Healthcare for the Armed Forces community: a forward view

From serving to civilian life:
health and wellbeing for all

Contents

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Executive summary

Healthcare for the Armed Forces community: a forward view should be seen as a companion document to the NHS Long Term Plan (LTP), outlining the commitments NHS England and NHS Improvement is making to improve the health and wellbeing of the Armed Forces community, serving personnel (regulars and reservists), veterans and their families. The Armed Forces community will already be seeing the impact of changes in services driven by the LTP, such as the expansion of veterans mental health services and this is our opportunity to build on these improvements.

In addition, *Healthcare for the Armed Forces community* reflects the emergent priorities from *We are the NHS: People Plan 2020/21* and the changes the NHS has made as a consequence of dealing with the COVID-19 pandemic.

Based on feedback from patients and their families, as well as commissioners, providers, the Ministry of Defence (MOD) and Armed Forces charities, we have identified nine commitments to supplement the work already underway in regions and through integrated care systems (ICSs) to meet the goals and ambitions of the LTP. Working together across regions, ICSs, Defence and charities, as well as with patients, service users and families, will ensure that we can make tangible improvements for the Armed Forces community.

For more information, visit the NHS website at www.nhs.uk and search for Armed Forces

Introduction

1. The NHS Long Term Plan (LTP), describes the steps required to create an NHS fit for the future. The actions it sets out are intended to deliver better healthcare to the whole population – including the Armed Forces community of serving personnel, reservists, veterans, and their families and carers. The importance of the LTP for the Armed Forces community is reinforced by the specific commitments it includes to improve the physical and mental health of this population.

2. In parallel, society's obligations to the Armed Forces are set out in the Armed Forces Covenant which provides a framework for the duty of care the United Kingdom owes its Armed Forces. Furthermore, the NHS Constitution establishes the principles and values of the NHS in England and commits to ensuring that those in the Armed Forces, reservists, veterans and their families are not disadvantaged in accessing health services. Where appropriate, we will contribute to the delivery of the Government's commitments on the future of the Armed Forces Covenant.[1]

3. A partnership agreement is in place between NHS England and NHS Improvement and the MOD to support the joint working that delivers the Armed Forces Covenant requirements. Commissioning good quality healthcare for the Armed Forces community should be based on the Covenant, and its principles underpin this plan.

4. Our plan needs to ensure that we meet the needs of the Armed Forces community, recognising that there is a need for healthcare during service, leaving service and after service. Healthcare for the Armed Forces community builds on the foundations of the LTP and the Armed Forces Covenant to set out nine commitments from serving to civilian life, expressing our ambition for future healthcare for the Armed Forces community.

5. This plan sets out these nine commitments for NHS England and NHS Improvement which have been informed by the views and experiences of the Armed Forces community. Each commitment provides information on what the NHS will do, in partnership with the MOD, the Office for Veterans' Affairs, Armed Forces charities and other organisations, to improve the care and support delivered to this population.

6. Our commitments complement the MOD's Defence People Mental Health and Wellbeing Strategy 2017-2022, which details the support for serving personnel across five broad themes in their careers: join well; train well; live well; work well; and leave well. They also support the implementation of the MOD's Strategy for our Veterans, with the aim that 'all veterans enjoy a

1 For further information, please see: https://www.gov.uk/government/news/new-pledges-for-the-armed-forces-announced-in-queens-speech (20 August 2020)

state of positive physical and mental health and wellbeing, enabling them to contribute to wider aspects of society'.

7. We are the NHS: People Plan 2020/21 – action for us all, together with Our NHS People Promise, sets out what NHS staff can expect from their leaders and from each other. We recognise that there is vital intersection between the military medical community and the NHS and we will work to ensure that the military medical community are able to become integrated with and benefit from the NHS People Plan.

8. The COVID-19 pandemic exposed some of the health and wider inequalities that persist in our society. COVID-19 has had a disproportionate impact on many of those who already face discrimination or disadvantage[2]. As the NHS started the process of restarting and recovering services, urgent actions were identified that that need to be put in place to support this process. Our plan reflects these actions with a focus on inclusive access to services, improving mental health services and addressing health inequalities.

9. Integration and Innovation: working together to improve health and social care for all[3], builds on the ambitions in the LTP and the accelerated collaboration of the last year. It proposes legislative changes that, subject to Parliamentary approval, will come into force by 2022. This forward view lays the foundations for the healthcare of the Armed Forces community in a landscape of statutory ICSs.

2 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/908434/Disparities_in_the_risk_and_outcomes_of_COVID_August_2020_update.pdf

3 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/960548/integration-and-innovation-working-together-to-improve-health-and-social-care-for-all-web-version.pdf

The Armed Forces healthcare commissioning landscape

10. The Armed Forces in the UK consists of the Royal Navy, the Royal Marines, the British Army and the Royal Air Force. The Armed Forces community includes serving personnel both regulars and reservists, veterans, and their families and carers. It is a unique population, with specific health and wellbeing needs based on its demographics, activities and occupations.

11. Responsibility for Armed Forces healthcare is split between the MOD and the NHS. Defence Medical services (DMS) provide a range of services for regular serving personnel in the UK, those serving overseas and in some cases their families. From an NHS perspective, commissioning responsibilities are discharged through NHS England and NHS Improvement as a direct commissioner of services for those registered with a DMS practice, and through clinical commissioning groups (CCGs) for patients registered with an NHS GP, such as most families and all veterans. In addition, NHS England and NHS Improvement commissions some bespoke services for veterans[4].

12. Service charities also play a vital role, including the delivery of care and support, driving research to better understand the needs of this population, and providing advocacy for the Armed Forces community. This contribution is particularly effective when working in partnership with health and social care, recognising the positive impact this is having on the health and wellbeing outcomes of this patient group. More information about many service charities and their specialist roles and support is available on the Confederation of Service Charities (COBSEO) website.

13. The LTP set out the ambition that by 2021, every region of England will have its own Integrated Care System (ICSs)[5] and this is being rapidly progressed. ICSs bring together local health and social care organisations to take responsibility, manage resources and plan healthcare services for their local populations.[6] As the COVID-19 pandemic has shown, working together as a system is vitally important to the delivery of services; we must ensure that DMS are appropriately represented at place and system level and that the need for a nationally consistent approach is balanced with local priorities.

4 For more information about commissioning responsibilities see: https://www.england.nhs.uk/publication/who-pays-determining-responsibility-for-nhs-payments-to-providers/

5 https://www.england.nhs.uk/integratedcare/integrated-care-systems/

6 For more information about the structure of the NHS, see: https://www.england.nhs.uk/participation/nhs/

Engagement in developing this plan

14. Development of this plan, and the commitments and actions set out in it, have been informed by the views and experiences of serving personnel, reservists, veterans and their families. In talking to them about their experiences of the NHS, looking at what has worked well and what could be improved, common themes and issues have arisen.

15. We have benefitted from the ongoing input and advice from the Armed Forces Patient and Public Voice Group (AFPPV Group) comprised of serving personnel, veterans and their families, as well as representatives from the Families Federations, MOD and Armed Forces charities. They have ensured that these commitments are a true reflection of the health and wellbeing needs of the Armed Forces community and the associated actions are tangible and deliverable.

16. We have also engaged a range of healthcare professionals, statutory and third sector organisations working with and supporting the Armed Forces community to capture their views and suggestions on priority areas and actions to focus on and deliver. In addition, we have actively engaged with the seven regions of NHS England and NHS Improvement, through Regional Directors of Commissioning.

17. As we progress the work set out in this document and deliver on our commitments, we will continue to put lived experience at the heart of our decision making to ensure that the services we commission, and the changes and improvements we make, best meet the health and wellbeing needs of this patient group, regardless of where they live in England.

18. Our work is underpinned by five principles developed by National Voices as part of the response to the COVID-19 pandemic. The principles are:

    - Actively engage with those most impacted by the change.
    - Make everyone matter, leave no-one behind.
    - Confront inequality head-on.
    - Recognise people, not categories, by strengthening personalised care.
    - Value health, care and support equally.

Delivering in partnership

19. This plan is for all, the Armed Forces community who will benefit from its implementation and for those, our partners, who will ensure that it is implemented. It aims to spread good practice across the country, to ensure a care offer for the Armed Forces community that meets the requirements of the Armed Forces Covenant. This plan will deliver:

    - better health and wellbeing for the whole of the Armed Forces community
    - a more joined-up experience of care for serving personnel and their families as they move around the country, and transition from service to civilian life
    - faster and more local access to high quality, personalised and responsive mental health services for veterans
    - greater value for money.

20. Many of the actions set out in this plan are already being delivered in some parts of the country, including through local schemes to deliver the LTP, and there are examples of excellent care for serving personnel, veterans and their families.

21. Whilst many of the actions in this forward view relate to the specific commissioning responsibilities of NHS England and NHS Improvement, they cannot be implemented in isolation and rely on strong relationships with our national and local partners, across the NHS, third sector, MOD, local government, other government departments and the Royal Colleges.

22. Overall responsibility for working with these partners to deliver the plan rests with NHS England and NHS Improvement's Armed Forces healthcare commissioning team. This team will continue to work with the seven NHS England and NHS Improvement regional teams to deliver, in partnership, the elements of the work programme that need to be integrated within ICS activity. Key considerations for ICSs, which would support this community, are highlighted at the end of each commitment.

23. Progress with the delivery of this forward view will be monitored through specific groups. These groups will include members with lived experience. Overall responsibility for delivery will sit with the NHS England and NHS Improvement Armed Forces Oversight Group.

Commitment 1:

Working in partnership to commission safe, high quality care for serving personnel and their families

24. The serving population is generally young, and physically and mentally fit. Maintaining good health is of critical importance to the Armed Forces' ability to function, so it is vital that serving personnel can access high quality secondary care services, when and where needed.

25. Serving personnel access primary care, mental healthcare and a range of other services through DMS but, where secondary and community care is required, this is commissioned and paid for by NHS England and NHS Improvement through a single direct commissioning team. This team also commissions secondary care for those families of serving personnel who have chosen to register with a DMS practice rather than an NHS GP practice. Reservists are cared for by their NHS GP but receive occupational health advice and care from a DMS GP when mobilised.

Our commitments:

26. NHS England and NHS Improvement will, through a single Armed Forces team, continue to **commission high quality, safe and effective secondary care services** to meet patient need, from a wide range of hospitals across England. We will also review performance to make sure that **our patients are not disadvantaged** by their serving status.

27. The Armed Forces health team will, through DMS and regional teams, ensure that Armed Forces patients are aware of **NHS 111** first and that patients should call NHS 111 prior to attending A&E. The use of NHS 111 first will help to keep patients safe and ensure that they are directed to the correct healthcare service. In addition, ambulance services will be implementing hear and treat alongside see and treat measures, which will help to ensure patients access the most clinically appropriate urgent and emergency care service.

28. Commissioning policies specify the services, treatment and care that will be provided to a population of patients with a certain condition or health need. We will **develop and manage commissioning policies** that reflect the needs

of the Armed Forces community and, where a bespoke policy does not exist, we will consider any requests for access to a service or procedure against the same criteria as requests relating to other local patients. We will review those requests on an annual basis to determine whether any new policies need to be developed. We will also implement any national clinical access policies that relate to treatments of low clinical value to ensure consistency across England.

29. The LTP commits to further improvements in services for those with musculoskeletal (MSK) conditions, such as back and neck pain, including direct access to MSK first contact practitioners. We will build on this work to ensure that the Armed Forces community has **access to MSK first contact practitioners** and, where appropriate, to DMS primary care rehabilitation services.

30. We will use Getting it Right First Time (GIRFT) and NHS RightCare methodologies to identify and **address unwarranted variation in the provision of care** for serving personnel and their families. A consistent offer in care will form part of the restoration of services in the NHS.

Key considerations for ICSs

- Having due regard to health and social care needs of the Armed Forces community in planning and commissioning high quality healthcare services.

Commitment 2:

Supporting families, carers, children and young people in the Armed Forces community

31. For families of the Armed Forces community, life can have additional worries and complications, including separation from spouses, partners, families and friends; social isolation; sudden caring responsibilities; frequent and unplanned moves; and bereavement. There is a growing body of evidence suggesting partners and spouses have an increased risk of developing mental health and wellbeing difficulties, if their serving partner is suffering from post-traumatic stress disorder (PTSD) or poor mental health.[7] Accessing the right services that are targeted to their needs can feel very challenging and, of the 22% of families who required access to mental health treatment in 2019, over half experienced difficulties or were unable to access the help they needed.[8]

32. Families can also face a range of issues in accessing public services, including healthcare, housing, education and employment. This is even more difficult if family members have additional needs due to a physical, mental health or learning disability. All of these difficulties can be compounded by local commissioning approaches which may mean that some families are also concerned about whether their treatment will be funded when they move to a new area.

Our commitments:

33. As set out in the Armed Forces Covenant, those in the Armed Forces community who are on a waiting list for treatment should **never lose their place on a waiting list** if they move from one area to another. Changing location should not result in a reduction in the quality of care or a gap in

7 (a) Donoho C, Laerd-Mann C, O'Malley C, Walter K, Riviere L, Curry J, Adler A (2017) Depression among military spouses: Demographic, military and service member psychological health risk factors, Depress Anxiety. 2018; 35: 1137-1144
(b) Turgoose D, Murphy D, A systematic review of interventions for supporting partners of military Veterans with PTSD (2019), Journal of Military, Veteran and Family Health, 5(2)2019

8 Page 19, Ministry of Defence (2020) UK Tri-Service Families Continuous Attitude Survey Results 2020 [Available from: https://www.gov.uk/government/statistics/tri-service-families-continuous-attitude-survey-2020] (20 August 2020)

the provision of services. NHS England and NHS Improvement will work with other commissioners and providers of healthcare, to ensure that this community is not disadvantaged by the frequency of their moves (a quarter of families moved house during 2019/20[9]) when accessing services and that their **treatment plans are not disrupted by this.**

34. We will also work with the Army, Navy and Royal Air Force Families Federations and other relevant organisations, such as service charities and the MOD, to **engage with Armed Forces families about their experiences of healthcare**. Our aim is to better understand families' health needs and the barriers to accessing healthcare they face and identify how we can improve the care and support provided to them. We will use the findings of an England-wide engagement exercise to help inform future improvements in care and support for Armed Forces families.

35. We will work with Public Health England (PHE) and the MOD to refresh the guidance 'The role of health visitors and school nurses: supporting the health and wellbeing of military families', which will help **health professionals support the health and wellbeing of children in Armed Forces families.**

36. Serving personnel and their families should have confidence that they are not missing out on the screening programmes that the NHS has determined would be beneficial for them. We will work with the MOD and PHE to ensure that all eligible DMS-registered patients are **automatically included in the NHS adult and child screening programmes**, including those for breast and bowel cancer, rather than relying on local manual systems.

37. **Reducing health inequalities through health promotion**, has never been so important; we will work with the Local Government Association to improve access for DMS-registered patients to health promotion services, commissioned by local authorities, such as those for weight loss, smoking cessation, alcohol and drug misuse, and sexual health support.

38. The LTP sets out how carers will receive the recognition and support they need. We will ensure that carers in the Armed Forces community can benefit from these developments by encouraging **adoption of Care Quality Commission (CQC) quality marks for carer-friendly GP practices** in the Royal College of General Practitioners (RCGP) veteran friendly GP practice accreditation scheme (see commitment 4, below) and raising **Armed Forces families' awareness of the support available to carers**.

39. We will **work in partnership with the MOD to provide good quality** healthcare services for the Armed Forces community, regardless of where commissioning responsibilities lie. The NHS and MOD are working together to jointly develop the Catterick Integrated Care Campus (CICC), a single integrated care hub, which brings together primary care from NHS and DMS, community and mental health services, social care services, and others, including the third sector schemes. The CICC will see a model of advanced

9 Page 23, ibid

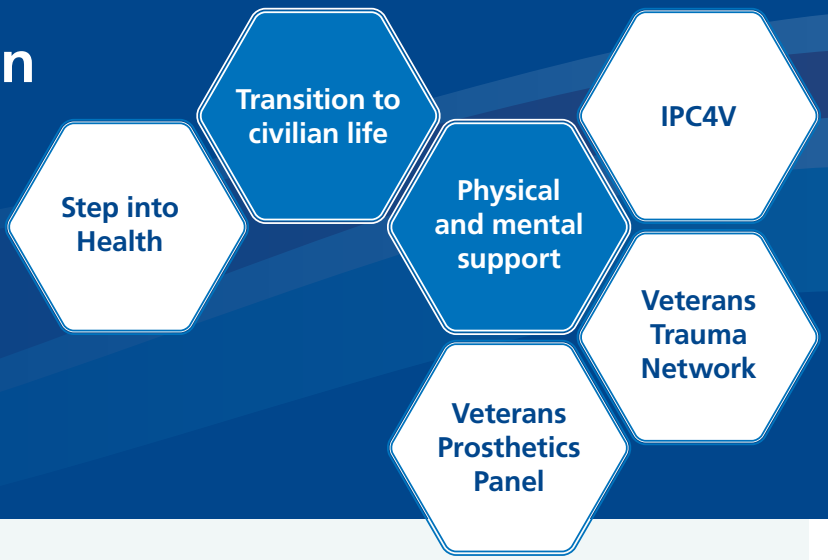
primary care, which builds upon the opportunities and new ways of working that have been generated as a result of the COVID-19 pandemic.

Key considerations for ICSs

- Ensuring provider access policies support the Armed Forces Covenant, particularly addressing the importance of continuity of care.
- Implementing The role of health visitors and school nurses: supporting the health and wellbeing of military families' guidance.
- Supporting access to local health promotion programmes for DMS registered patients.
- Considering how carers from the Armed Forces community can be supported in local carers' strategies.

Commitment 3:

Helping the transition from the Armed Forces to civilian life



40. Most serving personnel make the transition from Armed Forces to civilian life successfully, but for some service leavers and their families, the transition can be more difficult when the change is unplanned or when an individual has complex and enduring health issues. Service leavers can face a range of barriers in accessing the right care, including a lack of understanding of their illness or injuries and a failure to recognise the impact of traumas they may have experienced in service or on transition from military life. They may have limited knowledge of the services available to them and may seek treatment options outside the NHS without a proper assessment of their needs.

41. Armed Forces leavers with complex injuries or illness require a joined-up, personalised approach to their care that begins before they have left the Armed Forces. They need choice and control over how their care is planned and delivered; and need to be treated by health and social care professionals who understand the impact of their experiences. Armed Forces veterans tell us that accessing this kind of care over their lifetime can be difficult.

42. NHS England and NHS Improvement, together with the MOD, Armed Forces charities and those with lived experience, has developed the Armed Forces Personnel in Transition: Integrated Personal Commissioning for Veterans (IPC4V) Framework, which is a new, personalised care approach for Armed Forces personnel who have complex and enduring physical, neurological and mental health conditions attributable to their service. Through the support of a dedicated veterans' welfare manager, individuals have more choice and control over how their care is planned and delivered, with all the organisations providing care working in collaboration. This approach aims to put into place agreed health and wellbeing arrangements whilst the individual is still serving, ensuring that care and support starts at the right time and continues as they move into civilian life.

For more information, visit the NHS website at www.nhs.uk and search for Armed Forces

43. IPC4V builds upon other veteran specific programmes including the Veterans' Prosthetics Panel, which ensures that veterans can access the latest prosthetics technology and the best quality prosthetic care; and the Veterans Trauma Network (VTN) – designed by veterans and their families and supported by the service charities Blesma: The Limbless Veterans and Style for Soldiers – which is for veterans with service related physical injuries.

Our commitments:

44. We will expand the IPC4V programme to focus on veterans who have a long-term physical, mental or neurological health condition or disability. In 2021, we will establish pathfinder sites to test phase two of IPC4V, looking in particular at how personalised support can be provided to **veterans who have ongoing health and social care needs**.

45. The Veterans' Prosthetics Panel will continue to operate so that **veterans are able to access the latest technology** and be confident that their limbs will be replaced when needed. We will also work with the MOD to maintain access to the Complex Prosthetics Assessment Clinic for eligible veterans and we will explore whether there are further opportunities for the NHS and the MOD to work together in this way for the benefit of veterans with specialised physical health needs.

46. Many of the veterans treated by the VTN have complex mental health, chronic pain and physical health issues. We are **piloting joint VTN clinics with NHS veterans mental health services in London**, with the aim of rolling these out across England.

47. As the number of referrals to the VTN increases, including for injuries such as mild traumatic brain injury, we will continue to monitor the developing science, support the development of new pathways for these patients where they are needed, and involve those with lived experience in this work. **We will consider how the scope of the network could increase**, to reduce delays in transfers of care, and to link more closely to community care, social services and the IPC4V Framework.

48. Funded by NHS England and NHS Improvement, and aligned with the People Plan, Step into Health works with employers within the NHS to embed recruitment of ex-service personnel into existing practice and create effective local partnerships. Since 2017, Step into Health has facilitated the employment of over 700 veterans in the NHS and expects to support a further 500 gain employment in the NHS during 2020/21. The programme aims to at least maintain this level beyond 2021. To help achieve this ambition, **NHS England and NHS Improvement will be pledging its support to Step into Health as an employer ready to recruit ex-service personnel**.

49. NHS England and NHS Improvement has recently updated its policy on the employment of reservists and will work towards gaining recognition for this

in achieving an Employer Recognition award[10]. This will help NHS England and NHS Improvement to **recruit and retain the high-quality individuals that are or wish to be members of the reserve forces**.

Key considerations for ICSs

- Supporting the roll out of universal personalised care, including the veterans pathway.
- Engaging with the Step into Health programme and Employers Recognition Scheme.

10 https://www.gov.uk/government/publications/defence-employer-recognition-scheme/defence-employer-recognition-scheme

Commitment 4:

Identifying and supporting Armed Forces veterans

50. Veterans are individuals who have served for at least a day in the Armed Forces, whether as a regular or as a reservist. Generally, veterans report having similar standards of health to the general population.[11] This can mask some specific issues for particular groups or individuals, such as those with hearing difficulties, mental ill health and musculoskeletal conditions. Medical advances mean that veterans with service-attributable, life-altering injuries are living longer than previously, creating a need for life-long care.

51. Veterans have the same right as everyone else to enjoy positive physical and mental health. They also, under the Armed Forces Covenant, have a right to priority access to services when required as result of their service and subject to clinical need. Identifying veterans and their families, however, can be a challenge.

52. Veterans, their families and carers are a diverse group, and the NHS, cannot offer the support they require if they do not know about them. The first step in meeting their health needs is to find ways of identifying veterans within the general population. There is no central database of veterans and, even when veteran status has been disclosed – for example in a GP practice – that information may not be available to other health professionals involved in the veteran's care. Equally, veterans may choose not to declare their veteran status; this could be because they do not wish to disclose this information, they are unaware of the benefits of identifying themselves, or because they are not asked. As a result, they may not receive the priority or bespoke treatment for which they are eligible.

Our commitments:

53. To ensure serving personnel and their families are well-prepared as they leave the services, we will work with the MOD to ensure that they have enough information about NHS primary care services and that personnel are

11 https://www.gov.uk/government/statistics/annual-population-survey-uk-armed-forces-veterans-residing-in-great-britain-2017 (20 August 2020)

registered with an NHS GP before they leave. This includes knowing where to go for advice, such as the NHS website and the NHS app.

54. NHS England and NHS Improvement, in partnership with the RCGP, has developed a new scheme, the Armed Forces veteran friendly GP practice accreditation, which supports family doctors to better identify and then treat veterans. The scheme was piloted in the West Midlands and has since widened its scope so that all GP practices in England can apply for accreditation. We will work with the RCGP to roll out veteran-friendly accreditation across the country, prioritising those areas with high numbers of veterans and allowing interested practices to sign up ahead of planned implementation. We anticipate that, by 2022, all primary care networks (PCNs) will have at least one accredited practice.

55. We will work with newly-established PCNs to develop expert GP practices, which will support the **interface between NHS primary care and defence primary care services**. We will target this support in areas with high concentrations of Armed Forces families, reservists and veterans.

56. NHS trusts are also recognising their role in supporting veterans through the Veterans Covenant Healthcare Alliance (VCHA) – a group of trusts which have been accredited as 'veteran aware'. As of March 2021, 59 **NHS Trusts** have been accredited as veteran aware; our ambition is that all NHS Trusts, acute, ambulance, community and mental health, should meet this standard, as veterans seek treatment from all these providers. This programme will also be rolled out across hospices and the independent healthcare sector.

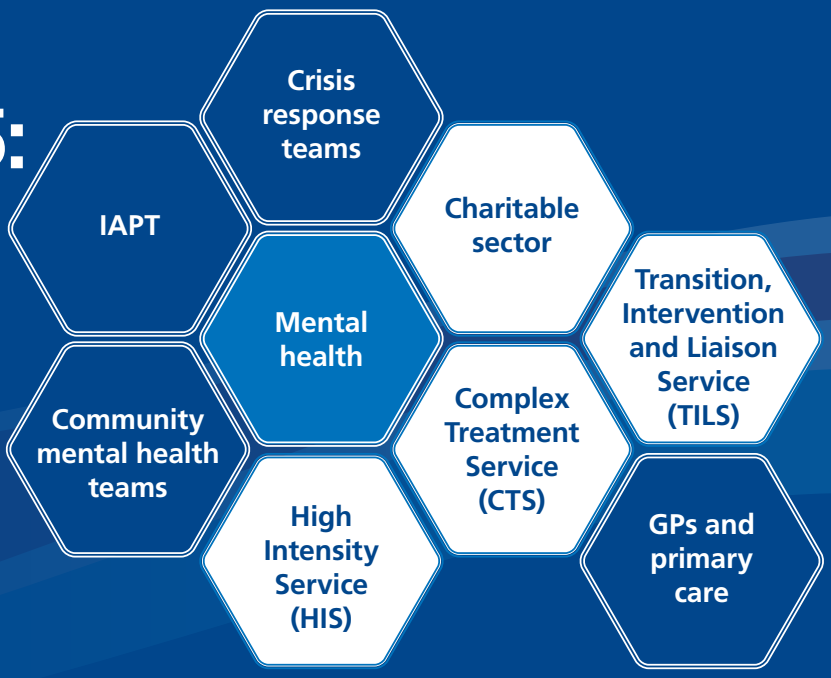
57. Individual clinicians also need to be aware of the specific needs of veterans and how they can meet them. We have worked with the RCGP to include Armed Forces health in the curriculum for trainee GPs, with significant involvement from NHS England and NHS Improvement's Clinical Reference Group for Armed Forces healthcare. We are now working with other Royal Colleges to **support and promote the use of the revised Health Education England and RCGP veterans awareness training modules** amongst a wider group of NHS staff, including medical staff, nurses and allied health professionals.

Key considerations for ICSs

- Supporting practices to become veteran friendly accredited under the RCGP scheme.
- Building relationships at 'place' level with local DMS practices to support the interface between Defence and NHS primary care.
- Supporting providers to become accredited under the VCHA.
- Promoting the use of veteran awareness training modules in local training needs.

Commitment 5:

Improving veterans' and their families' mental health



58. Although evidence suggests that veterans' health and wellbeing is generally consistent with – or better than – the rest of the population, leaving the Armed Forces and its culture can sometimes create challenges.[12] This can include loss of social support networks, relationship problems and difficulty finding employment. In the most extreme circumstances, it can lead to more serious issues, such as homelessness and substance or alcohol misuse.

59. Mental healthcare provision for veterans needs to be multi-layered. It should begin by focusing on the support provided by the veteran's family and home environment and should increase in intensity as an individual's need becomes greater. Mental health services need to be good quality, joined-up and easily accessible.

60. To improve access to the right support, three dedicated mental health services are in place for veterans and service personnel who are making the transition to civilian life, including reservists. These are the Veterans' Mental Health Transition, Intervention and Liaison Service (TILS) and the Veterans' Mental Health Complex Treatment Service (CTS) and the Veterans' Mental Health High Intensity Service (HIS) pathfinders. Together these three services constitute Op COURAGE: The Veterans Mental Health and Wellbeing Service.

61. The TILS works with the MOD to offer mental health support to those in transition from the Armed Forces, along with providing treatment to veterans and helping them to veterans access mainstream mental health services.

62. The CTS is an enhanced outpatient service for ex-serving personnel who have service-related, complex mental health difficulties that have not improved with previous treatment, it is accessed via the TILS.

63. There is a cohort of patients for whom additional, intensive support is needed and so, in partnership with stakeholders, we have developed and implemented the HIS pathfinders. These are pilot services, which started to launch in the

12 Page 18, The Strategy for our Veterans, Ministry of Defence, 2018. Available from: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/755915/Strategy_for_our_Veterans_FINAL_08.11.18_WEB.pdf (20 August 2020)

autumn of 2020, supporting veterans who are in a crisis and / or need urgent or emergency mental healthcare. The services provide crisis care, therapeutic inpatient support, help with coordinating care across organisations and support and care for family members and carers where appropriate.

64. Findings from these pilots will help to infirm future provision for this patient group which, together with the TILS and CTS, stand alongside the full range of NHS provided mental health services available to everyone in England.

65. This approach is intended to fully join up mental health care pathways so that coordinated decisions are made in the most effective way possible to improve outcomes for veterans.

Our commitments:

66. Over the next five years, we will expand our support for all service leavers and veterans, regardless of when they leave the Armed Forces. We will work with the MOD to **identify service personnel who should be referred to TILS as they leave the Armed Forces**, to ensure there is no break in care. We will also **increase the capacity of the TILS and CTS and improve local access**.

67. We will implement a clinical registry to **record patient outcomes** over time for veterans accessing The Veterans Mental Health and Wellbeing Service. This will help to inform future veterans mental health service models.

68. We will work with Armed Forces charities to **develop and implement a common assessment framework for veterans mental health services**. This framework will join up assessment processes across NHS providers and the charitable sector, provide veterans with a single reference point for their mental health needs, standardise documentation and speed up information sharing.

69. We have awarded grants to the charitable sector to accelerate the use of social prescribing to reduce isolation. We have also ensured that veterans and families are able to access online support services like TogetherAll. In the longer term, we will take account of patient experiences of these services and the learning and insight from HIS to inform a final **integrated mental health service model** that incorporates the TILS, CTS and HIS (Op COURAGE: The Veterans Mental Health and Wellbeing Service) into a single care pathway that builds on the digital transformation of services that started during the pandemic.

Key considerations for ICSs

- In addition to local actions to implement mental health services and develop provider collaboratives, improving the recording of ex-British Armed Forces indicator in data sets (Improving access to psychological therapies (IAPT) and Mental Health Services Data Set).
- Ensuring that the Armed Forces community can access local mental health services.
- Providing a 'parity of esteem approach' to trauma services to offer a holistic response to each individual in need of care and support, with their physical and mental health needs treated equally.

Commitment 6:

Supporting veterans in the criminal justice system

70. The number of veterans within the criminal justice system is proportionally low compared to the general population. This means that a small number of veterans are known to the criminal justice system, either through police custody or the prison or probation services. Veterans with complex needs, however, can be at increased risk of offending if they are not properly supported.[13] These individuals may not be receiving the care and treatment they need before, during or after custody and may have long-term and complex needs, including substance and alcohol misuse or mental illness. A recent study found that veterans referred to liaison and diversion services were more likely to have an anxiety disorder and depression than the general population.[14]

71. Service charities also provide valuable support in criminal justice settings, but access is inconsistent. Alternatives to custody exist, such as **community sentence treatment requirements**, but these are alternatives that are not always investigated for veterans.

72. Veterans may enter the criminal justice pathway; when they self-refer or are referred by a third party, or when they come into contact with the police under suspicion of having committed a criminal offence. The services that form the pathway need to be available in a range of locations, to support access at the point of need. This includes police custody suites, magistrates' courts and Crown Court, prisons and community settings.

73. Services need to continue through all points of the criminal justice pathway, but the earlier the point of contact, the better the outcome is likely to be for both the individual and the criminal justice system. The pathway includes a prison release process, which begins 12 weeks before discharge and involves consideration of housing, education and employment, as well as clinical needs, such as alcohol or substance misuse.

13 Community Innovations Enterprise (2016) From Gate to Gate https://bulger.co.uk/prison/From%20Gate%20to%20Gate%20%288th%20September%202016A%29%20%281%29.pdf

14 Short R, Dickson H, Greenberg N, MacManus D (2018) Offending behaviour, health and wellbeing of military veterans in the criminal justice system, PLoS ONE 13(11): e0207282.

74. NHS England and NHS Improvement, in partnership with Care After Combat, Project Nova (a collaboration between Walking with the Wounded and RFEA the Forces Employment Charity) and Nottinghamshire Healthcare NHS Foundation Trust, is testing a veterans whole care criminal justice pathway in the form of the Veterans ReGroup programme. This will join up a range of services aimed at reducing rates of offending and re-offending amongst veterans and provide co-ordinated care and support to help meet the specific needs of veterans and their families.

Our commitments:

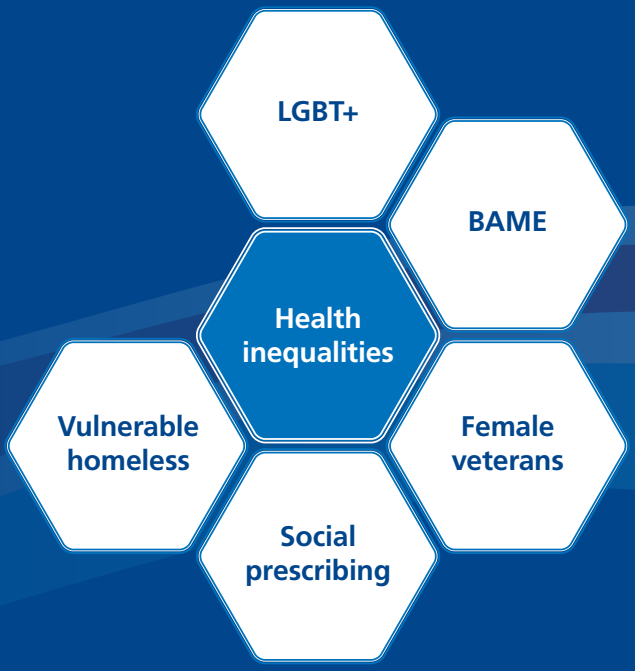
75. We will use learning and evaluation from the current pathfinders to **develop a service model that meets the needs of veterans and can be commissioned in all parts of England from 2022**.

Key considerations for ICSs

- Ensuring that plans to support those experiencing mental health crisis support, include safer custody and national suicide prevention work.
- Supporting local services to deliver the community sentence treatment requirement programme as an alternative to custodial sentence.

Commitment 7:

Identifying and addressing inequalities in access to healthcare



76. There are around 2.1m veterans in England with the number of veterans over the age of 65 predicted to fall over the next decade and the number of veterans aged over 90 likely to double. Currently, around 10% of veterans are female, which is expected to rise to 13% by 2028.[15]

77. There is a growing number of Black, Asian and Minority ethic (BAME) serving personnel, including the Gurkhas from the Nepalese community, as well as members of the UK, Commonwealth and other overseas populations, who can experience greater health inequalities than other ethnic groups. As of April 2020, this group represents 8.2% of serving personnel.[16] As the serving population grows, so too will the number of veterans from these communities.

78. In line with the general population, we anticipate that some of the same issues of vulnerability to illness and disease will be present. These will be caused by a variety of factors, including genetic predisposition to certain health conditions and stigma around mental health. Due to good occupational health services within DMS and rigorous health screening at selection, there is less likely to be differential rates of access to healthcare. Data on ethnicity is currently poor for both serving and veteran populations and small population sizes for individual groups make statically significant data difficult to obtain.

Our commitments:

79. The LTP commits the NHS to addressing health inequalities, which along with the health inequalities highlighted by COVID-19 and Black Lives Matter, illuminates the importance of focusing on specific and measurable actions that should be taken by the NHS. In support of this, we will develop **bespoke plans to address health inequalities for our BAME population**.

15 https://www.gov.uk/government/publications/population-projections-uk-armed-forces-veterans-residing-in-great-britain-2016-to-2028 (20 August 2020)

16 https://www.gov.uk/government/statistics/uk-armed-forces-biannual-diversity-statistics-2020 (20 August 2020)

80. We will also work with the MOD and other healthcare providers to improve the collection and recording of ethnicity data, so that inequalities can be identified and addressed. Furthermore, we will ask providers to prioritise those in groups at significant risk of COVID-19.

81. With the proportion of female veterans increasing, during 2021/22, we will undertake engagement work with **female veterans to better understand their physical and mental healthcare needs**. The outcomes of this will inform the actions we need to take to ensure that the services we commission – such as veterans mental health services - are appropriate, inclusive and accessible.

82. We will **work with the LGBT+ Armed Forces community** to determine the specific physical and mental healthcare needs of these individuals. We will use this engagement process to further develop our commissioning policies and consider how best to deliver personalised care that supports the LGBT+ community's health needs and experiences.

83. We will be developing a **cross-cutting transformation programme around all health inequalities in the Armed Forces community population**. As part of this, we will work closely with our regional teams and local systems led by ICSs, the Armed Forces and charitable organisations to identify and tackle the changing needs and challenges for veterans in England.

84. We will work with the military charitable sector to **develop the role of social prescribing in relation to the Armed Forces community**, building on the grants we made during the pandemic. Our aim is to ensure that serving personnel, veterans and their families can access this support, and that it is linked to The Veterans Mental Health and Wellbeing Service.

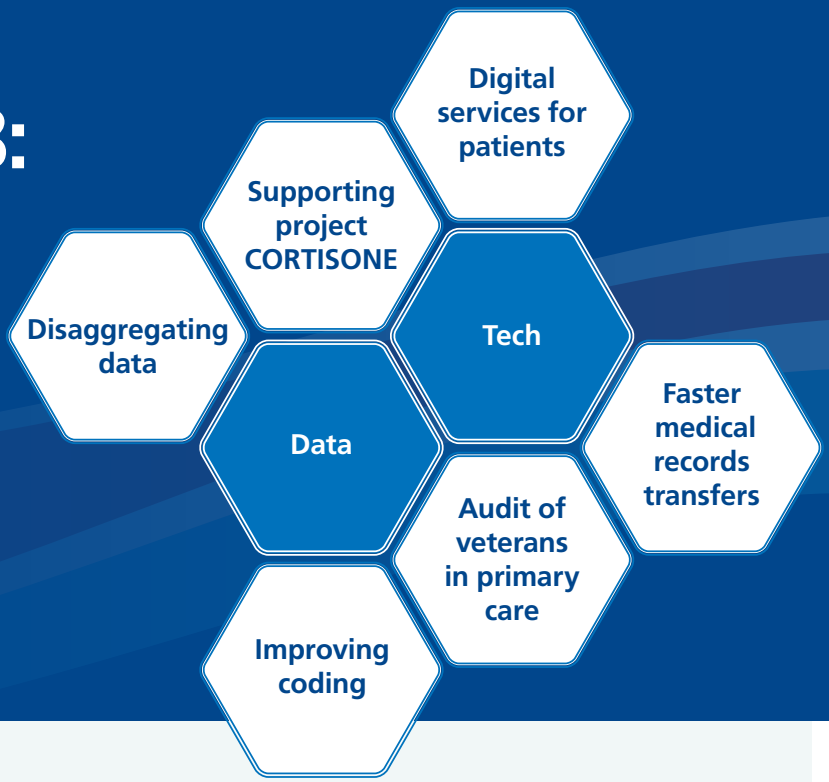
85. For the most vulnerable veterans who are experiencing homelessness, we will work with providers of services to the homeless community – including GP practices – to **raise awareness of statutory and charitable sector services and support available to veterans**. In parallel, we will work with our commissioned providers to ensure that our services are accessible to veterans with no fixed abode or who are not registered with a GP.

Key considerations for ICSs

- Improving the quality of protected characteristics demographic data to enable better assessment of equality impact.
- Thinking about how the Armed Forces community can be supported through social prescribing programmes – do local offers reflect their needs?
- Raising awareness of the needs of veterans in commissioned homelessness services.

Commitment 8:

Using data and technology to improve services



86. All our commitments are underpinned by a need for effective information sharing across organisational boundaries. NHS England and NHS Improvement, NHS Digital and MOD's ambition is for medical records to be shared in a timely, accurate and appropriate way to enable serving personnel and their families to move seamlessly between services. This is consistent with developing and implementing a full shared care record, allowing the safe flow of patient data between care settings, and the aggregation of data for population health.

87. The MOD is introducing a new Armed Forces medical information system for the DMS through its CORTISONE programme. A core component of CORTISONE is a comprehensive electronic health record capability that can interface with external providers. Importantly for the NHS, it will fully connect with the NHS Spine – allowing the exchange of electronic medical information and e-referrals between DMS and NHS providers.

88. The collection and sharing of data about how service personnel, veterans and their families use the NHS, along with information about their treatment and health outcomes, is also important and can help NHS England and NHS Improvement commission better services that meet patients' needs.

89. Whilst work is in progress to record and share data across organisational boundaries, such as recording veteran status in primary care and mental health systems, this is not done consistently.

Our commitments:

90. To support a smooth transition from service to civilian life, particularly for the wounded injured and sick, we are **streamlining the process of releasing service leavers' medical records** and improving their transfer to NHS GPs.

91. We will work with the MOD to **support the introduction of CORTISONE as smoothly and as swiftly as possible to support continuity of care** and the

provision of good quality care.

92. We will work with the MOD and NHS Digital to ensure that DMS-registered patients can benefit from the **range of digital NHS services** to which the rest of the population have access.

93. We will work with the MOD to ensure that they are able to **access the full range of services through the e-Referral service** (eRS). In addition, we will look to maximise the use of advice and guidance functionality to support social distancing and remote consultations, enabling military consultants in the NHS to support a greater number of service patients across England.

94. We will work with regions, providers and the MOD to ensure that DMS patients can benefit from patient initiated follow-ups (PIFU).

95. To fully understand the needs of the Armed Forces community, and therefore deliver the best standard of care, NHS England and NHS Improvement will:

    - work with healthcare providers, including primary, community and acute services, to help the consistent and accurate coding of activity relating to patients from the Armed Forces community.
    - work with NHS Digital and the GP Extraction Service to carry out a national audit of the number of veterans that have their veteran status recorded in their GP records. The results of this audit will serve as a baseline against which we will measure improvements in the recording of veterans.
    - Analyse the outcome of the 2021 Census, which will contain a question on previous Armed Forces service to better understand the health needs of veterans.

Key considerations for ICSs

- Working with healthcare providers, across all care settings, to consistently and accurately code the activity relating to patients from the Armed Forces community.

Commitment 9:

Driving research and innovation in Armed Forces healthcare

96. Our ambition is to support and encourage investment in areas of research and innovation that we believe will be transformative for the Armed Forces community, including research into areas where the evidence base is less clear.

Our commitments:

97. We will work with partners in the NHS, MOD, third sector and academic institutions to **commission research that will strengthen the evidence base in identified priority areas**.

98. To better understand the clinical effectiveness of osseointegration implants for amputees, we will commission an **international review of the currently available research on the clinical effectiveness** of these procedures. This will include consideration of the individuals that received direct skeletal fixation during the MOD's funded programme that began in 2015. This research will allow the NHS to consider whether to recommend the procedure for routine commissioning and, if it should, under what circumstances.

99. In partnership with the MOD and NHS research centres across England, we will support an evidence review of the research on the **long-term impact of service-acquired brain injuries in the veteran community**. This research will provide monitoring information over a longer period to support commissioning decisions for the veteran community.

100. As a priority we will build on national research into health inequalities to better understand the **specific needs of the BAME Armed Forces community**. We will also commission further reviews to help understand the wider needs of the Armed Forces community. The first will aim to better understand the health needs of female veterans, particularly those veterans with sexual, physical and mental trauma. The second will focus on the specific needs of the **LGBT+ Armed Forces community**. These reviews will influence future commissioning of services to ensure we can deliver patient-centred care.

101. We will undertake research to investigate how the **families and children of serving personnel** are affected by an individual's service.

102. We will build on national work on **Hidden Harms**, such as domestic abuse and violence, to understand the impact within the Armed Forces community and how this might be addressed.

103. Over the next year, NHS England and NHS Improvement will work with pilot sites who are already engaged in suicide prevention work to **understand the rate and causes of suicide in the veteran population** and develop good practice in suicide reduction for this group.

104. NHS England and NHS Improvement, in partnership with the MOD, has also commissioned Manchester University to investigate **suicide risk amongst those who have left the UK Armed Forces** and make comparisons with the general population. This study will be completed by the end of 2022 and will help to inform future partnership work on suicide prevention.

Key considerations for ICSs

- Including Armed Forces communities in local suicide prevention initiatives and bereavement support services.
- Having due regard for the health and social care needs of the Armed Forces communities in all local research plans and needs assessments.

Conclusion

105. This forward view sets out the commitments and supporting initiatives that we are taking to deliver better health and wellbeing, better quality of services for the Armed Forces community and sustainable use of resource within the NHS.

106. However, we cannot deliver this in isolation and will need the support of our health colleagues to achieve our ambitions. This forward view is an opportunity to work with the emergent ICS partnerships to ensure that the needs of the Armed Forces community are reflected and addressed in local plans and strategic direction of systems.

107. The commitments provide a framework for discussions with ICS partnerships as to the key health issues for the Armed Forces community and offer flexibility as to the implementation of initiatives as a reflection of system maturity. In support of this, we have set out a number of key considerations for ICSs.

108. This forward view is not just for the NHS, it is for our partners in Defence and across the third sector, setting out our vision for health and wellbeing for the Armed Forces community. The pandemic has shown this that there is synergy in joint working and this will continue into the future as we all work towards our common goal of health and wellbeing improvements for the Armed Forces community.

109. We have not set out any explicit actions for our partners, however we recognise that our plan will only be delivered through cohesive efforts. As *Integration and Innovation: working together to improve health and social care for all* has set out, we need to work together to support physical, mental, social and economic needs of our population. As partners we all have a role to play in this, either directly delivering care or services; as an employer; or supporting the members of the Armed Forces community to achieve a positive state of health and wellbeing.

110. Finally, and most importantly this forward view is for our patients, for those who need to use the services of the NHS and for those who support them to do so. It sets out our commitment to improve services for them, so that they know that we will honour the nation's moral obligation to them and that we will support, respect and treat them fairly.