



MINISTRY OF DEFENCE



# **Partnership Agreement**

**Between**

**Ministry of Defence and NHS England for  
the Commissioning of Health Services for  
the Armed Forces**

**June 2018**

# Joint Statement

This Agreement sets out the strategic intent and commitment for the Ministry of Defence (MOD)<sup>1</sup> and NHS England to work together.

We recognise our respective statutory responsibilities and independence, but will collaborate and cooperate to achieve our aim of ensuring safe and effective care, which deliver value for money and improves health outcomes for the Armed Forces community<sup>2</sup> and supports the delivery of the Armed Forces Covenant. The Armed Forces Covenant sets out the relationship between the Nation, the State and the Armed Forces. It recognises that the whole Nation has a moral obligation to members of the Armed Forces and their families and it establishes how they should expect to be treated. It exists to redress the disadvantages that the Armed Forces Community faces in comparison to other citizens and to recognise the sacrifices that they have made.<sup>3</sup> The vision is that Armed Forces personnel and their families should receive excellent healthcare from the NHS, tailored to their particular needs, in accordance with the Armed Forces Covenant and consistent with civilians in the area which they live.<sup>4</sup>

This will present challenges which cross departmental and organisational boundaries. They require a joint approach by the MOD and NHS England, which goes beyond the words written in this document: it must be embedded into the way in which we work. In recognising the unique healthcare needs of the Armed Forces to maintain fitness for task, this may mean working in different ways to enable us to make the challenging decisions that will set the direction for transformational change and improved healthcare outcomes. This will need to be done by a combination of core NHS funded and delivered services and those funded or provided from elsewhere (including MOD).

This Agreement is an enabling document; it leaves the detailed decisions about service delivery to be made by those who know and understand the delivery of healthcare service and those who understand the needs and best interests of the Armed Forces and their families. Most importantly, it sets out a partnership approach, which enables MOD to work together with their colleagues in the NHS in planning and organising the delivery of healthcare. The effectiveness of this agreement will be monitored through MOD/UK Departments of Health Partnership Board, which will explore mutual areas of co-operation and recommend actions to the individual parties represented at the Board.

Signature: 	Signature: 	Signature: 
Lt Gen MCM Bricknell	Lt Gen R E Nugee	Kate Davies
Surgeon General	Chief of Defence People	Director H&J, AF & SARCs, NHS England
Date: 31 May 2018		

<sup>1</sup> Ministry of Defence (MOD) is defined as the Chief of Defence People (CDP) and Surgeon General (SG) areas of responsibility for the purposes of this agreement.

<sup>2</sup> For the purpose of this document, the Armed Forces community will consist of serving members of the Armed Forces and their families registered under Defence Medical Services practices in England and Reservists while mobilised or those posted overseas, who choose to return to use NHS services in England. It also includes veterans living in England.

<sup>3</sup> Armed Forces Covenant- Ministry of Defence, 22 March 2013.

<sup>4</sup> Securing Excellence in Commissioning for the Armed Forces and their families – NHS CB, March 2013.

# 1. Context and Shared Purpose

## Purpose

- 1.1 The Health and Social Care Act 2012 has provided opportunities to provide a more consistent standard of care for those serving in the AF in England. There is a need to ensure continuity of care for those moving between NHS care in England, Devolved Administrations and Defence Medical Services (DMS) facilities in UK and overseas.
- 1.2 Service personnel will become veterans and an increasing number of Reservists will be mobilised. Good continuity of care for those entering, serving and leaving AF service is paramount. Similarly due to the mobility of AF personnel and their families, there will be regular changes to their service provider and commissioners<sup>5</sup>. All parties will need to take into account the wider circumstances beyond the immediate health needs of those that are serving.
- 1.3 The MOD is charged with protecting the UK and [Crown Dependencies](#). Service personnel are based across the UK and [overseas](#) and can return to the UK to receive NHS care. All service personnel must experience no disadvantage in accessing timely, comprehensive and effective healthcare in England and the DAs, in particular when access to care is cross border within the UK. Although the DAs are responsible for commissioning care for the AF registered in their countries, any disparities within healthcare across the UK will be addressed through the MOD/UK Departments of Health Partnership Board Access & Equity Sub-Group.
- 1.4 The purpose of health services are to promote health, prevent illness and injury, and to diagnose, treat and rehabilitate those whose health can be improved and manage the care of those that cannot. It is essential that the unique healthcare needs of service personnel across the UK and overseas is fully recognised and focuses on ensuring that personnel are fit for their operational tasks; therefore, some clinical and health interventions may not fit within the core offer of the NHS. It is also appropriate to recognise those veterans and the families of serving and former serving personnel may have unique health care needs that need to be addressed by the NHS.
- 1.5 This Agreement is intended to facilitate a single point of contact for access for the MOD to engage with other commissioning and provider parts of NHS England, (including Clinical Commissioning Groups (CCGs), NHS Trusts, etc.). Similarly Future Healthcare within Headquarters Surgeon General (HQ SG) will act on behalf of the MOD and provide the principle point of contact for the NHS with other providers and stakeholders in the MOD for matters related to healthcare delivery. Service Personnel Support, within the Chief of Defence People<sup>6</sup> area, will act on behalf of the MOD for health, wellbeing and welfare personnel related matters and provide the principal point of contact for the NHS with other providers and stakeholders for this purpose.
- 1.6 MOD and NHS England will work together to ensure that the MOD's health and welfare arrangements with the NHS are coordinated to provide the best outcomes and experience for patients and their carers.

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<sup>5</sup> NHS England will be the main commissioner for those under DMS practices (i.e. there are some areas such as primary care and elements of mental health that remain the responsibility of DMS).

<sup>6</sup> ACDS Pers Cap (within CDPs area) chairs the MOD Defence People Health and Wellbeing Board

- 1.7 The Partnership Agreement sits below the interdepartmental MOD/UK Departments of Health Partnership Board and sets the strategy for the delivery of the mandates and instructions given by the respective departments. DHSC is not a party to the Partnership Agreement.
- 1.8 This framework provides a working document for staff in each organisation and a reference for other organisations, covering how we will:
- Work together
  - Use information; and
  - Enable issues to be referred to the other organisations in appropriate circumstances.
- 1.9 Collaboration is not limited to the details laid out in this document. This will include working in a flexible fashion in order to improve outcomes and the quality of provided services to the AF community.

## Ambition

- 1.10 MOD and NHS England are committed to working together to ensure safe and effective services which improve health outcomes for the AF community. These services must:
- Be tailored to the needs of the AF community, in accordance with the Armed Forces Covenant.
  - Ensure that patients experience a seamless transition between services, minimising any risks associated with accessing care commissioned and provided to the AF community (see 1.2 above).
  - Provide as a minimum the same standards and quality of care that can be expected by the civilian community.<sup>7</sup>

## Roles

### NHS England

- 1.11 NHS England is a non-departmental public body which operates within the wider health and social care system. Its overarching role is to ensure that the NHS delivers continuous improvements in outcomes for patients within the resources available. NHS England will fulfil this role through its leadership of the commissioning system. Working in partnership with CCGs and a wide range of stakeholders, it will secure better outcomes, as defined by The Mandate, set by the DHSC and the NHS Five Years Forward View processes; it will actively promote the rights and standards guaranteed by the NHS Constitution; and will secure financial control and value for money across the commissioning system. Except where otherwise stated, the NHS can only discriminate between different groups within the population on the basis of clinical need (and not on employment type), but should seek to minimise any disadvantage and meet consistently the particular health needs of individual population groups, such as the AF community.
- 1.12 The system of commissioning for the NHS requires NHS England to provide national consistency in areas such as quality, safety, access and value for money. From April 2013<sup>8</sup>

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<sup>7</sup> Securing Excellence in Commissioning for the Armed Forces and their families – NHS CB, Mar 2013

NHS England<sup>9</sup> took on a number of the services previously paid for by others (i.e. secondary and community services for serving personnel and those registered with DMS GPs in England). In addition NHS England is responsible for the direct commissioning of specialised care, primary care (for NHS patients i.e. GP services, dental, pharmacy, optometry), and care for those in Justice settings and some aspects of public health for the general population (i.e. national screening programmes and the vaccinations and immunisation programmes). These latter services are delivered through Regional teams that sit between the local CCGs and NHS England's National Central Team. Armed Forces Health is specifically commissioned, on a regional basis, by a single regional team that supports the operational delivery England.

1.13 NHS England has a wider role to support CCGs in their duty to commission health care for those parts of the AF community for which they have responsibility (i.e. Veterans and service families registered with NHS GPs and non-mobilised reservists).

### **Headquarters Surgeon General**

1.14 Future Healthcare sits under the Directorate of Defence Healthcare within Headquarters Surgeon General. In the context of this document, HQ SG has the following specific roles:

- Develop a strategy in consultation with NHS England, DHSC, and Health Departments in the DAs to support the commissioning of secondary and community healthcare to meet the health needs of the AF and those dependants registered with Defence Primary Health Care (DPHC).
- Commission community and in-patient mental healthcare services for service personnel to meet their specific needs, meeting, for example, the lower admission threshold for access to specialist services required for AF personnel.
- Develop, implement and sustain an effective strategy for commissioning Defence specific specialist clinical services where necessary.
- Deliver a primary care service<sup>10</sup> to entitled personnel within the UK and the AF community when overseas and, where necessary, refer patients to NHS services (community, secondary or specialised).
- Work with Partnership Agreement members, and their sub-groups to ensure that there is continuity of clinical care between those moving between MOD and NHS commissioned or provided care.

### **Chief of Defence People**

1.15 CDP's mission is to set and assure People policies and processes in order to sustain the delivery of Defence outputs. To achieve this Defence will need to deliver and maintain the human component, ensuring that Service personnel are invested in, in order to succeed on operations, and are supported and sustained in ways that they are always prepared for all tasks.

1.16 SP Support, in turn ensure that the AF are physically, mentally and emotionally robust enough in order to deliver Defence tasks, with appropriate support to Service personnel and families. SP Support also ensure that all in the Armed Forces community are not

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<sup>8</sup> Prior to this MOD (and then from October 2012 NHS Primary Care Trusts) had had these duties

<sup>9</sup> In addition NHS England will commission mental health and dental services for families under DMS GPs and some elements for serving personnel.

<sup>10</sup> Including primary medical and dental care, occupational health, travel medicine, mental health and rehabilitation services.

disadvantaged by virtue of Service life and that on leaving the Services, they make a successful transition to civilian life, secure in the knowledge that they will be continually supported by the wider AF community for the rest of their lives.

1.17 In the context of this role, SP Support will:

- Work with Partnership Agreement members, and their sub-groups to maximise opportunities for all Service personnel and families to enjoy a state of positive physical and mental health and wellbeing.
- Oversee the delivery of the Defence People Health and Wellbeing Strategy.
- Lead the work under the Defence People Mental Health and Wellbeing Strategy.
- Work with DHSC and NHS England to provide timely advice on veterans' general health issues.
- Provide the main point of contact for the Armed Forces Covenant.
- Develop a veterans' strategy which will encompass health and wellbeing.

## 2. Joint Strategic Aims

2.1 Together we will agree strategic aims on which to work over the period of the agreement. More detailed priorities to support these aims are at Annex B and will support the key areas of work below:

A. Identify the health needs of the AF community.

- Work in partnership to identify any existing Health Needs Assessments (HNA) of the AF community.
- Commission any new HNA as required.

B. Development and delivery of a Joint Commissioning Plan.

- Review data in relation to referral and outcomes.
- Incorporate any changes relevant to the unique health needs of the AF community and identify who will provide, commission and pay for these services.
- Development of appropriate pathways which meet the specific needs of the AF community and maximise their operational effectiveness.
- Take account of evolving methods of delivery and advances in clinical practice.

C. Ensure that AF personnel are seen by NHS healthcare providers in a timely fashion.

- Ensure high standards of patient care, safety and experience to deliver the core values within the NHS Constitution

- Utilise quality measurement tools to drive continuous improvement in services and outcomes.
  - Identify evidence to support the development of new or alternative pathways, including those that cross between DMS and NHS led and commissioned services.
  - Identify agreed procedures that are within the core NHS Offer and those that will normally require separate arrangements.
  - Agree a process of dealing with potential disagreement where the specific healthcare needs of the AF community and NHS Constitution may differ.
  - Ensure there are no regional variations to healthcare commissioning and delivery for the AF Community to enable equity of provision nationally.
- D. Improve the health transition of AF personnel into civilian life.
- E. Improve physical and mental health services for veterans, reservists and AF community (including those of families of serving, reservists and veterans.)

### 3. Governance for Delivering Joint Aims

3.1 This agreement has been driven by the views of NHS England and MOD, who will work together at all levels to implement this Agreement in practice. Terms of Reference for the MOD/UK Departments of Health Partnership Board are at Annex A. These will be supplemented by stakeholder interface as detailed in Table 1.

3.2 The agreed governance structure is summarised below:

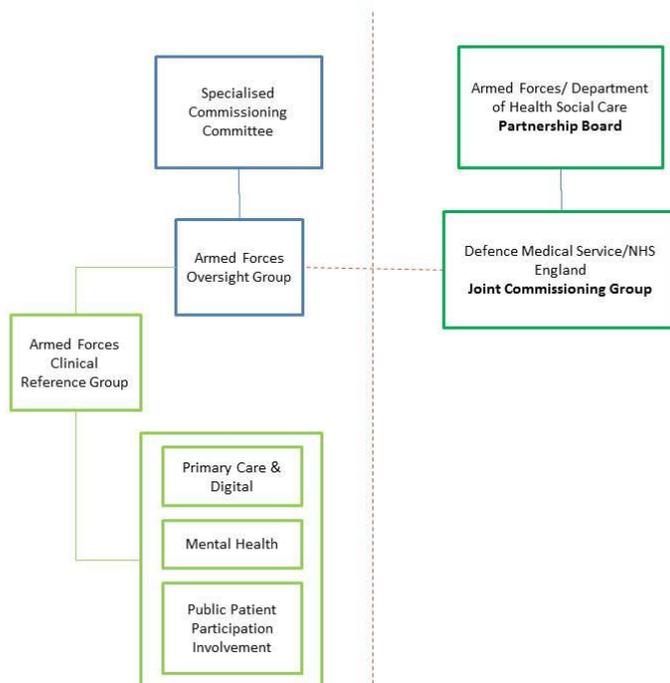


Diagram 1

NHS England / MOD Joint Governance Arrangements

Table 1: Stakeholder Interface and key boards:

Meeting	Aim	Frequency	NHS/DH/DAs	MOD
<b>MOD/ UK Depts of Health Partnership Board</b>	Deals with Cross Governmental Issues across the UK	Termly	- Director of NHS Specialised Commissioning - Devolved Administrations	Surgeon General Dir HDT DMedPolOpCap ACDS(Pers Cap) Hd SP Support
<b>Access &amp; Equity Sub-Group</b>	Ensure commonality and consistency in healthcare delivery to MOD patients by the UK Health Departments	Termly	- Hd AF & Veterans Health DH - Hd Armed Forces and their Families and Health & Justice and SARCs - DAs Reps	- Dir HDT (Chair) - Comd DPHC - Comd DMG - Hd FHC - DH FHC - Hd SP Support - SG Fin Sec 3 (Sec)
<b>Armed Forces Joint Commissioning Group</b>	Delivers Annual Commissioning Plan in England	Termly	Director AF Commissioning NHS England	- Hd FHC - DH FHC - AH SCT - D/ Comd DPHC - SO2 Reqmts SCT (Sec) - Hd Welfare Policy
<b>Armed Forces Clinical Reference Group</b>	Gives clinical advice and support to the development of strategy and the delivery of the Annual Plan	As necessary	Chair of Armed Forces Clinical Commissioning Group - Hd Armed Forces and their Families and Health & Justice and SARCs	Hd FHC D/Comd DPHC Hd Welfare Policy

- 3.2 The Partnership Agreement will be reviewed annually and changes made by mutual agreement.
- 3.3 NHS England and SG staffs will use the specialist evidence to support their decisions and use the Armed Forces Clinical Reference Group (CRG) to provide independent holistic clinical advice. All partners will develop methods to become more responsive to the needs and wishes of patients and the wider stakeholders.
- 3.4 The partners will co-operate fully in relation to the disclosure and exchange of information, intelligence, evidence, policy formulation and documentation in a timely way and in accordance with relevant legislation and case law. There will be occasions when shared information (such as guidance or standards etc.) cannot be disclosed either publicly or to other organisations, unless explicit consent is obtained and except as required or permitted by law. This protocol is subject to the duty of confidentiality owed by each partner to those providing the confidential information.

## Communications Strategy

- 3.5 NHS England and MOD will develop and implement a joint communications strategy to support and underpin the shared principles and priorities in this agreement.

## Complaints and Dispute Resolution

### *Complaints*

- 3.6 All complaints originating from those under DMS care, including MOD commissioned care pathways and DPHC, should be raised through the care provider's complaints procedures.
- 3.7 All complaints in community secondary and specialised healthcare should be raised via the NHS England complaints procedure.<sup>11</sup> This does not include those functions for which NHS England is not responsible for commissioning. These should be raised with the local CCG.

### *Dispute Resolution*

- 3.8 All issues which relate to concerns by commissioners regarding healthcare providers should be actioned as a dispute. Dispute processes cannot entertain complaints by individual patients or their representatives.
- 3.9 Where a dispute emerges between providers of healthcare these should always be raised in the first instance, and at the earliest opportunity with the provider and copied to the commissioner. Issues should be put in writing and any resolutions recorded and reported via the Regional team to the JCG.
- 3.10 In the event that disputes cannot be resolved at this level, they are to be raised in writing with the Partnership Board. The Board's decisions will be recorded in writing and partners will be expected to respond to the decision agreed.

## Mechanisms for Overseeing the Agreement

- 3.11 Governance arrangements will be established in order to ensure effective working as set out above. These will be supplemented by specific task and finish groups established to take forward the joint priority areas at 2.1. These stakeholder arrangements are shown above in Diagram 1 and summarised in Table 1 and will be kept under review.

Date these TOR approved .....

Date TOR to be reviewed .....

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<sup>11</sup> For the NHS England complaints procedure, see [www.england.nhs.uk/contact-us/complaint](http://www.england.nhs.uk/contact-us/complaint). This includes information about how to appeal via the Parliamentary and Health Service Ombudsman (PHSO).

## **Terms of reference of MoD/UK Departments of Health Partnership Board**

### **Purpose**

The purpose of the MOD/UK Departments of Health Partnership Board (PB) is to ensure that the MOD and UK Health Departments work together to meet the requirements of the Armed Forces Covenant and to improve the health and healthcare of the UK Armed Forces before, during and after deployment, and of their families and veterans.

### **Principles**

These Terms of Reference (ToR) are agreed by the PB. Unless reviewed, the PB should be governed by the principles of the Strategic Partnership Document which:

- Confirms the joint intent of the MOD and the UK Health Departments to continue the partnership between military and civil healthcare services and provide for a cross cutting partnership aimed at delivering the best healthcare needs for the Armed Forces, their families and veterans.

### **Core objectives**

MOD/UK Departments of Health Partnership Board Core Objectives are:

- To provide oversight on the current and future health and healthcare of Service Personnel, their families and veterans including:
  - Armed Forces Covenant – delivery of health and well-being requirements and ensuring ‘no disadvantage’ to the Armed Forces Community;
  - Transition of seriously injured personnel – ensuring the smooth transition from MOD care to NHS care; and
  - Reservist issues – including delivery of the Government’s objectives outlined in Future Reserves 2020.

These core issues will form the standing agenda of PB meetings.

### **Structure**

The PB will comprise:

Two Co-Chairs	Surgeon General, MOD Director General, Social Care, Local Government and Care Partnerships, DH England
Board Members	Director Medical Policy and Operational Capability, MOD Director Healthcare Delivery and Training MOD Assistant Chief Defence Staff (Personnel & Capability), MOD Hd of SG Secretariat and Finance, MOD Deputy Head Strategic Commissioning Team, MOD Deputy Director Mental Health and Disability, England NHS England Director of Specialised Care Director General Health and Social Care, Scotland Director of Mental Health, NHS Governance and Corporate Services, Wales

Director of Policy on Mental Health, Disability and Older People's Services,  
DHSSPS, Northern Ireland

Executive Team      Assistant Head of Surgeon General's Secretariat, MOD  
Support              Head of Armed Forces and Veterans' Health Team, DH England

**Joint Executive:** Will work under direction of the PB Co-Chairs and changes of membership are to be ratified by the PB Co-Chairs.

**Task-and-Finish Groups and Sub-Groups:** At the request of PB Co-Chairs and Board Members, individual PB members may agree to appoint short-term "task-and-finish" groups or longer term "Sub-Groups" to examine specific issues or undertake work of wider interest to the PB. Each group will have a Board Member (or nominated representative) to champion and direct its work. The authority to undertake any work will come from PB members' own organisations rather than the PB. These groups will provide updates on progress and recommendations where necessary at PB meetings.

### **Meetings**

Meetings will be held three times a year.

Additional meetings may be scheduled as directed by the PB Co-Chairs.

The Joint Executive will be responsible for scheduling meetings as directed by the PB Co-Chairs and the meetings will generally be hosted in turn by member Departments.

### **Papers**

PB meeting agenda to be agreed in advance by the Co-Chairs.

Papers to be circulated at least seven days before the meeting.

### **Secretariat**

Responsibility for the PB Secretariat lies with the PB Joint Executive and their responsibilities include:

- Arranging PB meetings;
- Compiling and circulating agendas and papers; and
- Taking, updating and circulating the minutes

The Joint Executive has the authority to monitor, help shape and report back the output of work relevant to the PB's rolling priorities, and to seek augmenters as required by representatives of the Board Members' organisations.

**Joint Priorities for NHS England and MoD – 2018-2020**

The workplan areas to achieve the joint aims at section 2 are reviewed routinely. They reflect key areas of work that are derived from joint discussions between NHS England and MoD and drive the key areas of work for 2-3 year periods.

The currently agreed priorities are:

- Joint support, organisation and workforce development - MoD and NHS restructuring and organisational review outcomes, primary care delivery and rebasing and review of options for joint workforce secondments and/or exchange;
- Timely access to care - IT interfaces and data sharing – supporting timely access to health care, transition and continuity of care;
- Family support - Improved support to families (including children and young people, safeguarding and reservists' healthcare);
- Mental health awareness and delivery - Improve serving, veteran, AF community and professionals awareness in MH, access and delivery of serving and veterans MH model of care;
- Communications, users and professional support - Improved comms, media and awareness of services, support and delivery to armed forces community;