



Framework for patient and public participation in armed forces commissioning

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Framework for patient and public participation in Armed Forces Commissioning

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Summary of key points and actions for armed forces commissioners

- Patient and public participation is an essential component of commissioning, and should be considered at all stages of the commissioning cycle (planning, buying and monitoring health and care services).
- NHS England commissioners should work in partnership with the Ministry of Defence, and others to make health services for the armed forces community joined up and effective.
- Consider the need for - and best approach to – participation, depending on the situation, the population in question, and existing sources of information and insight; these sources may be national, regional or local.
- Keep good records of your approach to participation including how you have assessed the legal duty to involve the public in commissioning.
NHS England commissioners are required to document their assessment of whether Section 13Q (the legal duty to involve the public in commissioning) applies using the [standard form available on the NHS England intranet](#).
- Plan for participation – including identifying benefits (with measures of impact where appropriate) and costing participation activity; participation plans need to be factored in to overall business planning and programme planning.
- Involve people early on, not as an afterthought.
- Involve people in ways that are appropriate to their needs and preferences, and provide them with the necessary information, resources and support to enable them to participate.
- Work with and through partners in involving people, including other commissioners, providers, patient and public networks, Healthwatch, and the voluntary and community sector.
- Feed back to those you have involved about the impact of their participation. Explain how their participation has influenced commissioning, and if not, why not.
- Document and report on participation activities and **impact** for assurance and quality improvement purposes, publicising and celebrating success and sharing learning.

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1 Introduction

This framework is a guide for armed forces commissioners - and anyone who is interested, including patients and the public, the voluntary sector, and providers of health and social care services – on how to involve patients and the public in the commissioning of health services for the armed forces community. Our definition of ‘patients and the public’ includes service users and carers and the definition of commissioning is ‘how people are involved in planning (policy making and relevant programmes), buying and monitoring services’. The armed forces community and the range of services for them are described in section 2.1 and 2.2.

Whilst participation is an essential consideration in our work, and is not merely a ‘nice to do’ task, we recognise that it can take many different forms. For example, patients and the public may be involved through consultation, by being sent a newsletter, or through face to face meetings.

The framework is designed to be read in conjunction with the NHS England [Patient and Public Participation Policy](#) and the [Statement of Arrangements and Guidance on Patient and Public Participation in Commissioning](#).

The policy sets out our ambition to strengthen patient and public participation in all of our work, and how we intend to achieve this. This is in line with the vision for the NHS to achieve better health, better patient care and improved NHS efficiency, as set out in the [Five Year Forward View](#). Our values are rooted in the [NHS Constitution](#), which states that the NHS belongs to us all. Our policy and associated documents are based on the belief that health services and outcomes are better when people who need, use and care about services have meaningful opportunities to be involved in them.

The Statement of Arrangements is for NHS England commissioners working in all areas of direct commissioning (primary care, public health, health in justice, specialised services and services for the armed forces). **It identifies where our legal duty to involve the public in commissioning under Section 13Q of the Health and Social Care Act 2006 (as amended) applies.** It sets out guidance for commissioners on how to involve the public, including:

- Principles for fair and proportionate involvement
- When public involvement should take place
- Case studies.

This framework has been co-designed with the Armed Forces Patient and Public Participation and Involvement Group (AF PPIIG), membership of which is shown in the acknowledgements section.

2 Context

2.1 Who are the armed forces community and what are their key health needs?

The armed forces community includes:

- Serving personnel
- Reservists
- Veterans
- Families of serving personnel, reservists and veterans
- Carers.

The table below shows the population of serving personnel and reservists as at 1 January 2016.¹

	Naval Service	Army	Royal Airforce
Regulars	29,800	80,300	31,160
Reservists	2,270	22,550	1,820

The number of family members registered with [Defence Medical Services](#) (DMS) is approximately 15,000².

[The Annual Population Survey](#) 2016 estimates that there are currently 2.2 million veterans in England (2.6 million in Great Britain) of whom 52% are 75 years of age or over.

Serving personnel

Serving personnel are individuals who are currently serving as members of the Naval Service (including the Royal Navy and Royal Marines), Army or Royal Air Force. The health of serving personnel is of critical importance to the services' ability to function. There is an explicit requirement for the DMS to consider the impact of any illness or injury on serving personnel's ability to do their job (occupational health). The DMS ensures that serving personnel receive treatment which meets the needs of both the individual and the service.

Families of serving personnel

Service families are much more geographically mobile than the general population with 27% of service families moving at least once during the past 12 months³. There are also significant periods of separation for families with the worry of illness, injury and death during military deployments.

¹ [Government statistics on the location of armed forces personnel](#)

² Ministry Of Defence, Quarterly NHS Commissioning Population Statistics 1 July 2016

³ Ministry of Defence (2015) Tri-Service Families Continuous Attitude Survey 2015

Accessing NHS services can be challenging, particularly when their families need to move from one geographical area to another, with care differing between areas.⁴

Reservists

The Armed Forces also consist of reservists. These personnel have a 'reduced commitment', tend to live in their own home, hold a civilian job and fulfil their military commitments in their spare time. However they can also be mobilised,⁵ at which point they are treated the same as serving personnel until they are demobilised, when they become veterans. There are also reservists who undertake periods of Full-Time Reserve Service with differing levels of commitment. Those serving under Full Commitment (FC) conditions of Service are entitled to DMS registration.

Veterans

Veterans are those who have served for at least a day in HM Armed Forces, whether as a regular or as a reservist.

As this is such a varied group, reaching and engaging them can be a challenge. Not all veterans are registered with a GP⁶ or have declared their veteran status to their GP. They may suffer disadvantage if their veteran status has not been recognised. In these circumstances they may not receive priority or bespoke treatment, which they are eligible for under the [Armed Forces Covenant](#).

Different age groups of veterans have differing needs. For example veterans aged 16 to 54 are more likely to experience [common mental health problems](#), such as [depression and anxiety](#), than comparable age groups in the general working population.⁷

Families and carers of veterans

Families of veterans are geographically spread over the whole nation and this creates a difficulty in not only identifying the veteran/family/carer, but also their specific needs. Family members and carers may face significant stress in the transition to civilian life, including in relation to their physical and mental health. Social isolation is particularly pertinent in families and carers as they are no longer supported within the 'Forces family' environment and are left to access services within the complex civilian systems.

⁴ Better Understanding the Support Needs of Service Leaver Families, 24 February 2015

⁵ Reserve Forces Act 1996

⁶ Source: Call to Mind: A framework for action, Community Innovations Enterprise on behalf of the Forces in Mind Trust and NHS England, pg. 24, June 2015

⁷ Source: Call to Mind: A framework for action, Community Innovations Enterprise on behalf of the Forces in Mind Trust and NHS England, June 2015

Health needs associated with service life

The nature of service life gives rise to a number of health needs that are specific to this population. They may manifest themselves in-service, as a reason for discharge, or emerge after service. These include:

- Increased incidence of musculo-skeletal injuries
- Mental health issues
- Higher than average misuse of alcohol
- Noise-induced hearing loss
- Non-freezing cold injuries also known as ‘trench foot’
- Stress associated with frequent moves and separation between service personnel and their families.

The health needs of armed forces personnel (including reservists and veterans) may impact significantly on the mental and physical health of their family members and carers.

2.2 Services for the armed forces community

NHS England has been commissioning services for the armed forces and those families registered with a DMS practice in England since 1 April 2013.

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 (serving personnel and families registered with DMS).

Community and mental health services are currently managed through a national risk-share agreement between NHS England and local clinical commissioning groups (CCGs).

NHS England is also the lead commissioner, or provides support arrangements, for other services, such as cervical screening for DMS registered patients overseas, or out of hours primary care services.

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 healthcare when on active operations and prior to return to the UK
- Rehabilitation services for musculoskeletal (MSK) and some neurological services for serving personnel
- Mental health community and inpatient services for serving personnel (but not families).

Hospital based medical welfare services for service personnel and their families are provided by the [Defence Medical Welfare Service](#).

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 (National Health Service Act 2006).

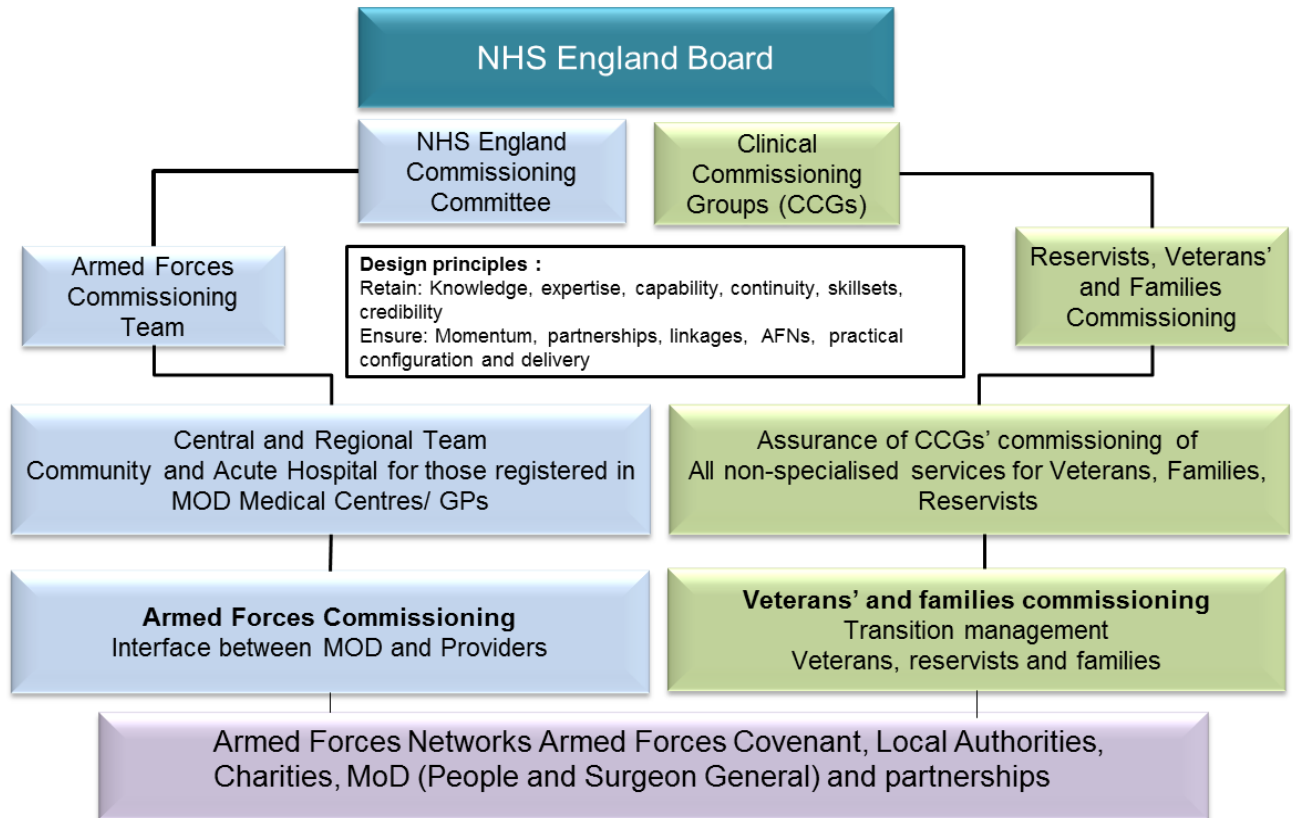
NHS England has specific duties and separate funding to commission the following veterans' services:

- A small number of veterans' mental health services, including online and specialised residential services and veteran specific psychological therapies in response to '[Fighting Fit](#)'⁸
- 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
- Online psychological support services for veterans and families
- Inpatient post-traumatic stress disorder (PTSD) services for veterans.

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 where the provider of the care that they receive is located.

⁸ Ministry of Defence(2010) Fighting fit: a mental health plan for servicemen and veterans

NHS England - Armed Forces (AF) Health



This framework supports the [Armed Forces Covenant](#), under which the NHS has a number of duties:

- The armed forces community should enjoy the same standard of, and access to, healthcare as that received by any other UK citizen in the area they live.
- Family members should retain their place on any NHS waiting list if moved around the UK due to the service person being posted.
- Veterans should receive priority treatment where it relates to an injury or condition as a result of their military service, subject to clinical need.
- Those injured in service should be cared for in a way that reflects the nation's moral obligation to them, by healthcare professionals who have an understanding of armed forces culture.

The delivery of the Covenant requires NHS England to work in partnership with multiple stakeholders. In the public sector these include:

- Ministry of Defence (MOD):
 - Surgeon General for healthcare delivery and expertise
 - Chief of Defence People for veterans and tri-service welfare
 - The individual chains of command of the three armed services: Royal Navy, Army and Royal Air Force

- Reserve Forces and Cadets Associations and its national council.
- Local authorities and their representative bodies such as the local government association (LGA) and increasingly devolved parts of the health and social care system.
- Other parts of the health system including:
 - Public Health England
 - Health Education England
 - NHS Improvement
 - NHS Digital
 - NHS providers and their representative, such as NHS Employers
 - CCGs
 - Department of Health and devolved administrations' health systems
 - Providers of care inside the justice system.(relating to veterans involved in the justice system).

They also include non-public sector partners such as:

- Service charities and their umbrella bodies such as the Confederation of British Services and Ex-services Organisations (Cobseo)
- Charity and private providers of care to veterans and service personnel.

These relationships are managed through the armed forces commissioning teams and through a series of armed forces networks (AFNs) - see section 3.2.

Case study: Working with the voluntary sector on veterans' prosthetics care

Veteran 'J W' was commissioned by the Royal Marines Charitable Trust Fund and the [Blesma Association](#) to write a report examining the reasons why a small number of veterans were going overseas for their prosthetics care. J W is one of the veterans who has received care from both the NHS and an overseas provider and is therefore uniquely placed to describe the experiences of veterans in the various systems.

J W's report, 'Improving clinical care for veteran trans-femoral amputees', includes interviews with a number of veterans and makes recommendations about how the care of a very small cohort of veterans could look going forward. One of his recommendations is that veterans could be cared for, after service discharge, at the Defence National Rehabilitation centre (once opened) and by Defence Medical Rehabilitation Centre (DMRC) Headley Court in the interim.

NHS England and the MOD have worked together with Blesma to agree a pathway that sees a small cohort of veterans, such as those described by the report, receiving short term prosthetics care at DMRC Headley Court when the NHS has not been able to meet the veterans' needs.

More information related to the above case study can be accessed in the [White report](#).

2.3 Equality and health inequalities considerations

NHS England has a legal duty to promote equality and to have regard to reduce health inequalities⁹. NHS England has completed an [Equality and Health Inequalities Analysis \(EHIA\) for the NHS England Patient and Public Participation Policy and associated documents](#), which is available on the NHS England website.

Participation should be inclusive, and targeted towards those who may experience barriers to accessing services and poorer health outcomes than average, including those eligible to access services who do not use them.

Activities should be planned and adapted to ensure equitable access to public participation opportunities regardless of a person's cultural, linguistic, religious background, communication and accessibility needs. Participation activities should have regard for the nine protected characteristics as defined under the Equalities Act 2010:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race
- Religion or belief
- Sex
- Sexual orientation.

People from these protected characteristic groups can experience barriers to participation. Potential barriers are described in the participation policy EHIA referenced above, along with recommendations and resources for reducing the barriers.

Participation budgets should support accessible engagement. This means that commissioners should have allocated funds to pay for accessible venues and offer catering at events that are suitable for special dietary needs. NHS England has a clear [expenses policy](#) that ensures individuals are not out of pocket as a result of participation.

Commissioners are required to support the [Accessible Information Standard](#). This mandatory standard aims to make sure that disabled people have access to information that they can understand and any communication support they might need.

Auditing and monitoring participation of equalities protected groups, e.g. in events and formal governance roles, supports commissioners to manage and improve performance, patient experience and outcomes by involving a diverse range of services users.

⁹ Equality Act (2010), Health and Social Care Act (2012)

3 Governance, reporting and assurance

NHS England is committed to involving patients and the public at each stage of the commissioning cycle for armed forces services. The commissioning cycle refers to the different activities that make up the process of planning and buying health services and ensuring that services are being delivered to the right quality standards and within the available financial resource.

NHS England commissioners and those working on national policy and programmes that affect how armed forces services are commissioned should consider participation as an integral part of commissioning. Participation can add value at all stages of the commissioning cycle and can happen using a range of methods.

The diagram below shows some ways that commissioners may involve patients and carers in armed forces commissioning.



Case study: Developing mental health services for veterans

In January 2016, NHS England launched a national engagement on NHS veterans' mental health services. The purpose of the engagement was to seek views from veterans, family members and carers, as well as staff and organisations providing treatment and support in this area, to help inform future service provision from April 2017.

Prior to the launch of the engagement, a thorough analysis of existing insight around the mental health needs of veterans took place; [Call to Mind: A framework for action](#) was of specific relevance in helping to inform the engagement plan.

NHS England began a programme of pre-engagement to prepare for and inform the engagement. This included meeting with a number of service charities (SSAFA, Royal British Legion and Poppy Factory) and key stakeholders (NHS Armed Forces Networks (AFNs), the NHS England Armed Forces Patient and Public Participation and Involvement Group and Cobseo networks) to discuss the engagement and how best to reach veterans and their families. The insight captured from these discussions and meetings helped to inform the engagement approach and production of supporting materials, which included an engagement document, questionnaire, leaflet and poster (all written in plain English). These were tested with a wide range of people, including veterans (users and non-users of veterans' mental health services), families, commissioners, clinicians and mental health professionals. This helped to ensure the material was easy to read and understand and used the correct terminology in relation to the armed forces. As a result of the feedback received, the questionnaire was split into six parts to make it easier for people to respond to specific questions that related to them.

NHS England needed the support of a wide range of organisations and stakeholders to help raise awareness of the engagement. A supporting toolkit was therefore produced for sharing. It included the engagement material, along with copy for newsletters, websites, intranets and Twitter, discussion aids, a slide pack and briefings. This was sent to NHS trust, CCG and local authority communications and engagement colleagues, HIVEs, Healthwatch, AFNs, Cobseo, service charities, existing providers of veteran's mental health services and other interested parties.

Veterans are considered a group at risk of experiencing health inequalities, which was important to consider for the engagement. NHS England therefore undertook the following activity to help support their involvement:

- Sought the help of SSAFA in promoting the engagement with its 6,500 volunteers, including prison in-reach volunteers.
- Attended the national Cobseo Criminal Justice System Cluster meeting to discuss the engagement and how best to involve veterans in the criminal justice system. This was followed with regular engagement updates and sharing of the engagement toolkit to support local activity.
- Provided regular engagement updates and the toolkit via Cobseo's weekly newsletter and website to encourage service charities to respond and promote locally with veterans and their families.
- Translated the engagement document, questionnaire and poster into Nepalese to support the involvement of the Gurkha community. They were tested with The Gurkha Welfare Trust, and promoted via their channels.
- Offered respondents a range of ways in which to respond. This included an online questionnaire (available on the NHS England engagement web portal)

a hard copy questionnaire that could be returned in an accompanying freepost envelope, and face to face, email or telephone questionnaires. People also had the option to request alternative formats and languages if required.

- Sought the help of Big White Wall (a national anonymous digital service that supports people experiencing common mental health problems) in reaching veterans and their families. They emailed registered veteran and family member users and promoted the engagement via their website, Facebook and Twitter accounts.
- Recognised the stigma associated with mental health and included statements in the engagement document and online questionnaire confirming that people's responses would remain anonymous and would only be used to inform decisions about veterans' mental health service provision. Respondents were also given the choice as to whether or not they provided personal details.
- Asked for the support of Homeless Link and Crisis to raise awareness of the engagement amongst their volunteers and networks.
- Arranged media interviews and a series of blogs that featured veterans with mental health difficulties and a family member.

In total, 1,274 people and organisations responded to the engagement – from veterans themselves, to wives, husbands, partners and family members of veterans, as well as, but not limited to, charities, NHS organisations and staff.

The findings from the engagement have helped to inform the service specifications for enhanced service provision from November 2016 – March 2016 and from April 2017. Improvements include:

- Extended opening hours with a core service from 8am – 8pm, seven days a week.
- A care co-ordinator who will provide a single point of contact for the patient and other organisations.
- Access to service provision across all four NHS England regions.
- A variety of ways to provide patient advice and care models, such as via Skype, webinar, text, email, face to face and community/in-home visits.

3.1 Commissioning arrangements

The commissioning arrangements for the armed forces are complex and are shown in detail in the document [Securing Excellence in Commissioning for the Armed Forces and their Families](#) and in the table below:

Armed Forces commissioning responsibilities



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

3.2 Governance structures

The Armed Forces Oversight Group (AFOG)

This group has responsibility for ensuring that patient and public involvement is embedded in commissioning arrangements, including assuring the quality of participation arrangements and that appropriate feedback loops are in place. It is chaired by the Director for NHS Commissioning.

The Armed Forces Clinical Reference Group (AFCRG)

This group provides subject matter expertise to the AFOG and for commissioners. The Armed Forces (and their Families) Clinical Reference Group (AFCRG) brings specialist clinical expertise and advice together with the views of patients, family members and carers to support the direct commissioning function of NHS England. The group is able to do this through information and recommendations provided by the Armed Forces Patient and Public Participation and Involvement Group (AF PPIG). In particular, it supports:

- Oversight of the commissioning of healthcare for those registered with DMS.
- Advice and support to CCGs in their duties with regards to other parts of the armed forces community (i.e. non-mobilised reservists, veterans and most families of serving personnel).

- Transition between DMS led care and NHS care on transition out of the armed forces.

The AFCRG aims to:

- Promote the highest quality and consistent standards of treatment and care for members of the armed forces and the families, veterans and reservists.
- Deliver a strong and consistent clinical voice.
- Advocate for 'joined up' services for armed forces and their families. Eradicating the risk of people 'falling through the gaps' in services and ensuring information and data flows between DMS and the NHS.
- Promote equivalence of care based on the delivery of evidence based and clinically effective interventions and pathways.
- Provide expert clinical advice based on patient contact to the Armed Forces Oversight Group (AFOG) and the Armed Forces Patient and Public Participation and Involvement Group (AF PPPIG) so that they may best consider commissioning priorities in the context of effectiveness and cost.

The Armed Forces Patient and Public Participation and Involvement Group (AF PPPIG)

The purpose of the Armed Forces Patient and Public Participation and Involvement Group (AF PPPIG) is to bring together key stakeholders, to ensure that patient and public participation is central to armed forces commissioning.

The group is a sub-group of the Armed Forces Clinical Reference Group (CRG) and exists to:

- Act as a central point and conduit for armed forces health service users, communities, families and carers to participate in all aspects of armed forces commissioning activities. These include:
 - Commissioning policies for those registered with DMS Medical Centres.
 - Priorities and service specifications of bespoke services for veterans.
- Deliver a 'critical friend' role to NHS England and statutory partners. This means delivering a challenge function where this is needed.
- Provide advice and guidance on commissioning plans, patient and public participation processes and engagement of armed force communities.
- Contribute to the improvement of services, engagement and patient experience for services commissioned for the armed forces community.
- Connect to CCGs, local authorities and statutory bodies through networks such as the AFNs, the CCG PPI Lay Members Network and through NHS England newsletters.
- Collectively develop a work plan to improve the participation of armed forces communities in the NHS, promoting the use of existing expertise, networks and insight.
- Receive and act on information and updates provided by AFNs and other stakeholder information and intelligence.

- Raise and escalate risks identified where participation processes are not happening or improvements to NHS England commissioning of armed forces services can be improved.
- Provide updates on emerging theme, issues and recommendations to the AFCRG.

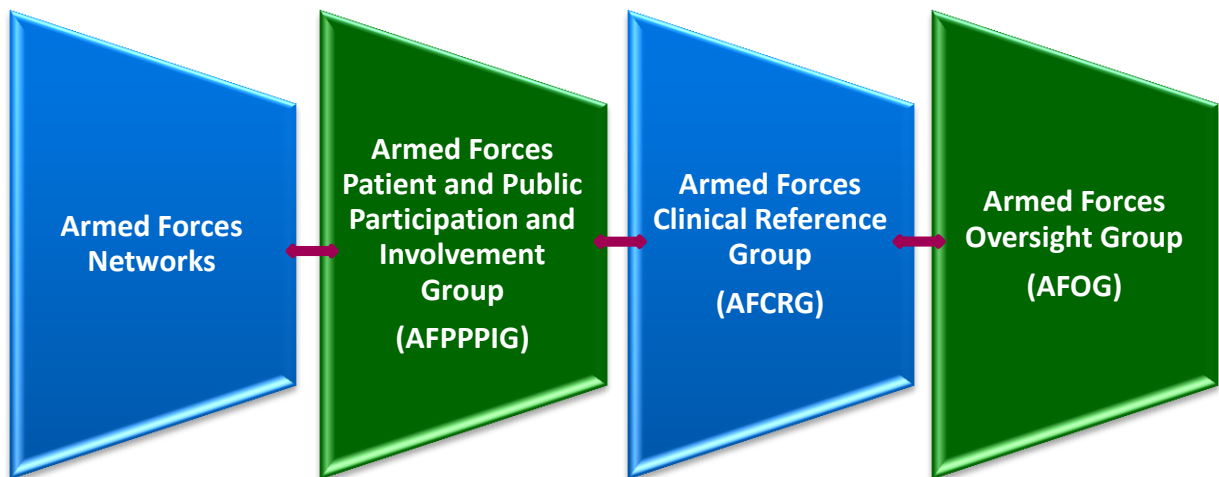
These objectives connect to NHS England’s corporate priorities to create the conditions for an equal, balanced and reciprocal relationship between citizens and the NHS; and to enable patient and public voice and insight to be routinely used in the planning and delivery of services.

Armed Forces Networks (AFNs)

There are a number of regionally-based NHS AFNs in England (currently 9) with membership reflecting the make-up of the armed forces community. Members include serving personnel (clinical, recovery staff and chain of command), veterans, family members and carers of veterans and serving personnel, GPs and professional clinical staff, representatives from service charities, other voluntary sector organisations supporting armed forces communities, NHS England, CCGs, NHS trusts and local authorities, as well as locally relevant groups and people. Each one reflects local needs and demands, as well as the armed forces community make up. They support decision making and commissioning, aid transition, problem solving, support awareness, communications and feedback, act to empower the membership (collectively and individually) and provide an opportunity for networking across the complex systems that the armed forces community works and lives within.

AFNs are important forums for engagement and feedback activity. The AF PPPIG will develop more formalised links with the AFNs, supporting and linking patient and public participation processes at a regional and national level. This approach will give a connected pathway from the AFNs up to the AF PPPIG, feeding into the AF CRG and through them into the Armed Forces Oversight Group (AFOG)

Governance structure



3.3 Responsibilities for participation in armed forces commissioning

The national and regional teams work together to ensure:

- Patient and public participation is undertaken at all stages of the commissioning process, whether this is commissioning at national, regional or local levels.
- Patient and public participation is built into service provider contracts.
- Assessment of whether Section 13Q (the legal duty to involve the public in commissioning) applies to particular commissioning activities, planning for and undertaking any necessary patient and public participation in commissioning. The assessment and plan must be documented using the [standard form](#) available on the NHS England intranet.
- Participation activities and their impact in commissioning are documented and reported for assurance and quality improvement purposes.
- Quality assurance of patient and public participation is undertaken and a quarterly report is made to the AFOG.
- Feedback generated from patient and public participation is used, alongside other relevant data, to inform policy, programmes, commissioning decisions and service specifications.
- The approach outlined in this framework is consistently applied with a commitment that patient and public participation is 'everyone's business'. This includes supporting formal and peer to peer learning, and celebrating success.
- Monitoring, evaluation and reporting of implementation of this framework is ongoing.

How the national and regional Armed Forces commissioning teams involve patients and the public and use their views in commissioning

Identification of healthcare needs and aspirations; strategic planning; service design and improvement

- Engaging patients, service users, families, carers and other stakeholders as part of any local health needs assessment process – bringing together quantitative and qualitative information to feed into strategic planning and priority setting.
- Linking with the Equalities and Health Inequalities team to carry out equality impact screening and assessment, as appropriate, to identify the needs of particular groups within the population.
- Empowering staff to gather and use intelligence from patient and family contact.
- Working with independent voluntary sector partners, groups and networks to gain insight into needs and priorities.
- Setting up workshops with third sector partners - who are experienced in involving 'experts by experience' - to facilitate strategic planning.
- Regularly reviewing existing patient and public participation mechanisms to understand existing patient experience.
- Co-producing/co-designing services with service users, families, carers and other stakeholders.

Procurement and contracting

- Using patient engagement workshops with local providers and stakeholders to ensure that key service feedback, experience and recommendations are fed into service specifications. A range of methods may be needed to hear from diverse groups.
- Involving service users, families and carers in:
 - The development of tenders
 - Procurement panels, including evaluating bids and tenders and
 - Making decisions on how resources are allocated.
- Ensuring that service specifications set out clear expectations for providers regarding patient and public participation, including reporting activity and impact.
- Maintaining an audit trail identifying where patient feedback from engagement activity has impacted on procurement, including specification design and bid evaluation.
- Seeking views on procurement proposals and how services are procured.
- Ensuring that service user representatives are given feedback post-procurement, with a focus on the outcomes e.g. 'you said and we did'.
- Regularly seeking information to review and communicate any lessons learnt by the appropriate means, such as workshop sessions, updates and reporting through the governance structure.

Monitoring and quality assuring services

- Involving service users, families and carers insight in monitoring and assurance processes.
- Ensuring that data from monitoring visits (including partner and provider organisations) is included in the assurance process.
- Monitoring complaints and compliments and feeding into the contract management process where appropriate.
- Reviewing at contract management meetings reports from providers on how they are involving patients and the public, specifically, whether they are delivering their participation commitments as set out in their tender.

Good practice is shared, for example there is a regular slot at local Armed Forces Healthcare Provider Network events.

4 Resources

4.1 Patient and public networks and sources of insight

A key principle in making best use of patient and public insight in commissioning is to review and analyse existing insight sources at the start of any public involvement planning process. Where possible, use information that already exists to add value to any direct engagement approaches and to avoid service users and stakeholders being asked the same questions they have answered previously.

Service user data from armed forces health services should also be reviewed with an understanding of who gathered the data and how. Independent service user/patient feedback is critical where service users have been able to speak freely without fear of repercussions from providers or staff within services.

The main sources of patient insight in armed forces are:

- Families Federations’ publications/magazines/research, surveys and reports
- Armed Forces Continuous Attitude Survey (AFCAS) and Families Continuous Attitude Survey (FAMCAS)
- Defence Medical Welfare Service (DMWS) – patient satisfaction surveys
- Quality reports from (veteran) contracts
- Formal research, such as that undertaken by the MOD, Forces in Mind Trust and Community Innovations Enterprise
- General patient insight sources, e.g. service user organisations, Healthwatch, and voluntary sector groups
- Service user and carer stories
- Social media such as Facebook, Twitter and [Big White Wall](#)
- Complaints via the [NHS England Customer Contact Centre](#), and national Ombudsman’s reports
- Care Quality Commission inspection reports
- Healthwatch reports
- Local scrutiny committee reports
- Information from patient representative groups
- National surveys
- The [Equality Delivery System](#) for the NHS (EDS2)
- Case studies
- Local government initiatives i.e. Children’s Centres (data is collected on minority and specialist groups to drive targets and achievements in relation to Ofsted)
- Local Community Services i.e. Health Visitors, Midwives, Speech and Language Therapists, Occupational Therapists, Physiotherapists. Again, target driven and have interface with key groups
- [Anglia Ruskin Veterans’ and Families Hub](#)
- [King’s Centre for Academic Research](#)
- Local Authority Joint Strategic Needs Assessments.

A few examples of some of the larger organisations, charities and networks that support patient and public participation in NHS armed forces healthcare are:

Network/ Organisation/ Charity	What they do/ who they support
The Confederation of Service Charities (Cobseo)	Represent, promote and further the interest of the armed forces community.
Blesma : The Limbless Veterans	An armed forces charity that supports limbless veterans for the duration of their lives.
Royal British Legion	The charity helps members of the Royal Navy, British Army, Royal Air Force, veterans and their families all year round. They also campaign to

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	improve their lives, organise the Poppy Appeal and remember the fallen.
Help for Heroes	Provides direct, practical support for wounded, injured and sick service personnel, veterans and their loved ones.
SSAFA – Armed Forces Charity	SSAFA works in partnership with other military charities and specialist organisations to help armed force families to get the support they need.
Army Families Federation (AFF)	AFF is the independent voice of army families and works hard to improve the quality of life for army families around the world - on any aspect that is affected by the army lifestyle. AFF is independent of the army and offers confidential advice.
RAF Families Federation (RAF – FF)	The RAF Families Federation provides all RAF personnel and their families - regular and reserve, single or married - with timely and professional support, assistance and an independent voice regarding issues or concerns that they may have.
Naval Families Federation (NFF)	The NFF's vision is for all naval service families to: be able to have their views heard by those in positions of power; feel valued and be treated with fairness and respect; and thrive in their communities of choice.
Gurkha Welfare Trust	Provides financial, medical and development aid to Gurkha veterans, their families and communities.
Army Welfare Service (AWS)	The Army Welfare Service is the army's professional welfare provider; it delivers a comprehensive and confidential welfare service responsive to the needs of individuals and families and the Chain of Command in order to maximise the operational effectiveness of our servicemen and women. The AWS' remit includes regular soldiers, their families and communities, the Army Reserve and reservists and, in certain circumstances, veterans, other services and MOD civilians serving overseas.
Defence Medical Welfare Service (DMWS)	The St John and Red Cross DMWS is a registered charity that works with NHS trusts, charitable partners and the MOD to provide practical and emotional support to the armed forces community when they are receiving treatment as either an in or out-patient. DMWS has a national footprint operating in 34 hospitals across England providing medical welfare to serving personnel and their families.
Ministry of Defence (MOD)	Protects the security, independence and interests of our country at home and abroad. It works with our allies and partners whenever possible. Its aim is to ensure that the armed forces have the training, equipment and support necessary for their work,

	keeping within budget.
Regional Armed Forces Networks	Nine regional networks, closely aligned to the military regional structures, meet regularly to ensure close collaborative work between local and regional people (those commissioning, delivering, supporting or caring) in the NHS, MOD, local authorities and service charities.
NHS Choices	Healthcare information and support for the UK's 10 million-strong armed forces community, including serving personnel, reservists, families and veterans.
HIVES / Royal Navy and Royal Marines (RNRM) Welfare Information Offices	A HIVE/ RNRM Welfare Information Office is an information network available to all members of the service community. It serves both married and single personnel, together with their families, dependants and civilians employed by the services.
Statutory partners and stakeholders	<ul style="list-style-type: none"> • CCG Lay Member Network • Scrutiny Networks • Provider involvement infrastructures • Local authority participation infrastructures • Healthwatch • Local voluntary and community sector collaborations • Health and Wellbeing Boards • Professional networks (e.g. clinical, practice managers) • Strategic Clinical Networks and Senates

Case study: Encouraging use of READ codes by Portsmouth CCG

In 2013 Portsmouth CCG introduced a change to the registration questionnaire of GP practices so that it included a question asking about veteran status or armed forces background. The GP can then record this status with a READ code in the patient's electronic notes. As well as introducing a specific question on the registration form, educational sessions were held at GPs' monthly meetings to encourage the use of the identification and coding of the armed forces community. This has been done mainly by highlighting the benefits of identifying their background, which are primarily that there are a range of services and support available to them such as Veterans' Outreach Support, Naval Families Federation). Many of the local services have been on board with this by offering an enhanced offer of services as an incentive to GPs, for example the Solent Improving access to psychological therapies (IAPT) services guarantee to see veterans within seven days of referral which is quicker than for the general population. So far they have managed to code around 2,000 veterans out of the total population of 217,000, and around 1,431 families out of 7,000. Codes for reservists have been introduced in 2016.

4.2 Further advice, training and support for commissioners

NHS England has developed a range of resources to guide or support commissioners with participation planning and activity.

Teams:

- NHS England regional communications and engagement teams and patient experience teams (it should be noted that there is some variability in regional and local arrangements due to structural differences).
- NHS England Public Participation Team in the central support team provides advice and guidance on participation. The team also offers training to commissioners who want to improve their participation skills (available via the Learning Management System on the NHS England intranet).
- National and regional equalities and health inequalities leads can provide advice on undertaking equality impact assessments and key considerations for engagement and consultation relating to the commissioning of services, especially when looking at reaching equalities protected groups and groups that experience inequalities in access to services and outcomes. Veterans, for example, are a group at risk of health inequalities, more so for those who are elderly and/or disabled).
- The NHS England central Events Team and regional and local office NHS England Communications and Engagement Teams can provide advice and guidance on public events.
- The Digital Communications Team can support commissioners to develop public online surveys and consultations for the [‘Consultation Hub’](#).
- In highly complex and/or high profile situations, it may be necessary to seek legal advice through the NHS England Legal Team and/or specialist communications and engagement expertise through contracting services.

Web based resources to support participation include the following:

- [Bite size guides to participation.](#)
- [NHS England Patient and Public Voice expenses policy.](#)
- [Templates for recruiting members of the public into participation roles.](#)
- [‘In Touch’](#) is the patient facing bulletin where events, public consultations and involvement opportunities can be advertised.
- [The Involvement Hub](#) – a central source of participation resources, learning and best practice.
- [The Equality and Health Inequalities Hub](#) brings together equalities and health inequalities resources and provides useful links and information for the sharing of best practice.

External support:

- Commissioning participation support or working in partnership with other organisations with specific expertise is extremely effective.
- Local voluntary sector organisations may have strong existing relationships with local armed forces services.
- Service charities will have links to veterans and service/veteran families.

- National organisations have often developed strong forums of user voice.
- Commissioning Support Units.

4.3 Ways to engage with different armed forces communities

4.3.1 Serving personnel

Context:

There are opportunities to engage with serving personnel who are based within England, for example in army barracks. However, this population is highly mobile and subject to deployment overseas, which can make engagement challenging.

By the nature of their job, the majority of serving personnel are healthy, fit and active, and tend to be younger than the general population. There is a growing group of younger people suffering severe injuries (e.g. requiring multiple amputations) during service.

Literacy and numeracy levels vary amongst armed forces personnel. It is important to consider average reading ages and [health literacy](#) and comprehension when developing engagement materials for particular groups.

Core principles:

- Serving personnel should be involved in shaping and improving the services that they receive.
- Participation activities will need to take into account the different ways of working in each of the armed forces services (Royal Navy and Royal Marines, The Army, The Royal Air Force).
- The armed forces community includes diverse groups with different needs and participation activities will need to take account of the needs of different groups. For example there are cultural differences between white British soldiers and the large numbers of Commonwealth citizens including Fijians and Nepalese Gurkhas who are employed by the British Army.
- The culture of the armed forces, due to the very nature of their role is hierarchical and different ranks may take different views. This needs to be considered when engaging with serving personnel, taking a view on whether any engagement should be undertaken by rank rather than a cross slice.
- Serving personnel may not readily have access or have limited access to computers and internet. Therefore a diverse range of approaches should be used.

Ways to engage:

- NHS England is working with DMS to get direct access to service users registered with its medical centres.
- Utilising communications channels such as 'The Soldier' magazine to reach serving personnel.

- Defence Intranet is a shared service across all three armed forces. The homepage flags up news items and could be a potential route for reaching serving personnel via surveys or information.
- Link with the British Forces Broadcasting Service, which is a worldwide service reaching all serving personnel.
- Link with the HIVES/RNRM Welfare Information Offices to get information out. Some of the HIVES/RNRM Welfare Information Offices have newsletters that are made available to serving personnel and their families in a variety of formats.
- The MOD runs regular roadshows across barracks and serving personnel are used to engaging in this way. This may be an approach to consider for more direct service personnel engagement.
- Posters may assist in getting the message across, for example if you wanted to engage service personnel around musculoskeletal problems.
- YouTube is another very good tool that the Military uses. The MOD has used this tool quite a lot, most recently with regards to RAF Engineers.
- Utilising social media including Facebook and Twitter.
- The Naval Families Federation and RAF Families Federation also engage with serving personnel in a variety of ways including magazines, websites, social media and e-newsletters.
- Hospital based medical welfare support provided by the Defence Medical Welfare Service (DMWS).

Want to learn more?

[E-learning programme to support improved care for serving personnel, veterans and their families](#)

[Armed Forces Continuous attitude survey \(AFCAS\) gives insight into personnel's experiences within the armed forces](#)

[NHS Choices](#)

[Army HIVES](#)

[RNRM Welfare Information Offices](#)

[RAF HIVES](#)

[Defence Medical Welfare Services](#)

4.3.2 Reservists

Context:

This group moves between services provided by the MoD when mobilised and the NHS as civilians.

Although the health needs of reservists are likely to be very similar to the general population, recognising that they live a largely civilian life, they do have regular occupational health reviews with the MoD, and their deployment to military service has been linked to some poor health outcomes.

Reservists report higher rates of PTSD after deployment (6%) compared to those not deployed (3%).¹⁰ There are some important differences in the context in which reservists are deployed compared to their regular counterparts. These differences can affect their experience during deployment and the impact that this deployment has on their physical and mental health upon return. They include:¹¹

- Family, friends and colleagues of reservists not understanding what they have been through when deployed.
- Reservists are at increased risk of relationship difficulties when they return from deployment.
- Reservists will often deploy as individuals within units of regular personnel and may therefore not know their comrades, and when asked they are more likely to experience feelings of isolation and lack of unit cohesion.
- Reservists are more likely than regular personnel to report having traumatic experiences during deployment.
- Reservists may experience more stress because the rapid mobilisation time does not leave them much time to process adverse fears and put their affairs in order.

Reservists are particularly difficult to identify as they can rapidly switch from being part of the general population to being part of the serving population (on mobilisation/de-mobilisation). Therefore approaches in sections 4.3.1 - serving personnel and 4.3.5 - veterans are both relevant. Reservists make up about a sixth of serving personnel at any one time.

Specific issues of managing civilian life and a military life may impact on the healthcare reservists use and the methods to engage reservists will change over a period of time depending whether they are mobilised or not.

Reservists tend to be older and have higher educational attainment than regular personnel. They take on a variety of roles, many of which require specialist skills

¹⁰ King's Centre for Military Health Research. Mental Health Summary sheet. KCMHR, 2010

¹¹ Browne T, Hull L, Horn O, Jones M, Murphy D, Fear NT, Greenberg N, French C, Rona RJ, Wessely S, Hotopf M. Explanations for the increase in mental health problems in UK reserve forces who have served in Iraq. *Br J Psychiatry*. 2007;190:484-9

(e.g. medical) and usually brought in to replace individuals, rather than being part of a formed unit.

Core principles:

- Reservists should be involved in shaping and improving the health services they receive.

Ways to engage:

- Consider utilising publications that already exists e.g. Reserve Forces and Cadets Association (RFCA). A government funded organisation, publishes 'The Volunteer' magazine in the north west of England.
- Consider working with Defence Relationship Management who liaise with employers of reservists.
- Consider a direct approach to regiments or units that are fully made up of reservists, for example attending drill nights.

Want to learn more?

[Ministry of Defence \(2011\). Future Reserves 2020.](#)

[Future reserves research programme](#)

[Defence relationship management](#)

[Defence Medical Welfare Service](#)

4.3.3 Service and ex-service families

Context:

Families play a key role in supporting those in service and service leavers in a successful transition to civilian life. Families can include any combination of spouse, partner, children, siblings and carers. Their views are vital in helping to shape a service model for the future provision of armed forces services.

Service families include:

- Spouses/partners and children of serving, ex-serving personnel and reservists
- Parents of single service and ex-service personnel
- Carers.

Service families often have additional pressures on family life, which may include:

- Stress around deployment
- Extended and repeated periods of separation from spouses and partners
- Social isolation from family and friends
- Additional and sudden caring responsibilities
- Frequent moves of location with sometimes minimal notice.

Ex-service families often have additional pressures on family life, which may include:

- Additional, stressful and sudden and unprepared for caring responsibilities
- Stress during transitioning into civilian life for the family unit and ex-serving personnel
- Stress caused by financial instability.

NHS England has a formal mechanism for getting regular feedback and immediate escalation of issues from the armed forces' families' federations and uses the Families Federation data reports to assess progress.

Core principles:

- Service families should be involved in shaping and improving the services that they receive.
- Due to the nature of the armed forces lifestyle, creative methods of access may need to be devised, although service families may be more accessible than service personnel.
- Consider ways of accessing parents of serving single soldiers/sailors/airmen, reservists' families and service families living in their own homes.

Ways to engage:

- DMS Medical Centres that register families may provide a practical route into accessing service families, particularly spouses and partners, around health issues.

- Promote engagement and publicity with GP practices across England, not just in garrison areas, to access service or reservists' families – e.g. there are 300 serving Naval personnels' families living in Derbyshire.
- Utilising publications such as the Families Federations quarterly magazines: Homeport (NFF), Army & You (AFF), Envoy (RAF FF) and other groups such as the FANDF e-Newsletter or the Ripple Pond website.
- Utilising social media via the Families Federations websites, Facebook page and Twitter etc.
- HIVE and single service welfare providers –also have Facebook and web pages.
- British Forces Broadcasting Service (BFBS).
- Promote engagement and publicity with GP practices across England.
- Utilising social media via, Facebook, Twitter, Big White Wall etc.
- Link with forces focused organisations such as Royal British Legion, SSAFA, Help for Heroes, Veterans Agency, Cobseo.
- Link with non-statutory organisations and charities such as Food Bank, Carers UK, Citizens Advice Bureau, Victim Support, Mind, Salvation Army and other religious organisations such as Church of England, homeless shelters, Samaritans, likely to include local agencies too.
- Link with statutory organisations such as local authorities, police, emergency services, housing, Department for Work and Pensions (including JobCentre Plus), children's centres, education.
- Link with key events throughout year including Remembrance Sunday, local or regional armed forces events, as these are key times when ex-serving communities will attend events to show respect.
- Links with Reservist Centres (was Territorial Army) as these could be a point of access for those not near a camp/garrison/forces base during first few months of leaving the forces.
- Hospital based medical welfare support for families provided by the Defence Medical Welfare Service (DMWS).

Examples of support to service families:

- The RAF deployment café at the RAF base Odiham where families are supported through the deployment cycle. They support Reading Force, a charity which support communication with the serving parent through reading.
- 'Talk about partners going on Exercise, being Dispatched or Deployed' (T.E.D.D) is a group where children and families are supported to manage day to day life whilst partners are away. Topics for discussion include managing children's emotions/behaviours; temper tantrums, how you cope, your self-esteem (Previously Deployment Café) at RAF Odiham.
- Incredible Years Parenting Programme - 11 week course (Middle Wallop Army Air Core).

Want to learn more?

For more information about service families visit:

[Naval Families Federation](#)

[Army Families Federation](#)

[Royal Air Force Families Federation](#)

[The Forces Additional Needs and Disability Forum \(FANDF\)](#)

[The Ripple Pond](#)

[Armed Forces Covenant webpage](#)

[MOD Families Strategy](#)

[HEE e-learning for healthcare Service families' session](#)

[Anglia Ruskin Veterans' and Families Institute](#)

[Forces in Mind Trust](#)

[King's Centre for Military Health Research](#)

[FAMCAS \(Families Continuous Attitude Survey\) gives some insight into the user experience](#)

[Defence medical Welfare Service](#)

4.3.4 Service children and young people

Context:

Consideration needs to be given to identifying the age range for service children and young people's engagement (army recruits can join as young as 16 years old).

When engaging children and young people of service families the following may need to be taken into account:

- Children and young people may attend boarding school
- They may be part of isolated communities
- They may experience frequent moves and change of healthcare provider (particularly pertinent with Children and Adolescent Mental Health Services (CAMHS) provision).

Core principles:

- Service children and young people should be involved in shaping and improving the services that they receive.
- Make participation fit the armed forces lifestyle and the age of the child/ young person.
- Consider those children/young people with additional needs and disability and how their voice can be heard.

Ways to engage:

- Consider linking with the parents of service children and young people. This could be facilitated by the Families Federations or through the welfare support such as the Army Welfare Service (AWS), Community Development Workers (CDWs) who run the youth clubs in Army garrisons, the Royal Navy and Royal Marines Welfare Service (RNRMWS) provides welfare and information officers and Community Development Workers. RAF - SSAFA Social Work Service, Community Support Officers and Air Play.
- Utilising publications such as the Families Federations' quarterly magazines: Homeport (NFF), Army & You (AFF) and Envoy (RAF FF) and other groups such as the FANDF e-Newsletter.
- Utilising social media via the Families Federations' websites, Facebook page and Twitter etc.
- Make contact with the MOD Directorate of Children and Young People (DCYP)
- MOD tri –Service Youth Forum team.

Case study: Identifying needs

In Catterick we have utilised the Strength and Difficulties Questionnaires (SDQs) to establish where the child is having difficulties with regards attachment and negative behavioural presentation. Using the SDQ as a screening tool allows the practitioner to identify the environment in which the child is presenting with difficulties and separates the types of difficulties the child is experiencing. By identifying the area of difficulty within the child's presentation the practitioner can offer timely intervention and signpost to appropriate agencies, highlighting the need to embrace a multi-

agency approach to delivering the right care at the right time. In addition, to identifying areas of difficulties, the SDQ highlights the child's areas of strength. By identifying the strengths within a child who is presenting with emotional or behavioural difficulties due to attachment the practitioner and other agencies can reinforce praise, thus developing self-esteem and self-worth. Having a team around not only the child, but the whole family, whilst staying child focused, offers a wraparound service that will hope to meet the needs of the child and their family.

Case study: Supporting wellbeing:

Within the barracks in the North West, the Child and Family Health Team is now visiting the monthly coffee afternoon run by the welfare and children's centre support workers. This coffee and play afternoon takes place in the barracks' community centre. This ensures health education can be delivered to support families' identified needs. During these coffee afternoons the health visitor will weigh babies and assess mothers' maternal health. This valuable multi-agency working ensures safeguarding information is shared, families receive health education and, most importantly, that no new families are missed, as they all receive a health questionnaire to complete which the health visitor collects at the coffee afternoon. There have also been two health event days run on the barracks, promoting local services, all of which were well received by the military community.

Want to learn more?

[Directorate of Children and young people and Children's Education Advisory Service \(CEAS\)](#)

[The Royal Navy and Royal Marines Children's Fund](#)

[The Royal Caledonian Education Trust](#)

Single service welfare agencies:

- [AWS](#)
- [RNRMWS](#)
- [SSAFA Personal Support and Social Work Service RAF](#)

[KCMHR – Children of Military Fathers](#)

[Tri –Service Youth Forum](#)

[Armed Forces Covenant webpage](#)

[Children's Society Young Carers](#)

4.3.5 Veterans

Context:

A veteran is defined as:

‘Anyone who has served for at least one day in the armed forces (Regular or Reserve), as well as Merchant Navy seafarers and fishermen who have served in a vessel that was operated to facilitate military operations by the armed forces.’

[\(Department of Health 2008\)](#)

Veterans have similar levels of health to the general population. However, a significant minority have poor outcomes, some of which may be related to their time in the armed forces.

It is important that veterans are able to be involved in conversations about the NHS but this can sometimes be difficult to do because:

- Veterans are not typically a known group, therefore reaching and engaging them can be a challenge. It should also be noted that despite the health commitments set out in the Armed Forces Covenant, many veterans are not registered as such with their GP.
- Access to services can be problematic for veterans as a result of presenting health needs. For example, those veterans who have a mental health condition may find that their presenting health needs often do not fit mainstream mental health services criteria.
- Members of the armed forces share a unique culture and language and many veterans perceive themselves to be different to civilians. This can be a barrier for some veterans when it comes to engaging with civilian services.
- Some veterans may be from other countries and so there may be an additional language and cultural barrier – e.g. Gurkha communities.
- Members of the armed forces receive their healthcare through DMS and so veterans may be unfamiliar with the NHS, especially if they joined the military at a young age.
- Veterans are overwhelmingly male (89%) and men are typically [less likely to engage with services](#).
- The military recruits disproportionately from deprived areas of the country and people from disadvantaged socio-economic backgrounds are [typically less likely to use many types of services](#).
- A small number of veterans will be homeless or in the criminal justice system. These individuals may require different engagement strategies.
- Reservists who are not currently mobilised are defined as veterans and may need a specific engagement approach. For more information see section 4.3.2 of this document.

Ways to engage:

To ensure that engagement is sensitive to the unique culture and language of the armed forces it is important to seek advice from veterans and family members in

advance of planning a strategy and producing any materials. Ideally, veterans and family members should be involved in the engagement strategy from the beginning.

It can be difficult to engage veterans. Often recommendations from fellow veterans can go a long way. The following channels may be useful:

- National veteran networks. Some of the more established veteran charities like the Royal British Legion will have links to large numbers of veterans. See [Cobseo](#) for more details about veteran charities in the UK.
- Local veteran networks. Many areas of the country will have well established local networks for veterans – e.g. the [Britannia Veterans' Hub](#) in Norwich, Norfolk. Local Authority [Community Covenant](#) Officers may be a good place to start when looking to identify key local links and [Veterans' Breakfast Clubs](#).
- Use of Veteran Health Ambassadors (Doncaster CCG initiative).
- Specific veteran charities. Many veteran charities exist to meet a specific need and will be a useful channel for more targeted engagement activities – e.g. Blind Veterans UK will be a key contact when seeking to talk to blind veterans. Visit the [Cobseo website](#) to find out details of member service charities.
- Military organisations and networks. Some veterans may still want to keep in touch with the military – e.g. they may listen to the [British Forces Broadcasting Service](#). These routes can be a way to engage with veterans as well as current military personnel. This is especially true for those individuals who have been recently discharged and who may still be receiving treatment and support through DMS, according to the terms of the Armed Forces Covenant.
- Publications, such as Pathfinder and Veterans' World
- Hospital based medical welfare support for veterans and their families provided by the Defence Medical Welfare Service (DMWS).

It should be noted that the term 'veteran' covers a diverse range of individuals. Many veterans do not want to be identified as veterans when they leave the military and there is a risk that their voices will not be heard if engagement is conducted exclusively through veteran specific channels. To that end, it may be helpful to consider:

- Traditional NHS engagement channels – e.g. Patient Participation Groups.
- Non-veteran specific organisations that might be working with veterans – e.g. Salvation Army, Mind, Alcoholics Anonymous (which has armed forces champions).
- Health and care services that may be frequented by veterans. This could include veteran specific services (e.g. nationally procured NHS mental health and specialist prosthetic services) but also mainstream services, like pharmacies, which are often used by older people (many of whom will be veterans).

Case study: Understanding veterans' experiences of mental health services

From April 2015-16, Healthwatch Norfolk conducted in-depth interviews with 30 veterans from Norfolk and Suffolk about their recent experiences with local mental health and drug and alcohol services.

Veterans were recruited to the study through various channels following an eight month recruitment campaign:

- 18 veterans were recruited by working closely with local veteran agencies
- Three were recruited through non-veteran charities
- Five were recruited through local mental health services
- Four self-referred to the study.

Healthwatch Norfolk worked very closely with a small number of 'key recruiters', all of whom were local veteran agencies who had expressed an interest in the study. Most veterans were recruited in this way. Other engagement strategies included:

- Distributing 2,000 leaflets with information about the study around Norfolk and Suffolk. The majority were distributed in places likely to be frequented by veterans (e.g. Royal British Legion drop-in centres, Help For Heroes stores). Others were placed in general locations with high footfall like libraries.
- Advertising the study on Radio Norfolk and at the Royal Norfolk Show (in the military tent).
- Advertising through local veteran agencies (usually online).
- Advertising through local non-veteran specific charities (usually online).
- Advertising through local military organisations – e.g. on the Facebook pages of Reservist units and at the [Department of Community Mental Health](#).
- Advertising through statutory services and networks – e.g. leaflets in A&E departments, Patient Participation Groups, CCG engagement leads.
- Using service leaver data from the [Ministry of Defence](#) to identify areas of Norfolk and Suffolk with high veteran populations and placing written adverts in the parish council magazines/newsletters in and around these areas.

The engagement strategy and materials were tested with veterans at a meeting of the local Combat Stress support group. A steering group consisting of service users (veterans) and key professionals was convened at the start of the project to provide further oversight and guidance.

All participants were updated about the study's progress and had the opportunity to feedback on a draft report ahead of publication.

The study was classified as 'service development and quality improvement' and so [Health Research Authority ethical approval](#) was not required. Healthwatch Norfolk took a number of measures to ensure that the study was conducted in a safe and ethical manner. Formal approval was granted to speak to patients from the local mental health NHS Trust and a document was produced setting out partnership working arrangements, to ensure that individuals were referred to the study appropriately.

The study incorporated elements of the Community Action Research model, whereby Healthwatch Norfolk worked closely with key stakeholders to respond to issues as and when they were raised by local veterans. In total, Healthwatch Norfolk completed 23 successful activities to improve services for veterans across Norfolk and Suffolk, including:

- Working alongside Health Education England, the Ministry of Defence and numerous military and veteran agencies to provide veteran specific training for 272 GP students across the East of England.
- Organising and chairing an engagement event where local veterans, families and professionals were able to talk to commissioners from NHS England about their views and experiences of using NHS mental health services, as part of a wider NHS England review about the effectiveness of dedicated mental health services for veterans.

Want to learn more?

[Views and experiences of using mental health services: feedback from veterans in Norfolk and Suffolk](#), Healthwatch Norfolk (2016)

[E-learning programme to support improved care for serving personnel, veterans and their families](#)

[Defence medical Welfare service – aged-veterans](#)

[Veterans' Foundation](#)

[Help for Heroes](#)

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