Veterans Mental Health

NHS England and CONTACT

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Initial objectives

- Work on a common assessment framework (CAF) for use by both NHS and charity/independent military mental health treatment providers registered with CQC across the 4 devolved administrations

- Use the CAF, especially for veterans moving between or accessing multiple services (both statutory and non-statutory) **the common information** collected and the **information-sharing capabilities** of the system will mean that veterans will not be required to repeat their medical and military histories multiple times

- Identify the best way to implement the CAF to suit different providers.

- Work with the professions involved into how differing cultural attitudes to some of the issues might be addressed, and also to look at developing some generic guidance for some of the challenges around information governance and data sharing.

Veterans Mental Health services

CQC registered Mental Health services provided by the NHS and Armed Forces charities fall into:

(a) IAPT type services

(b) Community MH team services

Clinicians want choice and flexibility in the assessment tools they use however recognise the benefits of using an **agreed mandatory core data set**.

Action : Determine what the core MH data information will include .

Validated assessment tools in use across the NHS and Armed Forces Charity Providers (not exhaustive)

- Hospital Anxiety and Depression scale
- Edinburgh Mental Health Wellbeing Scale
- International Trauma Questionnaire
- Panic Disorder Severity Scale
- Health Anxiety Inventory
- Body Image
- Clinical Registry
- IAPT data set
- Mental Health Core Data Set
- Others

The sub-group has developed and refined a framework document in response to feedback, including essential and desirable criteria, divided it into separate sections for different categories to aid providers who may carry out different types of assessments at different stages

Action: Finalise and agree which validated tools are recommended for use and ensure the MH Core data set is included as part of those assessment tools .

How might we implement Veterans Mental Health core data set ?

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Shared Care Record

The aim of the Local Health and Care Record programme is to create an information sharing environment that helps health and care services continually improve the treatments used, ensures that care is tailored to the needs of each individual, and can empower people to look after themselves better and make informed choices about their own health and care.

The Shared Care Record will allow health and care professionals to view appropriate information contained in:

- GP practice medical records
- Information from secondary care, including hospitals, mental health and community services
- Radiology and pathology results
- Maternity records.

Benefits of the Shared Care Record

- Reduction in the amount of times people have to repeat their histories to different health and care providers.
- Development of robust systems to ensure personal health and care data is always fully protected and secure.
- Ensures data from the NHS and care providers is shared safely, securely and lawfully, respecting an individual's choice of what is shared.
- Supports local areas that are already adopting best practice (by following the ICO Data Sharing Code of Practice2) in the collection, protection and use of health and care data to go further, faster.
- Makes better use of information from people's health and care records, to understand more about health and disease, improve public health for the population, develop new treatments, monitor safety, and plan and deliver health and social care services more effectively.
- Builds on existing local leadership, accelerates the compliant, secure and ethical sharing of information to improve patient care locally
- Spreads benefits more rapidly across England by co-creating and co-designing the architectures and standards needed to enable information to be appropriately and safely accessed and used to enhance individual care to patients as their care is provided within different health and social care organisations.
- Will create a set of national standards that all local health and care record initiatives across England will be re quired to follow

There are a number of Pathfinder sites across England developing this concept successfully who will work with us to explore the inclusion of CQC registered Veterans Mental Health providers with data set inclusion

Other Opportunities - Summary Care Record

The NHS has introduced the Summary Care Records to improve the safety and quality of patient care.

- The Summary Care Record is an electronic record which will give healthcare staff faster, easier access to essential information to help provide people with safe treatment when needed such as in an emergency or when the GP practice is closed
- Individuals can enable healthcare professionals working in different care settings to access Key information from their GP record. Currently, SCRs are widely used across NHS urgent and emergency care, such as NHS 111, 999 and Accident & Emergency Departments. However, the SCR may also be used in planned care to provide up to date clinical information.
- The Accessible Information Standard ('the Standard') requires health and care professionals to identify, record, flag, share and meet the information and communication needs of patients with a disability or sensory loss.
- The Standard requires GPs and some other GP practice staff to record details of patients' information and / or communication needs in their patient record using specific terms or 'codes' which are listed in GP Practices' clinical record systems.
- Recording information in a patient's GP record is especially important, as it enables the information to be shared with other health and care professionals, including through the SCR.
- The Summary Care Record will automatically contain important information about any medicines allergies, bad reactions to medicines previously experienced.
- Additional information to your Summary Care Record can be added - this may include significant medical history and details about immunisations, communication needs and personal preferences.

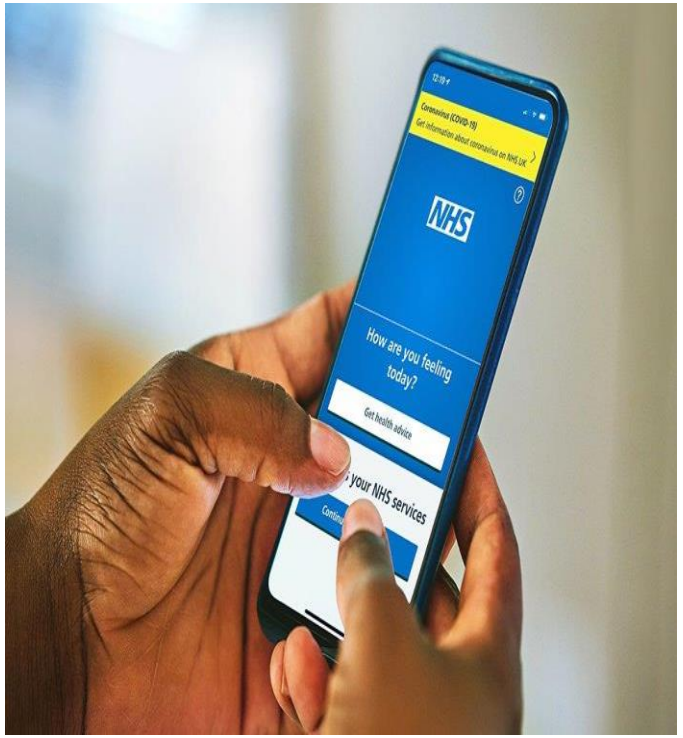
Action: Raise awareness of the application and link to the NHS England commissioned RCGP accreditation of Veteran friendly practices programme

Patient Record (Health Record)

When a person visits an NHS or social care service, information about them and the care received is recorded and stored in a health and care record. This is so people caring for that individual can make the best decisions about an individuals care.

The information can include :

- name, age and address
- health conditions
- treatments and medicines
- allergies and past reactions to medicines
- tests, scans and X-ray results
- specialist care, such as maternity or mental health
- lifestyle information, such as whether you smoke or drink
- hospital admission and discharge information



Action: Raise awareness amongst Veterans about the Health Record and how to access this digital application

In summary

- Agree what the core information Mental health data set will include
- Agree the use of a number of **validated** Mental Health assessment tools and ensure the core MH data set is included in all
- Work with NHS England Pathfinder exemplar sites to explore the inclusion of the CQC registered Veteran Mental Health service providers data set
- Encourage the uptake of the Veteran Mental Health Summary Care and link to the NHS England commissioned RCGP Veteran Friendly accreditation programme
- Raise awareness amongst Veterans about the Health Record and how to access this digital application