHS systems and will be updated automatically if details change. The majority of military patients have NHS Numbers, but these will be made more easily visible to the NHS and will be verified on recruitment. Patients joining without previous contact with the NHS in England or Wales will be allocated an NHS Number as part of the standard registration process..
60. By 31 March 2013 the military patient population in England will all be registered on the NHS GP lists as having their DMS Medical Centre as their GP provider. Military Medical Officers will be registered on the NHS systems as GP equivalents. DMS Medical Centres will be registered on the NHS systems as GP Practice equivalents, and will have access to certain NHS systems e.g. Choose and Book.
61. Choose and Book will be the default patient referral mechanism for the military population and regular reports on referral activity will be generated for all DMS Medical Centres
62. The NHS CB will be able to produce a single report on the commissioned activity for all DMS medical centres and all Armed Forces-related hospital activity will be as visible as it is for all other NHS patients
63. Starting in April 2013, the military patient population will be added to the national screening registers for all appropriate services (i.e. cancer, diabetic retinopathy and Abdominal Aortic Aneurysm).

Scheduled secondary care

64. When a military patient is referred by their Medical Officer to the NHS for scheduled care, be it via Choose and Book or on paper, it will be the same as for any NHS patient. The identity of the patient, their medical centre or Medical Officer will, due to security concerns, all be “civilianised”. Their patient demographic data will be maintained and updated if necessary each night by a bespoke National Health Applications and Infrastructure Services (NHAIS) system. The NHS-funded provider Patient Administration System (PAS) will record the military patient, their medical centre, Medical Officer and their resultant care, as it would for any NHS patient, with the subsequent reporting returns flowing from the provider to commissioners as for an NHS patient. Information systems will capture the completed care episode data for all DMS

Medical Centres as for any NHS GP practice. As the NHS CB will be the responsible commissioner for all DMS Medical Centres, the reporting and funding liability will flow directly to it from the NHS provider.

Unscheduled Secondary Care

65. When a military patient is provided with secondary care in an unscheduled setting, the NHS provider would follow its standard process to trace the patient and, if successful, to record their demographic data, identify their military Medical Officer (visible as the GP equivalent) for clinical engagement and therefore the responsible commissioner for funding.

Community health services

66. The community health services needed by the Armed Forces and families registered with DMS Medical Centres will be commissioned by the NHS CB through its lead Area Teams, working where appropriate in collaboration with local CCGs. The lead ATs will generate reports on use of community care services delivered to patients of DMS Medical Centres. Public health services e.g. sexual health services will be commissioned and funded by local authorities and can be accessed by members of the Armed Forces and their families.

Next steps

67. In the coming months the NHS CB will provide more details about the operating arrangements and work programme to address them, including:
 - a. Explore the interdependent relationships critical for the operating model and take any action to ensure they work effectively
 - b. Identify sensible indicators to ensure health outcomes for members of the Armed Forces and their families are improving
 - c. Continue to work with stakeholders to identify risks and manage the transition
 - d. Clarify arrangements for commissioning support services
 - e. Test standard operating models and where necessary make adjustments.
 - f. Development of a communications plan for the NHS and other key stakeholders

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