The Chavasse Report
“Raising the Bar”

Improving Armed Forces and Veteran Care Whilst Raising NHS Standards for All
A strategic partnership between the Nation, the Armed Forces, and the NHS
As we approach the 100th anniversary of the start of World War I, Service Personnel, Reservists and Veterans quite rightly hold a special place in our hearts and minds. Moreover, the Armed Forces Covenant recognises our moral obligation to ensure that they are not disadvantaged compared to others. The Covenant emphasises that special consideration should be afforded to those who have given the most, especially the injured, just in case we forget the sacrifices they have made.

The nation has made great strides in this area recently, but there is more to do given the unpredictable frequency and nature of modern military conflict.

Inspired by the selfless heroism of Captain Noel Chavasse VC and Bar in 1917, Professor Tim Briggs has highlighted areas where we can and should do more for the injured. His guiding principle is to ensure better and greater continuity of care for those people severely wounded in action or suffering debilitating musculoskeletal infirmity as a consequence of their military service. Not only does he highlight the problems around the management of musculoskeletal injuries, the most common cause of downgrading and discharge from the forces but also suggests the solutions. He emphasises the need for a network of NHS hospitals to provide the care for veterans and proposes setting up a number of NHS Veteran Rehabilitation units, linked to those within the military, to make sure of a seamless transition of care and shared learning between the DMS and the NHS. This will improve care for all patients and provide a very much more consistent approach to rehabilitation, indeed some of my fellow Falklands veterans - often forgotten by the ‘system’ - are living confirmation of the urgent need for this.

Professor Briggs is already forging ahead with his NHS England funded “Getting It Right First Time” programme of work which will improve the quality of orthopaedic care for all. The knowledge gained from this will suggest the networks that need be developed to improve the musculoskeletal care of both NHS patients and Veterans. He is also working with funding charities on an initial enhancement to the NHS rehabilitation infrastructure across the nation.

On behalf of all veterans and those in the military service of the nation, I commend his commitment and strongly encourage others in positions of authority and influence to follow suit by enacting his recommendations.

HRH The Duke of York, KG
ii. Captain Noel Godfrey Chavasse

VC and Bar, MC
9th November 1884 – 4th August 1917

Noel Chavasse qualified in medicine from the University of Liverpool in 1912 and worked for Sir Robert Jones, the founder of the British Orthopaedic Association (BOA) as his houseman. He joined the Royal Army Medical Corps (RAMC) in 1913 and was attached to the 10th Battalion of The Kings (Liverpool Regiment), the Liverpool Scottish, a Territorial battalion. During World War I (WWI) Chavasse was promoted to Captain and remained attached to the 1st/10th (Scottish Battalion) of The Kings (Liverpool Regiment). He saw action in Belgium in June 1915 where he was awarded the Military Cross (MC) and mentioned in Dispatches.

In 1916 Noel was awarded his first Victoria Cross (VC) whilst rescuing men from no-man’s land during the battle of Guillemont despite being injured himself. His second VC was awarded during the Allied offensive of Passchendaele in 1917 where he was again wounded but refused to leave his post and continued to care for his men. He died two days later of his injuries on the 4th August 1917.

Chavasse’s headstone is in a small cemetery in Brandhoek New Military Cemetery Vlamertinge and is the only one on the Western Front carved with two VCs.
Citation for the award of The Victoria Cross for his actions on 9th August 1916 at Guillemont

Published on 24 October 1916:

Captain Noel Godfrey Chavasse, M.C., M.B., Royal Army Medical Corps.

For most conspicuous bravery and devotion to duty.

During an attack he tended the wounded in the open all day, under heavy fire, frequently in view of the enemy. During the ensuing night he searched for wounded on the ground in front of the enemy’s lines for four hours.

Next day he took one stretcher-bearer to the advanced trenches, and under heavy shell fire carried an urgent case for 500 yards into safety, being wounded in the side by a shell splinter during the journey. The same night he took up a party of twenty volunteers, rescued three wounded men from a shell hole twenty-five yards from the enemy’s trench, buried the bodies of two Officers, and collected many identity discs, although fired on by bombs and machine guns. Altogether he saved the lives of some twenty badly wounded men, besides the ordinary cases which passed through his hands. His courage and self-sacrifice, were beyond praise.

Citation for the award of second Victoria Cross for his actions between 31 July and 2nd August at Wiette, Belgium

Published on 14 September 1917: War Office

His Majesty the KING has been graciously pleased to approve of the award of a Bar to the Victoria Cross to Capt. Noel Godfrey Chavasse, V.C., M.C., late K.A.M.C., attd. L’pool R.

For most conspicuous bravery and devotion to duty when in action.

Though severely wounded early in the action whilst carrying a wounded soldier to the Dressing Station, Capt. Chavasse refused to leave his post, and for two days not only continued to perform his duties, but in addition went out repeatedly under heavy fire to search for and attend to the wounded who were lying out.

During these searches, although practically without food during this period, worn with fatigue and faint with his wound, he assisted to carry in a number of badly wounded men, over heavy and difficult ground.

By his extraordinary energy and inspiring example, he was instrumental in rescuing many wounded who would have otherwise undoubtedly succumbed under the bad weather conditions.

This devoted and gallant officer subsequently died of his wounds.
Military training is by necessity arduous and it is therefore not surprising that musculoskeletal injury is the greatest cause of secondary care referral for Service personnel, although patients are managed whenever possible by rehabilitation delivered by the Defence Medical Services within the Defence Medical Rehabilitation Programme. The veteran population is also at increased risk of earlier presentation of musculoskeletal problems as a result of the arduous nature of military training and operational exposure that they have undertaken during their Service career. Moreover, the greater reliance on Reservists will place additional pressure on the NHS to deliver timely access to elective orthopaedic care and rehabilitation if the Government’s direction to increase the use of Reservists in the future is to be delivered. The Defence Medical Services are therefore committed to working with NHS England and the Devolved Administrations to deliver optimal orthopaedic care for Service personnel, Reservists and veterans.

Professor Tim Briggs, President of the British Orthopaedic Association, approached me earlier last year indicating his desire to create improved access to quality NHS elective orthopaedic care for Service personnel, Reservists and veterans within the UK under the banner of the Armed Forces Covenant and the ‘duty of the nation’.

His proposal is contained within the Chavasse Report. It builds on his previous paper, entitled ‘Getting It Right First Time’ (GIRFT), which sought to identify regional centres within England that would act as ‘hubs’ for managing elective orthopaedic care and provide a better evidence base for the most appropriate intervention for patients with musculoskeletal conditions. His aim within the Chavasse Report is to identify NHS hospitals on a regional basis that would provide timely access for elective orthopaedic care for Service personnel, Reservists and veterans under the banner of the Armed Forces Covenant. If this can be incorporated within NHS care pathways in the future, it would help to maximise the fitness of currently serving personnel and Reservists and provide early and appropriate elective orthopaedic interventions for the veteran community.
iv. Message from The Author

2014 is the one hundredth anniversary of the start of WWI. Captain Noel Chavasse was awarded his two VCs during this conflict. His citations describe a doctor who was clearly dedicated, and valued the care and wellbeing of his men above all else. These values should still be central to what we do today. He was, and should continue to be, an inspiration to the medical profession and allied healthcare professional groups, to always strive to do the best for patients, no matter the circumstances in which we may find ourselves. It is remembrance of his dedication, and selfless action in times of extreme adversity that inspired me to write this report.

I am a senior consultant orthopaedic surgeon in the National Health Service (NHS), and am regularly asked to see serving and retired military personnel. It has become clear to me that, when the military are no longer responsible for their care, our heroes often have to fend for themselves. The quality and provision of care is variable across the country and, despite these times of financial austerity, we can and should address this urgently. In my opinion, if we do not act quickly, the care of our heroes, now and in the future, will be further compromised.

The Surgeon General Air Marshal Paul Evans gave his full support when I approached him with the idea of compiling this report. General the Lord Dannatt and Mr Andrew Selous MP, both ex-servicemen, have given encouragement throughout. Consequently, I assembled a small team of medical personnel from the Services and the NHS to establish the scale and nature of the problems, and to try to offer solutions for them. This report has focused on musculoskeletal disease, the commonest and most pressing problem in need of a long-term solution; however, it could be used as the template for other surgical and medical disciplines.

I sincerely hope that this report will be a catalyst for action, and help to strengthen the partnership between our Armed Forces, The Nation and the NHS to ensure reliable access to high quality and timely musculoskeletal care for members of the Armed Forces whether they are serving regular, volunteer reserve, or retired. It will also improve the quality of musculoskeletal care and rehabilitation services across the country for the whole of the NHS which will benefit us all.

Professor Tim Briggs
MBBS(Hons), MD(Res), MCh(Orth) Liverpool, FRCS(Ed), FRCS(Eng)
Consultant Orthopaedic Surgeon,
Royal National Orthopaedic Hospital
President of the British Orthopaedic Association
Member of Council Royal College of Surgeons, England
Fellow of the Royal College of Surgeons, Edinburgh
I’m writing on behalf of all the members of the Noel Chavasse’s family. You asked us for permission to use his name to title your report “Improving Armed Forces and Veteran Care Whilst Raising NHS Standards for All”.

As a family we are so heartened that Noel’s inspired behaviour touches a prominent person in the modern medical world. It is flattering for all of us that he is still remembered in such a way by you. What a tremendous honour it will be for Noel to receive this recognition. As you point out in your introductory comments, it is nearly one hundred years since his death. Most people’s reputation dies with them or if they’re lucky it lasts for a few years after their death. But for Noel his reputation is enhanced as time goes by. So this is a tribute for him to be placed in a position of such respect.

How much he would have agreed with the spirit of what you’re saying - that all injured servicemen deserve care and support.

Noel would have a crude understanding of the details of how our healthcare system works but he would no doubt support wholeheartedly bringing different parts of our society together to serve injured service people.

So, as a family, we are happy and honoured for you to use Noel Chavasse as the source of inspiration and title for your report.

With best wishes and regards,

Yours sincerely,

Peter Chavasse

11th September 2013
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1.0 The Case For Change

Since 1945 our armed forces have been involved in 25 conflicts and it is likely that the number of conflicts affecting UK interests will increase. At the same time, there is a contraction in the number of regular forces and an increase in the number of reserve forces, especially those attached to the army. The experience gained from the recent conflicts in Iraq and Afghanistan has resulted in huge advances in the medical care and survival of injured personnel, including those with very serious injuries such as the loss of one or more limbs. These types of injuries occur in young, fit, healthy, highly motivated individuals who want to regain maximum function and mobility as soon as possible. The facilities provided by the military for acute treatment and early rehabilitation are excellent. However, when the individuals concerned are discharged from the military and enter the systems of the NHS, there is a dearth of experience in the forms of treatment, or indeed of the appropriate facilities, needed to provide for the very specific on-going care of the injured.

Also, regular military personnel may need timely access to certain specialised services that are not provided by the military, to ensure they are able to return to active duty as soon as possible.

Volunteer Reserves need to be battle-ready within four weeks of call-up for duty. They rely on the services provided routinely by the NHS. Military personnel with musculoskeletal problems account for almost 60% of medical discharges from the forces, and even those who are fit and well at discharge are at a greater risk of developing musculoskeletal problems, at an early stage in their later life. Retired personnel therefore need to be able to access high quality, timely, on-going care and services.

The MOD, in conjunction with NHS England has made great strides since the 2010 inception of the Armed Forces’ Covenant, developing comprehensive mental health support services to veterans and catering for the needs of the very seriously injured. Whilst this is laudable, a further hard focus is required on those military personnel and veterans with serious musculoskeletal problems.

All this is in the context of an NHS under pressure, despite real terms increase in funding, to contain costs in the face of growing demand as the population ages and lives longer. New commissioning arrangements will effect change, but this will take some time.

There is a clear and pressing requirement for a systematic method of ensuring that ex-Forces personnel are able to access expert care within the NHS. The changes we need to make will require some re-configuration and should be guided by front-line clinicians working closely with management to ensure equitable on-going access to high quality services – if we do anything less than that we will be failing the vulnerable.
Initials: CW  
Male Age 27  
Army – Serving  
Years of service 5  

History:
- Low back pain developed lifting weights on exercise. Severe pain failed to resolve.
- Seen by Medical Officers frequently and sent for multiple courses of Physiotherapy.
- Whilst on deployment low back pain so severe forced repatriation to UK.
- MRI scan showed 2 level disc prolapse.
- Surgery: 2 level discectomy, followed by revision surgery within 2 months complicated by nerve damage, wound infection, and spinal fluid leak.
- On-going foot drop and severe low back pain.
- Required referral to specialist centre and successful three level fusion carried out.

Issues:
- Difficulties encountered by CW in navigating the system.
- Little information about surgeons and outcomes.
- Poor aftercare.
- Allowed little involvement and choice in his healthcare.
- Little concern about ability to work on leaving the military.
- Rules appear skewed against back pain sufferers.
2.0 The Aims

To provide a comprehensive, fast-tracked, high quality musculoskeletal service for all armed forces personnel, through an enhanced partnership between the Armed Forces and the NHS.

To provide musculoskeletal care (both routine and specialist) for Reservists and veterans, through a UK Network of Health Service Hospitals (NOHSH). These will be NHS facilities that provide musculoskeletal care to defined standards of quality and access, including rehabilitation. They will be expected to provide a fast tracked, high quality care package, and to see serving personnel as well if requested to do so by the DMS. These hospitals already serve the NHS needs of the local civilian population and will continue to do so. They will help drive up standards across the whole NHS and supply the same standard of care as MOD’s Regional Rehabilitation Units (RRUs).

To ensure access to care is equitable for all service personnel, whether serving or retired, wherever they reside in the UK.
3.0 Executive Summary

3.1 The Problems

- Likely increase in conflicts involving UK interests.
- Reduction of manpower within the armed forces with more reliance on Reservists especially in the army.
- Increased need to keep current serving personnel and Reservists fit and battle-ready.
- Reservists currently reliant on timely NHS treatment to maintain battle readiness.
- Musculoskeletal conditions the commonest cause of downgrading and loss of fighting fitness.
- Lack of developed pathways of care across the UK for fast-tracked treatment of Reservists and those personnel retired, either with injuries requiring on-going care, or fit.
- Lack of shared learning and care pathways between Rehabilitation units of the Armed Forces and the NHS in England, Wales and Scotland to ensure shared learning and a seamless transition of and continuation of care.
- Injured forces personnel who are subsequently medically discharged into the community find it difficult to access continuing care and rehabilitation services.
- The NHS is under huge pressures with increasing demand due to an ageing population who are living longer, especially for musculoskeletal services accounting for 25% of all surgical interventions within the hospital setting.
- Despite real term increases in NHS funding, this rising demand will place further pressures on the ability of the NHS to deliver a timely service.
- Commissioning of services in the UK differs between nations. In Wales and Scotland it remains centrally funded with control maintained by NHS Wales and NHS Scotland. In England, commissioning has, for the main part been devolved down to local CCGs, however, some of the budget for specialist services remains under central control.
3.2 The Solutions

- Re-launch and strengthen the healthcare element of the Covenant delivery to include high quality, timely, on-going care for forces personnel in active service, volunteer reserves and those retired with musculoskeletal problems. NHS Scotland has taken the lead in reminding its healthcare workforce of their responsibilities – England and Wales should do the same.

- Achieve agreement and co-operation across the different health economies on delivering the scope of care in the Covenant.

- Deliver a referral to treatment target of 6 weeks for serving and forces personnel, and 12 weeks for veterans.

- Education of General Practitioners (GPs), hospital doctors and allied health professionals about what the Armed Forces Covenant means and how to access the fast track referral pathway.

- Ensure all service personnel during their discharge planning from the services are made aware of referral methodology.

- Ensure all service personnel, whether in active service, on standby, at the point of discharge or already retired, are aware of the referral methodology.

- Create a single point of contact for advice and referral for patients with a musculoskeletal problem such as a website (or patient advocacy liaison service dedicated to forces personnel).

- Form a UK network of health service hospitals committed to providing the care required.

- Enable co-operative, cross boundary working arrangements between the NHS and DMS, including the rehabilitation units, to allow NHS personnel to learn from the experience of military counterparts, especially in rehabilitation, so that maximum gains in function and mobility are maintained. With the recent appointment of an NCD for Rehabilitation in England this pathway will improve. There are no plans currently for this in Wales and Scotland.

- Establish new NHS veteran rehabilitation units within the NOHSH Network and link them to the rehabilitation units currently treating service personnel to ensure a seamless transfer of care from the military to the civilian providers. Civilian NHS patients will also have access to the care provided by these units.

- Ensure that the eight specialist rehabilitation/prosthetic services highlighted in the **Murrison Report “A Better Deal for Military Amputees”** continue to receive already agreed levels of funding now and into the future, so that they can deliver the prosthetic needs of the current amputees, and those that require amputations later, in order to enable them to maintain maximum function and mobility.

- Extend the scope of the national orthopaedic pilot “**Getting it Right First Time**” to include a national stocktake of Rehabilitation services currently provided by the NHS and make recommendations on how to improve these. This will be achieved by working closely with the Chartered Society of Physiotherapists and the National Clinical Director for Rehabilitation.

- Create a sub-group of the Armed Forces Clinical Reference Group (AFCRG) for specialist orthopaedics and rehabilitation to allow the rapid development of a specification for specialist musculoskeletal problems, which addresses the care for personnel with specialist needs and for Reservists on standby for call-up. This will ensure that appropriate funding is available and prevent delay in treatment and rehabilitation.

- Community services should have a designated link person for armed forces personnel.
Initials: DR  
Male Age 53  
RN – Veteran  
Years of service 11.5

History: Bomb blast to both lower legs
- Surgery to both legs, left recovered, right required Total Knee Replacement. Discharged from the service after 2.5 years.
- After two knee replacement revisions complicated by infection.
- Above knee amputation.
- Rehabilitation standard piston prosthesis, and on-going severe stump pain.
- Unable to access Headley Court once discharged from the Services.
- Eventually obtained specialist help and support.
- Revision surgery with state of the art implant.

Issues:
- Nobody knew how to deal with battle injuries.
- Doctors have little knowledge in the small centres.
- Local doctors suggested electric wheelchair.
- Lack of knowledge amongst healthcare professionals about rights of veterans.
- Information transfer poor.
4.0 The Armed Forces

4.1 Current Military Organisation

The British Forces are respected throughout the world for their professionalism, expertise, and for “getting the job done”. They are composed of three armed services, the Royal Navy (RN), the Army and the Royal Air Force (RAF), who operate synergistically together to meet operational demands. Each comprises Regulars and Reserves. Recruitment to the Armed Forces comes from all over the UK and the Commonwealth, although there are certain areas that have traditionally provided more recruitment.

The total size of British Armed Forces peaked during the First and Second World Wars but has reduced since the end of the Korean War in the 1950’s. Indeed, by October 2012, UK Regular Forces numbered 165,890, while the Volunteer Reserve Forces (excluding University Units) totalled only 29,960 in April 2012.

The outcome of the Strategic Defence and Security Review of 2010 was the reduction in the size of the Regular Forces with an increase in the size and role of the Reserve Forces. By 2020, the Army Regular Forces will number 82,000 and the army Reservists alone are planned to increase to 30,000.

4.2 The Role of the Armed Forces

The Armed Forces provide security to the UK and operate to deliver British foreign policy. The fitness and training standards are demanding to ensure that every individual is fit for his/her operational role. It is therefore accepted that the training is arduous which will inevitably produce injuries. It is therefore critical that access to timely and quality healthcare is available to diagnose and treat these personnel to minimise sickness and maximise fitness for role.

4.3 Number and Type of Injuries

Musculoskeletal conditions are the commonest cause of downgrading and loss of fighting fitness. There are two distinct groups:

a. **Force Generation** - This is the bedrock of injury presentation and directly relates to the culture and training to optimise fitness for task. This requirement will become more acute as the size of the force reduces.

b. **Conflict Trauma** - From 2008-2012, 544 patients were seen and treated at the Royal Centre for Defence Medicine (RCDM) Birmingham and Defence Medicine Rehabilitation Centre Headley Court as a result of injury and natural causes/illness caused by the conflict in Iraq, and 3801 from the conflict in Afghanistan.

4.4 Medical Discharges

In recent years the number of medical discharges has steadily increased. There were 470 Regular Naval Service medical discharges in 2011/12, 963 Regular Army discharges and 182 Regular RAF medical discharges. Once we withdraw from Afghanistan it is likely that the rate of medical discharges will accelerate, with a natural lag between being injured and the completion of appropriate rehabilitation to allow re-integration into civilian life. This varies between patients and can take up to several years.

Another factor to take into account is the annual churn rate, which is when serving personnel leave at the end of their service contract. This makes up the greatest number of annual discharges. The total number of discharges (including retirement etc) in 2011/12 was 21,370. Due to the size of this figure it is estimated by the Royal British Legion that there are 4.8 million veterans alive in the UK. The armed forces community, including past and present and their immediate family, totals about 10 million.

Musculoskeletal injuries are the most significant cause for medical discharges. As a consequence, it is likely that there will be a considerable need for on-going musculoskeletal health provision for these veterans as they age. However it is difficult to quantify the costs of on-going medical and rehabilitation needs due to lack of data collected on veterans continuing needs. Many of the veterans return to the part of the country from where they were recruited, however, some will inevitably move to a different area, with a subsequent change of health care provider and the detrimental loss of continuity of care.

When service personnel are discharged, the NHS becomes the sole provider of their on-going care. There is a risk that they will not receive on-going care in a timely manner. Investigations and treatment plans could be different to civilian counterparts and surgical interventions maybe necessary at a much earlier stage due to increased severity of the musculoskeletal disorders. Some NHS providers might well be unable to treat complex problems and need to refer patients onwards, possibly outside the local commissioning area. The risk of this, along with a variable and patchy rehabilitation network, is for veterans to miss appropriate clinical consultations and get lost ‘in the system’.
4.5 Natural Wastage – The Churn Rate

In addition to the medical discharges that occur annually across all three services, fit men and women leave the forces at the end of their service time. This accounts for the greatest number of discharges and is known as the annual churn rate. This figure varies but between 15,000 – 22,000 may leave the services annually. Although most are discharged fit and well, due to the nature of the jobs they were undertaking, they are potentially more likely to suffer from musculoskeletal problems at an earlier time of their life compared to the general population.
5.0 Current UK Provision of Healthcare to the Armed Forces

Over the last 50 years, there have been significant changes to the delivery of health care to serving personnel and veterans. The DMS is currently responsible for providing primary health care to all three services: Army, RN and the RAF with the NHS responsible for the provision of hospital-based care. The DMS works very closely with the NHS and other charitable trusts to ensure that optimum health care is provided to the 160,000 serving personnel (figures from June 2013).

5.1 General Provision
The DMS is staffed by around 10,000 regular uniformed and reserve medical personnel from all three services. The DMS provides primary care (general practice, dentistry, occupational medicine, rehabilitation and community mental health services) and secondary care on operations.

The primary care practitioner (uniformed or MOD employed civilian) is the first point of contact for active Service personnel and is based in the local Medical Centre or Sick Bay. The Medical Centre usually consists of a team of qualified primary care physicians, nurses, physiotherapists and exercise rehabilitation instructors.

The DMS is also responsible for rehabilitation through the Defence Medical Rehabilitation Programme that is based on a tiered approach usually dependent on complexity of injury. This consists of:

- **Tier 1** – Primary Care Rehabilitation Facilities (PCRFs)
- **Tier 2** – Regional Rehabilitation Units (RRUs). There are 15 Regional Rehabilitation Units (RRUs): Aldergrove, Aldershot, Bulford, Catterick, Colchester, Cosford, Cranwell, Edinburgh, Halton, Honnington, Plymouth, Portsmouth, St Athan and Tidworth, with 2 located in Germany.
- **Tier 3** – Defence Medical Rehabilitation Centre Headley Court for the most complex cases.

5.2 Provision of Secondary Health Care Across the UK

In the UK, Armed Forces personnel are now treated within the NHS based on clinical need and this is generally delivered by the local NHS hospital, some of which are NHS Trusts that host Ministry of Defence Hospital Units (MDHUs).

5.3 Placement of DMS Secondary Care Personnel

Over the last 40 years, secondary care provision has undergone significant changes with the closure of military hospitals both in UK and overseas.

As a direct consequence, there is much closer cooperation between the DMS and the NHS to provide treatment for the Armed Forces and also to maintain the skills of the Armed Forces medical personnel, and to provide high quality postgraduate training to serving clinicians. The MOD contracts with six NHS trusts to provide appropriate placements for the majority, but by no means all, of DMS secondary care personnel to meet this operational requirement:

- RCDM Clinical Unit at University Hospitals Birmingham NHS Foundation Trust
- MDHU Frimley Park Hospital, Surrey
- MDHU Northallerton, North Yorkshire
- MDHU Peterborough City Hospital, Cambridgeshire
- MDHU Derriford Hospital, Plymouth
- MDHU Queen Alexandra Hospital, Portsmouth

5.4 Armed Forces Covenant

The MOD defines the Armed Forces Covenant as “a relationship between the nation, the state and the Armed Forces. It recognises that the whole nation has a moral obligation to members of the Armed Forces and their families, and it establishes how they should expect to be treated.”

The MOD highlights the two principles behind the Covenant:

- The Armed Forces community should not face disadvantage compared to other citizens in the provision of public and commercial services.
- Special consideration is appropriate in some cases, especially for those who have given most, such as the injured and the bereaved.

The Covenant exists to redress the disadvantages that the Armed Forces community may face in comparison to other citizens, and to recognise sacrifices made. The Armed Forces Covenant itself is not a legal document but it has been referenced in law through the Armed Forces Act 2011. This Act ensures that the principles of the Covenant are recognised in law. It also obliges the Defence Secretary to report annually on progress made.
by the government in honouring the Covenant. The first Armed Forces Covenant Annual Report (2012) is only the beginning of a process to deliver the Covenant commitments, the next report being due in Nov/Dec 13.

The report sets out a number of areas requiring improvement and contains 29 new commitments, including implementation of a unified Defence Primary Healthcare Service.

5.5 Current UK Provision for Military Casualties

At present the majority of military casualties are repatriated to the University Hospitals Birmingham Trust’s Queen Elizabeth Hospital (QEH), the home of the RCDM Clinical unit. During their treatment at QEH, most military patients are treated together in a trauma ward staffed by both military and NHS medical staff when this is clinically appropriate. Armed Forces personnel who are SI or VSI abroad are airlifted to the UK by the RAF’s aeromedical evacuation squadron at RAF Brize Norton.

Armed Forces personnel recovering from orthopaedic and neurological problems are treated in the most appropriate military rehabilitation facility (PCRF, RRU or DMRC as described earlier). It is well recognised that the quality of acute care they receive and their subsequent rehabilitation is provided to a world class standard. In addition, there are also seven newly opened Defence Personnel Recovery Centres (PRCs) funded by the MOD, RBL and H4H.

The PRCs are a key part of the Defence Recovery Capability. They are residential facilities situated in or near garrisons available to all members of the Armed Forces during their recovery from sickness or injury. They aim to assist personnel back to either military service or a second career in a civilian occupation. PRCs are not hospitals or rehabilitation centres. They offer a more comprehensive, holistic, care package including activities such as Pilates, which are usually not available. It is thought that providing the right military environment increases recovery rates. Agencies and service charities provide advice and support to current serving personnel and their families as a ‘one-stop shop’ at many of the centres.

The PRCs:
- Colchester PRC: Chavasse VC House, opened in May 2012.
- Hasler Company, PRC Plymouth was set up in 2009 and is based in HMS Drake.
- Tidworth PRC: Tidworth House is a stately home owned by the MOD and leased to H4H since 2011.
- Germany: Brydon House PRC, opened February 2012.

The Defence Adaptive Sports and Adventurous Training Centre, often referred to as Battle Back, opened in October 2011. The purpose of the centre is to allow service personnel to achieve their best recovery from injury or sickness. It aims to provide both for the physical and mental recovery with adaptive sport and adventure training beneficial to the patient’s recovery combined with world class coaching from Leeds Metropolitan University to help those attending to have a positive mental attitude and manage stress.

5.6 Current Medical Provision for Force Generation Patients & Veterans

The NHS is responsible for the secondary healthcare of all servicemen and women in the UK, as well as the hospital treatment for Reserves and veterans. Priority access is provided for veterans for all conditions related to their service according to clinical need, regardless of whether or not they receive a war pension. On leaving the Armed Forces, veterans are provided with a summary of their medical records, which they should provide to their new GP on registration. The onus is placed upon the ex-Service personnel to inform their GP of their veteran status in order to ensure they gain access to priority treatment. In the past many Service personnel were unaware of this, as are many GPs working in Primary Care, and hospital staff in the secondary care sector. However, the MOD is in the process of introducing a new system from late 2013 which will see a letter placed into the Service Leaver’s NHS medical record when they register with a civilian GP. This will inform the new civilian GP that their patient has been under the care of the Defence Medical Services and should prompt the GP to consider whether there is a case for priority treatment, in line with clinical need. The MOD is looking to further improve their systems to allow for a summary of Service Leaver’s in-service medical record to be placed on the NHS medical record on registering with a civilian GP. These improvements will reduce the reliance on the patient to proactively declare their veteran status and GPs will have a better understanding of the veteran population under their care.
5.7 Summary of Secondary Care Provision for Armed Forces Personnel from the NHS

There are three distinct groups within the Armed Forces that need the expertise in musculoskeletal care that the NHS can provide:

a. Men and women currently serving are entitled to emergency and elective secondary care from the NHS.

b. The TA (renamed the Army Reserve), whose numbers will increase to 30,000 by 2020, and other reserve forces, will require timely access and expert care to ensure they remain fit and ready for training exercises or deployment if required. Due to the reduction in number of the regular forces we will become increasingly reliant on this group, and as a result these forces should be offered the same level of access and quality of medical care as the regular forces.

c. The largest group estimated at 4.8 million are those veteran Service personnel, who when discharged, may be injured or fit. Injured service personnel (both battle and non-battle injured) may require on-going surgical care and rehabilitation. Non-injured personnel, who have received an honourable discharge, can present with earlier onset of musculoskeletal disorders as a result of the arduous training and operations experienced during their Service career. They should receive timely access and expert care through the NHS, for current musculoskeletal conditions and those that develop later in life.
Initials: BH
Male Age 33
Army – Veteran
Years of service 9

Problem: Dislocation of shoulder

History:
- Fall suffering posterior dislocation of shoulder.
- Chronic instability.
- Lost medical records, no active treatment for 4 years despite instability.
- Referred to NHS, waited 8 months for out-patients appointment and further 6 months for surgery.
- On-going problems, multiple subsequent surgeries.

Issues:
- Y-list if sick for greater than 3 months.
- Sent home for 10 months no contact from unit.
- GP and RBL only helped him.
- Little information regarding veterans rights and healthcare provision.
6.0 The Scale of the Problem

Musculoskeletal injuries account for 60% of medical discharge from the forces. Our Reservists, as a consequence of the reorganisation of our fighting forces, will assume a more central role in our Nation’s security. Again the most common complaint preventing deployment or training is musculoskeletal. The Government has taken steps to re-dress the disadvantages that veterans face. They have announced the availability of £22 million to support veterans’ physical and mental health from 2010 to 2015. It was announced by the Department of Health in February 2013 that, as a result of the Murrison Report £11 million was to be designated, over the next 2 years for prosthetics and rehabilitation services across the country for ex-servicemen and women who are amputees. Of this £6.7 million will be shared by nine NHS facilities in England to access the latest technology and provide the highest quality of prosthetic care for veteran amputees. The MOD also announced in February that an additional £6.5 million was being made from the Treasury Reserve to ensure that all serving personnel and veterans injured in Iraq and Afghanistan will be able to upgrade to the latest prosthetics technology, including the Genium Bionic Prosthetics System, where clinically appropriate.

Although the military will be aware of personnel that undergo amputations whilst in service, some may require amputations at a later date when under the care of the NHS following discharge. However:

- There is no recognised fast tracked pathway within the NHS system to ensure urgent medical care for Reservists when outside the DMS system. The latter only applies when they are on active duty.
- The stresses encountered by the musculoskeletal system during service and training will significantly increase the risk of the premature onset of degenerative arthritis at an earlier stage in later life.
- The responsibilities of CCGs, NHS Managers, and clinicians in both the primary and secondary care sector towards Reservists and veterans as envisaged by the Armed Forces Covenant are not always fully appreciated and would benefit from much greater visibility to ensure awareness. In Scotland healthcare workers have been reminded of their responsibilities.

- When discharged from service it used to be the individual’s responsibility to inform the GP about their veteran status. However, as described above the MOD has addressed this issue and from late 2013 a letter will be placed in Service Leavers’ NHS medical records when they first register with a civilian GP. This should prompt the GP to consider whether there is a case for priority treatment, in line with clinical need.
- The evidence collected by the Royal British Legion and the experience of clinicians working within the NHS has clearly demonstrated that the Armed Forces Covenant is considerably less effective in supporting older veterans. Both they and clinicians are often unaware of the Covenant, and its implications to their care. As a result veterans may neglect to inform the GP that they are an ex-serviceman and provide the GP with their discharge report.
- All this has been compounded by the intense pace of NHS organisational change over the last 10 years to the extent that the healthcare needs of Armed Forces personnel who are serving or retired have tended to lose visibility and may therefore not have received appropriate priority.
- Specific problems with military healthcare include the lack of a clear fast-track referral pathway; the clinical importance of explicitly acknowledging the specialist requirements of this highly motivated group and their need to be returned to their prior level of occupational function.
- The establishment of the PRCs and RRU s, with help from the Armed Forces charities, is improving recovery in its broadest sense for serving personnel to ensure maximum restoration of function and mobility to this unique group of individuals. The appointment of a Director of Defence Rehabilitation as the national lead for rehabilitation and the identification of the nine Murrison Disablement Services Centres should help to improve the seamless transition of Service patients to NHS care in the future. These links need to be enhanced further to ensure shared learning and provide a seamless transition of care to maintain the best possible function and mobility in these patients.
- Funding for state of the art prosthetics has been agreed for veterans and nine DSC centers identified to provide this service. In Scotland a national amputation centre has been set up and a similar service exists. However it is likely that the number of late amputations has been underestimated. The funding stream has been identified for the next five years but not guaranteed beyond this.

- Once the acute episode of care and rehabilitation are completed within the armed services, often to a world class standard, for those discharged the pathways in place across the NHS and social care systems are not as visible as they could and need to be.

- Specific problems with military healthcare include the lack of a clear fast-track referral pathway, the failure to acknowledge the specialist requirements of this highly motivated group and their need to be returned to their prior level of occupational function.

- The establishment of the PRCs and PRUs, with help from the Armed Forces’ charities, is improving recovery in its broadest sense for serving personnel to ensure maximum restoration of function and mobility to this unique group of individuals. The appointment of a Director of Defence Rehabilitation as the national lead for rehabilitation and the identification of the nine Murrison Disablement Services Centres should help to improve the seamless transition of Service patients to NHS care in the future. These links need to be enhanced further to ensure shared learning and provide a seamless transition of care to maintain the best possible function and mobility in these patients.

- There is still significant disconnection between the MOD and the NHS with a clear separation of responsibilities. This results in a fragmented service overall and risks serving personnel, Reservists and veterans falling into “no man’s land” just when they need help most.

- Once the acute episode of care and rehabilitation are completed, often to a world class standard, there is no clear path way for continued support in the community other than that provided by the military charities.

Prof Michael Clarke, the director of the Royal United Services Institute stated: "With 82,000 we’ve got a “one-shot” Army. If we don’t get it right the first time, there probably won’t be a second chance."

In short, unless we work more cohesively and the boundaries of separation are broken down between the DMS and the NHS, we will not be able to ensure the maximum number of personnel is available if required, nor to guarantee the on-going care for those injured and retired.
Case Study 4

Initials: DM  
Male Age 36  
RN (Marine) – Veteran  
Years of service 6

Problem: High velocity projectile injury to knee

History:
- Oct 2008, gunshot to the right knee. Camp Bastion debridement and POP and sent to Kandahar for further recovery.
- Transferred to Selly-Oak for further treatment.
- Medial femoral condylar damage with > 90% patella tendon damage. Didn’t see a knee specialist, saw what he believed to be a general T&O Surgeon. Cast was replaced by an EX-Fix, which was converted to a plate when the soft tissues allowed.
- Headley court after discharge for rehabilitation. Metalwork failed – sent back from Headley Court to Selly-Oak – told there was nothing they could do other than knee replacement. Suggested referral to RNOHT.
- Referred to specialist centre – metalwork removed and given offloading brace, as knee too badly damaged for cartilage regeneration. Currently under yearly review.
- Now working in security and attends gym regularly.
- Couldn’t get appropriate brace through NHS – therefore buys them himself, they last approximately 2-4 months, so his local hospital will not supply this version although, happy to supply inferior version.

Issues:
- Felt forgotten after medical discharge.
- No understanding of NHS Covenant for veterans by healthcare worker.
- Offloading brace supplied by NHS poor quality and does not last.
- Purchases brace himself, lasts 2-4 months. Little help in accessing appropriate care.
7.0 The Solutions

7.1 The Armed Forces Covenant

Staff across the NHS need to be aware of the undertaking in the Armed Forces Covenant to provide quality care in a timely fashion. The Covenant therefore needs to be re-emphasised throughout England and Wales to ensure widespread understanding of the commitment to both serving and retired armed forces personnel, including Reservists.

New communication regarding the Armed Forces Covenant should explicitly state what is meant by fast-tracked timely care, as well as what is covered, who is eligible, and set goals for achievement. This needs to be supported across the UK with NHS England and the Devolved Administrations.

Service personnel need to be made aware during discharge from the forces of the referral methodology. The transfer of the patient care record from the DMS to the NHS on discharge must be championed to provide a summary of their medical records that also contains the treatment pathways already completed. Service personnel will be provided with a unique number/code that will be attached to their records and will identify them to their primary care service as a veteran.

Those veterans who have already left the services need to be informed of the referral process and provided with their unique identification number/code. This would place veterans in a position where they could remind their GPs and hospital practitioners in order to access the fast tracked care pathway in the future.

The link with the community care system is currently assumed but would benefit from further strengthening.

In order for the referral system to work, a single point of contact for advice and referral for patients with a musculoskeletal problem should be created.

7.2 Timely Access to NHS Care:

Serving personnel must be provided with timely access to a high quality NHS care pathway, including access to specialist services such as complex spinal surgery. In addition, they should be able to access novel therapies when clinically appropriate.

Reservists should be able to access a fast tracked, high quality pathway of care within the NHS to ensure that they are ready for training exercises or active deployment. This should happen at the same speed as occurs in the regular forces.

Veterans should receive timely access to both routine and specialist treatment from the NHS. This should include access to high quality NHS high rehabilitation units, with the aim of restoring veterans to their maximum mobility and functionality.

For serving personnel and those serving in the reserve forces we would propose a referral to treatment time of 6 weeks.

For those retired we propose a referral to treatment time of 12 weeks.

7.3 Network of Health Service Hospitals (NOHSH)

We propose the establishment of a NOHSH across the country to include Wales, Scotland and Northern Ireland. The resulting networks in England will divide the country into the following regions: London and the South East, Midlands and East Anglia, Northeast, Northwest, South and Southwest. All these hospitals will be current NHS units that are known for their high quality of care.

Approximately thirty to fifty hospitals will be required and it is proposed that these can be selected on the basis of the conclusions of the “Getting it Right First Time” report - a national orthopaedic pilot looking at all 145 orthopaedic providers in England. A unique data set has been produced that will inform local areas on ways of re-organising orthopaedic care and highlight excellent practice. This offers a prime opportunity to celebrate hospitals that deliver excellent orthopaedic care.

During this national pilot it is feasible to carry out a parallel stock take of the availability and quality of rehabilitation, an important component of improving and maximising recovery. The Chartered Society of Physiotherapists has expressed willingness to be involved in this exercise. This should include a review of pain management services. It will also allow us to identify a network of rehabilitation units that can provide care for veterans, many of whom have complex orthopaedic problems.

There need to be links between these high quality NHS rehabilitation services and the military rehabilitation units. This will ensure a seamless transfer of care for this unique group of highly motivated individuals from the military to civilian care. The nine DSC recommended by in the Murrison report should be linked into this network, with the support of BLESMA, to ensure veterans continue to
receive the prosthetics that they have been promised. A culture of cross-boundary working between NHS units and military units needs to be encouraged, in order to allow NHS personnel to learn from military counterparts. The appointment of a Director of Defence Rehabilitation as national lead for rehabilitation will undoubtedly enhance these opportunities. This will result in the maintenance of maximum gain in function and mobility when service personnel are discharged from the service.

This model also has the potential to assist in improving standards across the NHS to the benefit of the whole population.

7.4 Funding and Commissioning
Commissioning of services differs between nations: in Wales and Scotland it remains very much as before, with central control being maintained by NHS Wales and NHS Scotland. NHS Scotland has reinforced the Armed Forces Covenant by reminding healthcare professionals of their responsibilities for treating veterans. Commissioning has been reorganised in England following the introduction of the Health and Social Care Act in 2012. Commissioning responsibility for specialised services has been delegated to NHS England whilst routine services for Reservists and veterans have been devolved down to CCGs. In order to ensure access to care remains appropriate for Service personnel, Reservists and veterans, independent of where they reside in the UK, co-operation will be required across the different health economies. The establishment of the Armed Forces Clinical Reference Group and the specialist Musculoskeletal Reference Group will be crucial to facilitate this. This should also include specialist rehabilitation and provision of prosthetics for service personnel who require amputations, whether early or late, following their initial injury.

7.4.1 Devolved funding into CCGs for Routine Care
Funding for routine musculoskeletal problems whether on-going, or in the future, will be managed by CCGs. In the interests of consistency these groups should acknowledge the requirements of the Armed Forces Covenant in their planning. They will also need to agree on the fast tracked care principles within the Covenant for veterans and Reservists in order to ensure consistency of timely access.

If these solutions are implemented, high quality care, that the Nation and NHS has promised its Armed Forces, can continue to be provided within the current financial envelope (See diagram on following page). Additionally, the general population who receive NHS care will benefit from these changes.
Proposed Streamlined Military Personnel Patient Flows

Combined NHS MOD Forces
Clinical Reference Group
Advice to CCGs Military Covenant

Serving Military Personnel
6 week pathway

Voluntary Reserves
6 week pathway

Retired Service Personnel
12 week pathway

Defence Medical Services
(Medical Reception Services)
Combined NHS Referral Centre

Ministry of Defence Hospital Units /
Network of NHS Service Hospitals (NOHSH)

Regional Rehabilitation
Units *13
Defence Medical
Rehabilitation Centre

Personnel
Recovery
Centres

NHS Specialist /
Tertiary Care

NHS Rehabilitation
NHS Prosthetics
This year is the hundredth anniversary of the beginning of WWI. During this conflict, which was to last 1500 days, over 9 million died in uniform and more than 18 million were injured on all sides. The British dead numbered 908,371 and more than two million were injured.

This was the first major conflict where a system was introduced by the British Army to evacuate and treat the huge number of casualties that occurred. Sir Robert Jones, the founder of the BOA was its architect and he used the railway system to take casualties from the casualty clearing stations via the channel ports back to one of the 225,000 beds that were available through a network of services hospitals in the UK. After treatment and subsequent discharge from the forces, many had on-going needs for continuing medical care. However, there were no plans in place by the government to make sure the veterans were looked after. Ex-servicemen had to manage as best as they could, relying on hospitals that received public donations to remain viable and offer the care required.

In the last two conflicts, namely Iraq and Afghanistan, both the death toll and injury count has been very small in comparison. Further, with the medical advances made by the DMS, along with the widespread use of body armour and early evacuation from the scene of operations by helicopter, there has been an increase in the survival of service personnel who would previously have died on the battlefield. Their subsequent care at RCDM Birmingham and rehabilitation at DMRC Headley Court has been world class, but once discharged from the forces, the NHS is expected to continue to care for these highly motivated individuals.

Notwithstanding the Armed Forces Covenant which enjoins excellent care that is fast tracked and provided in a timely manner, it is clear from the evidence that subsequent treatment can be variable. This has been highlighted in the report “A better deal for military amputees” written by Dr. Andrew Murrison MP.

The “Chavasse Report” highlights the current problems and provides the solutions to ensure the on-going care of musculoskeletal problems for all service personnel by the NHS from 2014 onwards.

This report highlights the three groups that require NHS support, namely, those currently serving that need access to specialist care not available within the services provided by the DMS, those within the volunteer reserve whose usual care is the responsibility of the NHS, and finally, those that are discharged whether fit or with on-going musculoskeletal needs. The current system is not currently able to guarantee timely high quality care. In order to change this we need to:

- Re-energise and re-communicate the Armed Forces Covenant across the NHS in England and Wales. This should stipulate the referral to treatment times for serving and reserve personnel of 6 weeks and retired veterans of 12 weeks. This also needs extending into social services.
- Service personnel need to be made aware of their rights and the network of care available for them.
- GPs working in Primary care need to be made aware of the Covenant and what it means for ex-service personnel who require care.
- We need to ensure that CCGs are aware of their responsibilities when service personnel either serving or retired need access to musculoskeletal facilities.
- We need to establish a network of NHS hospitals which will be responsible for the delivery of orthopaedic care to retired and reserve service personnel, in terms of both treatment and rehabilitation.
- A Forces CRG responsible for the commissioning of specialised care has been established in England. It needs to produce a specification for specialist musculoskeletal care.
- These hospitals will be suggested as part of the “Getting it Right First Time” national professional pilot. This will be based on the availability and quality of the services provided. They will link into the nine prosthetics centres as identified by Dr. Andrew Murrison.
- We need joined up working between the DMS and the NHS to ensure a seamless transition of care.
- We need a partnership between the DMS and the NHS to ensure treatments, and rehabilitation skills are transferred across both organisations.
- NHS Scotland has reinforced the NHS Covenant to its healthcare providers within the last 18 months. England and Wales need to do the same.
- Create a single point of contact/patient advisory and liaison service for forces personnel and retired veterans.

The Nation and the Armed Forces quite rightly expect the NHS to rise to the challenge laid out in the Covenant, even in these times of austerity. This report proposes ways to deliver high quality, affordable and fast tracked care by working together within networks. Further, by encouraging excellence, we will see an improvement in standards of care and rehabilitation across the wider NHS.
I would like to thank **the Surgeon General** for his full support and encouragement when I first approached him with the idea for this report.

I would like to thank **General the Lord Dannatt**, and **Andrew Selous MP**, both ex-servicemen, for their confidence that we would deliver the report with the solutions to improve the care for serving and retired service personnel.

I would also like to thank the following for their significant contribution to this report. Without their substantial input and information gathering abilities, this report would not have had the evidence base to support it.

**Surgeon Commodore Alasdair Walker**  
*OBE QHS FRCS Medical Director*

**Surgeon Captain Graham Hill**  
*MBBS, FRCS(Orth) RN*

**Major Sush Ramakrishna**  
*MBBCh, MRCS. RAMC*

**Mr John Machin**  
*MA, MBBS, MRCS Specialist Training Registrar*

**Mr Jonathan Perera**  
*BSc, MBBS, MRCS Specialist Training Registrar*

**Mr Rob Hurd**  
*BSc CPFA Chief Executive Royal National Orthopaedic Hospital Trust*

**Mr Martyn Porter**  
*FRCS Past President of the British Orthopaedic Association*

**Mr Colin Howie**  
*FRCS Vice President of the British Orthopaedic Association*

Furthermore, I would like to thank the following for their editorial input into the report;

**Dr Geraldine Edge**  
*PhD FRCA Consultant Anaesthetist*

**Dr Rhiannon Briggs**  
*MBBS DA MRCGP. Medical Practitioner*

**Mrs Rachel Yates**  
*Project Director “Getting it Right First Time”*

Finally I would like to thank **Rear Admiral Mike Kimmons CB** for his help in securing support from the military charities.
10.0 Support

The following have agreed to offer their support to the report:

The Royal British Legion
The British Limbless Ex-Servicemen’s Association
Help for Heroes
The Patients Association

The Armed Forces Defence Medical Services

The British Orthopaedic Association
The Chartered Society of Physiotherapists
The Royal College of Surgeons of England
The Royal College of Surgeons of Edinburgh
The Royal College of Physicians
National Clinical Reference Group – Specialised orthopaedics
National Clinical Reference Group – Specialised Amputees
International Society for Prosthetics and Orthotics (covers 52 countries) Rehabilitation.

General The Lord Dannatt
Andrew Selous MP
Servicemen and women are making great personal sacrifices for this country and it is only right that the NHS honours its lifelong moral and legal duty of care for our armed forces. We agree with the armed forces covenant that veterans should receive priority treatment where it relates to a condition which results from their service, and the Defence Medical Services and NHS England must continue to support high-quality services for the benefit of serving personnel and the reserves. I very much hope this timely report will help to generate further debate, discussion, and action to improve the care our armed forces and their families rightly deserve.

Norman Williams
President, The Royal College of Surgeons of England

The care of soldiers after the battle has been a problem for society for as long as war has been waged. In the current generation, the immediate care of the wounded is first class and getting better all the time. But there is still a sense that once the physical wounds are healed, we have a tendency to forget the physical and psychological disability that persists and have a profound effect on the soldier. This leads to a need for continuing support, often for life. I personally hope this report will help to raise the needs of the injured soldier in our collective consciousness. We owe them our gratitude and respect.

Ian K Ritchie
President of the Royal College of Surgeons of Edinburgh

Our military personnel have selflessly devoted their lives to upholding the values of this country. In doing so many have sustained both physical and mental illnesses. It is clearly the responsibility of our National Health Services to provide them with the support they require once their military careers are over and particularly where those careers have been foreshortened by injuries sustained in service. The Chavasse report offers clear and sensible solutions and I feel this report is an outstanding piece of work and support its recommendations with considerable enthusiasm; both as an NHS doctor and as President of a Medical College. I trust that this report will encourage debate as to how the medical needs of those military personnel requiring care from the NHS can best be delivered honoring the tenets of the armed forces covenant.

J-P van Besouw
President of the Royal College of Anaesthetists
BLESMA – The Limbless Veterans’ Charity has always been at the forefront of coping with the consequence of significant musculoskeletal injury. Our members live with that consequence for the rest of their lives. We fully endorse the clinical solutions recommended by Professor Briggs. They are coherent, supportive, practical and effective, particularly those that impact on prosthetic services for veterans who have suffered attributable amputation, and we strongly commend their implementation at the earliest opportunity.

Jerome Church MBE
General Secretary BLESMA – The Limbless Veterans Charity

I believe it is a most comprehensive evaluation of the needs of the Veterans and the recommendations need full support of all relevant authorities and organisations involved in caring for the war-wounded in a holistic manner.

As Chair of the Specialist Commissioning Clinical Reference Group, relevant to the needs of the Amputees, I believe it is relevant to note that the recommendations cover all four countries in the UK and should ensure equity across the whole nation.

As President-Elect of the International Society for Prosthetics and Orthotics with membership across 52 countries world-wide, I feel that every nation should have a comprehensive plan to serve their own veterans and this report is a leading example.

We do hope that the recommendations are accepted and implemented.

Professor Rajiv S. Hanspal MBBS, Hon DSc, FRCP, FRCS
President Elect of International Society for Prosthetics and Orthotics

We support the key thrust of this paper which confirms the need for additional orthopaedic care and resources for service people who have been wounded, those who have left the service needing treatment now and in the future and to ensure that our smaller Armed Forces can deploy fit-to-fight.

D Francis G Dunn
President, The Royal College of Physicians and Surgeons of Glasgow

The long-term impacts of serious musculoskeletal injuries on Service personnel are largely unknown. Proposals such as those made by Prof. Briggs, which have the potential to improve outcomes from surgical interventions, have the unreserved support of The Royal British Legion and we are therefore pleased to commend his clinical solutions for improving healthcare across the Armed Forces community.

Chris Simpkins DMA, Hon.DUniv, DL
Director General, Royal British Legion
After over a decade of fighting, the country is looking for a period of peace but, for those who have been injured while serving, their battles will continue. The public has demonstrated by donation that it wishes to support our servicemen and women and demands that support be second to none. The Chavasse report, if fully integrated and delivered in true partnership, will deliver that support and ensure that our young men and women receive the care they deserve; for life. H4H supports this report and very much hopes that the recommendations are implemented.

Bryn Parry OBE  Co-founder and CEO Help for Heroes
& General the Lord Dannatt