

North East Joint Health Overview and Scrutiny Committee

Regional Review of the Health Needs of the Ex-Service Community Physical Health



Workstream Final Report
January 2011

NORTH EAST JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE

**REGIONAL REVIEW
OF THE
HEALTH NEEDS OF THE EX-SERVICE COMMUNITY**

**PHYSICAL HEALTH
WORKSTREAM FINAL REPORT**



Introduction

1. Advances in medicine and surgery have profound impacts upon society, with people surviving injuries and illnesses that history tells us they would not have traditionally survived.
2. The same is true of military injuries and 'field medicine'. Injuries that previously would have been too much for service personnel to survive are now 'survivable', due to advances in the technology and knowledge employed in military health services. This is, needless to say, something to be extremely thankful for. Nonetheless, it presents significant challenges for those individuals and health services when contemplating a recovery and a return to military life, or a life after the military, should a medical discharge ensue.
3. The very nature of armed conflict, and the physical exertions that it asks of combatants decrees that all are physically very fit and, therefore, young. As such, the recent and current armed conflicts that this country is engaged in present a generation of survivors whom have significant and possibly ongoing health and social care needs. Further, it is perfectly possible that, with a prevailing wind, such people could live another 50 years following discharge.
4. The overriding interest of the Workstream was to explore the support that people with such needs require, when they become a veteran or 'ex-service' and how that support is co-ordinated and delivered. It has become clear to the Workstream that such injuries can create a significant and expensive demand on services. The Workstream would like to make clear in explicit terms that it believes strongly that such people should be afforded every possible assistance in their recovery and future lives, nonetheless the high cost of such care needs to be taken cognisance of. In addition, whilst the Workstream is not a military or foreign affairs specialist (nor is it its remit), it appears clear that the UK will remain in Afghanistan for the foreseeable future. As such, we can unfortunately, expect more cases of serious injury. In the view of the Workstream, this reality is all the more reason to ensure that North East England's health and social care economy has the knowledge and the capacity to give the ex-service community the welcome and the support it deserves and has earned.
5. In addition to existing conflicts, there are of course, veterans of many other conflicts who continue to live in the region, with physical health concerns which could relate to active service.
6. With the above context in mind, the Workstream was keen to establish how well configured the local health and social care system is to deal with current, and future demand.

Evidence from presentations

Evidence from the SHA – Caroline Thurlbeck & Mike Procter

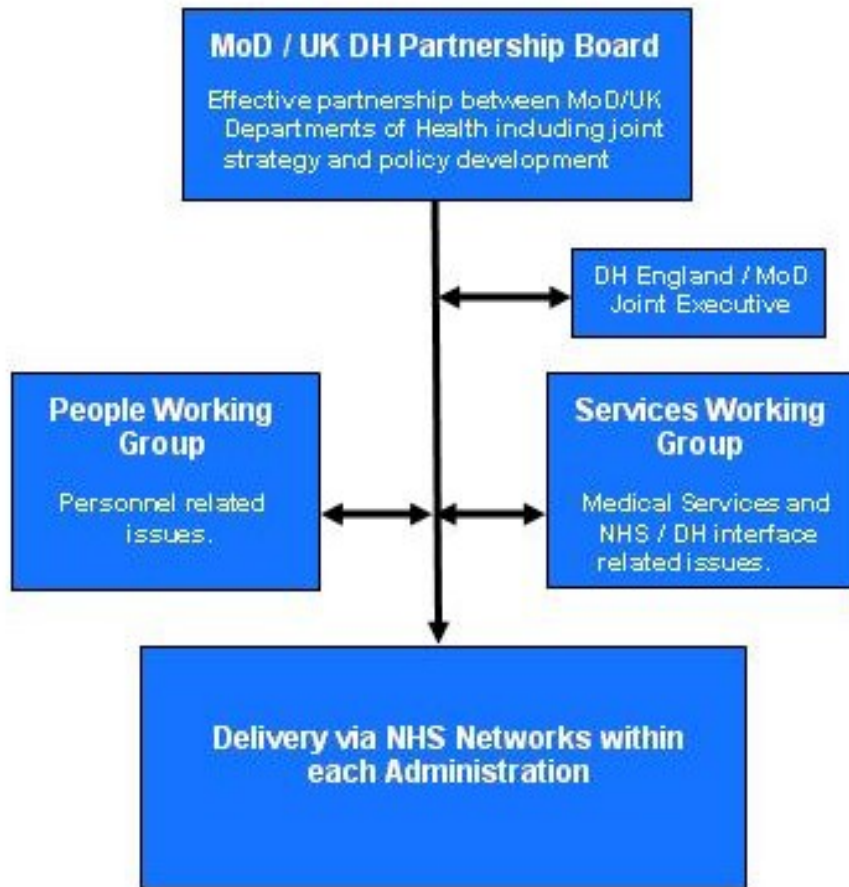
7. Following the overview day on 28 June, the Workstream was keen to speak to the regional NHS about what happens now for the physical health of the ex-service community, and what its plans are for the future.
8. The Workstream met with a Director of Commissioning from the Tees PCT Cluster and the Strategic Head of Performance from the North East Strategic Health Authority (SHA).
9. The Workstream considered an initial presentation from the SHA, which outlined a quantity of introductory information, ahead of the Workstream exploring a number of questions.
10. As an initial step and before considering the policy environment, the Workstream wanted to gain some sort of understanding as who, or what the ex-service community is, what does it mean? It was told that:

It means all those who are serving personnel, volunteer reserves, veterans and their families. It is estimated that there are around 10.5 million people in the UK who fall into this category.

11. To expand on this, the Royal British Legion¹ (RBL) have published figures which indicate the following:
 - There are an Estimated 4.8 million veterans in the UK and 5.37 dependents
 - 84% veterans are men
 - Veterans over 85 years will increase significantly over the next decade
 - 60% of the adult ex service community are aged over 65; this compares to 20% of the general adult population
 - 31% of the ex service community live alone compared to 19% of UK adults
 - Younger members of the ex service community are more prevalent in the North of the UK
12. To build on the last point above, the Workstream was particularly interested to hear if there were any specific figures for North East England. The Workstream heard that there are no firm figures about the North East England dimension, although the RBL has estimated that, based on the national profile, North East England has:

¹ Royal British Legion 2005

- 200,000 veterans
 - 400,000 veteran community
13. The Workstream acknowledged that whilst the above figures were an estimate, it highlighted a significant presence in North East England. The Workstream was mindful of a presentation given at the overview day which indicated that around 10% of service recruits come from North East England and the majority join the army. The Workstream felt it was important to consider this statistic against the context that North East England only contains around 5% of the nation's population. As such, North East England's contribution to the armed forces numbers is around double its percentage of population. The Workstream noted that upon discharge it is fair to assume that a large proportion of those people, return to the area they came from. In addition, the Workstream has heard on a number of occasions that a significant number of armed forces recruits from North East England tend to be from lower socio economic groups, with few other career options. This can impact upon their chances when they re-emerge from forces.
14. It is also worth noting that around 18,000 service personnel transition to NHS care every year and only a small number are regarded as seriously injured and will require significant ongoing health and social care. Whilst the most severe cases are fairly small in number, they are hugely significant and a barometer about how society looks after such people. This is a particular issue for North East England to get right.
15. The Workstream heard that there is a significant policy context to the topic of support for the ex-service community. Key documents are laid out below:
- July 2008 Command Paper
 - NHS Operating Framework for 2010/11
 - MOD/UK DH Partnership Board
 - Establishment of a North East NHS Armed Forces Network
16. An illustration of the MOD/UK Partnership Board is outlined below.



17. The Workstream heard that the first document to explore the theme of support for the ex-service community was the Service Personnel Command Paper: *The Nation's Commitment: Cross-Government Support to our Armed Forces, their Families and Veterans*².
18. The Command Paper is a substantial document, although its key points are:
- The Essential Starting Point of the document was that there should be No Disadvantage suffered by the ex-service community as a result of their active service.
 - Service people and their families should be able to manage their lives as effortlessly as anyone else.
 - The importance of the ex-service community being able to benefit from a Continuity of public services when required to frequently move home

² July 2008

- That there should be a Proper Return for Sacrifice - Service personnel & their families will receive the treatment and welfare support they need for as long as they require it.

NHS Operating Framework 2010/11

19. The Operating Framework made clear the government's expectations regarding the support to be afforded to the ex-service community. The key commitments are outlined below.

- PCTs to work closely with military services
- Smooth transition to NHS care injured Service Personnel
- Ensure dependants are not disadvantaged
- Priority treatment, including mental health treatment, for veterans

20. It was emphasised by the Operating Framework, as well as the NHS representatives speaking to the Workstream, that the way that the NHS deals with and supports the ex-service community is of paramount importance. In many ways it defines how effective the NHS is, dealing with a group that society owes a debt to, at their time of need. As such, it is identified as a key reputational issue for the NHS, which it simply has to get right.

21. Following the General Election in May 2010 and the creation of the Coalition Government, the NHS Operating Framework was re-released with amendments from the new Secretary of State for Health. The above commitments were restated in the new Operating Framework, providing a degree of policy consistency for the NHS, relating to the ex-service community. The NHS, relating to the ex-service community, has made a number of commitments. They are listed below.

- There is a guarantee that all those seriously injured will receive an early and comprehensive assessment of their long term needs before they leave the Armed Forces;
- There should be high quality care for life for those with continuing healthcare needs based on a regular review of their needs overseen by an NHS case manager;
- There is grant funding with Combat Stress (that they are matching) to work directly with mental health trusts to ensure that the services they provide are accessible to and appropriate for military veterans;
- There will be closer NHS links with a full range of third sector partners and charities with extensive experience of working with veterans, to share advice, knowledge and best practice to improve services for veterans;

- There is an entitlement for all veterans who have lost a limb whilst serving in the Armed Forces to receive, where clinically appropriate, the same standard of prosthetic limb from the NHS that they received or would receive today from Defence Medical Services as a result of major technological advances.
 - There are to responsible Directors within each Strategic Health Authority, together with Primary Care Trust champions, will be identified to ensure the needs of the armed forces, their families and Veterans are fully reflected in local plans and service provision; and
 - There should be improved transfer of medical records to the NHS on retirement from the armed forces, including greater GP awareness of veteran status of new patients to ensure veterans receive their entitlement to priority treatment for any injuries or illness attributable to their time serving in the Armed Forces.
22. In a North East Region context, the Workstream heard that a North East NHS Armed Forces Network was in the process of being established³. The Workstream heard that its purpose was to provide regional NHS leadership, advocacy and points of liaison for military health issues. Its aim to work with regional military, social services and third sector organisations, to ensure delivery of Armed Forces community programmes.
23. It was confirmed that there were a number of organisational leads in North East England to ensure the topic has a high profile. There is a SHA lead director and an operational lead within the SHA. Amongst Provider Trusts, there is a Lead Chief Executive, from the Tees Esk and Wear Valleys Foundation Trust. In addition a NHS Armed Forces lead has been identified within each PCT cluster. The Panel heard that the regional network was hoping to recruit a clinical director who, it was hoped, would be a Director of Nursing.
24. Following consideration of the presentation by local NHS representatives, the Workstream wanted to explore a number of themes.
25. At the evidence day on 28 June 2010, Members had heard that a particular problem for the ex-service community, and their physical health, was the scenario when someone leaves the forces and does not register with civilian health services and never does.
26. It was said that this can be a real problem as armed forces life is such that medical appointments are made for you and you attend when ordered to. As such, service personnel can afford to be fairly reactive to health matters, as they will typically be provided for. There is quite a

³ It later had its launch event on 29th September 2010

contrast with that approach in civilian life. Whilst NHS services are free at the point of delivery in the United Kingdom, the system, including General Practice, will not seek you out, invite you to attend or engage with you proactively. There are obvious reasons as to why that is not realistic. Nonetheless, there is a responsibility on the individual to register with General Practice, make appointments when needed and generally engage with services. This was highlighted as somewhat different to a military experience and if someone has been in the forces for a reasonable timeframe, this may be confusing. As such, it was suggested that service personnel being discharged should be registered with General Practice before they are discharged.

27. The Workstream was interested to discuss the concept of people returning from active service, with service related injuries, and how the local NHS dealt with that. The Workstream heard that if someone is seriously injured in active service, they would initially be treated and rehabilitated at Selly Oak (near Birmingham) or Headley Court (in Surrey). The first question at such facilities is whether the person can continue in the services. Should they not be able to continue and a medical discharge is considered to be appropriate, the person will identify the area they want to live in. At this stage, the Workstream was interested to understand how the Defence Medical Services (DMS) engage with the local NHS, to advise them of the person's impending return and their needs.
28. The Workstream was far from convinced that a great deal of conversations take place at the moment. The Workstream was advised that one of the roles of a PCT lead is to raise awareness of the issue, to make links with military personnel and to establish lines of communication, which could be utilised when someone was returning. The Workstream heard that a goal of the regional network would be that PCTs would have a case manager or key officer for each returning veteran (and any family) to ensure needs were met and they were put in contact with the people they needed to liaise with. This could include everything from medical support for ongoing health needs, to assistance with placing children in local schools to housing assistance. The Workstream felt that the concept of a case manager was a very good one and would be very keen to see such a development introduced. Indeed, the Workstream felt that a key role of the regional scrutiny exercise would be to argue for this development.
29. Whilst the Workstream acknowledged that PCTs would be crucial in assisting returning service personnel accessing the services they require, and funding appropriate medical care, Members were concerned to know what would happen post March 2013, when PCTs are scheduled to be abolished. In essence, the Workstream heard that no-one really knows what will happen, although there was clearly a need to proceed with this work and achieve as much as possible in the timeframe available. Progress could be made whilst engaging with the likely leaders of GP Consortia, to convince them of the worth of the

work and to commission adequate support in their future role. The Workstream heard that if this was done well, there was significantly less chance of the good work done by then 'falling between the cracks' and being lost. The Workstream accepted this argument, but feels that the impending demise of PCTs and SHA constitutes a very real threat to the embryonic support arrangements for the ex-service community, particularly in the field of physical health. The Workstream heard that by having a section dedicated to veterans' health in future Joint Strategic Needs Assessment (JSNA), the topic's profile would be kept high. In turn, this would make it more likely that GP Commissioning Consortia would inherit the responsibility and recognise it as a central part of the commissioning agenda.

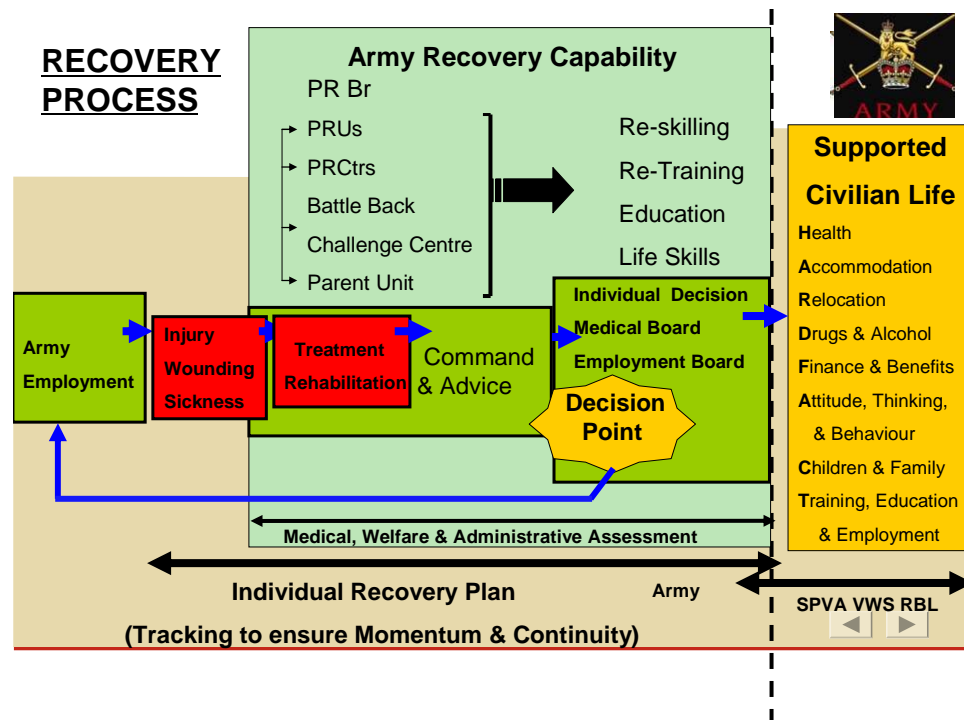
30. The Workstream was interested in exploring the topic of people returning with serious injury and ongoing physical health needs. Particularly, it was discussed as to whether civilian health services have sufficient expertise and experience to deal with the sorts of injuries and ailments that veterans could now return with, which are injuries which traditionally people may not have survived. It was accepted that military health services have a significant amount of experience and expertise in dealing with such injuries, although there was not thought to be any significant challenges in the level of expertise within the NHS. The Workstream did, however, hear of one possible tension between what people receive in the armed forces and what is available in the civilian NHS, which was also expressed at the evidence day on 28 June 2010. A small number of veterans have lost limbs and require prosthetics. The Workstream heard that the success of the Headley Court rehabilitation regime means the majority are highly mobile and require specialist limbs, which are very advanced and allow a great deal of movement by the wearer. The reality is that such military issue prosthetics are much more advanced than those traditionally available on the NHS.
31. People in their twenties or thirties wearing prosthetics will require work to be done to their prosthetics during their life time, including replacements. The Workstream heard that a real danger would be that a veteran using a military grade prosthetic, may develop a high level of fitness and mobility, which following discharge may be replaced by the NHS, using an inferior prosthetic. This would materially impact on the quality of life experienced by the veterans. As such, the Panel heard that the NHS provision of prosthetics to veterans (with service related injuries) will be equivalent to military issue, with reminder guidance being drafted to all NHS fitting centres. The Panel heard that this represents a learning curve for NHS personnel to become familiar with the prosthetics, as well as dealing with the additional cost. Nonetheless, the Workstream felt that this was a positive development.

Evidence from Mark Logie

32. The Workstream was keen to gain a Ministry of Defence perspective on service leavers and the support afforded to them as they leave.
33. By way of introductory information, the Workstream considered the following facts:
 - There are 800+ Service Leavers each year from bases in the region
 - In addition, there are 1,600 leaving training bases per annum
 - Many want to stay in the region
 - High % are seeking jobs in Transport and Communications, Construction or Manufacturing sectors, and in professional or skilled trade occupations
 - 15% want to start a business

Challenges faced by Service leavers include:

- Finding job opportunities, securing appropriate skills/qualifications, finding appropriate housing and financial issues (such as debt).
 - Lack of awareness amongst local businesses of workers & skills coming out of MOD bases
34. The Workstream heard that when someone has an injury or illness, before discharge is discussed, great consideration is given as to whether the individual can remain in the service in some capacity.
 35. The Workstream was interested to hear about Personnel Recovery Centres and the role that they play.
 36. The Workstream heard that following injury or illness, a trigger point was reached at 56 days, when someone goes into the PRC. The Workstream was advised that the PRC is not a medical facility, but a military environment where support and recovery are continued. A diagram outlining the process is overleaf.
 37. Within this environment and the environment of recovery units, the Workstream heard that there is a culture that a decision over someone's health and future 'takes as long as it takes'. Still, once a decision has been made that someone wants discharge on medical grounds, the Workstream was keen to explore the process that the individual would go through.



38. The Workstream heard that under current arrangements, responsibility does not transfer to post service providers (i.e. local authorities and NHS organisations) until an individual has left service and arrived in the local area. The Workstream heard that such a system where there is very little integration or service overlap, can create a situation where people can 'fall between the cracks' and a worry remains that people experience a noticeable dip in quality of care/service access upon discharge.
39. The Workstream heard that 450-500 people per annum leave the army on account of medical discharge. The Workstream noted that if North East England contributes around 10 -15% of military recruits, it is a reasonable assumption that the same percentage is being medically discharged back into the region.
40. The Workstream heard that it is crucial that the discharge process, and liaison between military and civilian health services starts around three months before the person is due to be discharged. This provides the best chance of the individual not 'falling between the cracks' and as much intelligence about the person and their needs as possible to be passed on.
41. It was said that this can actually be harder than it may appear. people tend to leave the forces at all times of the year, they do not leave at one time of the year, so the above would have to be a year round process, as opposed to a yearly handover.
42. Still, in terms of what should happen, the Workstream heard that the following process would be ideal:

MOD Team complete CHC Checklist

then

MOD Case Coordinator contacts Regional Strategic Health Authority (SHA)

then

SHA identifies relevant PCT and introduces PCT coordinator to the MOD Case Coordinator.

then

SHA refer to PCT for co-ordinator to be appointed for the seriously injured / ill.

then

PCT co-ordinator convenes multi-disciplinary team (MDT) involved with individual's care

then

Case conference

then

MDT completes Decision Support Tool (DST), to make a recommendation to PCT on CHC eligibility

then

PCT approves recommendation, develops and commissions care package

Or

LA assumes responsibility for care package depending on the requirements of the case.

43. The Workstream felt that the above process would be a huge improvement on what is currently offered and would ensure a smoother transition for the ex-service community. Still the Workstream queried how the above process, would be continued when the proposed changes to the NHS took effect and PCTs and SHAs were abolished.
44. It was acknowledged by all around the table that the proposed structural reforms to the NHS muddled the waters somewhat and left a

number of important questions unanswered. Nonetheless, it was said that it was better to establish a clear and robust process, which could be inherited and modified by the GP Commissioning Consortia, rather than waiting for something to be established in the future. Aside from the system's need to have some sort of process established, it was also crucial that returning veterans got a better experience of handover than they currently do.

45. The Workstream heard, again, that a co-ordinator within civilian health and social care services, with the power, responsibility and influence to take charge of matters was absolutely critical and was something that had to be established.

Evidence from RBL

46. In considering the topic of the Physical Health of the ex-service community, the Workstream thought it critical to hear the views of the Royal British Legion⁴.
47. By way of introduction, the panel heard that North East England branch of the Royal British Legion was one of thirty regional offices. It was confirmed that according to RBL's estimates, there are around 500,000 to 1million people living in North East England that constitute the ex-service community.
48. The Workstream was advised that around 50% of the ex-service community have a long-term condition, versus 35% of the general population. In addition, the Workstream heard that around 1 in 5 of the ex-service community live with multiple conditions.
49. Connected to that point, Members were keen to explore the topic of priority treatment for veterans. The RBL reported that a recent poll of GPs highlighted that around 33% of GPs were aware that veterans had rights relating to priority treatment and it was suspected that a fair proportion of those probably only knew about it due to recent media coverage. Further, it was highlighted that only around 10% of GPs had actually referred under the priority treatment initiative. In addition, it was reported that significant number of veterans do not know about their rights under the priority treatment initiative.
50. The Workstream was interested to explore how the RBL viewed the statutory agencies in the region and their approach to services for the ex-service community. The Workstream heard that even within an area that is relatively small, such as North East England, there is a

⁴ The Royal British Legion is a UK charity that provides financial, social and emotional support to millions who have served and are currently serving in the Armed Forces, and their dependants. The Legion was founded in 1921 as a voice for the ex-Service community.

great deal of variation with different PCT cluster areas having different processes to others.

51. The Workstream was advised that the Tees, Esk & Wear Valleys (Mental Health & Learning Disabilities) Foundation Trust have a lot of very good ideas about services for the ex-service community and seems very keen to educate staff about the sorts of issues that tend to impact upon the ex-service community. Still, it was said that getting in to using such services is often very difficult.
52. The Workstream was keen to explore good practice and good organisational approaches towards the ex-service community. The point was made that good practice and good services being developed seems to be down to individuals doing a 'good job' and possibly going further in their commitment to the issue, than they possibly 'have to'. This was a point that was unanimously accepted by those around the table and possibly highlights the key point of the issue. Good services and good approaches towards the ex-service community seem to be down to high quality members of staff and not necessarily policy and procedures embedded within organisations. The Workstream heard that this reality probably highlights that there is not sufficient organisational knowledge or organisational understanding about the issue as yet and the fact that individuals are so key highlights this perfectly.
53. The Workstream was given an example of how organisational systems were not necessarily set up to cope with the intricacies of providing services for the ex-service community. It was said that the RBL had significant historical experience of people leaving the forces and returning to an area they decided to settle in. Following which, they were told that they were not eligible for PCT support, as the person did not have a postal address in the PCTs area of responsibility.
54. The Workstream noted that whether someone had a family history in a given area of the country or not, it is fairly difficult to have a postal address in an area when you have been living in barracks or married quarters at a military facility in this country or abroad. Further, by agencies having such systems as that, it makes planning for someone's arrival in a given area, before discharge, all the harder. The same, it was said, can apply to joining dental surgery lists or general practice lists. Given that the at the previous meeting, the Workstream had heard the importance of military and civilian health services being in contact about individuals before formal discharge, to enable a seamless transfer, the above example seems slightly ridiculous and eminently avoidable. Whilst the Workstream heard that efforts were now underway to banish such practices to the past, the Workstream felt it was useful to consider the example and hear what can happen if agencies do not engage sufficiently.

55. Again, the point was made that historically, it was talented and committed individuals that ensured that problems would be rectified, as opposed to organisational systems allowing people's needs to be met as required.
56. It was emphasised that an ideal scenario would be to register individuals with General Practice and Dental Services, whilst they were still in the armed forces, as part of a gradual leaving process.
57. The Workstream was reminded that a fundamental point to relating to services for the ex-service community was the principle of 'no disadvantage', yet the RBL expressed the view that this does not always happen in practice.
58. The Workstream heard about the story of one representative from the RBL, who is also a veteran and in receipt of a war pension. The Workstream heard that he had a ankle problem following discharge from the services and sought GP assistance with it.
59. The Workstream was told that the GP either didn't know, or wouldn't acknowledge, priority treatment for veterans and it was only because that the individual knew of the policy that he was able to press the point. Nonetheless, it took him 9 months to have the problem addressed. This leaves the obvious question about what happens to veterans who are not in the fairly privileged position of knowing policy details and have the confidence to pursue the matter. The Workstream felt that such a circumstance highlighted the need for better awareness of the policy or an advocacy service for veterans.
60. The RBL advised the Workstream that unawareness of the policy may also be prevalent at Trust level, where there are a number of competing priorities and competing pressures. The Workstream was told that whilst the RBL does not have empirical evidence to support the point, it would suggest that ignorance of the veteran priority policy is fairly wide spread.⁵
61. Linked to this awareness of policy, the Workstream heard is a general lack of awareness amongst civilian health services about the impact that life in the services can have on the human body. To continue with above example, the Panel heard that the damage done to the average 30 year old's ankle is quite different to the damage done by six or seven years of active service. Without knowledge of someone's veteran status, GPs may make the assumption that someone's ailment isn't as serious as it is, or that the body part in question has come under 'normal' strain, when it may be something quite different.

⁵ Policy can be found here

http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_111886.pdf

62. The Workstream was interested to hear the views of the RBL as to whether there was anywhere in the country that had a particularly good service model relating to the physical health needs of the ex-service community. The Workstream heard that the RBL is not aware of any area which has a well thought out service framework relating to this.
63. The Workstream heard from the RBL that the topic of Prosthetics was undoubtedly a future challenge.
64. Building upon evidence that the Workstream had previously heard, it was said that people in the military who require prosthetics receive the very latest technology, which allows them to live very active lives. The question remained whether, as those people work their way through the system and leave the forces, whether the NHS has the expertise to cope with the military grade prosthetics. Further, whether the NHS would be able to fit such units when replacements are required. It was said that, in the view of the RBL, the NHS would have to rise to the challenge of better prosthetics, especially as it looks that there will be an expanding client base in the ex-service community.
65. The Workstream was told that the key for the development of services for the ex-service community was essentially one better communication and improved availability of information.
66. The Workstream was advised that this is essentially multi layered. Local authorities and NHS bodies need to have full clarity about their responsibilities regarding the ex-service community and be totally clear about the services they offer. They also need to have effective relationships with discharging military units and local partners to ensure that people do not 'fall between two stools'.
67. In addition, those individuals within organisations with a specified responsibility for liaising with the ex-service community need to be given the responsibility and freedom to act in the best interests of their clients and not be excessively bound by processes and procedures.
68. Finally, the ex-service community need to be empowered to ask questions if felt necessary. The Workstream heard that having one phone number to call to seek advice would be hugely beneficial, and those running the phone line could then 'join up the dots', between various organisations.
69. The Workstream heard that currently, the service offer to the ex-service community is piecemeal and rather ad-hoc. A standardised approach would be hugely beneficial, more efficient, an improvement on the current offer and possibly better value for money.
70. The Workstream was advised that something similar, albeit in a very embryonic stage, is currently on offer in North Yorkshire.

A Social Care perspective

71. As part of the evidence gathering process, the Workstream felt it was of crucial importance to seek the views of Local Government and specifically the views of Social Care Departments around the North East.
72. To do this, the Workstream approached the North East Branch of the Association of Directors of Adult Social Services⁶, as the representative body of all Directors of Social Care across the North East region. The Workstream prepared a series of questions, which were answered in writing by the North East Branch of the Association. The Workstream was advised that it is important to note that not all Local Authority service provision is the same, therefore the answers supplied are a summary. The following represents the questions asked by the Workstream, followed by response received from the Association.
- 73. Do local authorities have a clear picture of the extent of the ex-service community in its area of responsibility?**
- 73.1 *There is a general sense that local authorities do not have or hold this information. Local Authorities would come into contact with the ex service community as part of the LAs statutory duty to assess access to adult social care services (see below).*
- 74. Do local authorities include the needs of the ex-service community as part of the Joint Strategic Needs Assessment?**
- 74.1 *No, health and / or social care needs are not disaggregated in this way. The community's needs are therefore included in the JSNA under other issues: e.g. physical disability, mental health and illness, alcohol and homelessness, or – for older veterans – older people.*
- 74.2 *One LA suggested that specific information on people with a service history is gathered only when someone is admitted to prison, or when registering with a GP. They have asked for more details of the information on GP registration and will consider whether this is suitable*

⁶ The Association of Directors of Adult Social Services (ADASS) represents all the directors of adult social services in England. It evolved from the former ADSS (Association of Directors of Social Services) when responsibilities for adults and children's services within top tier local authorities were split between two new departments - the one for adults and the other for children. ADASS brings together the accumulated wisdom and understanding of the way services for adults are managed and financed as well as inputs from a widening responsibility for housing, leisure, library, culture and, in some case, arts and sports facilities. Its members are responsible for providing or commissioning, through the activities of their departments, the wellbeing, protection and care of hundreds of thousands of elderly and disabled people, as well as for the promotion of that wellbeing and protection wherever it is needed. Please see www.adass.org.uk

for inclusion in the JSNA. However, they feel that this will only provide a partial view of the community.

75. Have local authority given any thought as to how it may consider and provide for the needs of the ex-service community in its area of responsibility? Or do local authorities already have particular measures in place to support the physical health of the ex-service community?

75.1 *In general the physical health needs of the ex service community would be supported as part of the statutory services provided to those eligible for adult social care services. Those who are eligible for services can range across local authorities depending upon the FACS (Fair Access to Care Services) criteria which is implemented in any particular local authority.*

75.2 *Services are provided following a detailed individual assessment of need and tailored support plan. As part of the provision of universal services for all residents, we would provide advice and information and signposting to any ex-service personnel including help to access support groups, networks or NHS services.*

75.3 *Northumberland Council however uses Rothbury House on a spot contract basis for respite/short breaks to people with a service background. Rothbury House is a service provided by the Royal Air Forces Association located in the north of the county but taking guests from throughout Great Britain. The service, is fully adapted to meet the needs of anyone with a physical disability, has a lift, a range of adaptations and the staff are trained in moving and handling.*

75.4 *It is located close to the centre of the village and has extensive gardens and grounds. The service provides respite breaks primarily for ex-air force personnel – but also to personnel from other services - and their carers. The majority of its guests are older people, although short breaks have also occasionally been provided for under-65s. Our experience of the service is very positive and this is confirmed by formal inspection. The Annual Service Review of Rothbury House completed at the end of last year by the Care Quality Commission assessed its quality rating as a “three star excellent service”.*

75.6 *We also provide Disabled Facilities Grant for those people who are eligible and have established an arrangement with Soldiers, Sailors, Airmen and Families Association (SSAFA) where ex-service personnel are required to make a contribution to DFG.*

75.7 *Carers Northumberland – the county’s organisation for supporting carers – refers service and ex-service personnel and their families to*

SSAFA Forces Help for advice information and support. This includes access to a Family Escort Service.

76. How, in your view, could local authorities look to provide for, and maintain, the Physical Health of the ex-service community in their area of responsibility?

76.1 As previously stated the ex service community are able to access current service provision for the general population which is consistent with personalisation and with effective service provision. However, liaison with armed services to assess the extent, numbers and level of need (or specific needs) of the ex service community would possibly be beneficial.

76.2 It may be appropriate to begin to identify if there are issues with meeting existing eligibility thresholds for social care services which the ex service community currently face.

76.3 Another possibility could be to ensure that the current service community are up to date and briefed about what is available (support) for ex service men and women so they know what they can access when discharged from the armed services. Better information and advice needs to be shared between LAs and the Armed Services.

76.4 The example of service provision in Northumberland (previous question) is another example of how the specific needs of the ex service community can be met.

76.5 The physical health of any individual can be heavily reliant upon their mental health and we know that if a person is suffering from mental ill health their physical health can often deteriorate. There are specific health and social care issues for the ex service community including a greater risk of suicide in men under 24 years; Depression and Anxiety and Post Traumatic Stress Disorder (PTSD) therefore mental health provision is essential in keeping veterans fit and healthy.

76.6 In Durham there is a Veteran's Network which provides Integrated Mental Health Team staff who have additional awareness of Veterans needs. Acute psychiatric inpatient beds are provided by MoD for currently serving military personnel and two Community Psychiatric Nurses based at Merrick House specialise in the area of Veterans. The Support and Recovery Team provide in-reach support in hospitals through raising awareness of DCC services and Community Floating Support is offered to individuals with mental health needs, providing supported living assistance.

77. If service personnel return to your area, upon discharge, with ongoing physical health needs which amount to a disability, do local authorities have a process to liaise with Defence Medical Services and the PCT to ensure that there is a smooth resettlement for the veteran and any family?

77.1 As in previous answers Local authorities do not have a formal policy or specific procedures with the Defence Medical Services or the PCT to ensure a smooth resettlement. However, it is expected that existing inter agency protocols and partnership arrangements would address these needs.

77.2 Although not in specific partnership with the Defence Medical Services or the PCT there are examples of LA providing specific responses for the ex service community to support smooth resettlement. Northumberland's homelessness and housing options service has received caseworker training with the Royal British Legion to make the process for contacting sources of support for service personnel quicker and easier. In addition, contact has been established with a case worker with the same charity. A support worker is also available to complement the social housing allocations process,

77.3 The social housing allocations policy for Northumberland gives specific priority to people leaving the armed forces who are homeless or living in insecure accommodation and who have established a local connection with Northumberland in a variety of ways e.g.:

- have been brought up or lived for a considerable length of time in Northumberland*
- are normally resident in Northumberland;*
- are employed in Northumberland;*
- have a close family connection to Northumberland;*
- they have been in prison or hospital in the county.*

78. How can local authorities ensure that the changes outlined in the NHS White Paper, are used to ensure that local health and social care economies react well to the ex-service community in their locality?

78.1 The detailed changes outlined in the NHS White Paper are still subject to final decisions and it is difficult at this stage to be certain of their impact. However, it is clear that the existing emphasis on prevention and personalisation will be carried forward and will assist individuals with a service background to organise their care to match their specific requirements.

78.2 If planned changes in the White Paper do go ahead Local Authorities could consider the future role of the Health and Wellbeing Boards and GP Consortia in identifying current and future needs of the ex service

community and how these can be addressed. This could include a more prominent role for the needs of the ex service community being included in the JSNA which the LA will take a led role in developing in each area. Local authorities will also assume responsibility for Public Health in the near future. This again could be an opportunity for increased focus upon the ex service community.

78.3 *The 'Big Society' could also offer opportunities to develop services in the community to support the ex service community. This could be in the form of the creation of networks of local advocates to act as champions for the Armed Forces Community or through grant assistance to the voluntary sector to provide support.*

78.4 *Finally the White Paper and subsequent policy guidance from Government indicate a need for greater interaction / partnership working between health and social care. This could be an opportunity to better meet the needs of individuals from the ex service community and to take advantage of the findings from pilot project such as the Tees Esk and Wear Valley NHS Pilot. This is one of six pilot sites to host joint MoD, DoH and SHA project to provide treatment for veterans with mental health needs. 150 staff have been trained in military culture and mental health as part of veteran's pilot. If this proves successful it may provide information and advice which could be used to build upon in the future.*

Conclusions

1. The North East of England is an area that has a long and established history of providing recruits to the armed forces and remains a fertile recruitment ground to this day. Indeed, it provides a disproportionately high number of recruits, when one factors in the proportion of the national population, which resides in the North East. It is not unreasonable to expect that a significant number of those recruits will eventually return to the North East to settle, upon discharge. The implications of this is that the health and social care economy in the North East is required to be particularly sensitive and alert to the physical health needs of the ex-service community, as there will be a proportionately bigger ex-service community.
2. In connection with the above point, the changing nature of combat and particularly combat medicine, must be at the forefront of people's thoughts as they design a system to provide for the needs of the ex-service community. As is the case in the civilian world, military personnel are now able to survive injuries and illnesses that historically may have been too much to bear, due to advances in battlefield medicine. Whilst this is something to be very thankful for, it also creates a new generation of the ex-service community who may be returning to civilian life with complex and long term needs, that require significant levels of expertise and financial resource to meet. This is something that should be at the forefront of the health and social care

economy's thoughts when looking to provide for the ex-service community. It also increases the urgency with which the process of transition from military to civilian healthcare should be improved. The workstream is acutely aware of the country's ongoing military commitments and the sad likelihood that more casualties will follow, so it is something that should be addressed very swiftly.

3. There is a strong body of evidence to indicate that the ex-service community have worse health outcomes than the general population. However, the Physical Health Workstream has not come across any evidence to indicate that either the Defence Medical Services or civilian NHS do not provide the services expected of them to their target populations. The key point appears to be one of transition and the success, or not, of that transition from Defence Medical Services to the civilian NHS. Once an individual is fully engaged with either health system, the experience seems to be largely good. The workstream has heard from a number of sources that the transition for those leaving the forces, into the civilian NHS is patchy and extremely variable in its effectiveness. As such, it can often rely upon the individual, their support network or very good members of staff to make the transition work. It has been accepted by all who have spoken to the workstream that the link between defence medical services and the local NHS needs to be much tighter and much more systematic. The Workstream is confident that this need is accepted by system leaders and would expect such processes to become much more robust in the coming months.
4. Quite apart from medical services, there are lots of areas of civilian service where the ex-service community would benefit from earlier interaction. Services such as Jobcentre Plus and housing providers could begin to liaise with people, whilst they are still in the forces. This may facilitate a smoother transition for people.
5. Connected to the process of transition, Members are acutely aware that PCTs are having to negotiate a process where staff numbers are being cut significantly. It is unclear how easy it will be for such organisations to take on such new duties as having a named contact/case co-ordinator for the ex-service community.
6. It would be beneficial for Members to hear progress reports from PCTs about how they are establishing links with military colleagues to facilitate better discharge.
7. The implications of *Liberating the NHS – Equity & Excellence* are still being felt and worked through. Still, Members are conscious that a significant number of tasks are being laid at the door of local PCTs to pursue on behalf the ex-service community. The obvious question is what happens when PCTs are abolished?

8. It has become very clear in evidence that there is a huge cultural difference when someone leaves forces, and fairly simple civilian tasks such as making ones own appointments at GPs and having choices relating to healthcare can be counter intuitive to those with time in the services. Members feel that there is merit in investigating the viability of having a single advice line for the ex-service community, which could act as a single point of contact for advice, which could assist people as they acclimatise into civilian life. Such a service could be relatively low cost if supported and contributed towards by all relevant agencies.
9. Whilst the Workstream has focussed on the role of health and social care, there are a significant number of local authority services that could assist the ex-service community in integrating into an area and 'getting on'. As such, Members feel it is important that all local authorities nominate a senior officer to be a lead and conduit for the ex-service community.
10. The Workstream has been struck by how little we know about the ex-service community in the North East of England. We do not know its size, its geographical spread, age profile, typical employment status, health need or any other key intelligence. This lack of information has made it very difficult at times to scrutinise the topic and must make it extremely difficult for the planning and commissioning of services. Without such data, members would question whether the community's needs can be intelligently met.

Recommendations

- There should be a single point of access/phone line for all issues of support for the ex-service community, which could be commissioned and provided on a regional basis.
- There should be named senior staff to act as Case officers/co-ordinators in PCTs to act on behalf of the ex-service community whilst assistance is required. Further, PCTs should establish links with military based colleagues to facilitate better transition. Members should receive evidence demonstrating those links and how they are working.
- Local authorities should have a named senior officer to assist the ex-service community and act as a facilitator/conduit
- General Practice has a new role as future commissioners of health services. It is imperative that General Practice is aware of the priority treatment schemes for veterans and that it is utilised when appropriate if referrals are necessary. PCTs should emphasise this point to General Practice now.
- PCTs should begin conversations now with the embryonic GP Commissioning Consortia regarding the merits of commissioning for ex-service community. PCTs and Consortia should report back to Members

how the needs of the ex-service community are going to influence commissioning strategy during the transitional period and when Consortia have formally taken control of Commissioning budgets.

- Local authorities should include the ex-service community, as a clearly visible and specified section of Joint Strategic Needs Assessments, which should then drive commissioning decisions. The Workstream would also be interested to hear whether having a services representative on local health and wellbeing boards is worth exploring.
- It is crucial that Strategic Health Authorities, and their successor bodies, take a regional lead and commission detailed and accurate work to establish true size and nature of ex-service community. It should also seek the gain intelligence about those 'soon to leave', their likely destination and the demands that will place on localities. This should be a piece of work that is periodically refreshed to ensure it remains relevant.
- It is imperative that local NHS organisations work closer with military colleagues to ensure that people leaving the services are registered with GPs and dentists before formal discharge, so they have a 'foot in both camps' towards the end of their active service. This would ensure a smoother transition to civilian health services. This sort of forward planning should also apply to civilian agencies such as Jobcentre Plus and Housing providers, who can make contact and establish relations with leaving service personnel. This would enable a smoother transition into civilian life.
- It is of crucial importance that registered social landlords are aware of the prevalence of the ex-service community in the north east and they ensure that their allocation policies make specific reference to accommodating the ex-service community. Policies should recognise that the ex-service community will probably not have a recent history of residence in the locality.

