



# **Armed Forces and their Families Commissioning Intentions – 2017/18 to 2018/19**

## NHS England INFORMATION READER BOX

### Directorate

<b>Medical</b>	Operations and Information	Specialised Commissioning
Nursing	Trans. & Corp. Ops.	Commissioning Strategy
Finance		

### Publications Gateway Reference:

05984

<b>Document Purpose</b>	Strategy
<b>Document Name</b>	Armed Forces and their Families Commissioning Intentions 2017/18 to 2018/19
<b>Author</b>	NHS England
<b>Publication Date</b>	17 October 2016
<b>Target Audience</b>	CCG Clinical Leaders, CCG Accountable Officers, Directors of PH, Directors of Nursing, Local Authority CEs, Directors of Adult SSs, NHS Trust Board Chairs, NHS England Regional Directors, NHS England Directors of Commissioning Operations, All NHS England Employees, GPs, Emergency Care Leads, Directors of Children's Services, Ministry of Defence
<b>Additional Circulation List</b>	
<b>Description</b>	Our commissioning intentions for 2017 - 2019 outline the strategic intentions that plan to improve the way the services for Armed Forces and their families are commissioned.
<b>Cross Reference</b>	
<b>Superseded Docs</b> (if applicable)	Armed Forces Commissioning Intentions 2016/17
<b>Action Required</b>	NA
<b>Timing / Deadlines</b> (if applicable)	
<b>Contact Details for further information</b>	Shamila Kafait Health and Justice NHS England Quarry House Quarry Hill LS2 7UE s.kafait@nhs.net

### Document Status

This is a controlled document. Whilst this document may be printed, the electronic version posted on the intranet is the controlled copy. Any printed copies of this document are not controlled. As a controlled document, this document should not be saved onto local or network drives but should always be accessed from the intranet.

Prepared by:

Alison Treadgold, Head of Armed Forces Health (Midlands & North)

Jenny Kirby, Head of Armed Forces Health (South & London)

Andy Bacon, Assistant Head of Armed Forces Health (Central Team)

This information can be made available in alternative formats, such as easy read or large print, and may be available in alternative languages, upon request.

Please contact 0300 311 22 33 or email [england.contactus@nhs.net](mailto:england.contactus@nhs.net)

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

## Contents

Contents.....	4
Executive summary.....	5
Purpose.....	5
Our population.....	6
Our priorities.....	7
Meeting the commitments of the Armed Forces Covenant.....	7
Procurement of a national veterans' mental health service.....	8
Access to NHS Screening Programmes.....	9
Working together with the Ministry of Defence.....	9
Integrated High Dependency Care System.....	9
Place and population based care.....	10
Armed Forces Networks.....	10
Public and Patient Participation.....	10
Clinically driven change.....	11
Service developments.....	11
Our approach to contracting.....	12
Practical arrangements.....	12
Prior Approvals and Individual Funding Requests.....	14
CQUIN.....	14
Quality, Innovation, Productivity and Prevention (QIPP).....	14
Key contacts.....	15
Regional Team.....	15
National Team.....	15
Glossary.....	16
Responsible commissioners.....	17

## Executive summary

Our **commissioning intentions** for 2017 - 2019 outline the strategic intentions we are planning to improve the way we commission services for the Armed Forces and their families.

In summary to:

- Ensure **high quality services** are **accessible** to armed forces personnel and registered families to promote, protect and restore the health of the community.
  - We will work to meet the commitments of the **Armed Forces Covenant**
  - Improve access to **NHS screening programmes**
  - We will commission high quality, safe and effective healthcare in line with the NHS Constitution Standards
- **Improve the pathway** for service personnel and families as they leave the service with a particular focus on **mental health, prosthetics and continuing health care**
  - We will procure a new **veterans' mental health service**
  - We will work with the Ministry of Defence to implement the **Integrated High Dependency Care system**
- Improve **awareness** at local level by Clinical Commissioning Groups, providers and local authorities to ensure due consideration is given to veterans, reservists and service families
  - We will review our approach to **Armed Forces Networks**

## Purpose

1. These commissioning intentions provide notice to healthcare providers and give information to other commissioners of healthcare services about changes and planned developments in the commissioning and delivery of services for the Armed Forces and their families registered with a Defence Medical Services (DMS) practice by NHS England.
2. Together with planning guidance, the NHS contract, National Tariff system and CQUIN guidance they form a plan to be reflected in contracts, developments, service reviews and procurement opportunities for the two years from 2017/18 to 2018/19.
3. The prime purpose of these intentions is to enable healthcare providers to make early preparations, to engage with clinical leads and to make changes that benefit patients, with improved outcomes. These intentions should inform providers' plans at all levels.
4. These intentions also set out other planned changes related to the healthcare of the armed forces community that Clinical Commissioning Groups (CCGs) will wish to be aware of.

## Our population

5. NHS England has been commissioning services for the Armed Forces and those families registered with a DMS practice in England since 1 April 2013.
6. Our vision is to obtain the best health benefit within available resources by commissioning high quality, safe and effective care for Armed Forces personnel and their families, in accordance with the NHS Mandate, Armed Forces Covenant and the NHS Constitution.
7. 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:
  - Secondary care services, including emergency care;
  - community services;
  - mental health services (only for families registered with DMS).
8. NHS England also provides lead commissioner or similar support arrangements for other services such as cervical screening for those DMS registered patients overseas, or out of hours primary care services.
9. 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 (but not families).
10. The following services are also commissioned for the Armed Forces community by NHS England:
  - primary care for families registered with NHS practices;
  - dental, pharmacy and optometry services for families;
  - secondary care dental services;
  - specialised services;
  - public health services covered by Section 7A.
11. Most services for veterans are commissioned locally by CCGs, with a veteran being defined as someone who has served a day in HM Forces. There is no definitive record of the number of veterans in England as there has been no systematic recording of veteran status in healthcare records. GPs are encouraged to ask patients registering at their surgery if they are a veteran and Read<sup>1</sup> code them as “military veteran” on the system. There are also Read codes for “Member of Military Family” which can be used to identify family members.

---

<sup>1</sup> A coded thesaurus of clinical terms in use in primary care

12. There are two main estimates of the number of veterans in England. The Royal British Legion survey<sup>2</sup> estimated that there were approximately 2.8m veterans in the UK, whilst the recently published 2014 Annual Population Survey (APS)<sup>3</sup> which estimates that there are currently 2.6 million veterans in Great Britain (excludes Northern Ireland). The Annual population survey also provides a breakdown of the estimated number of veterans in each of the administrations in Great Britain. The APS estimates that there are 2.24 million veterans in England, 66% of who are over 65 years of age. There were over 800 very seriously or seriously injured personnel from recent conflicts such as Afghanistan and Iraq.
13. NHS England has specific duties and separate funding, including funding from LIBOR fines, to commission the following veterans' services:
  - Specific England wide veterans' mental health services, in response to "Fighting Fit". These are the services we are procuring for 2017.
  - On line psychological support services for veterans and families.
  - Post-traumatic stress disorder services for veterans
  - 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.
14. 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 CCG in which the provider of the care that they receive is located, this is sometimes referred to as the Host CCG. Further information supporting this is can be found at: <https://www.england.nhs.uk/ourwork/tsd/data-services/>
15. A grid detailing the responsible commissioner is at the end of this document.

## Our priorities

16. To achieve our overall priority of ensuring that the armed forces community receive high quality, safe and effective healthcare, NHS England needs to work with both the Ministry of Defence and CCGs across a range of areas.

## Meeting the commitments of the Armed Forces Covenant

17. NHS England as the commissioner of health services for the Armed Forces and families registered with DMS needs to ensure that it upholds the commitments of the Armed Forces Covenant. Specifically this means that:
  - Armed Forces patients should not face disadvantage compared to other patients in the provision of healthcare.
  - Special consideration is appropriate in some cases, especially for those who have given most such as the injured

---

<sup>2</sup> <http://www.britishlegion.org.uk/get-involved/campaign/public-policy-and-research/the-uk-ex-service-community-a-household-survey/>

<sup>3</sup> <https://www.gov.uk/government/statistics/annual-population-survey-uk-armed-forces-veterans-residing-in-great-britain-2014>

18. In practice this means that we:
- have a set of common access policies to ensure equity of access for service personnel and their families across England;
  - expect our providers to have due regard to the Armed Forces Covenant in managing their waiting lists and inter-provider transfers;
  - expect our providers to offer priority treatment to veterans, for service attributable conditions, subject to the clinical priorities of other patients;
  - commission some bespoke services for veterans, where we have been funded to do so – for example veterans’ prosthetics.

## **Procurement of a national veterans’ mental health service**

19. Whilst CCGs are the responsible commissioner for veterans’ services, NHS England has a system leadership role for veterans’ health service which includes commissioning some specified services. Towards the end of 2015/16 we began a programme of work to find out people’s views of NHS veterans’ mental health services, to ensure that feedback from veterans, family members and those involved in their care informed future service developments. The feedback is available at: <https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/09/veterans-mh-services-engagement-rep.pdf>
20. Feedback has highlighted the need to improve awareness of where veterans should go for help, raise the profile of NHS veterans’ mental health services and further increase understanding amongst health professionals of the unique issues faced by those from an armed forces background. It was also felt that more should be done to support a smoother transition from armed forces healthcare to the NHS to help ensure the right pathways of support are in place for veterans with mental health difficulties and the wider health needs of families are considered.
21. We will be undertaking a procurement exercise during the autumn of 2016 to commission veterans’ mental health services from April 2017, which more accurately reflect the needs of the people who use them. These “transition, intervention and liaison” services will offer:
- A service for those in transition - a transition / assessment and therapeutic mental health service for serving personnel who are in the process of leaving the armed forces and entering civilian life.
  - A service for veterans with complex presentations - A case management and co-ordination function for those veterans with complex presentations and particularly those who have suffered significant psychological trauma, where a military understanding would be beneficial, working alongside mainstream psychological and other mental health services.
  - A general service for veterans – a service for veterans who do not have complex presentation but would benefit from navigation and liaison support to other mental health services.
22. During 2017/18 we will review the current Post-traumatic stress disorder (PTSD) service using the principles of:
- Securing the needs of the people who use the services;



- Improving the quality of the services, and
- Improving the efficiency of the services.

## Access to NHS Screening Programmes

23. NHS Screening programmes for adults registered with a DMS practices are funded and commissioned by Public Health through the section 7A agreement. The numbers of patients eligible for access to these screening programmes are small due to the demography of our population and access to cervical screening is already in place. We will support our Public Health colleagues to ensure that from April access to NHS screening programmes for the Armed Forces population is improved for:

- Breast
- Bowel (scope and faecal occult blood)
- Diabetic Eye retinopathy
- Abdominal Aortic Aneurism

Further information on public health commissioning intentions is available at: [www.england.nhs.uk/](http://www.england.nhs.uk/)

24. Due to the mobile nature of the population, which affects patient access to testing in England and the IT systems used by the MOD there are differences, to the standard model, in how access to screening will be implemented. These differences mean that joint working across Armed Forces Health and Public Health teams at regional, national and local levels will be beneficial.

## Working together with the Ministry of Defence

25. During 2017 we will be reviewing our work plan with the Ministry of Defence to identify those areas where we can work together to maximise the outcomes for patients in the armed forces community.

26. Primary medical care services for the armed forces are provided by Defence Primary Healthcare (DPHC), but opportunities exist to work with DPHC to share learning and good practice, such as that from the Five Year Forward View for General Practice.

27. Additionally as part of the Army Basing and Estates programmes two areas have been identified as areas for joint (NHS and DPHC) primary care centres; these are in Larkhill and Catterick. Work is ongoing with NHS England (Primary Care) and local CCGs to progress these developments.

## Integrated High Dependency Care System

28. Over recent years the NHS and the MOD have worked together to improve the provision of services for veterans including prosthetic and mental health and smooth the transition process from serving to civilian life. For a very small cohort of service personnel with very complex physical, mental and neurological issues the transition into civilian life can be more challenging and we are working with the MOD to pilot an Integrated High Dependency Care System (IHDCS).

29. The objective of the IHDCS is to aid better assessment of integrated health and social care need and to provide focussed help to maximise the effectiveness and integration of services whether provided by MOD, NHS, Local Government or third sector. This improved management of funds, services and equipment aims to greatly improve the individual's quality of life.
30. Currently the services are funded and delivered from a number of sources including the NHS, MOD, Local Authority and a variety of Third Sector Organisations. This funding model will not change, however the new framework will enable and support individuals to improve the integration of these services, potentially through the greater use and management of Personal Health Budgets in order to deliver more holistic care to the individual.
31. The MOD is developing an options appraisal to consider the best way to take this work forward. Implementation is likely to begin in early 2017/18, subject to approval of the options appraisal.

### **Place and population based care**

32. The development of Sustainability and Transformation Plans (STP) has provided local communities the opportunity to develop greater collaboration across health and social care and deliver service transformation that results in long term sustainable health care. It is important, given the wide distribution of the armed forces population that we engage with STPs to ensure that we understand the impact of proposed changes, including new models of care, on our population.

### **Armed Forces Networks**

33. The Armed Forces Networks (AFN) offer an opportunity for commissioners and providers, as well as local authorities, MOD and charities to meet to consider the issues and needs of the armed forces community in their area. In addition to the networking capability that AFNs offer they provide an opportunity for dissemination and feedback, forming part of the Patient and Public Participation process. We will be review our existing models to develop a sustainable model with appropriate ownership to ensure they continue to be effective.

### **Public and Patient Participation**

34. Armed Forces commissioners are committed to establishing and implementing a new public and patient participation framework to inform and support our commissioning decisions and actions. The framework builds on the NHS England Patient and Public Participation (PPP) Policy, and has been co-produced with a mix of stakeholders including the Armed Forces PPP Group, and members of Armed Forces Clinical Reference Group (CRG).
35. Further engagement work is anticipated during the autumn of 2016 to strengthen our approach, with the final framework being in place to support our work from April 2017.

## Clinically driven change

36. We will be working with our CRG to review our activity to identify areas and pathways which, the Right Care methodology suggests may offer opportunities for improvement.
37. The following are key priorities in the CRG's work plan for 2017/18 and 2018/19:
  - Increase the profile and understanding of the Armed Forces community and especially veterans particularly in NHS general practitioners.
  - Improve the co-ordination of NHS services for patients with mental health problems for the Armed Forces Community including working with MOD for patients still serving, as they transition from being in uniform into civilian life and thereafter.
  - Improve the responsiveness of the NHS to musculoskeletal problems including rehabilitation
  - Improve the responsiveness of the NHS to Armed Forces issues by better integration with community in secondary care, possibly in partnership with vanguard sites, and in line with the intentions set out in the Five Year Forward View;
  - Improve the co-ordination and services of NHS care for family members of the Armed Forces Community
  - Improve the co-ordination of NHS services for members of the Armed Forces Community in contact with the criminal justice system.
  - Respond to changes in MOD provision following the Strategic Defence Security Review.
  - Improve the understanding of the requirements of the Armed Forces Covenant in partner organisations including NHS providers and CCGs

## Service developments

38. NHS England has a prioritisation framework to guide the work of its direct commissioning functions and a CRG, which enables decisions to be made regarding investment and if necessary dis-investment in services to best meet healthcare need within available resources. These proposals are assessed by the Armed Forces CRG which advises NHS England on all Armed Forces health commissioned services.
39. 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 within available resources.
40. 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.

41. For the avoidance of doubt, the regional commissioning team is unable to give support to cost increasing business case proposals outside of the national process. Providers should not initiate service changes or developments without prior commissioner approval.

## Our approach to contracting

### Practical arrangements

42. NHS England will normally only hold (or be party to) one NHS Standard Contract with any provider unless explicitly advised during any given procurement. Armed Forces health services requirements will be included as separate contract schedules within specialised service provider contracts, in a similar way that providers hold schedules for lead and associate CCG commissioners and, for those services, providers should invoice the South Central regional team.
43. NHS England has previously adopted a commissioner hierarchy amongst its directly commissioned services for the purposes of determining who the responsible payer is. This hierarchy has been developed into an algorithm and associated guidance (the Commissioner Assignment Method (CAM)). This is available at: <https://www.england.nhs.uk/ourwork/tsd/data-services/>
44. All contracts will use the following national standardised documents:
  - Indicative Activity Plan standardised formatted template
  - Local Prices standardised formatted template
  - Local Quality Requirements
  - Information Requirements (already in the NHS Standard Contract)
  - Service Specifications
  - Generic and clinical commissioning policies
45. To support continued reduction in local transaction costs further national standardisation of schedules will be considered over the next two years.
46. Increasingly as part of networked provider arrangements subcontracting will play an important role in commissioned services. In line with the NHS Standard Contract, providers will be expected to agree and obtain written approval in advance from the commissioner to enter into any material sub-contracts. This will include pharmacy services with particular reference to the Carter Review medicines optimisation recommendations. Existing sub-contract arrangements should jointly reviewed and documented within the 2017-19 contract as per the terms of the NHS Standard Contract. NHS England requires full transparency of sub-contracting pricing agreements including where these inform pass through payments, to be set out in the local price schedule. For the avoidance of doubt

providers cannot enter into agreements with an implication on reimbursement from NHS England without commissioner agreement.

47. NHS England will advertise intended contract awards and any market testing or procurement through the government 'Contracts Finder' website meeting the objectives of proportionality, transparency and non-discrimination for current or potential providers from the NHS, independent or third sector in line with the new Public Contract Regulations.
48. The introduction of HRG4+ and refresh of specialist top ups is a significant improvement in the accurate attribution of costs relative to patient complexity. NHS England does not expect to make payments above mandatory tariffs for services.
49. NHS England will only make payment where treatment complies with relevant published policies, and based on priced patient activity reflected in contracts. No resources are available for transitional financial payments. Providers will be expected to provide sufficient data to enable NHS England to validate invoices to ensure that all payments for armed forces health services are compliant with commissioning policy and are as per the rules of the National Tariff Payment System. The invoice validation process supports the delivery of patient care across the NHS and is vital to ensure NHS England fulfils its statutory duties of fiscal probity and scrutiny.
50. NHS England will operate in line with the National Tariff Document (NTD) when published.
51. Payments for high cost drugs and devices excluded from National Tariff should, if approved, be made on the basis of a pass through of the actual price charged to providers (prior to consideration of any contract level risk sharing mechanisms). Auditable information to validate payment of excluded drugs and devices will be required, in line with the NHS Standard Contract.
52. NHS England will also explore the opportunities for longer than 2 year contracts (including contract term and option to extend) with tier 1 and 2 providers where this affords opportunities for significant improvements in service quality and efficiency, and builds on effective existing contractual arrangements.

### **Capacity Planning and service developments**

53. Capacity planning to inform contract discussions will take place in the early autumn and should start from a 'no intervention'<sup>4</sup> basis. There are some demographic changes associated with the rebasing of service personnel and their families from Germany; these are not expected to be significant until the summer of 2018 and plans to manage the impact of these demographic changes with local CCGs and providers are at a mature stage. Commissioners will take responsibility for the final decision on these forecasts in line with their responsibilities to determine the level of care to commission.

---

<sup>4</sup> Forecasting future activity with existing demand management and QIPP measures but prior to incorporating additional QIPP measures or initiatives

54. The regional team 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.
55. Initiatives which impact on a 'no intervention' plan, with clear responsibilities and constructive engagement will be vital to ensure that contracts remain affordable. NHS England local offices will discuss a range of QIPP projects which have been developed by CRGs on a national basis, as well as locally identified projects. In many cases, provider clinical teams are in a good position to identify local opportunities and should add to the portfolio of planned change, to ensure that the volume growth and efficiency of pathways and episodes of care are addressed in plans
56. All new investment decisions will be subject to a prioritisation process. As set out in previous years providers should not initiate service changes and developments without prior commissioner approval as cost impacts will not be funded unless considered in advance through this process.

### **Prior Approvals and Individual Funding Requests**

57. There are a number of clinical commissioning policies that are subject to prior approval. These include the assisted conception policy and a number of policies for procedures that may be considered to be cosmetic. Treatments that have not secured prior approval will not be funded.  
[www.england.nhs.uk/commissioning/policies/ssp/](http://www.england.nhs.uk/commissioning/policies/ssp/)
58. Requests for prior approval should be made on the appropriate form and sent to [england.armedforcespriorapprovals@nhs.net](mailto:england.armedforcespriorapprovals@nhs.net)
59. Arrangements for Individual Funding Requests (IFRs) will continue in 2017/18 and 2018/19. Further details on IFRs, including the application form, are available at: [www.england.nhs.uk/wp-content/uploads/2013/04/cp-03.pdf](http://www.england.nhs.uk/wp-content/uploads/2013/04/cp-03.pdf)

### **CQUIN**

60. Armed Forces personnel and their families move home more frequently than the general population due to their military commitment. In seeking assurance that providers of NHS services are compliant with the Armed Forces Covenant in relation to 'no disadvantage' as a result of these moves, we focussed our 2016/17 CQUIN on ensuring the issues of mobility for armed forces community were reflected in access policies.
61. CQUINs for 2017/18 and 2018/19 will be developed in accordance with the planning guidance, to build upon the 2016/17 CQUIN.

### **Quality, Innovation, Productivity and Prevention (QIPP)**

62. There are a number of strands to our approach to QIPP. These are:
  - Ensuring we spend our resources in the most effective way.

- Working with 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 MOD to ensure that there is a tax payer benefit to our actions, for example commissioning services to increase deployability.
63. We will work with our colleagues in DMS to consider what QIPP opportunities may exist through delivering care in a different or more efficient way:
- repatriation / movement of minor procedures to out of hospital settings where this is both clinically and cost effective
  - reduction in the ratio of follow ups to new out-patient appointments where clinically 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.

## Key contacts

### Regional Team

Debra Elliott, Director of Commissioning, South Central, Director of Armed Forces Health Commissioning (Operations) for England

[Debra.elliott1@nhs.net](mailto:Debra.elliott1@nhs.net)

Alison Treadgold, Head of Armed Forces Health, Midlands and North

[Alison.treadgold@nhs.net](mailto:Alison.treadgold@nhs.net)

Jenny Kirby, Head of Armed Forces Health, South and London

[jenny.kirby@nhs.net](mailto:jenny.kirby@nhs.net)

### National Team

Kate Davies, Head of Public Health, Armed Forces and their Families and Health & Justice Commissioning

[Kate.davies12@nhs.net](mailto:Kate.davies12@nhs.net)

Andy Bacon, Assistant Head of Armed Forces and their Families Commissioning

[andy.bacon@nhs.net](mailto:andy.bacon@nhs.net)

Richard Swarbrick, National Lead for Armed Forces Networks and Transition,

[richard.swarbrick@nhs.net](mailto:richard.swarbrick@nhs.net)

Dr Jonathan Leach, Chair of Armed Forces Clinical Reference Group

[Jonathan.leach@nhs.net](mailto:Jonathan.leach@nhs.net)

Arthur Ling, Armed Forces and their Families and Health and Justice Commissioning Manager

[Arthur.ling@nhs.net](mailto:Arthur.ling@nhs.net)

## Glossary

AFN	Armed Forces Network
APS	Annual population survey
CAM	Commissioner assignment methodology
CCG	Clinical Commissioning Group
CQUIN	Commissioning for quality and innovation
CRG	Clinical reference group
DMS	Defence Medical Services
DPHC	Defence Primary Healthcare
HRG4+	Health resource group v.4+
IFR	Individual funding request
IHDCS	Integrated high dependency care system
MOD	Ministry of Defence
MSK	Musculoskeletal
NTD	National tariff document
OSV	overseas visitor
PPP	Patient and public participation
PTSD	post-traumatic stress disorder
QIPP	quality, innovation, productivity and prevention
STP	sustainability and transformation plan
UK	United Kingdom
VPP	Veterans' prosthetics panel



## Responsible commissioners

	<b>Serving Armed Forces / Mobilised Reservists</b>	<b>Families with DMS</b>	<b>Families not with DMS</b>	<b>Non Mobilised Reservists</b>	<b>Veterans</b>
Primary Medical Care	DMS	DMS	NHS - 1° care	NHS - 1° care	NHS - 1° care
Out of hours	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 – OSV	CCG - OSV			
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
Rehabilitation (post injury)	DMS provision				
IVF (WIS cohort)	NHS AF & DH			CCG & DH	CCG & DH

	<b>Serving Armed Forces / Mobilised Reservists</b>	<b>Families with DMS</b>	<b>Families not with DMS</b>	<b>Non Mobilised Reservists</b>	<b>Veterans</b>
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)		local authority	local authority		
Occupational Health	DMS				
Prosthetics	DMS & NHS - VPP	NHS - Spec	NHS - Spec	NHS – VPP / NHS – Spec	NHS – VPP / NHS – Spec
Wheelchairs	DMS	NHS - AF	CCG	CCG	CCG

Key:

CCG	Clinical Commissioning Group
CCG OSV	CCG Overseas Visitor funding
DMS	Defence Medical Services
DH	Department of Health
NHS - AF	NHS England (Armed Forces Health)
NHS - Dental	NHS England (Dental)
NHS - 1° care	NHS England (Primary Care)
NHS – PH	NHS England (Public Health)
NHS – Spec	NHS England (Specialised Commissioning)
NHS – VPP	NHS England (veterans' prosthetics panel)