Snapshot

physical health

Snapshot *Noun* [c] (UNDERSTANDING)

A piece of information or short description that gives an understanding of a situation at a particular time

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A plain language summary of research and evidence relating to the UK AF and veteran community

(Updated July 2021)

Produced by the FiMT Research Centre

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About the Forces in Mind Trust Research Centre

The Forces in Mind Trust Research Centre was established in October 2017 within the Veterans & Families Institute for Military Social Research at Anglia Ruskin University. The Centre curates the Veterans & Families Research Hub, provides advice and guidance to research-involved stakeholders and produces targeted research and related outputs. The Centre is funded by the Forces in Mind Trust (FiMT), which commissions research to contribute to a solid evidence base from which to inform, influence and underpin policymaking and service delivery.

About Snapshots

Snapshots are designed to aid understanding of complex issues in relation to the Armed Forces (AF), and to support decision-making processes by bridging gaps between academic research, government and charitable policy, service provision and public opinion. Snapshots are aimed primarily at those working in policymaking and service provision roles for the AF, and might also be useful to those seeking facts, figures, and informed comment to empower a more objective discussion among the wider population, including the AF community and the media. The purpose of these Snapshots is to review and interpret research and policy, and to set out brief, plain language summaries to ease understanding and perception.

The FiMT Research Centre has produced a range of Snapshots covering many of the main themes and topics relating to the AF, veteran, and associated families community. Due to frequent research and policy changes, Snapshots will be updated regularly to maintain their relevance. Contributions and comment are welcome via the Veterans & Families Research Hub, where the Snapshots are hosted.

While these summaries are produced using recognised research processes, they are written for a lay audience and cover only a selection of academic and grey (unpublished or non-commercial) literature relating to UK AF issues. While searches have been conducted by reviewing electronic databases and references from relevant articles and reports, as well as a review of websites provided by government and other appropriate organisations, our Snapshots are not intended to present every available source of literature and information source on the subject under consideration.

Version and authors

Based on an original version published by Dr Linda Cooper of FiMT Trust Research Centre in 2019, this current version was updated in July 2021 by Caitlin Barnes, Kristina Fleuty, Dr Graham Cable and Professor Michael Almond from the Forces in Mind Trust Research Centre.

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1 Introduction and definitions

This Snapshot summarises themes and issues relating to physical health and healthcare provision for the AF' community, including Service personnel, veterans and their families. The Snapshot is organised around three stages of military life: physical health and healthcare provision whilst in Service; during transition and resettlement; and post Service. It sets out policy responses and current structures of support, presenting research evidence where available.

The following terms are used in this Snapshot and are defined as follows (further terms and their definitions are here):

- The term **'transition'** is used to describe the period of (re)integration into civilian life from the AF. For the purposes of this Snapshot, it starts from the point during a period of military engagement at which serving personnel begin their resettlement process, which can continue for several years after they leave the AF.
- **'Resettlement'** describes the formal processes and procedures by which military-to-civilian transition is managed, and the formal support provided to AF leavers during this transition. It starts with the activation of the resettlement process and continues until the end of resettlement support provision. More details can be found here.
- The term '**Early Service Leaver'** (ESL) refers to those who leave the AF, for whatever reason, within four years of joining (the standard minimum term of service) or for disciplinary reasons.
- The UK Ministry of Defence (MOD) definition of a 'veteran' is anyone who has 'served for at least one day in Her Majesty's AF (Regular or a Reserve)'.
- For distinctions between '**Regular**' and '**Reserve**' AF roles and commitments, please see example British Army definitions.
- For distinctions between '**commissioned**' and '**non-commissioned**' ranks, please see here (although a United States explanation, it broadly equates to the British Army system and equivalents in the Royal Navy and Royal Air Force).
- The conditions for **medical discharge** are met when a medical condition or fitness issue results in an individual being unable to 'perform their duties and no alternative role can be found to suit their reduced functionality'.
- **Wounded, Injured and Sick** (often abbreviated to **WIS**) is the classification given to personnel who fulfil the criteria of being 'medically unfit for Service or medically unfit for duty and receiving medical care', (RAF), 'unable to undertake their normal duties', (Army) and 'unfit for Service in the maritime environment . . . who can only be employed for limited duties ashore' (Royal Navy). For progress to be monitored, all serving WIS personnel are logged in the relevant WIS Management System database.

2 Methods

For the first version of this Snapshot, a review was undertaken of the available UK evidence relating to serving personnel, veterans and their families, using standard reviewing techniques such as searching electronic databases, hand searching of references from relevant articles and reports, and a review of websites from government and relevant organisations.

This 2021 version (Version 2) supplements the above by considering relevant research conducted and reported on since the original version's publication in 2019, along with pertinent policy updates and developments, with the addition of material not included in the original version.

Due to the use of hyperlinks in this report, all references cited are restricted to those openly available online.

It is recommended that this Snapshot is read in conjunction with the others in this series, as many of the themes presented are linked to them.

3 What's new in 2020/21

Since publication of the previous version of this Snapshot, the management of physical health in the AF community has undergone development.

The Scottish Veterans Care Network (SVCN) was launched in Nov 2020, aiming to fulfil the covenant pledge of 'leaving no one behind'. The organisation brings together a wide range of specialists and social care providers for veterans and is assigned 6 objectives to achieve, including reducing barriers to care and the sharing of data and information.

The Veterans Trauma Network Wales (VTN Wales) was launched in Oct 2019, and hosting was transferred to the South Wales Trauma Network (SWTN) in early 2021. This is a central service, comprising five adult and paediatric trauma units covering South Wales, West Wales and South Powys, to assist patients in how to access appropriate care and meet veterans' needs as quickly as possible. Most veterans' injuries can be dealt with within the NHS referral pathway, however, when this is not applicable due to the severity of the injuries, VTN Wales can signpost and provide input which is unavailable elsewhere.

In England, advances have been made in the number of Veteran Aware NHS trusts, which have now reached the current target of 75. Further standards have also been developed for other types of provision including ambulance services and hospices. GP practices can become accredited as 'veteran friendly', with the number tripling to over 800 currently. It is estimated that by 2022 over 25% of practices in England will have been accredited.

Several changes in provision of physical rehabilitation for AF members have also been made. The Stanford Hall Rehabilitation Estate (SHRE), which replaced the previous facility at Headley Court from 2018, continues to grow facilities that are Defence and NHS-led; this is a major investment in patient care, supporting the NHS's Long-Term Plan. The SHRE includes the Defence Medical Rehabilitation Centre, known as 'DMRC Stanford Hall', which comprises several areas of treatment and has been operational for serving personnel since 2018. However, wounded veterans and

civilians will also obtain treatment and use some services within the new NHS facility on the estate, the National Rehabilitation Centre (NRC), which will provide further beds and services from 2024.

Reductions have been seen within the charity sector. For example, Help for Heroes closed four rehabilitation centres to veterans in 2020 due to financial issues heavily influenced by Covid-19. However, veteran care will continue within the community and online.

The following sections provide more detail.

4 Healthcare provision for the AF community

4.1 Commitment to AF' healthcare

The AF Covenant sets out the commitment made by the UK Government to provide healthcare to the AF community. The Covenant states that the AF community 'should face no disadvantage' and 'enjoy the same standard of, and access to, healthcare as that received by any other UK citizen in the area they live', retaining NHS waiting list positions should they have to move due to the Service person being posted. Veterans should also 'receive priority treatment where it relates to a condition which results from their Service in the AF, subject to clinical need'. There exists a framework for the commissioning of health care in England and information on eligibility for care for, regular serving, reservists, families and veterans.

The NHS is a key organisation delivering the UK Government's commitment to the Covenant, in relation to physical healthcare across the UK and within each devolved nation. It is reported that throughout the UK, policymakers working in the area of healthcare have reaffirmed their commitment to the Covenant via the introduction of new legislation and guidance; the Scottish Government introduced the Community Health Index to identify more easily serving personnel and their families and are working with NHS Scotland to ensure declared veteran status on a patient's medical record, so that it is immediately visible to the GP. In Wales, new guidance has been issued to GPs and healthcare professionals on priority treatment for veterans, whilst Northern Ireland's Health and Social Care authorities continue to monitor NHS waiting times for military families.

4.2 Healthcare delivered in partnership

The latest annual Covenant report reiterates that, in order to improve the way healthcare is delivered, organisations need to work in partnership. Joint service delivery from the MOD and NHS England, Scotland and Wales provides a more integrated and comprehensive healthcare service, for both AF (Regular and Reserve) and civilian populations, including veterans and their families. Whilst AF (Occupational, Operational, Primary Care, Rehabilitation and Mental) healthcare is the MOD's responsibility whilst personnel are in Service, it is the NHS's responsibility to provide most other healthcare services for the AF community, including for Reservists not on active duty and when individuals leave and become veterans. There are also pathways for which the MOD and NHS can provide effective joint care (see 'Healthcare Provision' below for further information). Charitable organisations can support these partnerships, providing substantial resources and support for those who have been seriously injured whilst in Service and where injuries result in the need for continuing post Service care. It was reported in 2016 that service charities spent at least £103 million

on provision for AF physical health that year, however it has since been highlighted by the Directory of Social Change (DSC) that the sector is reducing, with the Scottish sector shrinking at a faster rate in comparison to the rest of the UK.

In an attempt to coordinate efforts to uphold the Covenant between the multiple agencies at local and national levels (MOD, Department of Health & Social Care, NHS of each devolved nation, charitable sector, local authorities and elsewhere), in March 2019 the Integrated Personal Commissioning for Veterans Framework (IPC4V) was launched. The IPC4V seeks to ensure that organisations work together to provide support for the small number of AF personnel with complex and enduring physical, neurological and mental health conditions that are attributable to Service, with the aim of giving individuals more choice and control over how their care is planned and delivered.

In addition to the Covenant, in 2018, the first Veterans' Strategy was published, reaffirming the UK Government's commitment to veterans. The strategy names health and wellbeing as one of six key themes affecting veterans' lives and reasserts the need for collaboration between the public, private and charitable sectors. The Strategy states that the outcome for health and wellbeing should be that 'all veterans enjoy a state of positive physical . . . health and wellbeing, enabling them to contribute to wider aspects of society'. In 2019 the Office for Veterans' Affairs (OVA) was launched by the government to 'ensure realisation of the Vision set out in the Strategy for our Veterans'. A priority of the OVA was to deliver the UK Government Consultation Response in 2019, providing ways in which the set outcomes in the Veterans Strategy can be achieved, such as 'transferring medical notes from MOD to GPs on discharge' and 'increasing training on veterans' issues for other medical front-line staff'.

4.3 UK-wide healthcare

The aforementioned Covenant report also draws attention to country-specific initiatives across the UK. The Scottish Veterans Commissioner released a report in 2018 (followed by a progress report in 2020) that describes the key principles of the Scottish perspective on veterans' health to be 'to protect vital specialist services currently required by veterans with severe and enduring conditions, and secondly, to plan for their long-term care'. Recommendations from this report draw attention to the requirement to incorporate veterans' needs into national initiatives from the Scottish Government, such as into plans to establish a (Scottish) National Trauma Network to mirror the existing Veterans Trauma Network in England. The Scottish Veterans Care Network (SVCN) was launched in Nov 2020, aiming to fulfil the covenant pledge of 'leaving no one behind', focusing initially on six objectives including 'a mapping of stakeholders/specialist veteran's (sic) health and care services available in Scotland'.

The Scottish Government also currently funds Veterans First Point, provided as part of the NHS in Scotland. This network offers a point of contact for veterans and their families who require support for a range of needs, including physical health.

The South Wales Trauma Network (SWTN) was launched in Sep 2020, comprising five adult and paediatric trauma units covering South Wales, West Wales and South Powys. The Veterans Trauma Network Wales (VTN Wales) was launched in Oct 2019 and hosting was transferred to the SWTN in early 2021 to provide 'direct referrals for VTN Wales services within the Welsh tertiary centres'.

In Northern Ireland, the 'AF Liaison Forum' ensures equitable access to health and social care services by members of the AF, families and veterans, where there are specialised needs. General healthcare needs are met through GP services local to military establishments. This has been relaunched in Mar 2021 after a two-year absence.

Within NHS Improvement provision, accreditation was introduced for 'Veteran Aware' trusts almost exclusively in England that meet the criteria for offering the best care to veterans. This initiative is part of the Veterans Covenant Hospital Alliance (VCHA). The VCHA manifesto, released in February 2019, stated a goal to have 75 NHS providers accredited by the end of 2019. This has since been achieved and Veteran Aware standards have also been developed for other types of provision, including ambulance trusts and hospices. In a similar vein, GP practices can sign up to become accredited as 'veteran friendly' under a national scheme introduced in 2018, to improve medical care and treatment for former AF personnel. The scheme is backed by NHS England and the Royal College of General Practitioners (RCGP). It has been publicised that changes to the General Medical Services GP forms (GMS1 form) have been made to include a question regarding the identification of veterans by GPs, to facilitate access to healthcare priority treatment. The most recent Covenant report states that the number of practices accredited as veteran friendly has more than tripled to over 800 and is estimated that by 2022 over 25% of practices in England will have signed up.

5 Physical health provision whilst in Service

5.1 MOD healthcare provision

In the UK, all Service personnel receive medical treatment and healthcare provision through the Ministry of Defence's Defence Medical Services (DMS). The primary role of the DMS is to promote, protect and restore the health of the UK AF to ensure that they are ready and medically fit to go where they are required in the UK and throughout the world. The DMS is reportedly staffed by 8,200 Regular and 4000 Reserve Service personnel and 2,500 civilian personnel, and provides healthcare to the 136,600 (as at April 2021) UK regular forces personnel. In some circumstances family dependants of Service personnel or entitled civilians may also receive treatment from DMS staff, as well as other countries' personnel overseas, for example in areas of conflict.

The DMS treat personnel in the UK, overseas and at sea; general practice and specialised occupational health services are delivered through Defence Primary Healthcare (DPHC), which was piloted in 2013 and announced full operating capability in 2014. An academic review published in 2016 discussed the decision to merge primary healthcare for each of the three UK single Services into the unified DPHC. It concluded that the DPHC was 'one of the largest UK military medicine changes in delivery for a generation', and has been largely successful, with clinical performance showing improvement, although it is not formally inspected by the Care Quality Commission.

The MOD provides a tiered Defence Medical Rehabilitation Programme. Rehabilitation treatments (physiotherapy and exercise therapy) to restore military fitness following musculoskeletal injury or illness are provided locally on an outpatient basis at one of 152 Primary Care Rehabilitation Facilities (PCRF), located in the UK and Germany. For patients with injuries that cannot be cared for on an outpatient basis, there are short inpatient courses available at 14 Regional Rehabilitation Units (RRU), also located in the UK and Germany; services can also be delivered on deployment by field

hospitals. RRUs provide an intermediate level of treatment, with those needing more complex treatment attending DMRC Stanford Hall.

Located in the UK, the DMRC is the Ministry of Defence's main facility for the rehabilitation of injured Service personnel, providing inpatient clinical rehabilitation, training and research, to contribute to optimal military health and fitness. The new facility (located on the Stanford Hall estate near Loughborough) opened in 2018, replacing the original unit at Headley Court in Surrey. The DMRC aims to give the highest priority to the care pathway for injured personnel. All limb amputations are managed through the DMRC, in partnership with the NHS. The DMRC has also received support from many Service charities and this partnership is set to continue at the Stanford Hall location.

5.2 Service-specific provision

The Army Medical Services (AMS) provide Army medical policy, operational capability and healthcare through regular and reserve Army medical regiments that provide primary and pre-hospital emergency care, and through regular and reserve field hospitals. The AMS encompasses the Royal Army Medical Corps (RAMC), Royal Army Veterinary Corps (RAVC), Royal Army Dental Corps (RADC) and the Queen Alexandra's Royal Army Nursing Corps (QARANC). The AMS contributes the largest numbers of staff to the DMS and runs most field hospital deployments.

The Royal Air Force Medical Services (RAFMS) specialise in understanding how the unique attributes of the air environment affect both personnel and patients. The RAFMS comprises regular and reserve personnel, and the evacuation of casualties by air remains an RAF led initiative. The Centre for Aviation Medicine, based at RAF Henlow, is the lead in aviation medicine on behalf of Defence. The RAFMS includes the Princess Mary's Royal Air Force Nursing Service (PMRAFNS).

The Royal Naval Medical Service (RNMS) provides healthcare to ships, submarines and Royal Marine personnel at sea and on land. The RNMS provides primary care, deployed surgical support and deployable hospital care. The RNMS includes the Queen Alexandra's Royal Naval Nursing Service (QARNNS).

5.3 NHS statutory arrangements

Physical healthcare provision for the AF within the UK is delivered in partnership with the National Health Service (NHS). The NHS has a dedicated web portal of information and links to how members of the AF community, including veterans and their families, can access NHS services. NHS England is responsible for all secondary and community health services for the AF in England. Different arrangements exist for the NHS in all devolved administrations of the UK (Wales, Scotland and Northern Ireland), as healthcare is a devolved responsibility of each nation. Where relevant online and published information regarding physical health provision for the AF community in devolved nations exists, it is included in this Snapshot.

The Healthcare for the AF community: a forward view 2021, in line with the NHS Long Term Plan (LTP) and the Covenant, aims to deliver 9 commitments to the veteran community in England including 'identifying and addressing inequalities in access to healthcare and working in partnership to commission safe, high quality care for serving personnel and their families'.

An NHS England report recognises the statutory duty of the NHS to commission services for the AF community and this remains under constant review. The current version of the NHS Constitution specifically references the AF Covenant and therefore allows the NHS to provide 'priority services' for the AF community, where the Constitution prohibits such commissioning. The NHS is required to commission certain services for members of the AF and their families, to uphold high standards of care and quality, in line with the commitment made by the UK Government under the Covenant. This directive comes from the Secretary of State's Mandate 2021 update and is defined in Section 15 of the Health and Social Care Act 2012.

5.4 MOD/NHS partnership

To inform decisions regarding the commissioning of clinical services, the MOD produces statistics on the number of AF and entitled civilian personnel with a DMS registration. The latest figures show 170,852 people with a DMS registration, an increase of 2% from the previous year; despite the decreasing size of the AF there would seem to be an increase in the number of civilian registrations.

There is a Partnership Agreement between the MOD and NHS England which outlines the commissioning of health services in England for the AF. There are seven Ministry of Defence Hospital Units (MDHUs), which are military healthcare facilities embedded within NHS Trusts and civilian hospitals, located in the UK; these replaced the former network of military hospitals. There is also the Royal Centre for Defence Medicine (RCDM) located in the Queen Elizabeth Hospital, Birmingham. The RCDM provides medical support to military operational deployments, as well as providing secondary and specialist care for members of the AF. The RCDM is the main receiving hospital for military casualties (although there are other hospitals available to receive these patients, should that be necessary) and is the location to where those wounded on operations are transferred from field hospitals. Following initial medical treatment, many casualties then transfer to the DMRC. The RCDM is also a training centre for Defence personnel and conducts medical research. The influence of AF medical staff and capabilities within NHS institutions has driven innovation and changes within the wider NHS. This is, for example, evident within the development of civilian prosthetics as a result of work on military prosthetics.

5.5 Charitable healthcare provision for the AF community

Charities play a substantial role in physical healthcare initiatives for the serving AF community (post Service charitable support for veterans is discussed here). Physical health charitable providers promote the recovery, fitness and good health of the AF, including specific services targeted at the wounded, injured and sick (WIS). For example, the DMRC acknowledges the long-standing partnership between providers of medical and healthcare for the AF, such as the NHS, and MOD welfare and healthcare services, and charities; tri-Service charities Blesma, Combat Stress, Help for Heroes, HighGround, The Royal British Legion and SSAFA are noted as being 'principally associated with the activities [undertaken] in the DMRC'. Help for Heroes and The Royal British Legion are formal partners in the Defence Recovery Capability (DRC).

A Directory of Social Change 2018 report suggests there are 121 charities (10% of the overall AF charity sector) providing support for the physical health needs of the AF population. This support encompasses 'services which promote the recovery, fitness and general good health of the AF

community' and includes clinical provision as well as wellbeing and support. The same report found that at least 250,000 individuals accessed charitable healthcare services in 2016- 2017, which the report suggests indicates a 'substantial demand for physical health provision spread over a relatively small number of charities.'

It is reported that charities support the following physical illness and injury types; limited mobility, wounds, limb loss, sight loss, neurological disorders, musculoskeletal, hearing loss, cardiovascular, respiratory problems, neurodegenerative and chemical exposure.

Charities provide clinical and holistic approaches as part of their physical health provision. The most frequently provided physical health services are recreation (delivered by 41% of charities), adapted housing (38%) and sports/fitness programmes (37%).

Some charities distinguish between physical health support given to those with injury or illness attributable to Service. For example, of those charities providing support for wounds, 61.6% provide for Service-related wounds compared to 31.5% providing such services to all AF personnel.

In the case of limb loss, 51.5% of charities offer support for Service-related loss, whilst 42.2% offer such services to personnel regardless of Service-specific attribution.

6 The physical health of serving AF personnel

Overall, in 2020, the UK Regular AF (selected for good health at the time of recruitment) were at a significantly lower risk of dying compared to the UK general population. MOD statistics suggest that the Regular AF were at a 77% decreased risk of dying as a result of a disease related condition, and at a 53% decreased risk of dying as a result of external causes of injury and poisoning, than the general UK age-matched population. It is suggested that this could be due to the 'healthy worker effect', in that certain groups of people are excluded from the military environment, particularly those with illness or disability, and the AF population is a select group of individuals who are likely to have higher than usual levels of fitness and be at a lower risk of developing disease-related illness as a result.

In respect of the health and safety of the AF, it is reported that 55% of injuries sustained (including AF personnel and MOD Civilian employees) occurred during training and that the rate of injury is higher for untrained than trained personnel.

6.1 Operational casualties

Records show that, of the injuries sustained by UK Service personnel in Afghanistan (data covers the period between 2006 at the opening of the UK Field Hospital, to November 2014 at the closure of Operation HERRICK in Afghanistan), half of the injuries sustained were to the extremities, with the largest number to the knee or lower leg. Just under a fifth of injuries were to the head and neck. Explosions were the leading cause of combat injuries. Other injuries included climatic injuries, land transport accidents, slips, trips, falls and bites/allergic reactions (defined by the military as disease non battle injuries or DNBI).

Service personnel with medical conditions, including amputations or fitness issues, affecting their ability to perform duties will, in the first instance, be referred to a medical board for a medical

examination. If appropriate, the individual will first be downgraded, to allow for treatment, recovery and rehabilitation. All three Services operate a retention positive employment policy, which aims to keep personnel in Service where a job can be performed with the limitations imposed by an individual's illness or injury. For personnel who do not make a total recovery and for whom it is not appropriate to remain in Service, the board may recommend medical discharge.

Patients are given a Notification of Casualty (NOTICAS), which includes four classifications according to the severity of their condition; Very Seriously Injured (VSI), Seriously Injured (SI), Incapacitating Injury/Illness (III) or Unlisted Casualties (UC). NOTICAS applies to death, all forms of injury or serious illness. A patient's NOTICAS classification may change as they advance through treatment. There are further NOTICAS reporting categories used to specify several types of casualties that could be sustained when deployed on operations or when non-operational.

Figures show that between 2013-2016, 38% of DMRC inpatients were classified as VSI, 23% as SI, 19% as III and 19% as UC. From 2013-2016, of the 636 personnel who attended an Inpatient clinic at the DMRC, 47% remained in Service, 37% were Medically Discharged and 16% had left Service for reasons other than Medical Discharge.

DMRC Stanford Hall has a holding a capacity of approximately 200 beds, the new estate is 4 times larger than the former DMRC at Headley Court. The DMRC currently aids only serving personnel, with the target for the new partner NHS facility on the Stanford Hall Rehabilitation Estate, The National Rehabilitation Centre (NRC), aiming to take its first NHS patients (including veterans) in 2024 with a further 64 beds. The NRC is sponsored by Nottingham University Hospitals NHS Trust (NUH) and forms the national element of the overall Defence & National Rehabilitation Centre DNRC. A high degree of collaboration between the two facilities is envisaged.

Casualties receive further classifications for their injuries as a way of helping healthcare professionals determine their need and decide where the individual would be best placed to receive care. Hospitalisation is required for 'complex trauma' or 'neuro' cases; the 'complex trauma' classification includes injuries such as amputations or multiple fractures; the 'neuro' classification includes complex brain injuries, strokes and other neurological conditions. Facilities such as the DMRC accept these patients.

A recent Covenant Annual Report recognises that, as well as provision for Service-attributable injury, it is important that personnel with serious illness, and their family members, receive support. The 'Defence Personnel with a Significant Illness' project aims to support the needs of those personnel and their families with caring responsibilities. Families are supported through diagnoses, treatment and recovery, with the serving member helped back into Service employment where achievable.

7 Transition and resettlement

7.1 Medical discharge

Service personnel who sustain physical injuries, such as limb loss, may continue in Service to complete their engagement: if they regain sufficient medical fitness; if it is in the best interests of the Service, and; if the Service member wishes to do so. Some injuries result in physical limitations that reduce the likelihood of a patient being able to return to sufficiently productive Service. In this

case, the patient can be put forward for Medical Discharge from the AF. Medical conditions or fitness issues resulting from injury/illness which affect ability to perform duties, but do not result in Medical Discharge, would see the personnel medically downgraded to allow time for treatment and rehabilitation. In this case, personnel are awarded a Medical Deployability Standard (MDS) of Medically Limited Deployable (MLD) or Medically Not Deployable (MND).

Rehabilitation and discharge protocols are designed to support the individual's recovery to a point of stability, after which point discharge might be an option for personnel. All WIS related discharges are carried out under agreed protocols with the NHS; it is the responsibility of the lead Medical Officer (MO) to instigate the Transition Pathway Protocol by completing the NHS Continuing Healthcare Checklist and liaising with the receiving Clinical Commissioning Group (CCG) or Devolved Administration. Upon discharge, the healthcare needs of ex-Service personnel are provided for under the NHS, within the healthcare system as described elsewhere in this Snapshot.

During the period 2015-2020 there were 132 UK service personnel who sustained a traumatic or surgical amputation because of injuries or illness. Of these, one quarter were medically discharged. For those UK Service personnel who served in Afghanistan (2001-2020), 302 sustained injuries leading to traumatic or surgical amputation. Of these, three quarters have been medically discharged. For those UK Service personnel who served in Iraq (2003-2020), 34 sustained injuries which led to traumatic or surgical amputation. Of these, half have been medically discharged.

Approximately half of personnel medically discharged leave as a result of multiple medical conditions. During 2017-2018, 1,043 Army, 366 Naval Service and 169 RAF personnel were medically discharged. Certain demographic groups were significantly more likely to be medically discharged: females in the Army and RAF, Other Ranks (private [or service equivalent]-warrant officer) in all three services, Naval Service personnel aged 30-39 (with Royal Marines of all ages at a higher rate than Royal Navy) and Untrained Personnel (personnel who have not completed Phase 1 training) in the Army. With regards specifically to physical health, the main causes of medical discharges 2015-2020 were musculoskeletal disorders and injuries. These disorders and injuries led to 48% of Naval Service, 51% of Army and 39% of RAF medical discharges.

Medically discharged personnel who leave the AF prior to completion of their contract may be entitled to compensation from the AF where injury and illness have been caused or made worse by Service, as detailed here. Figures show that 54% of all injury/illness awards were for musculoskeletal (MSK) disorders.

8 The physical health of veterans and their families

8.1 Healthcare provision in the UK

When personnel leave the AF, responsibility for veterans' healthcare is transferred to the NHS, and veterans access primary care in the same way as civilians, but with the support of the Covenant as it applies to access to health care. In some instances, there is veteran-specific support for those with particular physical injuries or disablement, where the injury is due to Service.

Specific support for veterans and their families differs across the UK; as introduced previously in this Snapshot, each devolved nation is responsible for providing healthcare, in accordance with the needs of those veterans and their families living within that nation.

8.2 Healthcare provision in England

In England, the Veterans Trauma Network (VTN, established 2016) provides specialist care to veterans with traumatic injuries, utilising the NHS Major Trauma Centres and several acute and specialist trusts to deliver life-long reconstructive trauma and associated care. The Royal British Legion, Blesma and Blind Veterans UK support veterans with referral and pre/post-operative rehabilitation as part of the VTN. The VTN supports research, has strong links to mental health trauma services, and is fully integrated with veterans' GP services.

8.3 Healthcare provision in Scotland

The Scottish Government sets out provision for the wider AF and veterans, including a veteran's right to priority healthcare treatment, in the report Renewing Our Commitments. There are AF & Veterans Champions on local authority and NHS Boards across Scotland. Champions advocate for veterans and Service personnel to ensure needs are met and reflected in local healthcare service plans. NHS Inform, Scotland's national health information service, sets out health rights for veterans and details how veterans can receive support for physical healthcare needs.

NHS Inform provides specific advice on physical injuries, such as amputation. Veterans First Point (V1P) (introduced previously in this Snapshot) helps veterans and their families with several issues they may face in adapting to civilian life, including with their physical health from a network of drop-in centres across Scotland. Furthermore, the National Prosthetics Service (NPS) is Scotland's centre for designing and fitting prosthetic limbs and offers specialist treatment to military amputees. Veterans Scotland gathers resources and advice from a number of organisations that support veterans in key areas, including with their physical health needs, and the Veterans-Assist website makes these resources searchable.

8.4 Healthcare provision in Wales

The Welsh Health Circular policy document sets out the commitment of Health Boards and NHS Trusts in Wales to provide healthcare priority to veterans, in accordance with the Covenant. The same policy document states that there are Champions for veterans and for the wider AF community, to advocate for veterans and Service personnel to ensure needs are met and reflected in local healthcare service plans. NHS Wales also offers a 'Veterans' health and wellbeing' module, that can be taken by GPs as part of their continuing professional development, and which is funded by the Welsh Government. The module was developed to assist health workers in better understanding the specific health and wellbeing issues that veterans and their families may face.

8.5 Healthcare provision in Northern Ireland

The Northern Ireland Veterans' Health and Well-Being Study provides significant insight into the services providing support to veterans in Northern Ireland, and aims to establish improved

understanding of the current and future health needs of veterans. The study is ongoing and will comprise a series of reports, several of which are already published. The first report in the series, Supporting and Serving Military Veterans in Northern Ireland, concludes that there is a 'fairly expansive network of supports and services available to veterans based in Northern Ireland . . . [but] there is a notable lack of formal information sharing between organisations and across sectors'. This is reflected in a lack of easily accessible online information detailing veteran healthcare provision in Northern Ireland. The same report confirms that veterans in Northern Ireland receive statutory support as part of the wider population, and there are no statutory veteran-specific services or priority treatment. However, the report also suggests that, despite challenges surrounding the visibility of veterans in Northern Ireland, and the challenges facing those who provide support for them, there is a clear 'demonstration by service providers to ensure equitable provision for those veterans living in NI.' Later reports covered the health and well being of veterans, according to type of service received and reflected on the difficulty in carrying out research on veterans resident in Northern Ireland.

8.6 Challenges for veterans' healthcare provision

Most veterans receive healthcare through NHS primary care; it has been suggested that primary healthcare professionals need a greater awareness of AF culture and a more nuanced understanding of the specific needs of veterans and their families. For example, research published in 2014 suggested that 47% of GPs did not know how many veterans they were caring for, 75% of GPs had not seen the RCGP (Royal College of General Practitioners) leaflet on veterans' health, and fewer than 2% had used the RCGP on-line learning resource for understanding the veteran context.

Since 2014, advances have been made; as previously mentioned, the number of 'Veteran friendly' practices has increased and the RCGP has produced guidance for GPs on how to deal with veterans' healthcare needs in the 'veterans' healthcare toolkit'. The latter includes information on the NHS's duty to the AF Covenant and how to request a patient's AF medical records.

In relation to the responsibility of NHS England to commission services for veterans, new research published in 2019 suggests there are inconsistencies in 'adopting the principles' of the Covenant and a lack of 'commitment to and understanding of policy guidance […] for commissioning veteran-specific services.' The research concluded that there was a need to improve commissioning practices for veterans.

It also suggested that civilian nurses providing primary care need educational preparation to understand the specific needs of veterans, as nurses will often be a first point of contact for veterans accessing healthcare. A research paper proposed that 'nurses providing care require an understanding of the unique experiences and specific health needs of veterans to deliver evidence-based care.' '

There is evidence to suggest that health professionals need increased information on specific areas of physical care for which there may be a particularly high instance of veterans presenting for treatment and care. For example, research suggests that veterans who have sustained life-altering injuries as a result of Service may experience chronic pain. The research linked chronic pain to health problems such as musculoskeletal conditions. As confirmed by MOD statistics (discussed above), musculoskeletal problems are some of the most common reasons for medical discharge from the

British Armed Forces and there may be a significant number of veterans experiencing chronic pain. The research suggests that pain clinicians would benefit from better training to meet veterans' needs and promote veteran engagement and successful treatment. It also suggests that health professionals need training specifically to counter stereotypes about veterans and more information about the military context to support their assessment and onward referral of veterans' needs. There are examples of projects that have been initiated with the aim of closing this training gap. For example, the Military Human training series, run by York St John University, includes three courses designed to increase awareness around the health and mental health of the Armed Forces community. The courses are designed to enable front line staff, including those within healthcare professions, to gain insight into Armed Forces culture and use this knowledge to tailor relevant support for veterans and their families. Military Human training series, run by York St John University, includes three courses designed to increase awareness around the health and mental health of the Armed Forces community. The courses are designed to enable front line staff, including within healthcare professions, to gain insight into Armed Forces culture and use this knowledge to tailor relevant support for veterans and their families.

8.7 Charitable healthcare provision for veterans

Charitable support for the AF community, as introduced above, often continues for veterans and, in many cases, there are prominent examples of charitable support for the veteran community. A report states that support for physical health issues is the most common form of military charitable provision, with 82.6% of Service charities supporting veterans with Service-related physical health issues and 62.8% of charities supporting those with age-related physical health issues.

Help for Heroes announced a major restructure in 2020 to protect its recovery services from the financial impact of Covid-19, resulting in the closure of the several recovery centres. The remaining site (Tedworth House) will now only aid serving personnel, decreasing the support available to veterans. The charity will continue to offer services to veterans within local communities and online.

Charities provide ongoing support to WIS veterans, through grants that fund assistance dogs and home adaptations (including stair-lifts, handrails and ramps). Charities also provide advice and advocacy to support individuals in accessing other forms of help and support, with over 90% of AF charities delivering signposting services, over 88% delivering mentoring services and 76.5% operating helplines directly.

Charities may provide amputees with physical rehabilitation services (62.1% of Service charities report this according to research) and 40% of charities report awarding grants to individuals to assist them in being able to receive rehabilitation care from other providers. Furthermore, just over 30% of charities offer grants to individuals for respite care and 25.6% of charities deliver a nursing or care home service themselves.

The Veterans Gateway is available for any ex-service personnel and their families and is a first point of contact to a network of military organisations and service-charity provision across the UK. This covers areas from physical and mental health to housing and finances. The service also has a Veterans' Gateway mobile application which displays support in a user's local area with nearly 2000 charitable organisations and NHS facilities across the UK.

There is recognition in recent veteran population data that a significant proportion of the veteran community is ageing, indicating that 60% of veterans are aged 65 and over. Many Service charities focus on older veterans, including the Defence Medical Welfare Service.

8.8 The physical health of veterans

According to a 2017 population survey, there is no difference in the self-reported general health of veterans and non-veterans in the UK. For example, 35% of veterans and 35% of non-veterans aged 16-64, and 18% of veterans and 20% of non-veterans aged 65+, reported their general health as very good. There is also little or no reported difference between veterans and non-veterans of working age (16-64) with regards to whether health problems affect the type or amount of work carried out and whether previous health problems limit activity. Census 2011 data also shows four out of five working age veterans reporting good or very good health. One in five veterans reported that day-to-day activities were limited due to a health problem or disability.

Comprehensive cohort studies on the long-term physical health of veterans have been carried out on Scottish veterans and led by academics at the University of Glasgow. A study on Scottish veteran mortality by length of Service found that longer-serving veterans were at a significantly lower risk of death than early Service leavers. The same study found that smoking-related disease was the greatest contributor to increased mortality in early Service leavers. Findings from another study into the health of Scottish military veterans show a hidden burden for life and limb- threatening peripheral arterial disease in older veterans (see below).

There are some reported differences in lifestyle habits, such as smoking behaviours. Veterans of working age (55%) were significantly more likely than non-veterans of working age (44%) to have ever smoked. Furthermore, female veterans of working age (51%) were more likely than female non-veterans of working age (39%) to have ever smoked. This difference is also observed in female veterans of retirement age (57%) compared to female non-veterans of retirement age (41%). Veterans of working age who had previously smoked were significantly more likely to report suffering from chest and breathing problems.

A 2014 report suggested that the veteran population experienced higher levels of hearing loss and tinnitus, with veterans under the age of 75 being three and a half times more likely to report difficulty hearing than the general population. The report ascribes this to being likely due to environmental noise as a result of serving (such as in combat zones with exposure to sound emitted from weaponry and aircraft). Other causes of hearing loss evident prior to service, such as birth complications, infectious diseases, genetic predispositions and head injuries, would have rendered the individual unsuitable to undertake military Service. This is supported by a review of research studies published in 2017, which reinforced that noise-induced hearing loss (NIHL) was a significant and major health issue affecting the AF community. The Royal British Legion operate the LIBOR-funded Veterans Hearing Fund (VHF) to provide support to veterans who acquired hearing loss during Service. The charity also runs a mobility fund for wheelchairs, working closely with the Veterans' Prosthetics Panel (VPP).

8.9 The family context

A significant proportion of AF charities provide physical health support for the wider Forces community, including family members. It was recorded in a recent report that 69.6% of charities make provision for spouses/partners and 49.6% support dependents and serving personnel. There are 268 AF charities supporting families making up 14.8% of the AF charity sector as of July 2020. The most common areas of support are social groups, mental health support and education support. In particular, the AF Families Federations take on a significant amount of work in coordinating support, assistance and advocacy for the serving family. There are Families Federations for the Army, Royal Air Force and Royal Navy.

A 2014 review commissioned by Blesma (a charity for limbless ex-Service personnel) acknowledged that there is a need to understand better the impact of families and family relationships on a veteran's recovery from physical illness, as well as the impact on the family members themselves in respect of their own health conditions and/or as a result of taking on caring for the recovering veteran. The review highlighted evidence suggesting the involvement of family caregivers is important for the success of a patient's rehabilitation. However, the review recognised a need to increase awareness of and provision for the families and carers of veterans. recognised a need to increase awareness of and provision for the families and carers of veterans.

Research published in 2018 stressed the importance of assessing how families cope when a veteran is recovering from injury and differentiated between the needs of the veteran and family member involved in the caring relationship; suggesting that family members require tailored and individualised support to aid coping that may be different to the healthcare support required by the veteran.

The same research showed that, when caring for the physical health of a veteran, the main family carer may ignore their own health needs. For example, the study reported a high instance of carers with multiple health needs caring for veterans who might also have multiple health needs. To support the efforts of families in caring for the veteran, the research suggested that health professionals, such as GPs and nurses, need greater awareness and training regarding the potential specific needs of veterans (as previously discussed).

Research published in 2017 found that family members caring for WIS personnel would have appreciated 'proactive, direct and sustained communication from support service providers,' and suggested that 'family care coordinators' would have been of benefit to provide continuous and consistent care to families. A paper published in 2016 also identified that for families who provide unpaid care for WIS personnel, key support comes from partnerships involving charitable organisations. of benefit to provide continuous and consistent care to families.

Attention has also been focused on the physical health of children of AF or veteran families who may be young carers. A project report identified that young carers from AF families may be particularly vulnerable, as they also have to contend with other aspects of military life, such as the need to relocate and change schools, and the impact of deployment on their wellbeing. However, the report also points out that these young carers can be resilient, adaptable and proud of their family's way of life.

9 Conclusion

This Snapshot outlines physical healthcare provision for the AF community, including veterans and wider family members, and describes some of the key physical health concerns for the AF. It is worth noting that the mental health of the AF community should be considered alongside physical needs, but this Snapshot concentrates on physical health only; for mental health information please refer to the Mental Health Snapshot. Overall, both the Service and veteran populations report physical health similar to that of the general population. There are some specific differences, such as the increased risk of injury that comes with combat roles, which mean some serving personnel and veterans will require ongoing specialised care.

The AF Covenant sets out the commitment made by the UK Government to provide healthcare for the AF, a key point being that members of the AF should not face disadvantage as a result of Service in their access to physical healthcare.

Physical healthcare provision for the AF (for those serving and post Service) is often a three- way partnership between the Defence Medical Services (DMS), the NHS and Service charities. Whilst personnel are in Service, healthcare is provided primarily by the DMS, and post Service, for veterans and their families, the NHS has key responsibility. However, as is particularly evident in the care provided to WIS personnel, often there is need for joint service delivery from the DMS and NHS when personnel arrive back to the UK for continuing care. Charities make a significant contribution to the AF community, and this is particularly evident in the number of veterans accessing charity support for physical needs.

There is a move towards greater partnership between the DMS and NHS, particularly in trying to achieve recognition for the needs of veterans and their families through NHS systems of care and support. The formal partnership between NHS England, the devolved nations' Health Services and the MOD aims to provide joint initiatives across the full range of health needs for the AF community. For veterans and their families, it is important that, including during the transition phase out of the military, and particularly at the level of Primary care, families have clear guidance about how to access support. This need is recognised and there exist an increasing number of education, training and accreditation schemes to promote greater awareness of veterans among healthcare professionals.

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