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Duty and Care

Armed Forces Family Mobility and Health Care Report

Contents

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Foreword

We have been delighted to co-sponsor this important report. When we set out on this work with our partners, our aim was to support practitioners across Defence and the NHS in making practical and positive changes that would impact the lives of mobile military families. It is said – sometimes too often – that military families are resilient.

Whilst this may be true, coupling a mobile lifestyle with a family member with health care needs can often seem like an insurmountable problem. No family should have to be resilient all the time, and our aim is to remove the barriers when we can.

On many occasions the Families Federations have been approached for help when families have run out of options and feel that they are faced with either living separately – or the Serving family member choosing to leave the military. There may be occasions when those scenarios are right for some families – but if making simple changes can avoid this, simply put – it must be the right thing to do.

Our partners at NHS England and NHS Improvement, Anglia Ruskin University, and the MOD Families Team have been deeply engaged in this work, and we have been grateful for their support and engagement. We also want to thank the many military families who have shared their experiences with us over the years – and specifically to inform this report. Their voices are the most important ones here.

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Executive Summary

The primary objective of this report is to provide practical and operational recommendations for policy and practice, directed at care providers, the NHS, MOD, and families themselves, to tackle disadvantage and improve health outcomes for those families required to move frequently as a result of Service need. This study, was supported by NHS England and NHS Improvement, conducted by the Veterans & Families Institute for Military Social Research at Anglia Ruskin University (ARU) in partnership with the three Families Federations. Ethical approval for this research was granted by the School Research Ethics Panel for the Faculty of Health, Education, Medicine and Social Care at ARU.

Given that the study was carried out in 2021, the impact of, and any lessons that could be learned from, the concurrent COVID-19 Pandemic was built into the programme of investigation.

> *"So, we had to move."*

The UK Armed Forces are comprised of a highly mobile workforce, frequently posted to locations throughout England, across the borders of the devolved nations and overseas. While dispersed living (defined in some documents as living more than 10 miles from the place of work) is an increasingly attractive option for some, most military families make the choice to live accompanied with their serving partner; in 2021, more than three-quarters (77%) of military spouses reported living with their partners during the working week. For those military families who choose to accompany their serving partners, that decision brings with it a commitment to also be mobile in response to Service requirements. Each year a significant proportion of military families are required to relocate. Approximately one-fifth of military families may move for Service reasons in any year.

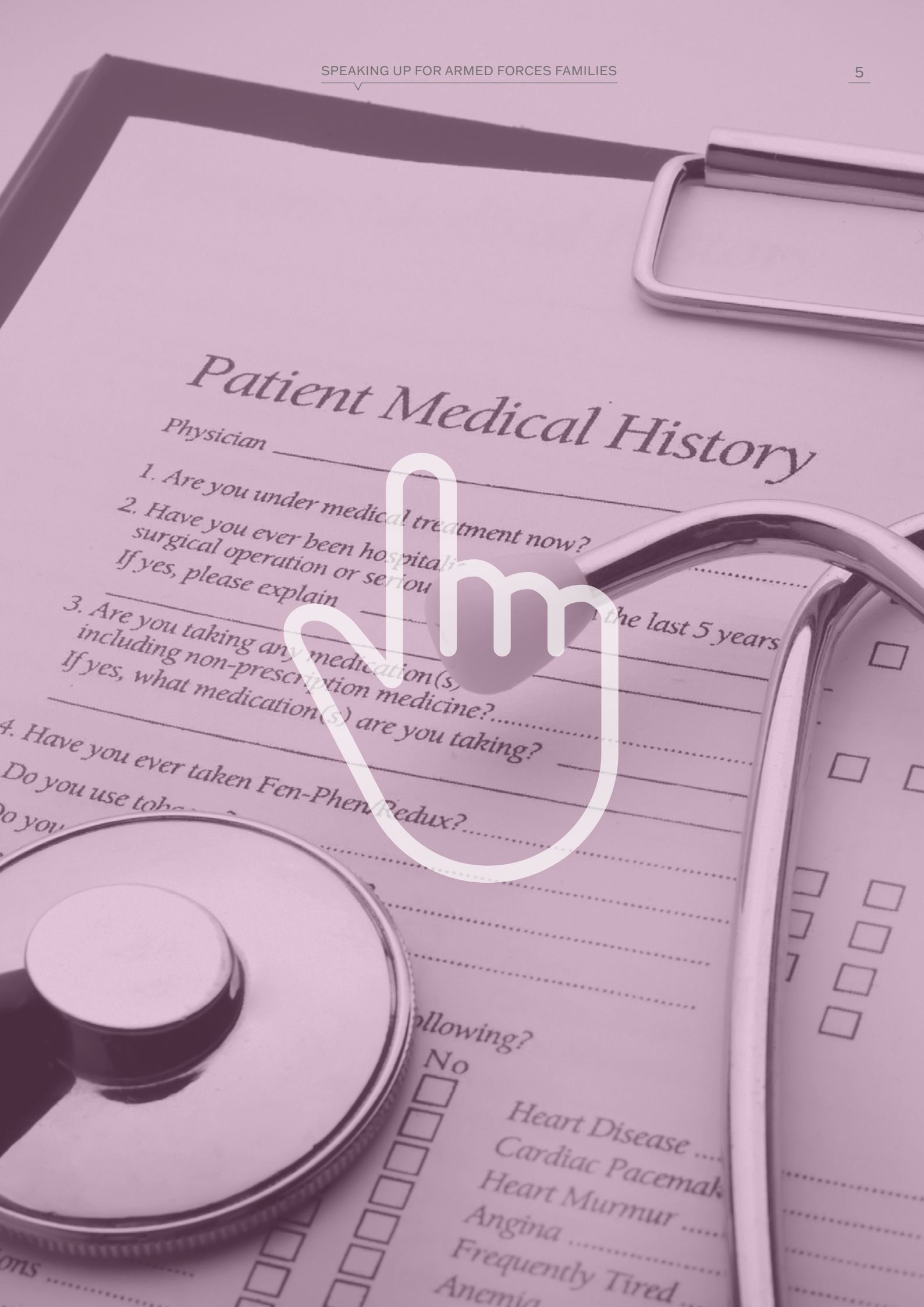
The health care needs of Service personnel are provided through the Defence Medical Services (DMS) and include primary health care, dental care, community mental health care, specialist medical care as well as rehabilitation and occupational medicine. In contrast, health care provision for most military families is reliant on NHS services available in their locale. The NHS delivers primary health care in England through contracted providers which include GPs, dentists and pharmacies. Secondary care is largely provided by NHS facilities and is commissioned through several locally based clinical commissioning groups (CCGs), which are in the process of evolving into a smaller number of larger integrated care systems (ICSs).

In Scotland, primary and secondary services are integrated and mainly delivered through 14 Territorial and seven Special Health Boards by NHS Scotland. In Wales, health care is mostly provided through NHS Wales, and delivered by seven regional health boards and three national focused Trusts. In Northern Ireland, health care is provided by five integrated Health and Social Care Boards and delivered through six Health and Social Care Trusts.

In certain circumstances, military families can access health services provided by DMS. Those families accompanying Serving personnel overseas, for example, are eligible to access primary health care through Defence Primary Health Care (DPHC) medical centres and secondary/specialist care through local services and contracted providers. Within the UK there are also several DPHC medical centres with which Service families can register. These are in locations which have large Service populations or are in remote locations which may have limited local health provision and/or where there is a training value for military health care staff.

The frequency of Service moves combined with the idiosyncratic/localised nature of health and/or military health care provision can present challenges to mobile families as they move across regional and national borders, particularly when those moves coincide with periods in which families are actively undergoing or continuing treatment. In 2021, significant proportions of military families reported requiring access to health and community care services including: dental care (82%); GP services (89%); hospital or specialist services (54%); and mental health treatment (18%).

While relatively few of these families reported relocating while in receipt of health care – ranging from 2% of those moving who were receiving mental health treatment to 9% of those moving who had ongoing GP treatment – their experiences are important to note. The majority of those who were in receipt of


Patient Medical History
Physician
1. Are you under medical treatment now?
2. Have you ever been hospitali-
surgical operation or seriou
If yes, please explain
the last 5 years
3. Are you taking any medication(s)
including non-prescription medicine?
If yes, what medication(s) are you taking?
4. Have you ever taken Fen-Phen/Redux?
Do you use toba
llowing?
No
Heart Disease
Cardiac Pacemak
Heart Murmur
Angina
Frequently Tired
Anemia

hospital/specialist, dental or mental health care were either unable to access this care after a move, or only managed to do so with some difficulty. In contrast, most Service families (58%) who had moved while receiving GP care had been able to transfer this to a new primary care provider without difficulty. These figures, however, have to be put in the context of the COVID-19 Pandemic.

Health care and the military family is a fluid policy area. Three significant publications, produced in the past 18 months, influence current policy development and the need for this study. In 2019, Gavin Williamson, the then Defence Secretary, commissioned an independent review to assess the needs of military families and the extent to which existing services were meeting those needs. The resulting report, *Living in our Shoes*, was published in 2020 and put forward 110 recommendations for the improvement of policy and services derived from the authors' extensive consultation with stakeholders and review of the existing evidence. Among these recommendations, are a number that specifically seek to drive improvements in the health and wellbeing of military families, including their experiences of, and access to, health and social care and ways in which military mobility might better be managed to improve health outcomes.

In March 2021, the UK Government published its official response to the report, accepting the vast majority of its recommendations and outlining a series of actions, commitments and specific support measures. NHS England and NHS Improvement's commitment to the improvement of the health and wellbeing of the Armed Forces community is further outlined in the document *Health care for the Armed Forces Community: a forward view*. Published in March 2021, it recognises that the Armed Forces community, when compared with civilian populations, can face additional life challenges including extended periods of separation from partners, families and friends; social isolation; frequent and unplanned moves; and difficulties navigating health systems with different treatment approaches and funding structures. The document sets out nine commitments, the second of which outlines NHS approaches to supporting families, carers, children and young people in the Armed Forces community. *The Forward View* is a companion document to the *NHS Long Term Plan* which makes recommendations for the ways in which approaches to the improvements for health provision to the Armed Forces community can be embedded within ICSs.

Through qualitative enquiry, this report aims to enhance understanding of the challenges faced by military families when trying to access, maintain and transfer health care while balancing Service need to relocate within England, across the borders of the devolved nations and overseas. Critically, it seeks not just to provide examples of where mobile military families have been disadvantaged as a result of health, community and military care systems failing to meet their needs, but also to evidence best practice where we have found it.

The first phase of the qualitative research comprised interviews with UK Service family members from across the three Services (Royal Navy, Army and Royal Air Force). The first phase of qualitative interviewing took place over a three-month period between January and March 2021. All of the interviews were conducted remotely via Zoom or MS Teams video platforms or via telephone. Interviews with the military families lasted between 60 and 90 minutes, and were recorded subject to the necessary consents and transcribed verbatim.

Interviews with military families were conducted using a semi-structured discussion guide. The use of semi-structured interviews offered a number of tangible advantages in this research context. It allowed for a meaningful comparison of data, while offering participants the flexibility of introducing contrasting ideas and perspectives. It also provided opportunities for participants to express their own thoughts "rather than being restricted by researchers' preconceived notions about what is important". Furthermore, semi-structured interviews allowed the research team to obtain the maximum benefit from the participants' contributions, in effect affording them the opportunity to be "the experts and to inform the research".

The second tranche of qualitative research comprised interviews with subject matter experts (SME) with some responsibility for providing, commissioning and/or advising on health care for military families or those who could offer insight from strategic or policy perspectives. These interviews took place over an eight-week period between April and June 2021. As with the family interviews, discussions with SMEs were also conducted remotely by phone or video conferencing platforms, were recorded with the participants' consent and transcribed verbatim.

A semi-structured interview schedule was also used to guide these discussions. SME participants for the research were identified through ARU and the Families Federations' existing networks. Among those who responded to an invitation to participate were representatives from the local authorities, MOD, NHS and the third sector.

Recommendations were synthesised from the report by SMEs from DPHC, the NHS and the MOD working with the Families Federations and ARU.

> *"I think there is an issue with timescales."*

All the families interviewed accepted the fact that mobility was part and parcel of a military career; many spoke of knowing what they "had signed up for" when they had become part of a military family. Even those with the most experience of relocation, however, still reported recurring anxieties and challenges which frequently accompanied a new posting or assignment. Notice periods of new postings or assignments varied markedly across the sample; it was also the case that individual families had historically experienced different notice periods depending on a particular post. Some families said they knew approximately a year in advance of when, if not precisely where, their next posting would be. At the other end of the spectrum, several families had been given as little as two weeks' notice to move. Those with complex and/or multiple health and social care needs unsurprisingly appeared to be the ones most impacted by relocation and felt that they had been disadvantaged as a result. Those with specific accommodation needs such as proximity to specific community and health care services, reported some additional relocation challenges. Most commonly these centred on the requirement to demonstrate recurrent evidence of need, often in the form of reports provided by occupational therapists or having to move into new properties before the necessary adaptations had been put in place.

Beyond the military processes of relocation, families generally felt that the burden of responsibility to manage the logistical challenges of a new posting fell to the families themselves. There were frequent reports of a reliance on informal networks, social media and web searches. Many of the participants talked of the changing nature of military life in this context. There was an overarching perception that the military in recent years had become less family centric and that this was reflected in the perception that support for mobile families was limited.

> *"I'm sorry to land on your door."*

Registering with a GP was one of the main priorities for families when negotiating a military move within the UK, as very little in the NHS can happen without completing this process. With so many varied experiences of military mobility extant within the research sample, most participants had at one time, or another encountered issues when registering with a new GP within the UK. In those examples of negative experiences, however, were instances where registration, while time-consuming and involving multiple form-filling, had been largely unproblematic. It is important also to stress that for the most part, participants talked highly of the standard of care they had received from one or more of their GPs and many valued the relationships they had managed to foster with them.

Participants talked of needing to have a physical address or proof of residence before being able to register for a civilian GP surgery. Depending on the notice periods they had received of their move and the efficiency with which housing applications had been processed, this had caused some delays in families being able to register and get on to the system. This is a cause of frustration and anxiety for some, particularly those who require regular medications or were in the middle of a diagnostic process or course of treatment. There was a very real concern among these individuals that delays in registering at a GP surgery might compromise the continuity of their care, leave them unable to access prescription medication or that they would have to wait longer for GP referrals to secondary or specialist care.

Having registered, a common sentiment expressed by families was that they could not get enough time with their GP; the allotted consultation periods were simply not long enough. This was particularly true for those who had just moved to a new area and were keen to introduce themselves and discuss their or their family's needs at the outset. For those with complex health needs, 10-minute slots did not seem sufficient time for the effective management of their case.

Equitable access to health care for mobile families had been compromised on occasions because of a lack of awareness among GP practice staff of the specific needs and circumstances of military families. Most of the participants, however, said that they mentioned their association with the military explicitly as a matter of course when registering with a new practice, although none said that this information had been sought by the practice when completing the registration process. Participants said that, by declaring their status as a military family, practice staff sometimes felt that they were trying to jump the queue or secure preferential treatment when in fact all they were trying to achieve was a seamless transfer of care and to ensure that they were not disadvantaged because of their mobility.

"My notes from Scotland never made it."

Families in the research cohort also experienced issues with the transfer of the records between primary care providers following relocation. Issues included: delays in the arrival of records at the new practice; those records being incomplete when they did arrive; or records being lost in transit. Problems with record transfer were particularly evident among those families who had experience of moving to and from the devolved nations and England, but there were also examples of problems arising when families switched from DPHC to NHS primary care.

An overarching sentiment expressed by the mobile military families was that relocation invariably resulted in participants, with every move, having to start over with their health care. Preliminary consultations and case reviews with GPs, for example, often resulted in participants being put on waiting lists for referrals to new regional specialists. This could be in spite of the fact that a care plan and in some cases a date for a procedure had already been set prior to them having to relocate. The issue, as a few of the participants pointed out, was that after every move they were treated as "new" patients, not as patients who had a treatment regime in place and were looking to "simply" transfer care between locations. It was a common experience among the families participating in the research that moving across regional or the devolved national borders had compromised their ability to access health care that had been previously agreed elsewhere.

Families discovered that surgical interventions and medications were not always supported by the CCG/ICS or the national NHS responsible for authorising health care in their new region or country. Families were keen to stress that they were not looking for shortcuts or favourable treatment, just that they should not lose access to care that had already started or previously been approved. For some there was a clear disconnect between their expectations of what care the NHS should provide and the day-to-day practicalities of health service availability in particular areas.

Military families were left to try and re-establish levels of care they had previously managed to negotiate with their health professionals whilst previous carers could offer advice but were able to exert limited or no influence on the management of their former patients' care once they had moved to another area. There was an overriding sense among the participants that relocation often removed, to varying degrees, families' agency and control of health care and health choices.

"So, he's still not in school..."

Some of the most complex cases relating to health care access and mobility recounted by the research participants were those that centred on the challenges of trying to secure the continued care and support for dependent children with specialist health requirements, mental health needs and/or special

educational needs and disability (SEND). Evidence from the families' accounts would suggest that these complexities were compounded further when trying to relocate between England regions, across the borders of devolved nations and returning from overseas.

Echoing some of the experiences families had with other secondary care, families reported regional/ national differences in the ways in which treatment was administered and care pathways were structured, which made the systems extremely difficult to navigate and comprehend. Families reported being informed of waiting times for Child and Adolescent Mental Health Services (CAMHS) of up to two years; timescales which were clearly problematic for those military families who were required to relocate often. Families felt that there was real danger that they might be side-lined as a result; if referral time potentially exceeded their time in an accompanied post, then they worried that care providers might be less motivated to prioritise their needs.

"We haven't got a dentist here."

Accessing NHS dental services was a problem reported by many of the military families. According to the participant accounts, demand for NHS dental care far outstripped supply, resulting in limited availability and long waiting lists. The issue for mobile military families was that waiting times for NHS dental services were often longer (typically 18 to 24 months) than the duration of their current posting; by the time they had made it to the top of the list, it was often time to move on. With every new posting, mobile families then had to restart this process, in effect never actually getting to the top of the list. Regional differences in NHS dental provision were also apparent in the families' accounts. Some had encountered few problems accessing dentists in Scotland, for example, but across England most had struggled to find places, with London singled out by a couple of participants as being particularly difficult. Some military families had simply not transferred their dental care between regions when they moved, choosing to travel often large distances for annual check-ups.

"Especially when COVID-19 hit."

A common theme across all the discussions with military families was the impact that COVID-19 had had on participants' ability to access health and social care. For many, lockdown measures had created additional layers of complexity which had further exposed them to health disadvantages. It was also the case that participants found it difficult to ascertain the extent to which their current struggles with health care could be attributed to COVID-19, or whether these were in fact indicative of the challenges of military mobility more generally. COVID-19 had certainly compromised families' ability to access GPs in person and the intermittent mandated suspensions of routine dental care had also been severely restrictive. COVID-19 also had impacted severely on some families' ability to access secondary and specialist care. There were reports of COVID-19 restrictions compounding the time taken to get referrals, but also limiting families' access to specialists and medical procedures. However, the overarching perception of participants was that COVID-19 had normalised remote interactions and in the context of health care families had welcomed the flexibility and convenience that this introduced to management of their care needs. SMEs also suggested that there might be merit in building on the public's increasing familiarity with and acceptance of video platforms to improve user experiences of health care. SMEs stressed concerns about the effect the pandemic was likely to have on waiting times and access to treatment. There was an overriding perception that increasing pressures on a post-COVID NHS were likely to exacerbate the potential vulnerabilities that mobile families already faced.

"Have you heard about the Armed Forces Covenant?"

Awareness of the Armed Forces Covenant, ensuring that those who Serve, or who have Served in the Armed Forces, and their families, are treated fairly and critically, "should face no disadvantage compared to other citizens in the provision of public and commercial services", among the family participants in this research study was relatively high. Although it is important to note that many of the families' first experiences of it came through their interactions with the Families Federations in the context of attempting to resolve health care challenges. While some admitted that their understanding of the Covenant was limited, many were able to articulate its core tenet. As a tool for professionals working within the military/health care space there was some evidence from the families' accounts that the Covenant could help to expedite positive outcomes. Families appreciated that "in the right hands" and when used by those with knowledge and expertise of the Covenant and its application – and indeed its limitations – it could be used to mitigate potential health care disadvantages experienced by mobile families. Limited knowledge of the Armed Forces Covenant amongst health care providers was an issue, but even when health professionals were aware of it, families often were left with the impression that it made little difference to their continuity of care or their ability to access health services in a timely manner.

What was evident from the participant accounts was that there was a disconnect between families' expectations of what the Armed Forces Covenant could achieve in health and community care contexts and health professionals' interpretations of their commitment to the Covenant and what was practicable. Ultimately, if waiting lists for particular referrals or procedures were a certain length in a new location, families felt health professionals, even if they were committed to the Armed Forces Covenant, were able to do little to mitigate the disadvantage they had experienced as a result of relocation.

Working with the NHS, the Royal College of General Practitioners has developed a veteran friendly accreditation scheme for GP practices that aims to embed Armed Forces awareness within practices and ensure that veterans are able to access the best care and treatment. Some of the SMEs commented that the 'veteran' label accompanying the accreditation scheme may impact on their effectiveness in addressing the needs of military families; families may not recognise that veteran accreditation applies to them. This may go some way to explaining the low levels of awareness of and engagement with accredited health services among families in the study.

Evidence was also provided by SMEs of other NHS initiatives that were raising awareness of the Armed Forces community among medical practitioners. Armed Forces health is now incorporated in the syllabus for trainee GPs, but contributions from NHS SMEs indicated an ambition to extend Armed Forces awareness into the consulting, diagnostic and administrative syllabus for hospitals. The rationale being that greater knowledge of Armed Forces contexts would help health professionals with their decision making. Many of the SMEs spoke positively about NHS commitment to improve health care provision for military families and its willingness to engage with cross-sector stakeholders.

"Everyone needs to know that they should fill that in."

While the families themselves, for the most part, felt that the military did little to take family health needs and circumstances into account when relocating Service personnel, MOD SMEs referenced Joint Service Publications (JSP) and single Service policies which allowed families to feed contextual information into military career management systems. Indeed, in certain cases, this is actually a mandatory requirement. MOD SMEs also suggested that Service personnel are encouraged to register dependants with additional needs (including acute or chronic health illness) and/or disability with Career Managers. Policy and guidance on the support available to Service personnel are detailed in JSP 820 and at single Service level through AGAI 108 (Army [now AGAI 81, Part 8]), BR3 (RN) and AP3392 (RAF).

SMEs noted that more could be done to encourage Service personnel to engage with existing systems of reporting family health and care needs and guiding them through the process of keeping Career Managers up-to-date and informed. As MOD SMEs suggested, without that information, there were limits to what support and guidance could be put in place to help families. SMEs perceived there to be a number of extant barriers to Service personnel providing information on family health and support needs. There was a perception that a degree of cultural reticence may persist within the military with regards to help-seeking, but also that Service personnel might be wary of divulging family health and care needs. While Service personnel may be aware of the ways and importance of registering family needs, this information may not necessarily be reaching non-Serving members of the family. This perception was iterated across all groups of SMEs from health care, the MOD, charities and local authorities and indicates a need to involve improved information flow to families.

"I already start to get the fear."

It was clear from the contributions of the military families that the complexities of regularly having to navigate health care services with every relocation impacted significantly on mobile military families' quality of life and wellbeing. Notices of pending moves, for some, were anxiety-inducing even for those who had experienced relocation multiple times. The toll that relocation and attempting to secure continuity of care had taken on military families' mental health and wellbeing was not inconsiderable. Participants described occasions when they had broken down in tears, felt like they were failing their children and even sought mental health support.

All the families interviewed had spent the majority of their time together as an accompanying partner. The challenges of having to co-ordinate health care with frequent relocations had, regrettably, forced some families to reconsider their future living arrangements. Other families reported having discussions with their partners about turning down certain postings or indeed leaving the Services because of the difficulties they had encountered balancing continuity of care and the interests of the family with military mobility.

Implications for Policy and Practice

The research has highlighted a number of areas in which military families have faced disadvantage as a direct consequence of their mobility. The research points to some clear opportunities for the MOD, health and social care providers, the third sector and the families themselves to help mitigate these health inequalities. A draft set of 15 recommendations were distilled from the study and presented for discussion at a half-day Recommendations Working Group, convened at the Union Jack Club, London on 01 November 2021. The Working Group comprised stakeholders from the MOD, NHS England and NHS Improvement, the Families Federations and ARU. A revised set of nine actionable recommendations were compiled following the meeting and circulated to the Working Group for comment. Agreement was also sought on the organisations and departments best suited to deliver against these recommendations.

Here is the complete list of these recommendations:

Recommendations

1. Gaining Confidence of Families

Greater consideration should be given to the impact that mobility has on some families and the pressure it places on health, social and community care and support services. Service personnel and their families need to be confident that in informing the Chain of Command (Career Manager, Medical or Welfare staff) of their medical or social care needs it will elicit a positive reception, promote an agreed and acceptable outcome, empower the family, support better career management and prevent health disadvantage in the assignment process. There are tri-Service discrepancies in the current process and the language used, although designed to protect the Service person and family, may be construed as discriminatory. The MOD should have a coherent, strategic and pro-active approach to communicating this subject to families. To avoid difficulties and disadvantage, particularly in short notice assignments, the benefits of registering and updating health, carer and social care needs should be better articulated to families in a language and format that is easy to understand and is accessible. All people in Defence (particularly Officers and SNCOs) should talk openly, creating a transparent narrative about how sharing information on their family is empowering and describing the benefits disclosure has brought to them. Those responsible for writing and applying relevant JSPs and single Service policies need to be well versed in the reasons this information is important, so that Career Managers can actively encourage Service personnel to share, explaining why it will help them, giving examples and providing reassurance. They should be aware that the language used is important and where appropriate make a lay language guide available, online, to families.

To be delivered by MOD Defence People Team and single Services.

2. Building on Existing Frameworks

The framework, policies and practices in place to protect and support families for potential overseas (non-UK) assignments appear to work well, the systems in place for domestic relocation do, however, have fewer safeguards. Aspects of policies for non-UK assignments should be adopted, in an appropriate format, for UK assignments, especially when crossing devolved national UK borders where differences in NHS policies and practice can be anticipated. MOD (CDP), single Services and Career Managers should consider how families are more involved in the pre-assignment process for overseas, and whether there is scope to adopt more of this approach for within UK moves. Where long term conditions are recognised a permanent marker or record needs to be maintained to avoid the need for repeated or duplicate data entry or recording by the family, a simplified guide on where and how this can be made is required. Signposting to a UK checklist for supportability is required, again extolling the benefits of disclosure.

To be delivered by MOD Defence People Team and DMS.

3. Encourage Families to Identify Current and Potential Needs to Primary Care

Families registered with NHS GP practices should ensure they are identified as Service families with the appropriate SNOMED code applied to their records, ideally on registration. This should be accompanied by a case management review at registration focussing on what may be complex needs. Reviews should include the planning for the potential deployment of the Service person which may place extra demands on other carers within the family and anticipate the need for increased social support.

To be delivered by DPHC, NHS England and NHS Improvement.

4. Expand the Education and Training of all NHS Staff to Understand the Needs of Mobile Military Families

Building on the excellent work of the Royal College of General Practitioners, the Veteran Friendly and Veteran Aware (a Veteran Covenant Health care Alliance initiative) schemes in primary and secondary care, work should continue to accelerate and expand these to include the families of Service personnel, possibly changing the programmes' names to better reflect this. The demands placed upon families by mobility and deployment need to be better recognised by the NHS. This commitment should emphasise that avoiding disadvantage in health care because of mobility is a core tenant of the Armed Forces Covenant.

To be delivered by NHS England and NHS Improvement.

5. Provide More Information to Military Families on the Variable Nature of the NHS, particularly when Moving Across Devolved National Borders

Families need to be made aware, at a basic level, that the NHS is not the same across English regions and even more differences may exist between the NHS in the devolved nations. Expectation management in moving needs to be considered and reinforces the recommendations to inform the Chain of Command that medical or social care needs exist and that the framework, policies and practices in place to protect and support families for potential non-UK assignments need to be adopted where relevant.

To be delivered by MOD Defence People Team, single Services, DPHC, NHS England and NHS Improvement.

6. Improving Transfer of Information

Transfer of health care records between primary care organisations in England should be seamless once a family is registered with a new GP. Similar systems need to be in place for the transfer of records between the devolved nations and DPHC, including when returning from overseas. Thought should be given where appropriate to encourage direct transfer of information and care between secondary care and between community care organisations where continuity of care may be compromised. Such transfer of care should include information of any timing of intervention, investigation or operation and where appropriate ensure this timescale can be adhered to. The goal should be to facilitate the most expeditious transfer of care, and systems should send and receive information in the safest and least disadvantageous way.

To be delivered by DPHC and NHS England and NHS Improvement.

7. Continuity of Care, using Remote Access

Building on the experience gained during COVID-19 the continuity of care offered by remote consultation should be capitalised upon. This would be of particular benefit where a long-term relationship is beneficial, particularly in counselling and psychological therapies (e.g., CAMHS). The NHS should ensure commissioning allows continuity and maintaining care with a single

provider, provided remotely, rather than having to switch multiple times on assignments. This may prove more efficient and clinically more effective.

To be delivered by NHS England and NHS Improvement Armed Forces Clinical Reference Group.

8. Single Point of Contact

Within nascent English NHS ICSs, there is a need for a single point of contact for Service families to seek advice, both before assignment and on arrival. Integrated Care Boards (ICBs) will need to communicate with each other about the needs of mobile families before moving and support continuity of care whilst transitioning, in complex cases. It is anticipated that ICBs, covering areas beyond health, should develop support networks for military families encompassing, primary, community and secondary care and include local authorities for education (SEND) and social care needs.

Inclusivity needs to be built into the network recognising the additional cultural challenges of non-UK Service families and the contemporary structures of the military family. Military families, military charities and Families Federations should therefore be represented on the networks. These networks and the single point of contact will need signposting to military families.

To be delivered by NHS England and NHS Improvement, ICBs and Families Federations.

9. Dentistry

Access to routine dental care is a significant problem for all. While not confined to military families, it is important to recognise that the impact of frequent mobility may exacerbate issues for military families. Alongside its ongoing work to restore services and improve access for all, NHS England and NHS Improvement, working with the MOD, should continue to look for ways to support Service families seeking dental care.

To be delivered by NHS England and NHS Improvement and MOD.

1. Introduction

Through qualitative enquiry, this report aims to enhance understanding of the challenges faced by military families when trying to access, maintain and transfer health care while balancing Service need to relocate within England, across the borders of the devolved nations and overseas.

Critically, it seeks not just to provide examples of where mobile military families have been disadvantaged as a result of health, community and military care systems failing to meet their needs, but also to evidence best practice where we have found it. The primary objective of the report is to provide practical and operational recommendations for policy and practice, directed at care providers, the NHS, MOD, and families themselves, in order to tackle disadvantage and improve health outcomes for those families required to move frequently as a result of Service need.

This study, which is supported by NHS England and NHS Improvement, was conducted by the Veterans & Families Institute for Military Social Research at Anglia Ruskin University (ARU) in partnership with the three Families Federations. Ethical approval for this research was granted by the School Research Ethics Panel for the Faculty of Health, Education, Medicine and Social Care at ARU.

2. Background

2.1 Mobile Military Families

The UK Armed Forces are comprised of a highly mobile workforce, frequently posted to locations throughout England, across the borders of the devolved nations and overseas. While dispersed living (defined in some documents as living more than 10 miles from the place of work)[1] is an increasingly attractive option for some, the majority of military families make the choice to live accompanied with their serving partner; in 2021, more than three-quarters (77%) of military spouses reported living with their partners during the working week[2]. For those military families who choose to accompany their serving partners, that decision brings with it a commitment to also be mobile in response to Service requirements. Each year a significant proportion of military families are required to relocate. Approximately one-fifth of military families (21%) reported moving for Service reasons in the past year. Army families are the most mobile; 24% of Army families moved for Service reasons in the past 12 months compared with 22% of RAF families and 11% of RN/RM families[3].

The relatively short duration of military postings also results in some military families having to move frequently. Again, there are variations between the Services (see **Figure 1**), but approximately one-half (49%) of Army families and more than 4 in 10 (42%) of all Service families have moved twice or more in the past five years[4]. Despite a significant proportion of families choosing to remain together, the frequency of relocation has an effect on the way military spouses feel about military life; one-third (32%) cite the number of house moves as a negative aspect of Service life[5].

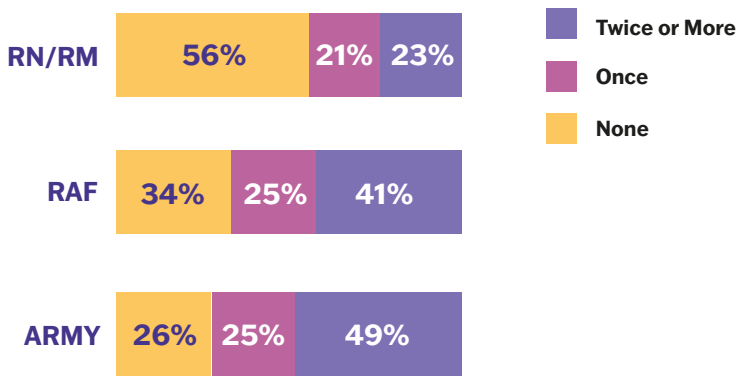


Figure 1.

% families by number of moves for Service reasons over the past five years.

(SOURCE: FamCAS 2021)

1 **https://www.raf-ff.org.uk/wp-content/uploads/2020/01/RAF-Dispersed-Families-summary-briefing-paper-Jan-20.pdf**

2 MOD (2021) UK Tri-Service Families Continuous Attitude Survey (FamCAS) 2021.

3 MOD (2021) FamCAS 2021.

4 MOD (2021) FamCAS 2021.

5 MOD (2021) FamCAS 2021.

2.2 Military Families: Health Care Provision

The health care needs of Service personnel are provided through the Defence Medical Services (DMS) and include primary health care, dental care, community mental health care, specialist medical care as well as rehabilitation and occupational medicine. In contrast, health care provision for the majority of military families is reliant on NHS services available in their locale.

For the most part, health care for families living in the UK is provided through the national health services available in each of the home nations that cater for the civilian populations. There are variations between the devolved nations in the ways in which public health care is managed and structured, but common to all is a commitment to the founding principles of the NHS that tax-payer funded, life-long health care should be available to all and be free at the point of delivery.

In brief, the NHS delivers primary health care in England through contracted providers which include GPs, dentists and pharmacies. Secondary care is largely provided by NHS facilities and is commissioned through several locally based clinical commissioning groups (CCGs), which are in the process of evolving into a smaller number of larger integrated care systems (ICSs). In Scotland, primary and secondary services are integrated and mainly delivered through 14 Territorial and seven Special Health Boards by NHS Scotland. In Wales, health care is mostly provided through NHS Wales, and delivered by seven regional health boards and three national focused Trusts. In Northern Ireland, health care is provided by five integrated Health and Social Care Boards and delivered through six Health and Social Care Trusts.

In certain circumstances, military families can access health services provided by DMS. Those families accompanying Serving personnel overseas, for example, are eligible to access primary health care through Defence Primary Health Care (DPHC) medical centres and secondary/specialist care through local services and contracted providers. Within the UK there are also a number of DPHC medical centres with which Service families can register. These are in locations which have large Service populations or are in remote locations which may have limited local health provision and/or where there is a training value for military health care staff.

2.3 Health and the Mobile Military Family

The frequency of Service moves combined with the idiosyncratic/localised nature of health and/or military health care provision can present particular challenges to mobile families as they move across regional and national borders, particularly when those moves coincide with periods in which families are actively undergoing or continuing treatment. In 2021, significant proportions of military families reported requiring access to health and community care services including: dental care (82%); GP services (89%); hospital or specialist services (54%); and mental health treatment (18%)[6] . While relatively few of these families reported relocating while in receipt of health care – ranging from 2% of those moving who were receiving mental health treatment to 9% of those moving who had ongoing GP treatment – their experiences are important to note[7].

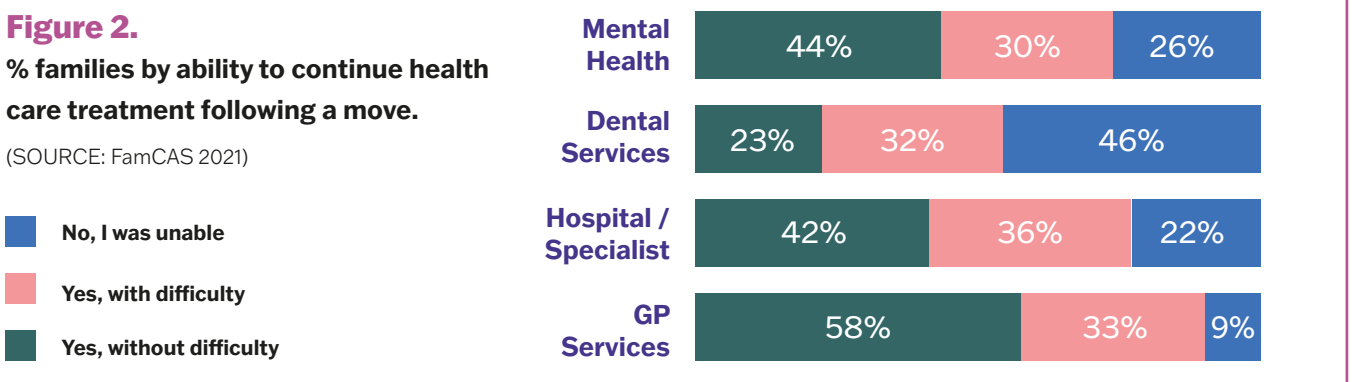
As illustrated in **Figure 2**, the majority of those who were in receipt of hospital/specialist, dental or mental health care were either unable to access this care after a move, or only managed to do so with some difficulty. In contrast, the majority of Service families (58%) who had moved while receiving GP care had been able to transfer this to a new primary care provider without difficulty. These figures, however, have to be put in the context of the COVID-19 Pandemic. The FamCAS 2021 revealed that 7 in 10 military families felt that their access to health care had been affected by COVID-19 and this may go some way to explaining the rise in military families reporting difficulty with their continuity of GP, dental and hospital care in 2021 when compared with 2020.

The most marked difference between these years is the difficulty families reported in trying to continue dental care; in 2020, 47%[8] of families said they were able to continue, without difficulty, dental care after a move compared with 78% who said the same in 2021[9]. This is perhaps unsurprising given that a temporary suspension of all routine dentistry was imposed in the first lockdown between March and June 2020. Military families' difficulties in accessing dental care are also evident among the general population[10]. What is evident from the FamCAS data, however, is that relocation presents significant challenges to military families trying to secure continuity of health care.

Figure 2.

% families by ability to continue health care treatment following a move.

(SOURCE: FamCAS 2021)



6 MOD (2021) FamCAS 2021.

7 MOD (2021) FamCAS 2021.

8 MOD (2020) UK Tri-Service Families Continuous Attitude Survey (FamCAS) 2020.

9 MOD (2021) FamCAS 2021.

10 See for example, CCQ (2021) COVID-19 Insight 10: Dental access during the pandemic, Care Quality Commission. Available at: **https://www.cqc.org.uk/publications/major-reports/covid-19-insight-10-dental-access-during-pandemic**

2.4 Policy Context

Health care and the military family is a fluid policy area. The past year has witnessed a number of publications and developments that will shape the ways in which future health and community services are delivered to the Armed Forces community. In 2019, Gavin Williamson, the then Defence Secretary commissioned an independent review to assess the needs of military families and the extent to which existing services were meeting those needs. The resulting report, *Living in our Shoes*[11], was published in 2020 and put forward 110 recommendations for the improvement of policy and services derived from the authors' extensive consultation with stakeholders and review of the existing evidence. Among these recommendations, are a number that specifically seek to drive improvements in the health and wellbeing of military families, including their experiences of, and access to, health and social care and ways in which military mobility might better be managed to improve health outcomes. In March 2021, the UK Government published its official response to the report, accepting the vast majority of its recommendations and outlining a series of actions, commitments and specific support measures[12].

Since the publication of *Living in our Shoes*, the MOD has engaged across sectors, including representatives from the devolved nations, UK Government departments and the third sector, aimed at improving support to Service families. This engagement has led to the development of an updated *UK Armed Forces Families Strategy* and the Action Plan to underpin it. The refreshed *Families Strategy* will sit within the newly formed Armed Forces Families and Safeguarding (AFFS) organisation/directorate and will be informed by selected research, including *Living in our Shoes*, as well as an extensive engagement with stakeholders and progress will be reported in the Covenant Annual Report from 2022 onwards.

In recognition of the specific pressures that the Armed Forces community potentially face, including the impact that mobility can have on continuity of care, the NHS additionally launched an online consultation in 2020 aimed at improving its offering to the Armed Forces community[13]. The online survey closed for submissions in November 2020, with the results of the engagement exercise published in August 2021[14].

NHS England and NHS Improvement's commitment to the improvement of the health and wellbeing of the Armed Forces community is further outlined in the document *Healthcare for the Armed Forces community: a forward view*[15]. Published in March 2021, it recognises that the Armed Forces community, when compared with civilian populations, can face additional life challenges including extended periods of separation from partners, families and friends; social isolation; frequent and unplanned moves; and difficulties navigating health systems with different treatment approaches and funding structures. The document sets out nine commitments, the second of which outlines NHS approaches to supporting families, carers, children and young people in the Armed Force community. *The Forward View* is a companion document to the *NHS Long Term Plan*[16] and makes recommendations for the ways in which approaches to the improvements for health provision to the Armed Force Community can be embedded within ICSs.

11 *Living in our Shoes*: *Understanding the needs of UK Armed Forces families:* 2020. **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/895236/Living_in_our_shoes_Full_Report__1__embargoed_30_June.pdf**

12 *Living in our Shoes*: *Understanding the needs of UK Armed Forces families: government response*. Retrieved from: **https://www.gov.uk/government/publications/living-in-our-shoes-understanding-the-needs-of-uk-armed-forces-families/living-in-our-shoes-understanding-the-needs-of-uk-armed-forces-families-government-response-accessible-version**

13 NHS. (2020). *Improving health and wellbeing support for Armed Forces Families in England – Have your say*. Retrieved from: **https://www.engage.england.nhs.uk/survey/health-and-wellbeing-support-armed-forces-families/user_uploads/armed-forces-families-survey-2020.pdf**

14 NHS (2021) *Improving health and wellbeing support for Armed Forces Families: You said we will do*. Retrieved from: **https://nff.org.uk/wp-content/uploads/2021/09/AF-families-engagement-you-said-we-will-do-August-2021.pdf**

15 NHS. (2021). *Healthcare for the Armed Forces community: a forward view*. Retrieved from: **https://www.england.nhs.uk/wp-content/uploads/2021/03/Healthcare-for-the-Armed-Forces-community-forward-view-March-2021.pdf**

16 NHS. (2019). The *NHS Long Term Plan.* Retrieved from: **https://www.longtermplan.nhs.uk/wp-content/uploads/2019/08/nhs-long-term-plan-version-1.2.pdf**

The Armed Forces Covenant[17] is now approaching its tenth year since its introduction in 2012 under the provisions of the Armed Forces Act (2011). It is a commitment by the nation to ensure that those who Serve, or who have Served in the Armed Forces, and their families, are treated fairly and critically, "should face no disadvantage compared to other citizens in the provision of public and commercial services." In the Queen's Speech 2019, the Government outlined plans to further incorporate the Armed Forces Covenant into law and this commitment was reiterated by the former Minister for Defence People and Veterans, Johnny Mercer, who confirmed this in 2020[18]. The *Armed Forces Bill* has now progressed through Commons Committee and Report stages and in the House of Lords had a second reading in September 2021[19]. Included within the Bill is a requirement for public bodies to have due regard to the principles of the Armed Forces Covenant in the areas of housing, education and health care.

17 **https://www.armedforcescovenant.gov.uk/**

18 Hansard (2020). HC Deb. 683, Col 973-4.

19 Hansard (2021). HL Deb. 814. **https://hansard.parliament.uk/lords/2021-09-07/debates/721EAA2B-6D02-4F1D-9AC1-DB4C07734B41/ArmedForcesBill**

3. Methodology

The primary aim of the research is to provide evidence to help inform a better understanding of military families' health needs and the barriers they face accessing health care. It focuses specifically on the ways in which families' access to health care is impacted by Service relocation. This evidence will feed into approaches to help improve care and support for Armed Forces families.

The research aim is addressed using the following methods.

3.1 Interviews with Mobile Military Families

The first phase of the qualitative research comprised interviews with UK Service family members (n=15) from across the three Services (Royal Navy, Army and Royal Air Force). The first phase of qualitative interviewing took place over a three-month period between January and March 2021. All of the interviews were conducted remotely via Zoom or MS Teams video platforms or via telephone. Interviews with the military families lasted between 60 and 90 minutes, were recorded subject to the necessary consents and transcribed verbatim.

Interviews with military families were conducted using a semi-structured discussion guide. The use of semi-structured interviews offered a number of tangible advantages in this research context. It allowed for a meaningful comparison of data, while offering participants the flexibility of introducing contrasting ideas and perspectives.

It also provided opportunities for participants to express their own thoughts "rather than being restricted by researchers' preconceived notions about what is important" (Berry, 2002)[20]. Furthermore, semi-structured interviews allowed the research team to obtain the maximum benefit from the participants' contributions, in effect affording them the opportunity to be "the experts and to inform the research".[21]

It is important to note that the sample for this study was criterion-based or purposive; participants were selected *because* of their problematic experiences accessing health care following relocation. All military family participants were recruited through the Families Federations. The participants had all contacted their respective Families Federations (and had been suitably motivated and empowered to do so) to seek support with one or more issues pertaining to health care which they had previously struggled to resolve independently. Participants were also selected to provide a diversity of experience and circumstance to ensure that, within a relatively small sample, the key constituencies of relevance to the research were represented. These 'constituencies' included all three Services; experience of health care tiers (primary GP, dental, secondary/specialist, community care, etc.); relocation within and across national borders; and access issue type (waiting lists, record transfer, continuity of care, etc.).

3.2 Interviews with SMEs

The second tranche of qualitative research comprised interviews with subject matter experts (n=23) with some responsibility for providing, commissioning and/or advising on health care for military families or those who could offer insight from strategic or policy perspectives. These interviews took place over an eight-week period between April and June 2021. As with the family interviews, discussions with SMEs were also conducted remotely by phone or video conferencing platforms, were recorded with the participants' consent and transcribed verbatim.
A semi-structured interview schedule was also used to guide these discussions. SME participants for the research were identified through ARU and the Families Federations' existing networks. Among those who responded to an invitation to participate were representatives from the local authorities, MOD, NHS and the third sector.

3.3 Analysis

The qualitative data derived from interviews was analysed using thematic analysis, a method for identifying, analysing and reporting patterns with qualitative datasets[22]. Thematic analysis is a systematic approach comprising distinct stages that start with data familiarisation and leading through a process of initial code generation, the construction and refinement of themes through to the production of a report.

20 Berry, J. 2002. "Validity and Reliability Issues in Elite Interviewing" in "Symposium on Interview Methods in Political Science", Leech, B. ed., *Political Science and Politics* 35:4, pp. 663-688.

21 Leech, B. 2002. Asking Questions: Techniques for Semistructured Interviews in "Symposium on Interview Methods in Political Science", Leech, B ed., *Political Science and Politics* 35:4, pp. 663-688.

22 Braun, V. & Clarke, V. 2006. Using thematic analysis in psychology, *Qualitative Research in Psychology*, 3:2, 77-101.

4. Findings

4.1 Families' Experiences of Mobility: Military Contexts

The military families involved in the study were selected purposively; all participants had encountered challenges when transferring health and/or community care services following one or more relocations. All had also sought the assistance of the Families Federations in an attempt to resolve health care access issues. The research sample of military families comprised a broad range of relocation experiences. Most participants had relocated multiple times as part of a military family. Two-thirds had moved five times or more; one family member recorded more than ten moves during the Service person's 15-year career. While the majority of family moves were between military sites within England, there were also accounts of overseas postings, as well as relocations between the devolved nations.

All the families interviewed accepted the fact that mobility was part and parcel of a military career; many spoke of knowing what they "had signed up for" when they had become part of a military family. Even those with the most experience of relocation, however, still reported recurring anxieties and challenges which frequently accompanied a new posting. These included uprooting families, transferring schooling, sourcing accommodation, accessing health services, separation from family, friends and established social networks and career opportunities for the non-serving partner.

4.1.1 Military Processes

Notice periods of new postings varied markedly across the sample; it was also the case that individual families had historically experienced different notice periods depending on a particular post. Some families said they knew approximately a year in advance of when, if not precisely where, their next posting would be. At the other end of the spectrum, several families had been given as little as two weeks' notice to move.

Across the sample there were also anecdotal accounts of other Service families that they knew having to 'up and leave' within similarly tight timescales. Most of the participants, however, reported a minimum of three to four months' notice to relocate; reflecting the Career Management Practice that states: "The formal notice of assignment for an individual is to be no less than 90 days".[23] Interestingly, many believed this to be sufficient time to allow them to re-organise some important aspects of their family lives, including new accommodation and school places for their dependent children. Given the majority of the families had moved multiple times, this perhaps reflects the fact that, through lived experience, the families interviewed had become practised at negotiating the challenges of relocation or maybe even that they had become somewhat desensitised to it.

Despite this, all had experienced issues attempting to transfer aspects of health and social care within the timeframes afforded to them by the military. Those with complex and/or multiple health and social care needs unsurprisingly appeared to be the ones most impacted by relocation and felt that they had been disadvantaged as a result.

The complexities of relocating within short timeframes were exacerbated, for some of the families, by the delay between receiving notice of a move and the receipt of an Official Assignment Order. Assignment Orders were required before families could apply for accommodation at, or near their new place of duty and obtain an address. Families stressed the importance of obtaining an address quickly as it was often a requisite for transferring health and social care, applying for schools and updating personal records. According to the accounts from the military families, Assignment Orders usually arrived within a week or two of receiving notice of a relocation, but some reported waiting substantially longer and having to chase the Chain of Command (CoC) to expedite the issue of the Assignment Order to enable them to begin the Service Family Accommodation (SFA) application and the moving processes.

> *"I think there is an issue with timescales and when we get our address. I think the last time was five weeks, which may sound like a lot, but…one family was booked to move in next door and two weeks before they were moving in, they had everything sorted, the kids were booked into a school – the offer for that house was removed and they were sent to a completely different area…so that family had two weeks' notice to move to a completely different area and I know that's not unusual."*

Many of the families described feeling "in limbo" while the SFA application was in progress. They were able to do some cursory research on, for example, the characteristics of the neighbourhood and services available within a general area, but without an address they were not able to begin the process of registering for school places, GP surgeries or transferring specialist care.

> *"Once you've applied for housing, you have an address and then you can start the process. You can make the current team aware that you'll be going, but until you've got that address you are kind of just in limbo."*

Those with specific accommodation needs such as adaptations, accessibility requirements and proximity to specific community and health care services, reported some additional relocation challenges. Most commonly these centred on the requirement to demonstrate a recurrent evidence of need, often in the form of reports provided by occupational therapists or having to move into new properties before the necessary adaptations had been put in place.

23 MOD JSP 755. Centre-Determined Policy for Career Management and the Administration of Tri-Service Positions and Assignments.

There was divided opinion among families on the extent to which the military took familial situations and needs into account when assigning new postings. For example, most mentioned that military processes were in place that allowed families to register specific environmental and educational needs when applying for new accommodation. Some families also recognised that systems existed for Serving personnel to make the CoC aware of other factors, including health and social care needs, that might impact on their ability to relocate smoothly. There were reports of families liaising with Welfare Officers, for example, prior to relocation to discuss requirements and concerns. Critically, however, not all families felt comfortable sharing potentially sensitive details of health needs and family circumstances with the CoC. Some also feared that being too candid about health and social care requirements might negatively impact on the career prospects of the Serving person and jeopardise future posting opportunities.

"I would say it is quite difficult. We don't tell the military everything about my health care because we don't want it to affect his career, especially since I gave up my career. So, if posts come up that are better for him, for promotion. You really don't want him not getting those because they [think] "what a faff, having a disabled wife dragging along." And that generally is the attitude that I've come across."

A significant proportion of the families interviewed, however, felt largely unsupported with relocation by the military, perceiving that it prioritised the Serving person and Service need rather than the wellbeing of the family as a whole.

"From the military? No, absolutely none. If anything, they just like to pile the stress on with – not being harsh – but sometimes with complete and utter incompetence."

There was an indication that more support from the military, particularly for those with complex health needs, would be welcome to help ensure a seamless transition of care.

"There is no "this is what you need to do". If it would, it would have been so nice, in a perfect world, "we know you have a medical condition, a medically complex child. So here is a list of things that we know you'll need to do. So, here you need to call this person, ring this person"...some simple direction with some, not just names as well, but things I might need."

4.1.2 Family Processes

Beyond the military processes of relocation, families generally felt that the burden of responsibility to manage the logistical challenges of a new posting fell to the families themselves. There were frequent reports of a reliance on informal networks, social media and web searches.

"It's left entirely to you...Google is your friend."

The use of social media for finding out about a new location and the quality of local services was frequently cited by families. For those who had been within the military fold sometime, Facebook was felt to fulfil a social and information exchange role that may have once been the preserve of in-person, on camp social functions.

"It used to be... there used to be this unwritten sort of network of welfare and it would be other army families plus the welfare team. Plus, there would be this big network which would give people an enormous amount of support because it would be people like me, speaking to younger wives and say, hey, maybe they'd have a child with a medical condition, and they were worried about moving. And I tell them all about how to do it and all the rest of it. And that just happened on every topic. It happened at coffee mornings and it happened at events and all the rest of it. But now we all work. We don't hold coffee mornings anymore. People don't live on patches. So that's all gone, all that support that people used to have. So, they've changed things without providing that support in a different way. I feel. So, there's a gap."

Many of the participants talked of the changing nature of military life in this context. There was an overarching perception that the military in recent years had become less family centric and that this was reflected in the perception that support for mobile families was limited.

"The MOD, as the military has got smaller... It used to be about looking after the whole family and the family being mobile. Now it's very much going down the road of...They look after the employee. The family is not their responsibility. And if you don't like the housing or don't like the disruption to health care, or your child's education or what have you, then don't do it. Buy your own house, live in one spot and have your mobile spouse or whatever, commute at the weekends or leave the military, you can do a different job."

In the absence of formal guidance from the military, most of the families interviewed had developed their own checklists to help better facilitate relocation. Families' priorities differed depending on individual needs, but for those interviewed – all of whom had experienced some friction with access to health care – transferring health care was unsurprisingly near the top of their 'to do' lists once they had been notified of a new posting. Families, for the most part had developed strategies over time to help organise relocations, often using learnings from previous experiences to inform and further refine their approaches to moves. As their narratives attest, however, despite their best laid plans situations often arose post-move for which they were unprepared.

Families all agreed that simple, practical information on their new locality would be of immense value; preferably in advance of the move but failing that on arrival at their new home. Participants said that this need not be anything too complex or exhaustive, but could include information on local facilities and amenities, contact information for local support networks – military and civilian – as well as GPs, dental practices and local hospitals. Some of this is captured in the government response to the *Living in our Shoes* report[24].

Some of the families recounted experiences of moving into properties overseas and/or some private-rented accommodation within the UK in which information packs of this type had been provided on arrival and suggested similar provision should be routinely made available in all Service accommodation.

24 HM Government (2021) *Living in our Shoes: Understanding the needs of UK Armed Forces families: government response*. Retrieved from: **https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/974334/20210229-FINAL_Selous_Response_O.pdf**

"I don't think you do receive any advice [in the UK]. And it's very different in Cyprus. There are processes and forms to fill in. And that's all, you know, when we moved in, it was all on the table. This is to register with the doctor, dentist and schools. Whereas back home in the UK, you have your own checklists and it's like, all right. We need to register the car, the insurance, the house insurance. We just go through our list every move."

"You're kind of left to your own devices, I guess, to try and find that information. And we were very lucky. We moved into this new house…So we got lists like house folder from the house builders and it has a list of takeaways, bus times, has dentists, doctors, clinics, which was really helpful but why did the house builder do that? Why does it not come [from the military] when you move in? Or even before you move, when you get your property accepted on the E1132. Why isn't there a system in place that sort of gives you a breakdown of local areas: these are a list of schools; this is the link to the website; these are the doctors; these are the dentists. You know, all of those amenities that you really need, and you have to put in place."

4.1.3 COVID-19 Context

Unsurprisingly, the COVID-19 Pandemic had added complexities to families' experiences of mobility. As a result of COVID-19, some had experienced substantial delays to previously scheduled postings. The uncertainty of how long COVID-19 restrictions might be in place had also forced some participants to reassess their family living arrangements; participants talked of bringing forward plans to move in together and also switching from unaccompanied to accompanied accommodation to mitigate the challenges of present and future lockdowns.

"So, basically, I chose to stay based where I was because two of my daughters have quite complex health needs. And so, continuity of care. Yeah, I did want to move them. So, I made the decision last year that actually, you know, three years of living apart, it was taking its toll, especially when COVID-19 hit. Yeah. Decided to do it and move. Yeah, it's been an uphill battle."

A number of families in the sample also comprised members who were categorised as clinically extremely vulnerable and shielding who had been required to move during the pandemic. This had added considerably to challenges of successfully negotiating relocation. For example, families with dependent children reported that they had not been able to visit prospective schools. There were also some examples of vulnerable families being allocated accommodation that had not been cleaned.

"We moved into this house…in the middle of a pandemic, bearing in mind I'm registered clinically extremely vulnerable because I'm on an immunotherapy drug. So, it affects my immune system, which means, you know, COVID-19 is going to see me right off. So, I'm moving in the middle of a pandemic, clinically extremely vulnerable and supposed to be shielding. The military, absolutely none of that will take into consideration the fact that I'm vulnerable in shielding."

4.2 Health Care: Mobility Context

The following section focuses on health care access and continuity and participants' experiences of navigating the health care systems. This section is structured by tier of health support to allow readers/target audiences to identify with ease specific areas of interest.

4.2.1 Primary Care

4.2.1.1 Registration

As noted previously, registering with a GP was one of the main priorities for families when negotiating a military move within the UK as very little in the NHS can happen without completing this process. With so many varied experiences of military mobility extant within the research sample, most participants had at one time or another encountered issues when registering with a new GP within the UK. In those examples of negative experiences, however, were instances where registration, while time-consuming and involving multiple form-filling, had been largely unproblematic. It is important also to stress that for the most part, participants talked highly of the standard of care they had received from one or more of their GPs and many valued the relationships they had managed to foster with them. Indeed, these positive experiences also extended to many of their interactions with secondary and specialist care throughout the UK.

Participants talked of needing to have a physical address or proof of residence before being able to register for an NHS GP surgery. Depending on the notice periods they had received of their move and the efficiency with which housing applications had been processed, this had caused some delays in families being able to register and get on to the system. This is a cause of frustration and anxiety for some, particularly those who require regular medications or were in the middle of a diagnostic process or course of treatment. There was a very real concern among these individuals that delays in registering at a GP surgery might compromise the continuity of their care, leave them unable to access prescription medication or that they would have to wait longer for GP referrals to secondary or specialist care.

4.2.1.2 Access

There were some divergent experiences of being able to access GPs once families had registered. In general, families had found it reasonably straightforward to get appointments, but that was not always the case. For those who had moved in the previous 12 months, access to their new GPs had been further restricted due to COVID-19 lockdowns and some of these participants were unable to ascertain whether difficulty booking one-to-one sessions with their new GPs was because of COVID-19 or whether this might be indicative of business as usual.

Across the sample, however, a common sentiment expressed by families was that they could not get enough time with their GP; the allotted consultation periods were simply not long enough. This was particularly true for those who had just moved to a new area and were keen to introduce themselves and discuss their or their family's needs at the outset. For those with complex health needs, 10-minute slots did not seem sufficient time for the effective management of their case. One participant, for example, had to book multiple separate appointments; she had not been allowed to schedule these back-to-back in order to discuss each of her specialisms.

> *"So, on this last one, if you think of how long you get with a GP [10 mins], we're only allowed to discuss one speciality per visit. And then obviously they're not emergency visits, so you've got to have a GP appointment for each visit. Because they're detailed, I need more than one appointment per visit per speciality? It took a long time."*

Participants spoke of the importance of developing relationships with the GPs, and indeed with all of their health workers, but some of the experiences recounted by the participants indicated that this had not always been easy to achieve. One participant, for example, waited seven months after registering before being told to book an appointment with a named GP. She was complimentary about her GP having established that contact, but that this delay was indicative of the fact that mobile military families could fall "between the cracks" of health care provision when they were required to relocate.

"So, I'd say we possibly registered with them from May onwards. And they'd only just got around [in January] to saying that day about a designated GP. She was very nice doctor, she was, and she was very helpful. "If you need anything, more prescriptions, repeat prescriptions then just email me." And she was really, really helpful. It was another thing that seems slightly disorganised. It's not to have a designated GP that would have been something like the old GP [first GP consulted with at that practice] might have mentioned. Yes, I think a lot of fumbling. That's what it feels like a lot of the time. It is fumbling and stumbling our way and learning as we go."

4.2.1.3 Armed Forces Awareness

Evidence from this research study also indicates that access to equitable health care for mobile families had been compromised on occasions because of a lack of awareness among GP practice staff of the specific needs and circumstances of military families. There were a number of accounts of participants finding it difficult to negotiate the "gatekeepers" of GP surgeries. Some had found practice managers a little inflexible when trying to register with and access a GP.

"I just could not get through. You know, I literally went and picked up a prescription from the receptionist. I said, "I'm really not too happy about that, just getting a prescription. I'd really like to talk to a doctor." And they just said "no." So it was a bit difficult. And I guess in hindsight, I just could have gone to a different surgery. But there's not that many locally, so it would have been a different town altogether."

Most of the participants, however, said that they mentioned their association with the military explicitly as a matter of course when registering with a new practice, although none said that this information had been sought by the practice when completing the registration process. Families talked of the importance of declaring their military associations at the outset. Those familiar with frequent relocation did so in the hope that this would expedite the smooth transition of care, but also felt it important to explain the family circumstances, the reason for arriving in the area and their history of mobility.

Making new GPs aware of their Armed Forces status did not, however, necessarily always result in the anticipated outcome or continuity of care. A number of participants recounted repeated battles with GP surgeries following a relocation to try and secure referrals to specialists in their new region. Even those who were seasoned movers and were, as a result well prepared to help facilitate a smooth transition of care, experienced barriers to accessing the health support that they required. The following participant, for example, expressed her frustration at having to fight to secure the requisite referrals and medication.

"And so I go in and I have a piece of paper, details on the conditions, all the departments, the specialists that I need to be referred to and say: "[specialism] is a priority because I've got to get medication brought to the house", you know, so many times a month. And they just looked at me like I'm a monster most of the time and they just go: "Well, we can't fit you in any earlier. You can ask for an emergency appointment." But it's not an emergency: "No, I'm just asking you… This is my previous GP. That's their email. That's their phone number. This is my NHS number. This is a transfer of care.Please register me. I'll fill out all the details. You just contact them and transfer it over and we're there". "This is what's meant to happen. Yeah. And it doesn't."

A commonly reported issue among those who had experienced problems with the primary care providers was that practice staff failed to understand and empathise with lived experiences of mobile military families. Participants said that, by declaring their status as a military family, practice staff sometimes felt that they were trying to jump the queue or secure preferential treatment when in fact all they were trying to achieve was a seamless transfer of care and to ensure that they were not disadvantaged as a result of their mobility.

"I don't think they were bothered. Whenever we move, I always say: "oh, I've just moved to the area because my husband's in the RAF." So, you know, "I'm sorry to land on your door." And I always try and make a little bit of a point of saying the reason I'm just suddenly appearing on your books is because I've been transferred in. Because why else would a grown woman suddenly appear with an illness needing expensive drugs that they have to pay for, without a good reason? You know, so I always make a point of saying I didn't. I don't want to land on your doorstep. I have no choice. And then maybe trying to get a bit of empathy from them."

4.2.1.4 Transfer of Records

Families in the research cohort also experienced issues with the transfer of the records between primary care providers following relocation. Issues included: delays in the arrival of records at the new practice; those records being incomplete when they did arrive; or records being lost in transit. Problems with record transfer were particularly evident among those families who had experience of moving to and from the devolved nations and England, but there were also examples of problems arising when families switched from DPHC to NHS primary care.

"I'm dealing with a problem, ongoing problem with my records. So, when we were in Scotland, my notes from Scotland never made it over the border. I mean, it seems insane, but they never got them. With it being a devolved health care system, I don't understand how it works, but it doesn't work if you move from Scotland to England. And obviously that happens quite a bit in the military. So, you know that that's a real pain.

Only from this last move have I learnt that's got to be something that I need to contend with because the military GPs do not talk to the NHS systems, they are on two separate systems. So that's a nightmare."

The absence of timely or complete medical records had a significant impact on participants' health care. There were reports of participants having to re-narrate their case histories or undergo further diagnostic tests, sometimes involving painful and intrusive procedures, just to re-establish clinical need. All of which set back participants' access to care, previously prescribed medications and sanctioned treatment regimes.

"So, I mean, I. And what you end up doing is you end up filling in the gaps for them. And some doctors will take your word for it because they realise that you're, you know, an intelligent grown-up, and some doctors won't. This time we've gone from a military GP, [station name], and we've transferred to a civilian GP here. And it took my notes I'd say three months to catch up. And for that three months, my GP here obviously, they couldn't prescribe my medication that I take daily. They couldn't refer me to the [specialism] at the hospital because they didn't have my notes. They didn't know I was clinically vulnerable [COVID-19] because I wasn't on the register. The information, all my details that the previous military GP had on their system he hadn't put on the NHS system. So, when the NHS notes caught up with me here, the civilian GP only had notes from 2016. They didn't even know I'd had a child."

4.2.2 Secondary and Specialty Care

Evident from participant accounts was the importance of a timely and seamless transition to a new GP. For those with secondary and specialist care needs, GPs were the conduit through which most referrals to health and community services were directed. Delays in registrations or other sources of friction that mobile families encountered when accessing a new GP invariably impacted on families' continuity of care and their ability to access the support that they needed. The more complex and/or specialist their health care needs, the more potential there was for interruptions in care. Among the sample there were families who were receiving care from multiple specialists, sometimes for different family members and examples of those receiving innovative treatments that were not always funded or sanctioned in every region.

4.2.2.1 Waiting Lists

An overarching sentiment expressed by the mobile military families was that relocation invariably resulted in participants, with every move, having to start over with their health care. Preliminary consultations and case reviews with GPs, for example, often resulted in participants being put on waiting lists for referrals to new regional specialists. This could be in spite of the fact that a care plan and in some case a date for a procedure had already been set prior to them having to relocate. The issue, as a few of the participants pointed out, was that after every move they were treated as "new" patients, not as patients who had a treatment regime in place and were looking to "simply" transfer care between locations.

"So, I go to my GP and say: "Right. I've got retroverted hips…and damaged muscle areas. That's just orthopaedics. Then they write to orthopaedics and go: "we have got a patient who has just arrived" and they say I've got to be a new patient. And I said: "no, no. I'm not a new patient. I'm just transferring care." So, anyway, once I get past all that then the staff for the orthopaedic surgeons say "well, actually we'll give her a new patient appointment." Which takes even longer. You get your new patient appointment. And the first thing to do is…instead of ordering my notes or my films or even looking at the information I sent them is "let's send you for films. We'll see you again in three months."

So, when we moved back to Catterick I thought, well "I'll go back to the GP who took me seriously in the first place. "So, I rang him again. He remembered me and he said: "No, I remember you. I'll see what I can do." This is during COVID-19 though. And I rang Middlesbrough and they just said: "you're not a patient here anymore. You're in Salisbury now." And that was it. I was just at square one. You're a new with referral. You need to get re-referred by the GP and start from scratch. It was that simple."

A number of families talked of missing out on pre-agreed procedures, operations and diagnostic tests as a direct result of having to relocate while waiting for a procedure. Included in these accounts were examples of procedures that were time sensitive such as treatments for severe allergies and orthopaedic surgery. Sadly, for some participants, the delays they had encountered while trying to refer their care to new specialists had resulted in these procedures being no longer viable. The following participant, for example, first had damage to her hips identified in 2015:

> *"And so, then I was put on a waiting list. And between all of that, I have, you know, steroid injections into my hips and things to have pain relief. And then, of course, I get there, and we are moving. And then by the time we move I get re-registered, I see a consultant, but it's been such a long time, they say: "We can't do that because they have now calcified. So, we can do the arthroscopy" because it's not like you just clear the tissue anymore. These are calcified. This damage is permanent. And then, of course, then they put you back on a waiting list to have the hip sockets resurfaced. And then you go on a waiting list and then we move and then I start all over again."*

…at the time of interview (2021) the participant was still waiting to hear from her new specialist about their intended course of action and the associated timescale.

4.2.2.2 Regional and National Disparity in Care Provision, Diagnoses, Treatments, Funded Procedures

While some of the issues reported in accessing health centred on delays in transferring records, registering with new GPs and awaiting referrals, regional disparities in health care provision also created additional layers of complexity for mobile military families seeking to access services after relocating. It was a common experience among the families participating in the research that moving across borders had compromised their ability to access health care that had been previously agreed elsewhere. Families discovered that surgical interventions and medications were not always supported by the CCG/ICS responsible for authorising health care in their new region.

> *"So, we had to move. And that's when they [CCG/ICS] were saying there was a money issue. So, it is a biologic drug. I believe it was about £1,000 to £1,500 every six to eight weeks for the treatment. But it's an expensive drug and I get it. You know, I know it's expensive, so I can understand hospitals not wanting to pay, but I didn't want to move."*

Within the sample there were a number of other examples of participants having to battle to retain their care and medication after moving. Examples of procedures and clinical approaches in this context included, but were not limited to, surgeries (varicose veins, breast reductions), treatment regimens (allergy immunisation, medication for autoimmune conditions) and the provision of home-based equipment for monitoring health conditions. There were also reports, particularly concerning CAMHS, where different areas would adopt different treatment and care pathways for conditions such as Autism, Asperger's and ADHD. Depending on the care structures of local authorities, CCGs/ICSs and private care contractors, participants found themselves struggling to comprehend and navigate these care pathways.

Among the research participants there were some differing expectations of what the NHS could and should provide military families as they moved around the UK. On the one hand, some families were cognisant of the fact that even for civilian populations, the precise nature and availability of health care could differ by region. A commonly used phrase in this context was that health care was somewhat of a "postcode lottery"; health care was a bit of a "luck of the draw" depending on what region you found yourself in. A contrary perspective was that as a national health service, the NHS should provide equitable access to care in all regions of the UK. Some felt particularly frustrated and confused by the fact that regional care offerings could differ so markedly across the borders of devolved nations, but also within England.

"It was like, yeah. Computer says no on all fronts. It's quite shocking really to think, what? This is the NHS. I've got an NHS number. Why is this not a seamless kind of transfer? How hard can it be? And that's obviously very hard. But with health care, in a country where it is supposed to be public, it shouldn't be one of those things getting different levels of care in Scotland, Hertfordshire, or Cornwall."

The issue for military families, however, regardless of which standpoint they adopted was that they should not be disadvantaged through their requirement to move. Again, families were keen to stress that they were not looking for shortcuts or favourable treatment, just that they should not lose access to care that had already started or previously been approved. But for some there was a clear disconnect between their expectations of what care the NHS should provide and the day-to-day practicalities of health service availability in particular areas.

Levels of preparedness for regional disparities in health care also varied between the military families with whom we spoke. Some reported having detailed conversations with their primary and/or specialist health care providers prior to moving in order to seek help and support with their transfer of care. There were some reports, for example, of specialist health care providers flagging to participants the differences in what CCGs/ICSs were prepared to fund prior to them moving areas. In some instances, specialist health carers had referred participants directly to other specialists (secondary to secondary) and transferred case notes and specifics directly.

While some then had an inkling that relocation might present problems accessing health care, others talked of how they were reassured falsely of how, as part of a military family, checks and balances were in place that would ensure that they would not be disadvantaged as a result of having to move. There were examples of how GPs, for example, had walked participants through the process of transferring health care across regions and had assured them that there would be no interruptions in their care.

"So, I got my date through. I contacted the allergy specialist. And I already knew that I would have to have injections once a year. And I had to call them, say my situation. And it was almost: "don't worry, when you move, I'm pretty sure [NAME] you will be able to get more treatment when you move." And, "these are the dates, these are the times [in the year] when we run this clinic. It has to be done now because of the pollen year; it just won't work. …pre-pollen season so Jan, early Feb. And we must have moved here at beginning of 2018…" because you are military, you've already had it approved, it shouldn't be a problem getting it again."

For some, it wasn't until they had moved that issues of health care access became apparent. By which time there was "no going back", and military families were left to try and re-establish levels of care they had previously managed to negotiate with their health professionals. There were reports of families trying to reconnect with former GPs and specialist carers after they had transferred care to another area, in an attempt to make sense of failures in the transfer of their care. Ultimately previous carers could offer advice but were able to exert limited or no influence on the management of their former patients' care once they had moved to another area.

"But in my head, I should have just had the injection in Cambridge and then just waited to fly down. But you can't do that, obviously. Once I changed medical authorities, I couldn't do that. It's just all a mess."

There were also reports of former care providers directly contradicting the approaches adopted by current health staff which further compounded the sense of frustration that some mobile military families faced when trying to ensure that they were able to retain an acceptable standard of care.

4.2.2.3 Loss of Agency

There was an overriding sense among the participants that relocation often removed, to varying degrees, families' agency and control of health care and health choices. Even those families that had moved often and had become reasonably practised and proficient at it, still reported encountering issues securing the continuity of their care. Evident in the accounts too, were protracted periods that families had to wait for referrals and/or for decisions on the continuation of treatments that could be open to debate or subject to alternate approaches. Nearly all talked of having to chase health care providers for information and for updates, even if this was to confirm with a new GP that all medical records had been transferred. Meanwhile families reported being in a state of limbo, not knowing of decisions that may have been taken on their behalf and critically no further along in trying to access the care that they required for themselves or other family members.

"Why does it take so long? What happened with the board? Why did it take so long to sit and make a decision on it?

I try not to dwell on the negative. It just is what it is. And things happen for a reason. It's just the messing around. If I could have just had phone conversations. I wouldn't have minded it…the process is just really disjointed. You don't really know where you're at with it. And so long…I wish I had an idea of how long it would take instead of waiting and waiting. So actually, I'm not getting anywhere.

So, you're, you know, six months, seven months down the line with no active treatment yet again…it's soul destroying.

But it's just like the NHS feels like it's an impenetrable force."

Some of the families, while still experiencing issues with transferring care, said they had become battle-hardened to relocation. Among this cohort were families who stressed the importance of taking ownership of their own health care provision; a position informed by the repeated health challenges that military mobility had exposed them to.

"It's been bumpy, but every time you move, you pick up something new. So, get ready for the next battle and you just brace yourself and get through it.

I do work with people with chronic conditions and how to be your own best advocate. Because before this I didn't…You don't realise, you know, when you're either younger or when you haven't really had to use the health care system, how vulnerable you are to, you know, things like this, things being lost or people not talking to each other. And everyone's busy. Everybody's got a huge amount on their plate. You can't you know, it's not about finger-pointing or anything. It's just you've got to take responsibility for your own care, I think."

Sadly, the sentiments expressed above, and echoed by others, evidence an expectation that military mobility will inevitably be accompanied by health care-related complications for those families with care needs. The lived experiences of participants highlighted reactive, rather than pre-emptive approaches to the management of health issues; often the extent of families' health vulnerability and disadvantage only becoming apparent once they had relocated and it being left to the families themselves to push for care equality.

4.2.3 Community and Education

Some of the most complex cases relating to health care access and mobility recounted by the research participants were those that centred on the challenges of trying to secure the continued care and support for dependent children with specialist health requirements, mental health needs and/or special educational needs and disability (SEND). Families recognised the complexities of trying to navigate child-centric health, education and community care scenarios, even while resident in just one location; there was an appreciation that children's services were under pressure and also a widespread view that such services were under-resourced and as a result difficult to access. This view was echoed by NHS, MOD and charity sector SMEs.

"And then when community paediatrics eventually got back to me, she said: "I appreciate that, but our waiting lists are so long we have no appointments to give her anyway." Let's take an example of a child trying to access CAMHS services, which is a nightmare, each location has a different threshold. And I'll say this in terms of my local practice, as far as I'm concerned, the system is set up for how not to see patients."

Evidence from the families' accounts would suggest that these complexities were compounded further when trying to relocate between England regions, across the borders of devolved nations and returning from overseas. Echoing some of the experiences families had with other secondary care, families reported regional/national differences in the ways in which treatment was administered and care pathways were structured, which made the systems extremely difficult to navigate and comprehend.

"In one area, paediatrics wouldn't diagnose Autism, CAMHS would. In another area it was somebody different…"

One family had returned from overseas and reported a protracted struggle trying to get a diagnosis and treatment regime, initially issued abroad, accepted by community carers within England. While awaiting a referral into the community care system, the family had to rely on medication they had brought with them from overseas and eventually had resorted to private health provision to ensure that their child would not go unmedicated.

Among the sample were families who had tried to "get ahead of the game" prior to the move; they had consulted with their existing care providers, attempted to ascertain potential problems and even contacted services in their new location to discuss their health and community care needs. Rather than providing certainty, however, in some cases these interactions added to their confusion and frustration and did little to resolve the care needs of their dependents. The following extract is a small snippet from a detailed conversation with one family which again outlines inconsistency and uncertainty in the processes of referring specialist care on relocation:

"I spoke with community paediatrics and I explained what I wanted to do. And they said that some areas you can slot into where you were and other areas you have to like, basically get your doctor to refer you and start the process all over again…I rang them directly to ask the question. I was passed from pillar to post. Because no area seemed to know which area we'd fall under. So, I think I spoke to five different kinds of community paediatrics in the area. They couldn't give me any answers…the hassle of trying to find where we'd fall under, to speak to the right people, it was like banging your head against a brick wall. I ended up getting so frustrated, I even ended up ringing the local doctors to ask them what CAMHS we'd fall under.

So, we moved here. He has an EHCP, which he had from my previous address. And we had that in September when we moved here. The local authorities have yet to find him a suitable school placement [6 months later]. So, he's still not in school…[previously] he was under the community paediatrics for Autism, and he was under CAMHS for his low moods and anxiety…I obviously asked for a referral for the same for him here…So currently we have not seen any community paediatrics or CAMHS since we moved in six months previously."

Families reported being informed of waiting times for CAMHS of up to two years; timescales which were clearly problematic for those military families who were required to relocate often. Families felt that there was real danger that they might be side-lined as a result; if referral time potentially exceeded their time in an accompanied post, then they worried that care providers might be less motivated to prioritise their needs.

4.2.4 Dental

Accessing NHS dental services was a problem reported by many of the military families. According to the participant accounts, demand for NHS dental care far outstripped supply, resulting in limited availability and long waiting lists. Families were largely aware that this situation affected both civilian and military families. The issue for mobile military families was that waiting times for NHS dental services were often longer (typically 18 to 24 months) than the duration of their current posting; by the time they had made it to the top of the list, it was often time to move on. With every new posting, mobile families then had to restart this process, in effect never actually getting to the top of the list and leaving them without access to NHS dental services.

"So, this is what I'm finding. Every time I try and get into a dentist there is always a 12-month waiting list, or 18 months or two years. At which point I've got to the top, at which point we move. Now I am here, we have moved again, I am being told: "yeah, there is an 18-month waiting list, but don't worry it is the same for everybody." But it's not the same for everybody…I've been on a waiting list for the last…you know, every two years, I've been I worked with 18 months to get top of it and it is time to move.

"I can't get dental treatment. Because here I am a number 900 on a list of waiting lists and I'm on the lists of three different dental surgeries waiting for treatment."

Simply identifying dental practices that were taking on NHS patients was problematic in itself. Families reported using a variety of channels to try and source practices that were taking on NHS patients, these included social media sites, local directories, word of mouth and NHS websites. With such high demand, however, news of dental practices opening their books for NHS patients invariably resulted in a rush to secure the few available places.

"In Cornwall it took quite a bit of time, like a year. But that wasn't through the NHS. It was through a local dentist, who just occasionally put a sign outside the door that they we're accepting new NHS patients and then that spreads through the military community… That's how you find out. You don't find out through the NHS."

A number of families had used NHS sites to try and identify dental practices that were taking on NHS patients, but had found information on this site to be inaccurate and outdated. Despite being prepared to travel, this participant was still unable to access treatment with an NHS dentist:

"We phoned around and we were given some websites. So, you have a look and it lists a whole load of dentists. We were trying places 30 to 40 minutes away. We tried everywhere. So, on the link on the website it lists a whole load of dentists and it says whether they are taking NHS. And it says the last time the information was updated. Now, some of them haven't been updated for ages, but I'll still try them. But others are saying they are taking NHS. But when you phone them, they're not. No word of a lie, I must have tried the best part of 40 dentists. Just going through each one of the lists. Phoned them all up. And as I say, we'd go 40 miles, 30 or 40 miles, from where we live."

Regional differences in NHS dental provision were also apparent in the families' accounts. Some had encountered few problems accessing dentists in Scotland, for example, but across England most had struggled to find places, with London singled out by a couple of participants as being particularly difficult.

In the absence of NHS places, many of the families had not been able to access dental services for themselves or their dependents, instead being forced to rely on emergency dental care as and when they needed or, for those who could afford it, private provision. Some had

been told that if they were able to pay, they would be able to circumvent waiting lists, but this was beyond the means of a number of the families we spoke with, some of whom were unfortunately already having to privately fund other aspects of the health care because of issues arising from their relocation.

> *"We haven't got a dentist here. I can't find one…It's going to have to be a case of an emergency appointment. I emailed quite a lot actually here. I've gone within…all the way up to Salisbury. I mean, none are taking on NHS and I have been told they'll take you but not NHS and you can take private care. But I've said I'm not being funny, but I can't afford it for me and four kids. Plus having to pay for a private speech and language therapist. So, at the minute she kind of overrules the dentist.*
>
> *Well I went online, a couple of dentists said that they take NHS patients. I phoned them and said: "I hear you are taking NHS patients." They said: "yes, absolutely but there is a waiting list, unless you want to go private and then we'll see you next week… so you are number 804 in the queue, so we would expect to get to you about this time next year."*

There were also anecdotal accounts of other military families who had simply not transferred their dental care between regions when they moved, choosing to travel often large distances for annual check-ups.

> *"And a friend of mine, for example, they were living in Catterick and she was commuting to, oh, somewhere in Northumberland because they happened to be posted there before, she didn't bother moving [dental practices] so she was commuting an hour and a half, two hours just to go to a dentist appointment because that's where she happened to be registered…It's dentists. This is a problem. But that might just be a problem for everyone."*

Continuity of dental care was an issue for a couple of the military families in the sample. One family, for example, had been forced to resort to emergency dental care for their child. They had returned from an overseas posting and had been unable to access care with an NHS dentist to continue dental care started while they were abroad. While they had appreciated being able to access emergency care, they were critical of the quality of care which had left their child with a temporary, colour-mismatched fix. With no dental place secured, they had concerns that this emergency treatment might not be long-lasting, could potentially lead to future dental complications and have an impact on their child's self-esteem.

4.2.5 COVID-19 Context

4.2.5.1 COVID-19: Impact on Access to Health Care

A common theme across all the discussions with military families was the impact that COVID-19 had on participants' ability to access health and social care. For many, lockdown measures had created additional layers of complexity which had further exposed them to health disadvantages. It was also the case that participants found it difficult to ascertain the extent to which their current struggles with health care could be attributed to COVID-19, or whether these were in fact indicative of the challenges of military mobility more generally.

> *"You don't know what is COVID-19 delayed. You know, that's the imponderable because the different medical departments seem to have different thoughts on how they are going to do this. Some are just not. Some are doing it via Teams. Some are doing it in person. So [daughter] has apparently been referred to ENT and audiology, has been referred for several months now. Haven't heard anything."*

In terms of primary care, COVID-19 had certainly compromised families' ability to access GPs in person and the intermittent mandated suspensions of routine dental care had also been severely restrictive. Some families, for example, were put off even trying and register for dental services.

> *"So, the big thing here is that we haven't even got a dentist. We've got obviously some civilian friends in the area and their kids can't see their dentist because of COVID-19 and they haven't seen them for more than a year. But at least they've got a dentist... Everyone's just said come back in a few months when COVID-19 starts to [ease], once lockdown, et cetera, et cetera. So, I suppose I'll start phoning around again in the next few weeks, potentially. But yeah, there isn't anybody who has said: "phone us back on a certain date. We'll have news for you then." ... honestly, it's the fact that I can't even get into any. Just kind of crazy."*

Others had postponed attempting to access dental care on the basis that they would not be able to visit a practice while COVID-19 restrictions remained in place.

COVID-19 also had impacted severely on some families' ability to access secondary and specialist care. There were reports of COVID-19 restrictions compounding the time taken to get referrals, but also limiting families' access to specialists and medical procedures.

"My 12-year-old was having three-weekly transfusions for her lack of immune system. Which stopped because of COVID-19."

The impacts of COVID-19 were felt particularly by families who were trying to negotiate and co-ordinate multiple care needs, requiring the input from multiple agencies and services to initiate care pathways following relocation. This was particularly evident in the accounts of families trying to access CAMHS; particularly difficult when referrals to it often came through schools and GPs, both of which were subject to closure or restricted access during the pandemic.

"But here, we've not had anything like that…I'm not blaming COVID-19, I'm well aware of the pressures that everyone is facing. My mum's a teacher, I get it and CAMHS is already stretched to capacity. I understand that they are understaffed. They are underfunded. I can't help but feel…I don't know whether it's this area or whether lockdown's taken its toll at this moment in time, that it is just an excuse for not doing their job as efficiently as they could as well as they could. I'm trying not to be awful because I am well aware of the pressures that they face. But I do feel at this point that COVID-19 almost becoming a bit of a scapegoat."

One family tried to self-refer to CAMHS, only to find that this web-based facility had been removed during the pandemic.

"So, by June last year, I'd had enough, and I was going to do a self-referral for the twins. However, they've shut that off now because of COVID-19. So, I can't make a referral. It has to come from a GP, health professional or school…that was during the first lockdown because I tried to go on the website to do it and they said they stopped this option because of COVID-19. They do provide a phone number, but I haven't phoned it. I'll be honest."

4.2.5.2 Long-term Impacts of COVID-19

In the context of COVID-19, SMEs stressed concerns about the effect the pandemic was likely to have on waiting times and access to treatment. There was an overriding perception that increasing pressures on a post-COVID NHS were likely to exacerbate the potential vulnerabilities that mobile families already faced.

"I think it is going to get more difficult as we… as we evolve out from COVID-19 and…and you know the health care services have got a massive regain to do and therefore waiting lists and access to care which is still restricted at the moment are going to take some time to get back. And that will impact more on Service families if we are mobile saying well you know you need to get access to this. I think that's going to become more and more of an issue than it was previously because of the timelines and because the nature of assignment and the referral waiting lists.

The problem is it's COVID-19 isn't it currently and dentistry I know has had quite a lot of issues because they had to close down for quite some time, so the waiting lists are going to be really scary. And so, I…actually that is going to make getting access to dental even more difficult."

4.2.5.3 Learnings from COVID-19

As part of the consultation with mobile military families and SMEs we were keen to assess whether there were any lessons to be learned or examples of good practice that might be of utility to mobile military families going forward that might improve their experiences of negotiating health care systems. The overarching perception of participants was that COVID-19 had normalised remote interactions and in the context of health care families had welcomed the flexibility and convenience that this introduced to management of their care needs. SMEs also suggested that there might be merit in building on the public's increasing familiarity with and acceptance of video platforms to improve user experiences of health care.

> *"Zoom seems to be a way that people are getting more and more comfortable with now because they've been using it over the pandemic. I think it should be built on because you can get the right people in the right room at the same time."*

Echoing the above sentiment expressed by the health care professional above, one family participant talked of how her son's case management team had convened remotely resulting in a more timely diagnosis.

> *"Sounds terrible but the pandemic actually helped because rather than these big meetings, which were taking hours out of everyone's day, they were just Zoom calling it and things were being done in 20 minutes rather than two hours. And the reason he got his diagnosis so quick was that it was all Zoom calls taking place."*

Mobile military families talked of consultations with primary and secondary care providers via telephone and video platforms. While ultimately the utility of these types of interactions was limited, they could not for example replace physical examinations or diagnostic procedures, mobile military families felt that they were beneficial in terms of accessibility, user experience and health outcomes.

> *"And great thing about COVID-19 is that we've had video consultations with Aberdeen rather than face to face unless it is needed to have something physical done.*
>
> *[My daughter] has three [specialism] appointments for her care. And we've done quite a few of those through Zoom and had online clinics with them. And that's worked quite well. And the fact that we haven't had to then go up to them and we've just been able to sit and chat and discuss it this way. And we've got everything we've needed to do through that. I quite like the fact that this team do talk to her and not me and ask her how she's doing and stuff. She does communicate a bit more when it's on a screen than she does face to face with them."*

Evident from participant accounts also was that remote consultations helped them feel connected with their care providers and more informed about the progress of their treatment. One family participant for example, emphasised how grateful she was to have received an unprompted call from her new GP.

The pandemic may potentially impact on the ways in which we all access medical services in the future with, for example, remote tech-supported triage becoming more the norm. While this has the potential of reducing waiting times to be seen and speeding up the diagnostic process, it does emphasise the importance of those administering these forms of triage being military aware. More accessible, but ultimately less personal health care could potentially disadvantage mobile military families. Participants talked frequently of the importance of building and maintaining relationships with health care providers, but many found this difficult to achieve while having to relocate frequently.

"So, basically, when we moved here December, it was in lockdown, so I was trying not to go anywhere. Yeah, we printed off a registration form. Filled them in. My husband took it into the surgery, left it there. And then literally, it was less than a week, the GP rang me directly. Just to say "hello" and asked, because obviously I've quite complex needs…It was actually lovely. He was asking me about them [health issues], how long I'd had them. What I needed, when that sort of thing. And again, about a week after that, I had appointments at the hospital for diabetes and for the immunology as well. Me and my husband, we were shocked, to be honest, because it's never happened. It's like the fact that I didn't have to chase anyone. They contacted me. For someone to just think outside the box like that and think: "oh, I need to get a lot sorted for this person, I'll give them a ring." And it was it was just lovely. Really, really good. And for someone just moving out here in the middle of a pandemic, that enough stress anyway, it was just a bit…It was a bit of reassurance and just a bit, you know, this is going to be good. It's going to be OK."

4.2.6 Impacts on Health Care and Mobility

It was clear from the contributions of the military families that the complexities of regularly having to navigate health care services with every relocation impacted significantly on mobile military families' quality of life and wellbeing. Notices of pending moves, for some, were anxiety-inducing even for those who had experienced relocation multiple times.

In addition to the impacts on physical health that breaks in treatment and care had on participants and their families, mobile military families also talked of the toll that relocation and attempting to secure the continuity of care had taken on their mental health and wellbeing. Participants described occasions when they had broken down in tears, felt like they were failing their children and even sought mental health support.

All the families interviewed had spent the majority of their time together as an accompanying partner. The challenges of having to co-ordinate health care with frequent relocations had, regrettably, forced some families to reconsider their future living arrangements.

"As soon as we're told we're going to move or as soon as I know we're moving. And obviously, you know, you're not an idiot, you know how long the postings are for. But when we start [to hear] the rumblings of we're going. This is where we're going to, maybe. This is when we're going, maybe. I already start to get the fear. Let's just say, because I experienced moving from one Primary Care Trust to another and one Primary Care Trust would pay for my medication and the other one wouldn't. So, I've already been through the process of fighting to keep the continuity of my drugs, basically. So, I've already done that once. And that was horrible and stressful. And that's when I got very poorly last time."

"This is the point where my husband and I are having to make some very difficult decisions. Although I am independent, you know, we made a vow to each other that we would stay together as a family. But this move has been so difficult in terms of the civilians we had to deal with and the move to get here was traumatic enough for me not to want to do it again. And, you know, health wise. Mentally as well as physically this last one has been so draining and traumatic, not just for me, because my husband has to watch this too…"

Other families reported having discussions with their partners about turning down certain postings or indeed leaving the Services because of the difficulties they had encountered balancing continuity of care and the interests of the family with military mobility.

Some families also had to bypass the NHS, out of necessity rather than choice, in order to secure the care that they needed. Participants talked of having to pay for private care for surgical procedures, specialist care, mental health support and dental treatment.

Going private, however, presented obvious financial challenges and was not considered to be a viable option for all families interviewed. There were reports from families with multiple care needs of having to make difficult health choices; having to prioritise certain private treatments over others due to cost.

4.3 Mitigating Vulnerabilities and Disadvantages

This section outlines, from both SMEs' contributions and families' experiences, extant policies and practices designed to support mobile families and help them navigate health care systems and the extent to which these meet the needs of mobile military families.

4.3.1 Armed Forces Covenant

The Armed Forces Covenant, is a commitment by the nation to ensure that those who serve, or who have served in the Armed Forces, and their families, are treated fairly and critically, "should face no disadvantage compared to other citizens in the provision of public and commercial services."
In the context of health care and mobile families, the principles of the Armed Forces Covenant mean that time accrued on NHS waiting lists in one location should be taken into account and relative positions on waiting lists should be transferred on relocation.

Awareness of the Armed Forces Covenant among military families is monitored regularly in the UK FamCAS series. The most recent iteration highlights the limited awareness and knowledge of the Covenant within Armed Forces families; approximately one-third (31%) had never heard of the Covenant, a figure that has remained relatively constant for the past three years. A further 18% said that they had heard of the Covenant, but knew nothing about it. The survey evidences the fact that few Armed Forces families considered themselves to be well informed about the Covenant; less than one-in-ten (9%) said that they had heard of the Covenant and knew a lot about it[25].

Awareness of the Armed Forces Covenant among the family participants in this research study was relatively high in comparison with the FamCAS cohort, although it is important to note that many of the families' first experiences of it came through their interactions with the Families Federations in the context of attempting to resolve health care challenges. While some admitted that their understanding of the Covenant was limited, many were able to articulate its core tenet; to ensure that members of the military community did not face disadvantage, in comparison with other citizens, when accessing public and commercial services.

In the context of health care access, families recounted examples of citing the Armed Forces Covenant in primary, secondary and community care settings, but there were mixed views on the extent to which families felt it had made a difference or had any immediate impact. On the one hand, participants talked of the positive ways in which intermediaries such as the Families Federations had been able to use the Armed Forces Covenant to leverage access to health and community care service following a relocation. As a tool for professionals working within the military/health care space there was some evidence from the families' accounts that it could help to expedite positive outcomes. Families appreciated that "in the right hands" and when used by those with knowledge and expertise of the Covenant and its application – and indeed its limitations – it could be used to mitigate potential health care disadvantages experienced by mobile families.

25 HM MOD (2021) FamCAS 2021.

"I contacted the Families Federation. And the only reason I contacted it is cause one of [husband]'s work colleagues said: "I have something similar with my wife. Tell her to speak to the Families Federation." We didn't even know the Families Federation existed at that point for such things. And it was them that said this Armed Forces Covenant means they can't take your care away from you. So, I was like, "OK". And then it was given back quickly."

For the most part, however, when families themselves cited the Armed Forces Covenant in primary, secondary and community health care settings their experiences evidence a limited knowledge of the Covenant among some health care professionals, or a failure to understand the ways in which it could be applied to help military families access the health care that they needed and in many instances the care that they had already been receiving prior to their relocation. There were reports of participants citing the Covenant in primary, secondary and community health care settings with limited success. In these contexts, there were examples of health professionals not knowing what the Covenant was, having to 'go away and check' and to ascertain the degree to which their particular setting was committed to delivering services against it.

"Well, after we came here, I was told that the Covenant covered them and they should slot in. So, when I spoke to the Child Development Centre, and I argued that with the lady, she told me she'd never heard of it. She'd have to look into that."

Limited knowledge of the Armed Forces Covenant was one issue, but even when health professionals were aware of it, families often were left with the impression that it made little difference to their continuity of care or their ability to access health services in a timely manner. A few families felt that while the intention of the Covenant was positive, their practical experience was that it lacked 'teeth'.

"So, I went to the GP and quoted the Armed Forces Covenant. And it's just you kind of get nodded at. But I don't think they acknowledge it. Well, they acknowledge it, but don't take it seriously or do anything about it. I think it's just words, really. It doesn't mean anything. Or in my case, it definitely doesn't hold any weight. Just kind of nodding along like: "I know the words coming out of your mouth, but what do you want me to do about it?"

What was evident from the participant accounts was that there was a disconnect between families' expectations of what the Armed Forces Covenant could achieve in health and community care contexts and health professionals' interpretations of their commitment to the Covenant and what was practicable. Families had cited the Covenant hoping this would protect them from disadvantage, but often the families felt that this was perceived by care professionals as their attempt to 'jump the queue' or receive preferential treatment. The families' point was not that they were trying to seek advantage, but that under the Covenant they should be entitled to the parity of care when they moved; a point that they had to emphasise often.

"And I remember calling and saying: "we need to get him an appointment to see a physio because we're moving." And she was like: "well, it's gonna be twelve weeks now." "Well, we can't wait for weeks." And she was: "Oh, that's the waiting time to see you." And I said, "No. Well, we're a military family and under the Armed Forces Covenant …", and I remember her just saying: "I don't know about this, it's twelve weeks."

Ultimately, if waiting lists for particular referrals or procedures were a certain length in a new location, families felt health professionals, even if they were committed to the Armed Forces Covenant, were able to do little to mitigate the disadvantage they had experienced as a result of relocation. The issue with the

Covenant, for families, was that while its commitments to support the military community were well intentioned, its language was too general and susceptible to (mis) interpretation. Families felt that there needed to be more clarity on how the Covenant should be applied to health and community care contexts.

If, for example, a family had been given a date for a referral or procedure in one location, under the Armed Forces Covenant it was not automatically the case that this date would be honoured in a new location. Rather, they might retain their relative position on a waiting list, but waiting lists varied across England and between the devolved nations. Participants could be halfway up a short waiting list in one region only to find themselves halfway up a much longer list in a new location. In effect this would be disadvantageous to the family, but care providers in the new location could arguably make the case the military family was being treated equitably compared with civilian populations in that area. This only served to exacerbate the frustrations of families seeking to navigate health and community care systems.

"There really needs to be some continuity across all NHS services so that it is clear. It needs to be signposted. I think if they are genuine about helping military families and making sure that military children do not face hardship and don't face discrimination because they are having to move around then they need to all be on the same page with this Covenant. They need to be all on the same page with everything. I would never expect to be able to jump the queue – I would never want to take a place away from another child, but if I am told my daughter expects to be seen in November then I expect her to be seen in November. I don't expect to wait six months and then be told that they are not the right people. They should know that.

I would say: "have you heard about the military Covenant, you have got to treat us the same way…" "but it's the same for everybody here, we're not having anyone jump the queue."

4.3.2 MOD Protocols and Approaches

While the families themselves, for the most part, felt that the military did little to take family health needs and circumstances into account when relocating Service personnel, MOD SMEs referenced Joint Service Publications (JSP) and single Service policies which allowed families to feed contextual information into military career management systems. Indeed, in certain cases, this is actually a mandatory requirement. For accompanied overseas postings, for example, Service personnel are required to provide information on dependant families' health care, social care and education needs which, along with medical screening, informs the MOD's supportability assessment process. Information on this process is outlined in JSP770[26] including the self-assessment forms for Service personnel to submit relevant details.

MOD SMEs also suggested that Service personnel are encouraged to register dependents with additional needs (including acute or chronic health illness) and/or disability with Career Managers. Policy and guidance on the available support available to Service personnel are detailed in JSP820[27] and at single Service level through AGAI 108 (Army [now AGAI 81, Part 8]), BR3 (RN) and AP3392 (RAF). In the Army, registration of additional needs and/or disability is a requirement. According to AGAI 108: "As soon as Service personnel are aware that a family member has a supportability need, they must inform their Chain of Command". Army Serving personnel are then required to complete a Career Management Notification Proforma (CMNP) detailing health, education and care needs. Other methods of Service personnel being able to input data on family needs, mentioned by SMEs included welfare fields available on JPA. There were a few reports from families of registering needs with regards to accommodation and adaptations through the SFA application process (as detailed in JSP464[28]) and in particular through form e-1132, accessed via defence intranet.

SMEs noted that more could be done to encourage Service personnel to engage with existing systems of reporting family health and care needs and guiding them through the process of keeping Career Managers up-to-date and informed. As MOD SMEs suggested,

26 MOD (2014) JSP 770. Tri-Service operational and non-operational welfare policy.

27 MOD (2012) JSP 820. Tri-Service disability and additional needs policy.

28 MOD (2009) JSP 464. Tri-Service accommodation regulations.

without that information, there were limits to what support and guidance could be put in place to help families. SMEs perceived there to be a number of extant barriers to Service personnel providing information on family health and support needs. There was a perception that a degree of cultural reticence may persist within the military with regards to help-seeking, but also that Service personnel might be wary of divulging family health and care needs.

"I think as well, you're battling against ingrained military culture in some respects that suggests rightly or wrongly, that we just get on with it and we don't air our dirty laundry in public. We don't talk about our personal life. We just crack on and we don't seek help or whatever. The stigma around welfare and things is firmly ingrained. Unfortunately, it's something which we do need to address, but it's something which we can't fix overnight."

Echoing some of the comments made by families themselves, SMEs recognised that Service personnel might harbour concerns that registering health and support needs might negatively impact career progression, limit assignment opportunities and the acquisition of skills and competencies.

While Service personnel may be aware of the ways and importance of registering family needs, this information may not necessarily be reaching non-Serving members of the family. This perception was iterated across all groups of SMEs from health care, the MOD, charities and local authorities and indicates a need to involve improved information flow to families.

"What we're very good at in the Forces is giving information to the Service person thinking they will take it home. It's very similar to your kid at school whose got his report, sticks it in the bottom of his bag and it's the same with Service people and stuff that we give them that we hope to take through their families. So, what we need to do is we need to get a proper gateway that is not bound by security, that is almost a families' app."

"Everyone needs to know that they should fill that in. Well you know it's out there, it's been out there for a long time and we will tell people, but not everyone will then fill it in because there'll be some suspicion it will damage their career and so on and so forth. They don't quite understand it or they don't quite realise what it does…or the message hasn't come down clearly and so on.

The career management process allows for an assessment of the family's needs. The Service person can feed in contextual information about their family, about additional needs, SEND and things like that. There is a process for capturing that information. I suppose my concern is how effective that is and how much are we encouraging promoting Service personnel to offer that information? How much do Service personnel understand the importance of it? What are the barriers to them offering that information? Are they concerned about what the implications might be for them, for their career.

The system is there, the problem is that there…there is (umm) there is a very real fear in the Service person and their family that disclosing that information will impact their career."

4.3.3 NHS Protocols and Approaches

Working with the NHS, the RCGP has developed a veteran friendly accreditation scheme for GP practices that aims to embed Armed Forces awareness within practices and ensure that veterans are able to access the best care and treatment. Accreditation requires GP practices to seek and record veteran status on registration and have a dedicated clinical lead at the practice for veterans. The veteran lead should also commit to undertake training, promote Armed Force awareness among colleagues, be responsive to veteran-related queries from co-workers and ensure that the practice adheres to the health commitments of

the Armed Forces Covenant; including its core tenet that the Armed Forces community should face no disadvantage when accessing health care. At the time of writing, approximately 1,100 GP practices in England are now accredited under this scheme; representing circa 1 in 7 of all GP practices in England. The recently published *Healthcare for the Armed Forces Community*, a companion document to the *NHS Long Term Plan*, asserts the NHS commitment to expand the accreditation scheme throughout the country, prioritising areas with high numbers of veterans. At a secondary care level, the Veterans Covenant Health Care Alliance is driving improvements in health care to the military community and comprises more than 50 NHS Trusts that have been accredited as Veteran Aware.

Although the families with whom we consulted had had limited experience or awareness of interacting with Veteran Aware GP practices or secondary care settings, SMEs talked positively of the role the accreditation scheme had in raising awareness of the issues that military families commonly face accessing health care after relocation; and indeed, promoting a better understanding of the needs of the military families more generally.

Some of the SMEs commented that the 'veteran' label accompanying the accreditation schemes may impact on their effectiveness in addressing the needs of military families; families may not recognise that veteran accreditation applies to them.

This may go some way to explaining the low levels of awareness of and engagement with accredited health services among families in the study. SMEs noted that support for non-Serving members of the military community had historically, and understandably, centred on veterans but there was a need to refine the language and messaging to make it more inclusive and ensure that military families were able to access the support that they needed and that stakeholders were suitably empowered to help them do so.

> *"The Veteran Aware side of it, I still don't think that will fully address the military family awareness…the focus tends to be with veterans, around PTSD. Ideally, it should be, you know the Armed Forces Community Aware or something like that. You know it's a bit of a clumpy title unfortunately for communities, but we tend to use that when we're talking about things that cut across."*

Evidence was also provided by SMEs of other NHS initiatives that were raising awareness of the Armed Forces community among medical practitioners. Armed Forces health is now incorporated in the syllabus for trainee GPs, but contributions from NHS SMEs indicated an ambition to extend Armed Forces awareness into the consulting, diagnostic and administrative syllabus for hospitals. The rationale being that greater knowledge of Armed Forces contexts would help health professionals with their decision making.

Beyond the GP accreditation scheme, evidence was provided by SMEs, of initiatives and approaches designed to support the needs of military communities in the context of health and community care provision. Portsmouth Hospitals NHS Trust, for example, in 2020 created a new role within Queen Alexandra Hospital with the appointment of a RN veteran as dedicated Armed Forces Covenant Lead Nurse. This Lead Nurse, with the full support of the hospital and Trust, has been given autonomy to develop the role iteratively. The Trust is also a Veteran Aware Trust and is part of the Veterans Covenant Healthcare Alliance.

Within the hospital setting the Lead Nurse has raised Armed Forces awareness through the delivery of face-to-face and virtual training; approximately half of the 7,500 staff had accessed his training courses at the time of writing. The Lead Nurse, as the principal advocate for the Armed Forces Covenant is empowered to ensure colleagues adhere to the hospital's commitment to the Armed Forces Covenant and serves as the single point of contact for members of the military community struggling to access health care in the hospital and also wider community support. The hospital was awarded the Defence Employer Recognition Gold Award in 2020. The Lead Nurse

undertakes a recruitment role engaging specifically with veterans and partners of Serving personnel, through the recruitment pages of the hospital website and virtual chat rooms. Beyond the hospital, the role also affords the Lead Nurse the flexibility to engage in community outreach and networking activities.

4.3.4 Collaborative Approaches

Among the military community-focused initiatives and approaches that SMEs cited as worthy of note, many shared common denominators. These included multi-agency, cross-sector collaborative working practices, with a focus on inclusivity and often driven by empowered and highly motivated advocates. High degrees of contextual awareness, an ability to 'speak' military and/or NHS, combined with local knowledge also seemed to feature repeatedly in the governance of these best practice initiatives.

The Armed Forces Network for Sussex and Kent & Medway is a multi-agency organisation, commissioned by local CCGs /ICSs designed to improve the lives of the Armed Forces community. Since its inception in Sussex in 2011, it has taken a holistic approach to health and social care support for the military community and from an early juncture made sure that "everyone was at the table" convening stakeholders from the reservists, regulars, veterans, charities, NHS and local authorities. The Network, among its many activities, provides resources and factsheets for the military community, including pathways to organisations offering support with, for example, health and social care, housing and employment issues.

The Forces Connect App has been produced based on the pathways developed by the Network and now includes support information for 24 English regions. The AFN also engage with the Nepalese and Gurkha communities in Kent and have developed a health care toolkit to help these communities access health and wellbeing support. In addition to its comprehensive information offering, the Network also undertakes regular training programmes including training to Armed Forces Champions.

At local authority level, examples were provided of cross-sector boards and committees overseeing the development of the regional commitments to the Armed Forces Covenant. The Armed Forces Covenant Board for Norfolk County Council, for example, comprises representation from members of the Armed Forces local active bases, military charities, Families Federations, NHS commissioners and representatives from specialist council officers, including those from the fields of social care, adult services and housing. The Armed Forces Covenant team reported a particularly laudable achievement improving access to health care in their region. In response to concerns raised by local military bases regarding the lack of dental provision for military families, the team has, after a protracted period, been able to set up a new NHS contracted dental practice that occupies a military building within RAF Marham which serves both military families and the local civilian community.

Many of the SMEs spoke positively about NHS commitment to improve health care provision for military families and its willingness to engage with cross-sector stakeholders. The following quote is from a MOD SME, but similar sentiments were echoed by other SME contributors.

> *"I would like to make a point on the record. The DHSC and NHS England especially I think in the health and well-being space are so well engaged in and they devote a lot of resource to engaging with us throughout the various groups to support families and they deserve a lot of credit for leaning into this."*

4.3.5 Family Approaches and Workarounds

In the absence of formal guidance, a number of families had developed strategies aimed at helping them navigate health care systems more effectively. Some families, as a matter of course, kept hard copies of their and their dependents' medical records. On notification of each move they would request printed copies of their records from their primary and/or secondary providers which they could take away with them; a low tech, but effective way to pre-empt the loss or delay in the transfer of their medical information following relocation.

Some families who were in receipt of on-going secondary or specialist care chose not to transfer this when they moved; instead preferring to travel sometimes significant distances for treatment and consultations. While these decisions often presented complex logistical challenges, some felt it preferable and necessary to ensure continuity of care. Other families had adopted similar tactics, where practical, to secure access to NHS dental care and using the addresses of families or friends in order to retain their NHS place.

5. Implications for Policy and Practice

The research has highlighted a number of areas in which military families have faced disadvantage as a direct consequence of their mobility. The research points to some clear opportunities for the MOD, health and social care providers, the third sector and the families themselves to help mitigate these health inequalities. A draft set of 15 recommendations was distilled from the study and presented for discussion at a half-day Recommendations Working Group, convened at the Union Jack Club, London on 01 November 2021. The Working Group comprised stakeholders from the MOD, NHS England and NHS Improvement, the Families Federations and ARU. A revised set of nine actionable recommendations were compiled following the meeting and circulated to the Working Group for comment. Agreement was also sought on the organisations and departments best suited to deliver against these recommendations.

A complete list of these recommendations is presented on pages 12-14.

6. Conclusion

The research with mobile military families uncovered many examples of families who had struggled to access health and social care services when they were required to relocate. In a sense this was to be expected given that the sample was purposively selected to include participants who had previously reported difficulties to the three Families Federations.

What was evident from the participants' accounts, however, were the inherent complexities of navigating health and social care systems that differed so markedly across regional, national and international borders. Diagnostic and treatment procedures often varied across jurisdictions and in some instances, families had to fight to retain previously sanctioned care and services following a move. The impact of these breaks in the continuity of care were profound. Participants talked of protracted periods in limbo while health and care systems struggled to respond effectively and compassionately to their needs. Some had missed or been denied time-sensitive treatments that had resulted in long-term deterioration of their health and wellbeing. The overriding sense was that mobile military families with on-going health needs were disadvantaged when compared with the general or civilian population. Most reported losing agency of their care. At times families had found it hard to comprehend the health- and care-related decisions that had been made on their behalf and often families simply did not know where to turn when attempting to seek resolution or redress.

It is important to state, however, that all participants had enjoyed positive experiences with health care providers and there were accounts of practitioners within primary, secondary and community care who

had exhibited empathy, efficiency and professionalism and had been aware of the specific challenges that military families face when having to relocate. From the interviews with SMEs and some of the families it was also clear that across the UK there are examples of individuals, organisations and collaborative initiatives that are committed to, and have been successful in, supporting military families with their care needs. The challenge going forward is to ensure these exemplars are visible and accessible to the families that need them most. Some of the worst-case scenarios provided by families in the context of health care provision could have been pre-empted if the families had known who to talk to pre- or post-move. Many of the families felt that a single point of contact embedded in destination communities, ideally military and MOD aware, would be hugely beneficial in enabling them to regain agency and make informed choices regarding their mobility and its potential impact on their health and wellbeing.

Improving the experiences of mobile military families' access to health and social care will require concerted and collaborative effort, but evidence from the research suggests that there is a cultural and institutional appetite to get this done. The report makes a number of recommendations for ways in which stakeholders, including the MOD, the NHS, local/national government and families themselves can re-imagine mobility and health. Critically these recommendations have been co-created and negotiated among stakeholders – the intention here is to arrive at a consensus of what the actionable priorities are in this context and to identify clear lines of responsibility and accountability. We very much hope this will lead to meaningful change and reduce the health disadvantage that the military families contributing to this research, and others like them, have historically faced.

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Appendix 1: Glossary

ADHD	Attention Deficit Hyperactivity Disorder
AFFS	Armed Forces Families and Safeguarding
AGAI	Army General Administrative Instruction
AF CRG	Armed Forces Clinical Reference Group
CAMHS	Child and Adolescent Mental Health Services
CCG	Clinical Commissioning Group
CDP	Chief of Defence People
CMNP	Career Management Notification Proforma
CoC	Chain of Command
DMS	Defence Medical Services
DPHC	Defence Primary Health Care
EHCP	Education, Health and Care Plan
ENT	Ear, Nose and Throat
FAMCAS	Families Continuous Attitude Survey
ICB	Integrated Care Board
ICS	Integrated Care System
JPA	Joint Personnel Administration
JSP	Joint Service Publication
PTSD	Post-traumatic Stress Disorder
RCGP	Royal College of General Practitioners
SEND	Special Educational Needs and Disability
SFA	Service Family Accommodation
SME	Subject Matter Expert
SNOMED	Structured clinical vocabulary for use in an electronic health record

Appendix 2: Discussion Guide Families

Mobile Military Families Study: Impact on Health Care

Confirm participant has seen the PIS, **signed the consent form**, reiterate verbal consent and emphasise right to withdraw and stop interview at any stage. Ask if any he/she has any questions about the information they have received.

Gain Consent for Recording

Thank you for agreeing to take part in this interview. The aim of this interview is to find out about your/ your family's experiences of accessing health care – particularly how the experience of having to relocate from one region/country to another may have affected the care you have received.

The aim of the study is to produce user friendly operational recommendations for the NHS, Ministry of Defence and practitioners working with serving mobile military families in order to improve health outcomes. This study is being funded by NHS England and supported by the Navy, Army and RAF Families Federations.

I am going to ask you a few questions but if there is anything you feel uncomfortable with then you don't have to answer, you can simply say you would rather move on to the next question. Also, if you decide that you do not want to take part after all, you can just say so and we can stop. There are no right or wrong answers, I am simply asking for your own views.

****Start Recording****

1. Background information (structured)

To start, can I please ask you to introduce yourself by telling me:

- **A.** Your military connection/history – your/your partner's military career, service role, time served, rank, etc.

- **B.** Where you live (first part of postcode) and how long you have been at your current location. Where else have you lived/been posted during your/your partner's military career (record places [first part of postcode] and dates of relocation) (aim: assess timings/frequency of relocations, record cross border moves, note for further discussion)

- **C.** A bit about you and your family (family composition, child(ren) age). AS THE FOCUS OF THE STUDY IS ON HEALTH CARE can you tell me whether you or your family have any specific health care needs (aim: basic family demographics, leading into specific health histories/needs help inform further discussion)

2. Mobile families: impact on health care (semi-structured)

Mapping exercise: ask participant to narrate the most recent re-location journey, from being informed of the move, preparation, support, information sources, concerns, etc. leading into a focus on health care…

A. Pre-move:

- When and how did you **first hear** about your relocation? Was this relocation a result of service **need or promotion**? Accompanied/unaccompanied an option? Weekly commute possible? Career pressure to move? Did move take into account family health needs? How much notice did you receive? Was this standard/did this give you enough time to prepare for the move?

- Prior to the move, what were your main concerns about relocating? (prompt education, accommodation, social/friendship networks, family, health, employment). How much of a concern was health care (Rank health care against other concerns)?

- What specific health care concerns did you have? (prompt re specific [noted from Section 1] as well as general health care needs. To include [as appropriate]

    - Primary GP/Dental registrations
    - Secondary (hospital care)
    - Specialist (tertiary)
    - Community Care
    - Prompts for above: waiting lists, transfer of medical records, specialist referrals (primary to primary; primary to secondary, etc.) continuity of care, relationship with health providers, etc.)

- Were you prompted to contact any of care providers above to inform them of impending move?

Were they responsive? Recognise you as a service family/familiar with AF Covenant commitments/ duties?

- What health-related support and advice did you receive and/or seek out re health care and relocation (Military – already in DMS/moving to DMS, NHS, FF, Military/Family Charities, etc.) [probe]: for perception of quality/utility of sources of advice, seek examples. Which advice/support did you find most helpful? Why? What was missing? [Identify and chart best practices and gaps in support]

- How informed did you feel about your health care entitlements? (assess familiarity with AF Covenant)

- In relation to health and wellbeing support, how confident/prepared did you feel prior to relocation that you had everything in place/would be able to negotiate the move successfully? (why/why not, residual concerns, etc.)

Mapping exercise (cont) ask participant to narrate their pathways to health and wellbeing support in their **current** location.

B. Post-Relocation: Primary Care

NHS GP Practice journey (facilitators/barriers to quality care provision):

- **Finding/registering with a new GP**. What was your experience of the transfer process from your previous GP to your new provider? [additional prompts]: What did you know about NHS GPs in the area? What information did you have/seek to help make a choice? Did you encounter any issues with the registration process? Did you or the GP recognise a need to identify as a service family? Had this information already been passed on (previous GP, health care provider) or did you have to start again? Did you encounter any issues with the transfer of medical records (cross border, NHS/DMS, Hospitals Community Care)?

- **Access/utility of services & support:** What have been your experiences of using your new GP services? [additional prompts]: How easy is it to make an appointment? How easy is it to get to? What has been your experience of the staff at the practice? (GPs, support staff, etc.) Are the staff AF-informed/ aware? Do they have an AF Champion? Have you been directed to AF-specific information, support groups, etc. [seek examples]

- **Care coordination:** [with reference to specific needs outlined in A] To what extent has your new GP been able to tailor/personalise health and wellbeing support for you/your family? [prompt where applicable]:

  - **Long-term conditions and/or disabilities** [types of support, GP actions, waiting times, patient access/barriers to support, experiences & outcomes]

  - **Conditions with long treatment times** [types of support, GP actions, waiting times, patient access/ barriers to support, experiences & outcomes]

  - **Referral to specialties** – [through GP (primary), secondary care to secondary, etc., patient access/ barriers to support, experiences & outcomes

  - **Mental health/wellbeing support** [types of support, GP actions, waiting times, patient access/barriers to support, experiences & outcomes]

  - Were specialist **Housing/equipment needs** considered? [e.g. ramps, stair lifts, bathing aids, etc.]

  - Specific difficult to source **medications** – pharmacy involvement, medication administration (e.g. injections by district nurse, etc.)

  - **Signposting support** (including information on AF-centric service/support providers. Record services, participant experiences, etc.]

- Thinking about the ways in which your GP has helped you navigate NHS health and wellbeing support, what has worked well/less well and why?

- What have you found the to be the most significant health/support challenges you have had to face during your last relocation? [note/rank] Why/in what ways?

- Thinking about the experiences we have discussed above, how do these compare with previous re-locations [prompt]: local/regional/national approaches, participant preparedness, information quality, AF-aware staff, etc. [identify examples of best practice]

(NHS) Dental Care

- Have you been able to access NHS dental care for you/your family?
    - Primary (general dental care, management/ treatment oral health)
    - Secondary (orthodontists, paediatric dentistry, restorative)
- If yes, please could you tell me about that process [identifying providers, waiting lists, etc.] If no, what are the challenges you have faced?
- How does this compare with previous experiences of accessing NHS dental provision when you had to relocate?

C. Post-Relocation: Experiences of Secondary Care

- Have you/your family accessed secondary care (e.g. hospital services, CAMHS, child development centres, etc.) while in your current location? If yes, can you provide brief details [prompt for name/ location of Secondary Care service]
- [if not previously covered] What was your experience of the transfer process from your previous to your current secondary provider? Did you encounter any issues with the referral process? Were you recognised/did you need to identify as a service family? Had this information already been passed on (previous primary/secondary/tertiary provider) or did you have to start again? Did you encounter any issues with the transfer of medical records (cross border, NHS/DMS, Hospitals, Community Care, etc.)
- How satisfied were you with the care provision? Were there any mechanisms/systems in place to help military families? [Veteran-aware hospital, references made to status as member of military family/GP notes, signposting to AF-specific services/ charities, etc.] How helpful was this AF-focused support?
- How did this experience compare with your use of secondary care in previous locations?

D. Impact of COVID-19 on Health & Wellbeing Support [aim: to assess whether there are any Learnings from Adaptation of Service Provision during Lockdown/Social Distancing directives]

- Has the pandemic affected your access to health care and support? If yes, in what ways? What impact has this had on your/your family's health and wellbeing?
- How have your service providers/support networks responded to the challenges of COVID-19? [prompt]: online support, consultation, etc. If yes, how have you found these changes to working practice? What has worked well/less well?
- Could online/remote care be of support/help or useful in your circumstances? Do you think this could help avoid changes/challenges in care that come with relocation? [would this be preferable to ensure continuity of care/avoid "starting over"?]

E. Wrap Up

- Do you think that being part of a military family has put you at any disadvantage in terms of access to health and wellbeing support? If yes, why? If no, what support/help have you received that has helped counter the challenges of relocation, etc.
- Armed Forces Covenant [tailor to previous discussion/if not previously covered]
    - Have you heard of Armed Forces Covenant? If yes, from what source(s)?
    - What is your understanding of the AF Covenant? How does relate to your interactions with health care providers? And access to health and wellbeing support? [AF-friendly/ aware primary/secondary care, FFs/charities/ support networks, etc.] – seek specific examples
- When you think about the things we have discussed today (for example, **tailor to issues discussed by participant**) is there anything else you have been thinking about during the interview that you believe is important to tell me?
- Have you any further questions?
- Thank you for your contribution to this work… [END]

Appendix 3: Discussion Guide Professionals

Mobile Military Families Study: Impact on Health Care

[Generic schedule to be tailored accordingly depending on role/organisation category]

Confirm participant has seen the PIS, **signed the consent form**, reiterate verbal consent and emphasise right to withdraw and stop interview at any stage. Ask if any he/she has any questions about the information they have received.

Thank you for agreeing to take part in this interview. We have completed a round of interviews with members of mobile military families and discussed with them issues they have encountered accessing health care. This is the second tranche of the qualitative research and aims to illicit insight from professionals with responsibility for advising, delivering or commissioning health care for military families.

In this session we would like to explore your interactions/role with mobile military families (MMF), the kinds of issues that arise re their access to/ continuity of health care, policies/processes in place, your perceptions of how well these address the needs of MMF, any examples of best practices and/or areas for potential improvement.

The aim of the study is to produce user friendly operational recommendations for the NHS, Ministry of Defence and practitioners working with serving mobile military families in order to improve health outcomes. This study is being funded by NHS England and supported by the Navy, Army and RAF Families Federations.

ETHICS: Ethical approval for this research was granted by the Department Research Ethics Panel in the Faculty of Health, Education, Medicine and Social Care at ARU.

[For military personnel this study has the approval of Head of Armed Forces People Support who has confirmed that MODREC is not required.]

We have a number of themes we would like to cover, but if there is anything you prefer not to talk about do let me know and we can move on. Also, if you decide that you do not want to take part after all, you can just say so and we can stop at any time. There are no right or wrong answers, I am simply asking for your own views.

Lastly: data gathered in this discussion will be used to inform a short report, will feed into research papers for academic journals and will help shape operational recommendations. Any contributions you make will be pseudo-anonymised – any quotes used will be assigned generic identifiers (MoD Representative, NHS).

Gain Consent for Recording **start recording**

Background information (structured)

To start, can you tell me a little about:

- **A.** Your role (and how that fits within wider remit of department)
- **B**. …and where the health care for MMF fits within this

Challenges & Barriers

- What specific challenges/barriers do you think MMFs face when accessing health care? [prompt if necessary]
- Record transfer (primary, secondary, specialist and community)
- Waiting lists (primary, secondary, specialist and community)
- Treatment funding
- Complex needs (co-ordination of)
- MoD Expectations, mobility, notice periods
- Across borders (CCGs / ICSs, devolved nations, international)
- DMS/Private to NHS

Checks & Balances

How should the system be working? What policies and protocols are CURRENTLY in place to help mitigate these risks (informed by responses from above, but prompt if necessary).

- MoD / Service / Unit level (seek JSP/Policy docs, etc.)
- NHS primary/specialist
- Community care / SEN
- Armed Forces Covenant

Best Practice & Areas for Improvement

How well are these policies/practices currently meeting the needs of MMF? [seek examples of best practice and areas for improvement].

- What's working well? [practices/policy docs where applicable, historical successes/approaches, etc.]
- What's working less well?
- Do you have any particular concerns/frustrations? Specific, recurring barriers to MMF being able to access the health care/support they require?

Approaches To Improvement

Given the above, and the remit of the study to provide practical/operational recommendations (MoD, NHS, health practitioners, etc.)

- In what ways do you think health outcomes for MMF could be improved?
- Who should be driving these improvements?

Fluid Policy Area

Obviously there is a lot of work currently taking place in this policy area (Selous, Family Strategy, NHS consultations, etc) – is there any issue in particular you are hoping/pushed for which you are keen will be highlighted/addressed?

COVID-19 Context

This has presented numerous challenges for practitioners, policy makers/advisers and families themselves. We have been exploring whether there might be learnings from responses to COVID-19 that might be taken forward to improve outcomes for MMF. Thoughts?

Case Studies

Case study examples for discussion [time permitting] – Tailor to participant (Covenant Awareness/effectiveness, waiting lists, care coordination, CCG / ICS treatment funding, re-telling/re-testing case histories, waiting lists, communication, notice periods, housing, etc.)

[END]

Naval Families Federation

Monday - Thursday 09:00 - 17:00
Friday 09:00 - 13:00

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02392 654374
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Monday - Thursday 08:00 - 19:00
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ROYAL AIR FORCE Families Federation

Monday - Friday 09:00 - 15:00

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