Ministry of Defence

NHS

Personalised care for veterans in England

A guide for clinical commissioning groups and local authorities

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Foreword

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, together with the Ministry of Defence (MOD), patients and their families, developed the Armed Forces personnel in transition: Integrated Personal Commissioning for Veterans (IPC4V) Framework, which takes a completely new approach to planning and commissioning care, focusing on what is important to the individual.

This framework, which was published in March 2019, sets out a framework to support Armed Forces personnel that have complex and enduring physical, neurological and mental health issues resulting from injury whilst in Service, with this support continuing as they transition to civilian life and beyond.

Available across England, it seeks to ensure that health and social care, together with the 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.

As NHS England and the MOD worked with key stakeholders to develop the IPC4V Framework, we were asked "What about those people who have already left the Armed Forces and have a long term physical, mental or neurological health condition or disability? What can they expect when it comes to personalised care and support?"

This document sets out what personalised care may mean for these veterans who are living in England. It focuses on England only as the model was developed with NHS England. Responsibility for healthcare in Northern Ireland, Scotland and Wales is devolved to the Northern Ireland Assembly, the Scottish Government and the Welsh Assembly Government respectively.

This guidance should be read in conjunction with the Armed Forces personnel in transition IPC4V Framework, which can be accessed at https://www.england.nhs.uk/wp-content/uploads/2019/03/armed-forces-in-transition-ipcv-framework.pdf.

Introduction

As set out in the Universal Personalised Care: Implementing the Comprehensive Model document, NHS England and NHS Improvement are supporting an all age, whole-system approach to ensuring 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. Personalised care represents a new relationship between people, professionals and the health and care system, and, as chapter one of the NHS Long Term Plan sets out, makes personalised care business as usual across the health and care system.

The delivery of personalised care is achieved by implementing the Comprehensive Model of Personalised Care. This model has been co-produced with a wide range of stakeholders and brings together six evidence-based and inter-linked components, each defined by a standard, replicable delivery model. The components are:

1. Shared decision making
2. Personalised care and support planning
3. Enabling choice, including legal rights
4. Social prescribing and community-based support
5. Supported self-management
6. Personal Health Budgets and Integrated Budgets.

The Comprehensive Model of Personalised Care provides an over-arching life-long view running through the NHS Long Term Plan. It will help to meet the triple aim of improved health and wellbeing, better care, and greater value for the public purse; so supporting the sustainability of the NHS.

Personalised care supports people from a range of backgrounds, and those facing health inequalities. For example, increasing people's level of choice and control, including the use of Personal Health Budgets (PHBs), enables the system to respond better to support people from diverse backgrounds, including, for example, veterans or those leaving the Armed Forces with a long term physical, mental or neurological health condition or disability.

Personalised care has growing momentum across health and social care. It is currently being demonstrated across a third of the country, including in the best integrated care system (ICS) and sustainability and transformation partnership (STP) geographies, benefitting 300,000 people. By 2023/24, around 2.5 million people in total will benefit from personalised care as business as usual across the health and care system, including 200,000 supported by a PHB. The aim is to double this by 2028/29.

Who is this document for?

This guide is aimed at those individuals and organisations who are leading or involved in supporting veterans through the delivery of NHS Continuing Health Care (CHC) or a jointly agreed care plan relating to a long term physical, mental or neurological health condition or disability.

Clinical commissioning groups (CCGs) and local authorities have legal duties and responsibilities in relation to CHC and must therefore have suitable governance arrangements in place to satisfy themselves that these functions are being discharged in accordance with relevant standing rules and guidance, including the National Framework for NHS Continuing Healthcare and NHS funded nursing care.

This document provides best practice guidance on how care and support for veterans with a long term physical, mental or neurological health condition or disability can be personalised using the Comprehensive Model of Personalised Care. It also provides information on support services that are available to veterans outside of the services commissioned by CCGs and local authorities that commissioners of care might find useful.

Personalised care for veterans

The UK Government definition of a veteran is anyone who has served in the Armed Forces for more than one day. The Annual Population Survey (APS)[1] estimates that there are 2.4m veterans living in Great Britain (of which 2.04m live in England). Like other members of the general population, this group will have a wide range of health needs and will need to access a broad range of NHS services. The APS states that there are no differences between veterans' and non-veterans' self-reported general health and health conditions, although for veterans some of their health conditions may have been caused or affected by their Service. For some veterans, having served in the Armed Forces is an important consideration in their everyday lives, for others it is less so. Not every veteran will think it relevant for statutory services to know that they have served, nor will everyone who has served want to be identified as a veteran.

Individuals who are eligible for CHC have had a right to have a PHB since October 2014. From April 2019, regions and CCGs should have plans to make PHBs the default delivery model for CHC homecare packages.

Conveniently, the formal review of a PHB is aligned with that of CHC at three and 12 months, but can also be undertaken at other times in between if deemed appropriate by a professional or the individual in receipt of the PHB.

This document is intended to describe what personalised care may look like for veterans with a long term physical, mental or neurological health condition or disability. The Comprehensive Model of Personalised Care brings together a range of evidenced-based components, many of which are already being delivered across England. The following sections describe individual approaches and what this might mean for these veterans. There is also information on veteran specific support, as set out later in this document.

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/774937/20190128_-_APS_2017_Statistical_Bulletin_-_OS.pdf

Support for veterans to manage long term conditions and disabilities

A long term condition is defined as a condition that cannot, at present, be cured; but can be controlled by medication and other therapies. Examples of long term conditions are diabetes, heart disease and chronic obstructive pulmonary disease.

It is recognised that in England, of the 30% of people who are living with at least one long term condition, some may be veterans who either developed their condition prior to discharge from military Service or more likely developed their condition after leaving the Armed Forces. Ensuring these people have the right support from the appropriate professionals with the right skills mix is important to ensure they can live well with their condition. However, this in itself will not be enough and the NHS needs to ensure that people have the right skills, knowledge and confidence to self-manage their condition and develop the resilience to deal with challenges and embrace opportunities. There are a number of personalised approaches which will be relevant to everyone living with a long term physical or mental health condition or disability. Some of these will enable veterans to tailor care and support to take into account preferences that relate specifically to their military Service. These components of personalised care are set out in the following pages.

Shared decision making and personalised care and support planning

At the heart of personalised care is shared decision making. This is a process in which people are supported by clinicians to a) understand the care, treatment and support options available and the risks, benefits and consequences of those options, and b) make a decision about a preferred course of action, based on evidence-based, good quality information and their personal preferences. It can create a new relationship between individuals and professionals based on partnership[2] and reduce unwarranted clinical variation[3]. Systematic evidence reviews show that people consistently over-estimate treatment benefits and underestimate harms. Shared decision making supports them to understand benefits and harms of options available and tends to reduce uptake of high risk, high cost interventions by up to 20%[4]. The NHS wants shared decision making to be the norm across the NHS – actions brought forward within Universal Personalised Care will see shared decision making embedded in pre- and post-registration professional training; at least 200,000 clinicians trained in shared decision making by 2025/26; and an expansion to the current shared decision making support to develop more decision support tools and e-learning resources in up to 30 specific clinical situations.

A good shared decision making process will mean that:

- people are aware that care, treatment and support options are available, that a decision is to be made and that the decision is informed by knowledge of the pros and cons of each option and 'what matters to me'
- clinicians are trained in shared decision making skills, including risk communication and appropriate decision support for people at all levels of health literacy and for those groups who experience inequalities or exclusion
- well-designed, evidence-based decision support tools are available and accessible
- shared decision making is built into relevant decision points in all pathways.

[2] Mulley et al, 2012

[3] Mulley et al, 2012

[4] Stacey, D. et al. (2014), Decision aids for people facing health treatment or screening decisions, Cochrane Database Syst. Review (1): CD001431

Personalised care and support planning is a series of facilitated conversations in which the person, and/or those who know them well, has a proactive, personalised conversation focused on what matters to them and that pays attention to their clinical needs, as well as their wider health and wellbeing. This process recognises the person's skills and strengths, as well as their experiences, such as having served in the Armed Forces and the things that matter the most to them. It addresses the things that are not working in the person's life and identifies outcomes and actions to resolve these.

Valuing people as active participants and experts in the planning and management of their own health and well-being 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. Extensive evidence shows that people's well-being, satisfaction and experience improves through good personalised care and support planning[5]. It has also been shown to improve GP and other professionals' job satisfaction[6]. There is some evidence of improved clinical outcomes and that it is at least cost neutral, as well as some evidence of small cost improvements[7]. NHS England and NHS Improvement anticipate that by 2029, 2.5m people with long term conditions will have a personalised care and support plan.

Enabling choice, including legal rights to choice

The scope of choice in the NHS is described in The Choice Framework. It sets out the rights to choice in healthcare, where to find information to help choose, and how to complain if choice isn't offered. NHS England and NHS Improvement support the implementation of the framework and ensure people have their legal rights to choice respected. Our ambition is that all the legal rights and contractual standards of choice are maintained throughout wider system transformation, with 100% of CCGs compliant with the minimum standards in the CCG Choice Planning and Improvement Guide.

[5] Coulter, A. et al. (2015), Personalised care planning for adults with chronic or long-term health conditions, Cochrane Database Syst. Review (3): CD010523

[6] Ibid.

[7] Health Foundation (2011), Year of Care: Report of findings from the pilot programme. London: The Health Foundation

Personal Health Budgets and Integrated Personal Budgets

A Personal Health Budget (PHB) is an amount of money to support a person's identified health and wellbeing needs, planned and agreed between them and their local CCG. It enables people to meet health needs/outcomes in ways that work for them; for example, employing their own personal assistant/carers who, because of consistency of care provision, can better understand their care and support requirements and also recognise changes in their condition which may need early intervention. For veterans, this could include employing individuals who understand the Armed Forces culture and its ongoing influence on that individual, rather than relying on a domiciliary care provider.

Currently, PHBs are being rolled out across England and the PHB offer varies from area to area, so veterans and health professionals should contact their local CCG.

All CCGs now need to offer PHBs for individuals, including veterans, who are eligible for CHC[8] and have had the legal right to a PHB since 2014. Other services where PHBs are an option include:

- wheelchair services
- joint packages of care (health and social care)
- mental health services (especially S117 aftercare).

A recent consultation showed overwhelming support for increasing rights to have a PHB, in addition to the three services above. Although a PHB may not be the right way to provide care and support for everyone, in some cases, they are an appropriate mechanism for providing the individual with the opportunity to receive a more tailored, personalised package of care that better meets their needs.

PHBs draw on personalised care and support planning, which enables a different conversation between people and the NHS and allows people to use NHS resources differently. PHBs can be managed in three ways (or a combination of these):

- Notional budget: the money is held by the NHS and services are commissioned by the NHS according to the agreed personalised care and support plan.
- Third party budget: the money is held and managed by an organisation that is independent of the individual and the NHS, purchasing services in line with the agreed care and support plan.

[8] https://www.nhs.uk/conditions/social-care-and-support-guide/money-work-and-benefits/nhs-continuing-healthcare/

- Direct payment for health care: the money is held and managed by the individual or their nominee or authorised representative and they organise care and support as agreed in the care and support plan.

PHBs are not about new money, but rather about using money that would have been spent on a person's care differently, in ways that work better for them. PHBs must meet the full cost of the care agreed in the plan. Reviews of care take place at regular intervals and these are carried out by the health professional/ organisation who support and fund the PHB.

An independent evaluation[9] published in 2012 showed that PHBs increased quality of life and reduced unplanned NHS care. In a recent independent survey, 86% of people said they had achieved what they wanted to with their PHB and 77% of people would recommend PHBs to others[10]. These findings are consistent with previous results from the POET PHB surveys of 2014 and 2015[11]. In 2017/18, over 28,000 people had a PHB.

[9] www.phbe.org.uk

[10] Quality Health (2018), Personal Health Budget and Integrated Personal Budget Survey 2018

[11] Hatton, C. and Waters, J. (2015), Personal Health Budget Holders and Family Carers: The POET surveys 2015 and 2014. London: Think Local Act Personal

Armed Forces personnel in transition: Integrated Personal Commissioning for Veterans

Armed Forces personnel in transition: Integrated Personal Commissioning for Veterans (IPC4V) is a specific programme aimed at supporting serving personnel that have complex and enduring physical, neurological and mental health conditions resulting from injury whilst in Service, with this support continuing as they transition to civilian life and beyond. IPC4V is a single offer across England. More information on IPC4V can be found at https://www.england.nhs.uk/personalisedcare/upc/ipc-for-veterans/.

Peer support and social prescribing

Peer support[12] in health and care encompasses a range of approaches through which people with similar characteristics (such as long term conditions or health experiences), give or gain support from each other to achieve a range of health and wellbeing outcomes.

The offer of peer support benefits can depend on the health condition. In mental health, outcomes such as empowerment, recovery and hopefulness were improved significantly. In diabetes, peer support led to significant improvements in depression, knowledge of the disease and biomedical outcomes.

There are a range of national and local peer networks, for example Spinal Injuries Association peer mentoring and the Limbless Association Limb Centre User Group Network, both of which are open to everyone with a spinal injury or amputation. There are also a number of Service specific charities, which offer peer support and mentoring, such as Blesma (member to member mentoring) and Combat Stress (peer mentoring).

Social prescribing[13] enables professionals to refer people to a 'link worker' to connect them into community support, based on 'what matters to the person', as identified through shared decision making or personalised care and support planning. Link workers develop a shared plan with people and introduce them to community groups and services. This could include groups focused on specific activity, such as walking or singing or in the case of veterans, they may help make links with local veterans groups. Evidence suggests that group activities can contribute to wellbeing, feelings of social inclusion and that healthy activities can be influenced in changing behaviour to benefit individual health. According to NHS England mapping (June 2018), over 60% of CCGs are investing in local social prescribing connector schemes.

There is emerging evidence that social prescribing can lead to a range of positive health and well-being outcomes, such as improved quality of life and emotional wellbeing[14]. NHS England and NHS Improvement want social prescribing to be mainstreamed in GP practices across England with every GP practice being able to link people with 'link' workers usually situated in voluntary sector organisations.

[12] NHS England (2017), Community capacity and peer support. Available online: https://www.england.nhs.uk/wp-content/uploads/2017/06/516_Community-capacity-and-peer-support_S7.pdf (accessed 8 June 2018)

[13] A review of the evidence assessing impact of social prescribing on healthcare demand and cost implications - Polley M., Bertotti

[14] Dayson, C. and Bashir, N. (2014), The social and economic impact of the Rotherham Social Prescribing Pilot. Sheffield: Sheffield Hallam University

Specific support for veterans who have health needs directly related to their Service in the Armed Forces

The NHS provides comprehensive care at the point of delivery irrespective of age or the cause of the need. The Armed Forces Covenant is an enduring promise to ensure that those who serve or have served and their families face no disadvantage compared to other citizens in the provision of public and commercial services and that, where appropriate, special consideration is given, such as for those who have been injured during their time in Service.

The Armed Forces Covenant states the following:

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

In planning care for veterans, it is important that CCGs and local authorities are aware of the services that NHS England and NHS Improvement commission for this population, as well as the additional support from a number of Armed Forces charities. These services can contribute to and support a care plan developed with the veteran and the local CCG and local authority.

The NHS in England has three specific programmes to help support veterans with Service related issues or health needs. These are discussed in more detail below:

- Veterans' prosthetics programme
- Veterans' Trauma Network
- The Veterans' Mental Health Transition, Intervention and Liaison Service (TILS) and the Veterans' Mental Health Complex Treatment Service (CTS).

Veterans' prosthetics programme

The Veterans' Prosthetics Panel (VPP) was established in 2012 as a way of ensuring that veterans can access high quality prosthetics regardless of which Disablement Service Centre (DSC) they attend. This additional funding is available only to veterans who have lost a limb whilst in military Service. A veteran who has left the Armed Forces, but whose limb loss is attributable to an injury sustained whilst in Service, also qualifies. Veterans who lose limbs after they leave the military or suffer limb loss whilst in the military, but not in a Service attributable incident, such as in a civilian road traffic accident, will continue to access services as usual through their local DSC.

The additional funding for veterans is for treatment that would not normally be provided by the NHS, for example higher specification prostheses than are normally available on the NHS. Funding is approved on a case by case basis, with DSCs making individual funding applications to the VPP, which clearly set out the requirement and the benefit that is expected if the request is supported. More information is available here https://www.nhs.uk/using-the-nhs/military-healthcare/veterans-physical-injuries/.

Eligible veterans are also able to access the Complex Prosthetics Assessment Clinic (CPAC) which is run by Defence Medical Rehabilitation services. CPAC supports veterans with particularly complex prosthetic socket needs who have previously been seen at the Defence Medical Rehabilitation Centre Headley Court.

Veterans Trauma Network

The Veterans Trauma Network (VTN) is the first NHS pathway for veterans' physical health, providing care and treatment to those with a Service-attributable healthcare problem. Located in ten major trauma centres (Plymouth, Oxford, London (three centres), Birmingham, Nottingham, Liverpool, Leeds and Middlesbrough) across England, the network works closely with Defence Medical Services, national centres of clinical expertise, veterans' mental health services (the Veterans' Mental Health Transition, Intervention and Liaison Service and the Veterans' Mental Health Complex Treatment Service), as well as military charities to provide a complete package of care. It is run largely by healthcare professionals who are either veterans or serving members of the Armed Forces. GPs can use a single national email (england.veteranstraumanetwork@nhs.net) to refer veterans to the service, where they will benefit from specialist care by military and civilian experts.

Further information is available here: https://www.nhs.uk/using-the-nhs/military-healthcare/veterans-physical-injuries/

The Veterans' Mental Health Transition, Intervention and Liaison Service and the Veterans' Mental Health Complex Treatment Service

The Veterans' Mental Health Transition, Intervention and Liaison Service (TILS) is a dedicated out-patient service for serving personnel approaching discharge from the Armed Forces and veterans who are experiencing mental health difficulties. The TILS provides a range of treatment, from recognising the early signs of mental health problems and providing access to early support, to therapeutic treatment for complex mental health difficulties and psychological trauma. Help may also be provided with housing, employment, alcohol misuse and social support.

The Veterans' Mental Health Complex Treatment Service (CTS) is an enhanced out patient service for ex-forces who have military related complex mental health difficulties that have not improved with previous treatment. The service provides intensive care and treatment that may include (but is not limited to) support for drug and alcohol misuse, physical health, employment, housing, relationships and finances, as well as occupational and trauma focused therapies.

Access to both of these services is through the TILS. Individuals can contact the service direct or ask a GP or a military charity to refer them. Further information is available here: https://www.nhs.uk/using-the-nhs/military-healthcare/nhs-mental-health-services-for-veterans/.

Hearing loss and tinnitus services

If a patient has acquired hearing loss and / or tinnitus relating to their time in Service, additional support can be funded through the Royal British Legion Veterans' Hearing Fund. To access the service, patients can be referred by their GP to their local NHS audiology department or an application form can be downloaded from here https://www.britishlegion.org.uk/get-support/financial-and-employment-support/finance/grants/veterans-medical-funds.

Mobility equipment support

The Royal British Legion has a Veterans' Mobility Fund, which provides specialist wheelchairs, orthotic equipment and other mobility related items for veterans who have a Service related serious physical injury and whose needs cannot be met through statutory services. Eligibility for the fund requires the condition to be attributable to Service and typically applicants will be in receipt of a War Pension or relevant award under the Armed Forces Compensation Scheme. To find out more, visit https://www.britishlegion.org.uk/get-support/financial-and-employment-support/finance/grants/veterans-medical-funds.

Veterans welfare

The Veterans Welfare Service provides advice, information and support to all veterans, across the whole of UK and Republic of Ireland, irrespective of any attributability of conditions.

For more information, please visit https://www.gov.uk/government/groups/veterans-welfare-service.

Veterans Gateway

Veterans can use the Veterans Gateway to access helpful information and charitable support at www.veteransgateway.org.uk.