Ministry of Defence

NHS England

Armed Forces personnel in transition

Integrated Personal Commissioning for Veterans (IPC4V)

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1. Foreword

The Integrated Personal Commissioning for Veterans (IPC4V) Framework was born out of the need to ensure that the small number of Armed Forces personnel who have complex and enduring physical, neurological and mental health conditions resulting from injury that is attributable to Service are effectively cared for and supported as they transition to civilian life and beyond.

The NHS in England, Scotland and Wales has a duty to ensure that those injured in Service receive priority treatment for conditions relating to their time in the Armed Forces (subject to clinical need) and are cared for in a way that reflects the nation's moral obligation to them. In support of this, NHS England has developed the IPC4V Framework which takes a completely new approach to planning and commissioning care, focusing on what is important to the individual.

Available across England, it seeks to ensure that health and social care, together with the Ministry of Defence (MOD) and other organisations, are working collaboratively with the individual and their family and / or carer to ensure the provision of personalised care, support and treatment that meet their needs in ways that work for them. The framework also aims to ensure that those who have given the most for their country can develop their knowledge, skills and confidence to manage their health and live their lives, backed by an enhanced multi-disciplinary team who are planning and providing care and support before they are discharged from the Armed Forces.

This new approach to planning and commissioning care and support has evolved over the last couple of years and been influenced, in particular, by the learning from a number of individuals with complex and enduring injuries attributable to their Service. Their involvement and that of their families and carers has been invaluable in helping to understand all aspects of their life, crossing health and social care and education. It has also been central to informing the development of an effective, relevant and sustainable framework that can be consistently used and applied across England.

Furthermore, the close involvement of a range of health and social care organisations, as well as military charities, has been instrumental in helping NHS England and the MOD ensure that these individuals get the very best care and support through application of this framework.

Their hard work and commitment has resulted in robust guidance that is underpinned by the ethos of valuing individuals as active participants and experts in the planning and management of their own health and wellbeing and ultimately ensuring that those who have suffered the most complex and permanent injuries attributable to Service are supported effectively for the rest of their lives.

By working in partnership and using the framework as a basis for providing Armed Forces aware care and support for these individuals, we can offer an effective and efficient service that places them at the centre and ultimately improves their experience of care and health and wellbeing outcomes for now and for years to come.

2. Introduction

Integrated Personal Commissioning (IPC) was the approach developed to support the delivery of personalised care specifically for people with long term conditions and complex needs. It integrates health and social care (and education and prevention, where relevant) around a person's needs, giving them greater choice and control over the care they need by focusing on what is important to them.

IPC and Empowering People and Communities (EPC)[1] together form the original basis for the Comprehensive Model for Personalised Care (see Annex C). This approach of integrating around the person and making the most of their potential and their communities cuts through organisational silos and provides a practical way for people themselves to be the best integrators of their care. Therefore, we are seeking to put personalised care at the core of the NHS in our efforts to integrate the system across England, alongside the work of Integrated Care Systems and Sustainability and Transformation Partnerships.[2]

Since 2017, work has been undertaken to design and test a programme known as Armed Forces personnel in transition, Integrated Personal Commissioning for Veterans (IPC4V). This is intended to support the small number of Armed Forces personnel who have complex and enduring physical, neurological and mental health issues resulting from injury that is attributable to their Service, as they transition to civilian life and beyond. It is based on the Comprehensive Model for Personalised Care and grounded in knowledge about this particular population.

In line with the Comprehensive Model for Personalised Care, IPC4V also supports organisations to develop partnerships with the Armed Forces charity sector to facilitate the seamless coordination of support that spans both statutory and voluntary sectors. In addition, MOD Veterans UK has appointed dedicated Veterans Welfare Managers (VWMs) to cover two regions (the North and South) of England.

[1] The EPC programme focused on supporting the systematic implementation of support for self-management (including the patient activation measure), social prescribing and community-based approaches

[2] Health and Select Committee (2018), Integrated care: organisations, partnerships and systems. Available online: https://publications.parliament.uk/pa/cm201719/cmselect/cmhealth/650/650.pdf (accessed 14 June 2016)

3. Who is this document for?

This guide is aimed at those people who are leading or involved in care and support planning for Armed Forces personnel that have complex and enduring physical, neurological and mental health issues that are attributable to injury whilst in Service. This planning should begin prior to these individuals being discharged from the Armed Forces with support continuing as they transition to civilian life and beyond.

The document provides best practice guidance on how to effectively plan personalised care in the context of supporting individuals with complex and enduring physical and mental health needs.

4. The emerging IPC4V Framework

4.1 The development of the framework

The development of a care planning framework for Armed Forces personnel has been based on the learning from a number of individuals with complex and enduring injuries that are attributable to Service, as identified by Armed Forces clinicians. With the consent of these individuals, multi-agency steering groups were set up to retrospectively review and understand their care planning as it has evolved, whilst drawing on the opinion and examples from these individuals, as well as from wider stakeholders. The learning from working with these individuals has been invaluable and has assisted in the development of this guidance in order to develop a comprehensive care planning framework.

IPC4V signals a completely different approach to planning and commissioning community, social care and other services, along with the adoption of evidence-based approaches to delivering personalised care for members of the Armed Forces with the most complex conditions and needs.

This new approach to care planning is delivered through enhanced multi-disciplinary teams, with care and support planning starting before the individual has been discharged from the Armed Forces. As part of this, it draws together the appropriate health and social care specialists, local commissioners and the Armed Forces charity sector at the level appropriate for each individual. It seeks

to enable individuals, carers and families to have choice and control the resources available to the individual to shape their own care. It also aims to support individuals to make the most of the community resources around them and to develop their knowledge, skills and confidence to manage their health and live their lives. It does this through holistic personalised care and support planning, targeted peer support, community capacity building and an expanded role for the Armed Forces charity sector.

In England there is also the option of a personal health budget (PHB), a personal budget for social care or an integrated personal budget. In the devolved administrations of Scotland and Wales, other arrangements exist. NHS England is working closely with the Welsh Health Board in the first instance to test this framework for those individuals who are expected to live in Wales after their discharge from the Armed Forces.

4.2 How does this work?

Personalised care and support planning is a series of facilitated conversations in which the individual and / or those who know them well, actively participate to explore the management of their health and wellbeing within the context of their whole life and family situation.

This process recognises the individual's skills and strengths, as well as their experiences and the things that matter the most to them. In the case of Armed Forces personnel in transition, IPC4V, it goes beyond traditional health and social care to focus on all aspects of the individual's life, including their goals and ambitions. It addresses the things that aren't working in their life and identifies outcomes and actions to help resolve them.

4.3 What are the benefits to personalised care and support planning?

Valuing individuals as active participants and experts in the planning and management of their own health and wellbeing ensures that the outcomes and solutions developed have meaning to the person in the context of their whole life, leading to improved chances of successfully supporting them.

Integrating health and social care at the point of assessment and planning means the individual does not have to repeat their story time and time again, as they have one assessment and planning experience that results in a single integrated personalised care and support plan.

5. IPC4V components

5.1 Personalised care and support plan

The personalised care and support plan is developed following an initial holistic assessment around the individual about their health and wellbeing needs. Essentially, the plan is the record of the care and support planning discussion, and includes details of the agreed needs and outcomes and how these will be met.

The key features

Perspective – this is a way of 'seeing people' and attitudes towards them that is fundamental to good personalised care and support planning.

The changed relationship and different conversation means that the individual:

- is empowered and builds knowledge, skills and confidence
- experiences hope and feels confident that the process and plan will deliver what matters most to them
- is central to developing their personalised care and support plan and will agree who is involved
- is seen as a whole person within the context of their whole life, whose skills, strengths, experience and important relationships are valued
- is valued as an active participant in conversations and decisions about their health and wellbeing.

Process – this is the overall process of personalised care and support planning.

A good personalised care and support planning process means that the individual:

- has the time and support to develop their plan in a safe and reflective space
- is able to access information and advice that is clear and timely and meets individual information needs and preferences
- feels prepared, knows what to expect and is ready to engage in planning that is supported by a single, named coordinator
- is listened to and understood in a way that builds trusting and effective relationships with key people
- is able to agree the health and wellbeing outcomes they want to achieve, in dialogue with the relevant health, education and social care professionals
- has the chance to formally and informally review their personalised care and support plan.

Plan – this is what a good plan looks like.

A personalised care and support plan:

- is a way of capturing and recording conversations, decisions and agreed outcomes in a way that makes sense to the person
- should be proportionate, flexible and coordinated and adaptable to a person's health condition, situation and care and support needs
- should include a description of the person, what matters to them and all the necessary elements that would make the plan achievable and effective.

5.2 Proactive co-ordination of care

A proactive approach to integrating care at an individual level around serving personnel with complex needs

IPC4V is aimed at improving the experience of care for serving personnel that have complex and enduring physical, neurological and mental health issues that are attributable to injury whilst in Service, with this support continuing as they transition to civilian life and beyond. In future, it is anticipated that IPC4V could be the predominant model of community based care for this patient group.

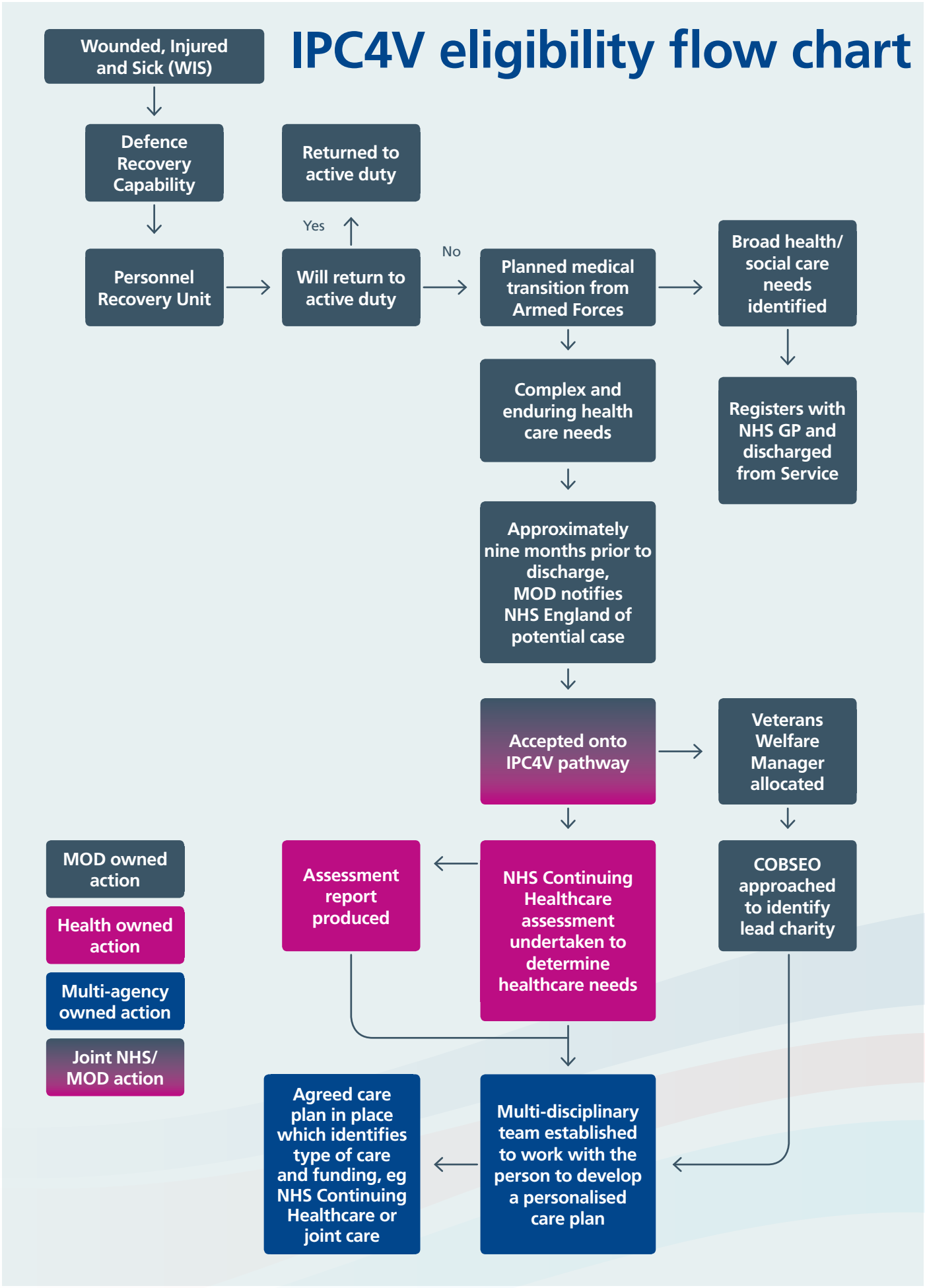
IPC4V uses person-level costing (costs defined at the level of the individual) to understand current service use and plan how resources can be used differently in accordance with individual needs and preferences.

Service personnel within this patient cohort are proactively approached and identified through referral whilst they are on the Defence Recovery Pathway. Once the referral has been made, a multi-disciplinary and multi-agency steering group is set up to oversee the case, ensure the right people are involved and address any challenges.

Using the IPC4V Framework to improve the care of highly dependent serving personnel and veterans, aligns with the principles governing the equity of healthcare delivery for Armed Forces and veterans irrespective of injury mechanism. The NHS will continue to be the primary provider of healthcare for veterans, with MOD input needed to help ensure that the commitments of the Armed Forces Covenant[3] are met.

[3] Armed Forces Covenant https://www.gov.uk/government/publications/the-armed-forces-covenant

IPC4V eligibility flow chart



5.4 A community and peer focus to build knowledge, skills and confidence for self-management

5.4.1 The Veterans Welfare Manager

IPC4V helps individuals build knowledge, skills and confidence, viewing individuals as active co-ordinators of their health and wellbeing (rather than passive recipients of services) and explicitly valuing the potential in communities. It does this by harnessing peer and community capacity to support self-management and through improved coordination of formal care services with community and voluntary sector resources. This builds on the recognition of the important role veteran specific voluntary organisations play in supporting these individuals.

IPC4V takes the learning from working with NHS England's wider personalised care programme to promote the use of evidence based approaches, including health coaching, self-management programmes and peer support. It also gives more detail on the various approaches and support for self-management.

In order to ensure continuity of care and support planning and provision of care, MOD's Veterans UK has appointed Veterans Welfare Managers (VWMs) to cover two regions (the North and South) of England. The role of the VWM is being tested during 2019/20 by working with the most complex cases. VWMs act in the capacity of a local area coordinator to play a vital part in 'bridging' between individuals, services and the community. They offer a range of support, including 'guided conversations' to help IPC4V participants identify further goals and actions, making connections to community based resources including veteran specific organisations and facilitating appropriate referrals back into health or social care.

The VWM will initiate an annual review of care with each individual and the statutory and non-statutory organisations involved in that person's care. They will also remain the single point of contact for each person should their care need to be reviewed at any time.

5.4.2 The agreement between the MOD and NHS England on the role of Cobseo and gateway into the charity sector

The charity sector, including Armed Forces charities, exists to help society and be of public benefit. Each charity has its purpose, which is defined in its charitable objectives. Common themes are holding statutory provision to account and not replicating it, while striving to meet individual needs that are not statutorily provided for. The sector has both general and specialist operators, at national and local levels.

The Confederation of Service Charities (Cobseo) aims to represent, promote and further the interest of the Armed Forces community by exchanging and coordinating information internally; identifying issues of common concern and coordinating any necessary and appropriate action; acting as a point of contact for external agencies to the members of Cobseo; and representing and supporting the needs and opinions of its member organisations, individually and collectively at central and local government levels and with other national and international agencies.

The small number of Armed Forces personnel eligible for IPC4V will experience a bespoke arrangement assisted by Veterans UK and its VWMs who will help to identify and meet their needs through charitable support.

The MOD and NHS England support the co-ordination of the charity sector through an appointed Director of the Executive Committee of Cobseo who will receive IPC4V applications from the VWM.

The Director will, together where appropriate with the Cobseo Director of Operations, discuss the application with qualified Cobseo member organisations to select a leading Armed Forces charity for each individual in the IPC4V programme, relevant to their individual needs. The VWM will be advised which charity will lead for each individual. The VWM and the lead charity then arranges collaboration with fellow charities, not just Armed Forces charities, drawing on their individual expertise, whilst working closely with the VWM, to support the individual.

5.5 Choice and control

A shift in control over the resources available to people, carers and their families, through integrated personal budgets

Delivering the change

Through Armed Forces personnel in transition, IPC4V, individuals have a personalised care and support plan and in England the option of a personal budget, personal health budget or integrated personal budget for all or part of their care.

Personal budgets are a commissioning tool that give an individual more control over the care they receive and more choice over how their needs are met. The evidence from health and social care shows that, when implemented well, personal budgets and personal health budgets are cost effective and improve an individual's quality of life and experience of care, whilst promoting self-management and reducing reliance on unplanned care.

In England there is the option of personal health budgets with three deployment options on managing funding that participants can choose from:

1. A direct payment option (where all or part of the personal health budget is paid directly to the individual or a carer to commission services).
2. A third party personal budget (where funds are placed with an organisation that buys the services the individual needs and accounts for the money to the commissioner).
3. A notional personal budget (where the relevant clinical commissioning group or local authority commissions and coordinates care on the individual's behalf).

(In England there is also an option of a personal budget where support is being funded by social care, which includes the three ways of managing the budgets described above. Direct payments for social care support are available across the UK.)

5.6 Personalised commissioning and payment

A wider range of care and support options tailored to individual needs and preferences, through personalised contracting and payment

Delivering the change

Creating a health and care system driven by people and communities and incentivised to achieve the outcomes most important to them, requires a different approach to commissioning, contracting and payment.

This shift requires facilitating local health and care markets so that IPC4V participants can access a wider range of personalised care, including from the Armed Forces charity sector. This work is underpinned by developing a common framework that builds on the market shaping duty in the Care Act 2014, and looks beyond conventional services and tariffs, towards stimulating the provision of new types of service in response to individual needs and preferences.

6. Next steps

This framework reflects a general approach and provides pointers that have been captured through the application of personalised care to the current circumstances of those Service personnel with complex needs. It is not intended to be prescriptive, but provides an indication of the approach that can be taken through the IPC4V lens when planning care for individuals. As this approach is used, it will be further developed and updated.

The NHS Long Term plan sets out the commitment to supporting veterans and NHS England is in the process of developing a wider offer that will be available to veterans who have ongoing health and social care needs. The guidance for this will be available in summer 2019.

Annex A:
An approach to IPC4V

The following table uses the framework of personalised care and support planning from IPC and applies it to IPC4V.

It reflects a general approach and pointers that have been captured through the application of IPC4V to the current circumstances of Service personnel. It is not intended to be prescriptive, but provides an indication of the approach that can be taken, through the IPC4V lens, to other and future personnel at the Defence Medical Rehabilitation Centre, Stanford Hall and elsewhere.

It is based on the core role of a 'Veterans UK Veterans Welfare Manager' (VWM) being in place. As this approach is used for more individuals, it should be further developed and updated.

Key steps

1. Context

The individual will be receiving a wide range of support from a variety of different people and agencies, including unit support, Stanford Hall and Personnel Recovery Units (PRUs).

There will be a range of people coordinating different aspects of the individual's care, though not necessarily in a coordinated way.

A range of different conversations will have already happened with the individual beginning to think through their support and life after discharge.

There won't necessarily have been proactive discussions with the potential commissioners of services in the area the individual will move to.

There may be a wide range of support available through transition and beyond for the individual, provided by a wide range of organisations, particularly including voluntary, community and social enterprise organisations specifically supporting veterans.

A dedicated VWM for IPC4V should be identified for the individual.

The individual should be informed that they will experience a coordinated approach to their care and support post-transition and what to expect.

2. Preparation

Identify key personnel involved in coordinating the individual's current care – including at Stanford Hall, unit support and PRUs.

Identify all existing assessments and plans that have been created for the individual.

The VWM speaks with all relevant personnel and considers all existing assessments and plans to understand the current situation and possible preferences.

The VWM spends time with the individual (and any other people the individual chooses, such as family members) to reflect on all existing information, and to share details about the process they can expect.

The VWM introduces relevant person-centred thinking tools to support the individual to begin to think through their future outcomes.

Any information completed before the conversation stage is captured and shared.

The VWM begins preliminary engagement with potential commissioners and providers of support that the individual might access.

3. Conversation

Drawing on information brought together during the preparation stage, a series of conversations take place between the individual, his / her VWM, the key personnel around them and any others, to think through:

- the outcomes the individual wants to achieve
- how to meet their identified needs
- what potential resources may be available to meet these.

This series of conversations can take place in any form the individual chooses.

The conversations are supported by the continued use of person-centred thinking tools. These include a care and support plan with the headings suggested for IPC4V (see Annex B).

Between conversations, the VWM liaises with all personnel involved in the individual's care (a) now, and (b) those potentially involved in the future.

The VWM also liaises with the potential commissioners and providers to understand what is and isn't available to help understand the different options for the individual to meet their identified needs and outcomes (including the use of a personal health budget in England).

4. Record and agree

A single summary care and support plan is produced for the individual. This plan will contain their identified needs and outcomes and how both of these will be met. It will also detail what resources are to be used to meet these needs and outcomes, and who provides what.

The needs and outcomes will be identified against the headings noted in Annex B.

The single summary care and support plan can include a one page profile of the individual, so that anyone involved in their future care can understand who they are supporting and what their needs and outcomes are.

The single summary care and support plan should link to any other formal care or treatment plan that is required.

This plan should be agreed by the individual or their representative and those responsible for commissioning their support.

It should be shared with all relevant people and organisations.

The entire process above can be coordinated by the VWM.

5. Make it happen

Upon agreement of the single summary care plan, the VWM will be responsible for coordinating action to put the plan into practice.

He / she will liaise with all relevant commissioners, agencies and providers to ensure suitable implementation of the plan.

6. Review

The VWM will maintain regular contact with the individual to understand the way in which the plan is being implemented.

The VWM will schedule and arrange reviews in line with the agreed review schedule in the individual's plan. This essentially requires a proportionate repeat of stages 2, 3, 4 and 5 of this framework.

Annex B:
List of areas personalised care and support planning should cover for IPC4V

The following areas were identified as elements of an individual's life that may be included in IPC4V care and support planning. They were generated through discussion of several case studies.

- Accommodation
  - Person's own
  - Local authority
  - Voluntary sector

- Domestic assistance (such as cleaning, cooking, ironing, gardening and day to day money management)

- Transport
  - Motability

- Carers
  - NHS Continuing Healthcare – including personal assistants and delegated tasks

- Health
  - GP
  - District nurses
  - Specialist provision, relevant to injury (such as a spinal cord injury centre)
  - Mental health
  - Wheelchair services

- Finance
  - Benefits (Department for Work and Pensions)
  - Monitoring / maintaining Armed Forces pension and compensation
  - Personal health budget

- Family / relationships
  - Child protection
  - Safeguarding
  - Fertility support

- Social / life / leisure
  - Could include a range of social and leisure pursuits relevant to each individual's lifestyle which will be supported primarily by the voluntary sector

- Work / education
  - Two year eligibility for specific support post-discharge
  - University funding for veterans
  - Access to work
  - Supported employment
  - Specific voluntary sector provision for veterans

Annex C:
Personalised care

The Comprehensive Model for Personalised Care is part of the NHS Long Term Plan's commitment to make personalised care business as usual across the health and care system.

Personalised care means people have choice and control over the way their care is planned and delivered, based on 'what matters' to them and their individual strengths and needs. This happens within a system that supports people to stay well for longer and makes the most of the expertise, capacity and potential of people, families and communities in delivering better outcomes and experiences when unwell.

This represents a new relationship between people, professionals and the health and care system. It provides a positive shift in power and decision making that enables people to feel informed, have a voice, be heard and be connected to each other and their communities.

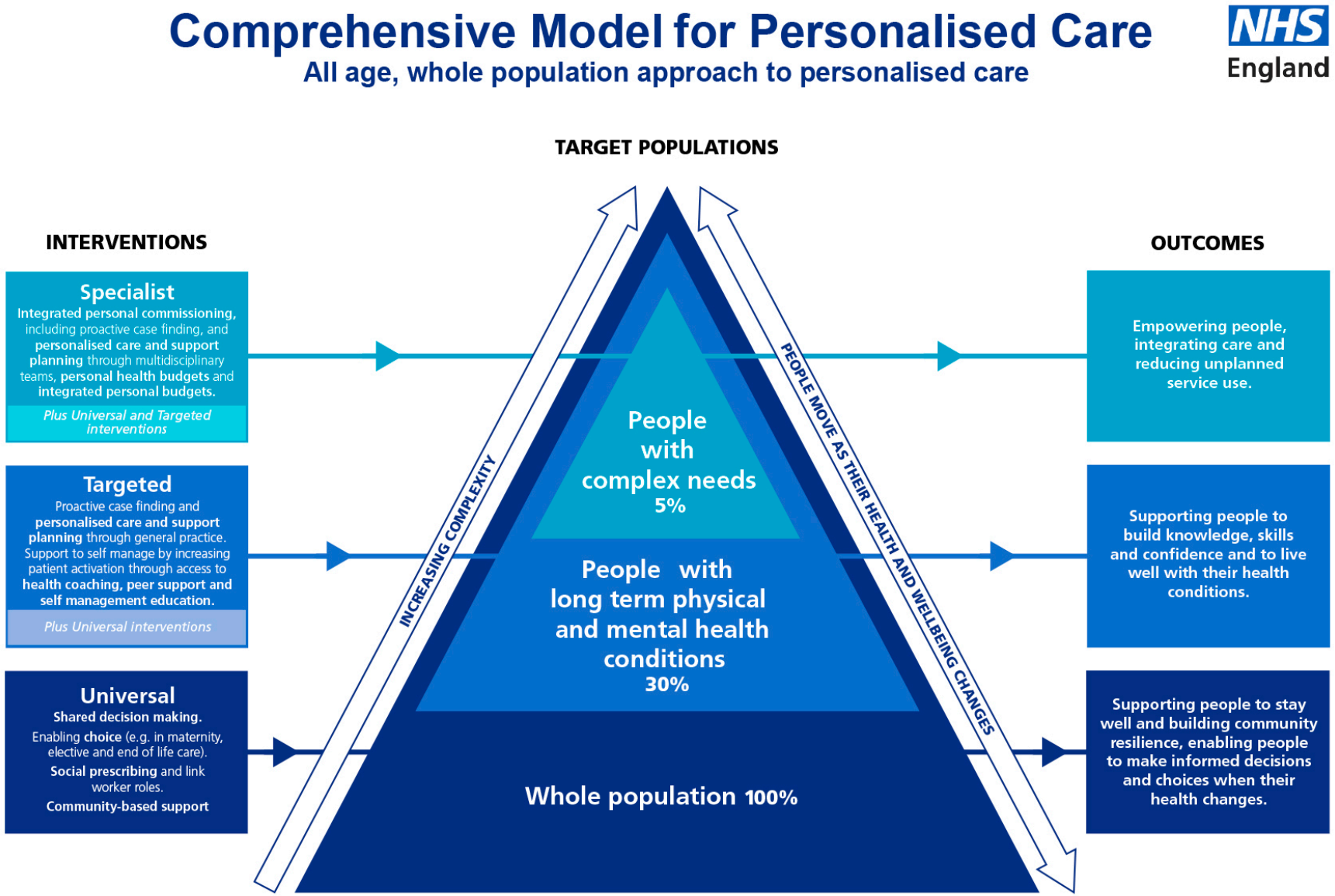
Personalised care is implemented through the Comprehensive Model for Personalised Care. The Comprehensive Model establishes the following:

- Whole-population approaches to supporting people of all ages and their carers to manage their physical and mental health and wellbeing, build community resilience, and make informed decisions and choices when their health changes.
- A proactive and universal offer of support to people with long term physical and mental health conditions to build knowledge, skills and confidence and to live well with their health condition.
- Intensive and integrated approaches to empowering people with more complex needs to have greater choice and control over the care they receive.

The Comprehensive Model brings together six evidence-based components, each of which is defined by a standard delivery model. These components are:

1. Shared decision making
2. Personalised care and support planning
3. Enabling choice, including legal rights to choice
4. Social prescribing and community-based support
5. Supported self-management
6. Personal health budgets and integrated personal budgets.

Figure 1: Comprehensive Model for Personalised Care



For more information, visit https://www.england.nhs.uk/personalisedcare/upc/

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