

# Snapshot t

## Physical Health

**Snapshot** *Noun* [c] (UNDERSTANDING)

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

© Cambridge University Press

**A plain language summary of research and evidence relating to the UK Armed Forces and veteran community**

Produced by the Forces in Mind Trust Research Centre



## About Snapshots

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

The [Forces in Mind Trust Research Centre](#) will produce a range of Snapshots covering many of the main themes and topics relating to the Armed Forces and veteran community. Due to the constant process of research and policy changes, Snapshots will be updated regularly in order to maintain their relevance. Contributions and comment are welcome via the [Veterans & Families Research Hub forums](#).

## Disclaimer

Whilst Snapshots are produced using recognised research processes, they are written for a lay audience. They are a collation and summary of available academic and quality [grey literature](#), to provide an overview of information on a particular theme or topic. Snapshots are written to inform and disseminate a large body of literature in an accessible way to as wide an audience as possible. They are not intended to be, and should not be regarded as, rigorous searches or reviews.

## About the authors of this Snapshot

Dr Linda Cooper and Kristina Fleuty are researchers at the [Forces in Mind Trust Research Centre](#).

## 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](#), which commissions research to contribute to a solid evidence base from which to inform, influence and underpin policy making and service delivery.

# Table of Contents

<b>1. Introduction and definitions</b> .....	1
<b>2. Methods</b> .....	1
<b>3. Healthcare Provision for the Armed Forces Community</b> .....	2
<b>Commitment to Armed Forces Healthcare</b> .....	2
<b>Healthcare Delivered in Partnership</b> .....	2
<b>4. Physical Health Provision whilst in Service</b> .....	4
<b>MOD Healthcare Provision</b> .....	4
<b>Service-Specific Provision</b> .....	4
<b>NHS Statutory Arrangements</b> .....	5
<b>MOD/NHS Partnership</b> .....	5
<b>Charitable Healthcare Provision for the Armed Forces Community</b> .....	6
<b>5. The Physical Health of the Serving Armed Forces</b> .....	7
<b>Operational Casualties</b> .....	7
<b>6. Transition and Resettlement</b> .....	8
<b>Medical Discharge</b> .....	8
<b>7. The Physical Health of Veterans and their Families</b> .....	9
<b>Healthcare Provision in the UK</b> .....	9
<b>Healthcare Provision in England</b> .....	9
<b>Healthcare Provision in Scotland</b> .....	9
<b>Healthcare Provision in Wales</b> .....	10
<b>Healthcare Provision in Northern Ireland</b> .....	10
<b>Challenges for Veterans’ Healthcare Provision</b> .....	10
<b>Charitable Healthcare Provision for veterans</b> .....	11
<b>The Physical Health of Veterans</b> .....	12
<b>Physical Health of Veterans Case Study</b> .....	13
<b>The Family Context</b> .....	14
<b>8. Conclusion</b> .....	15

## 1. Introduction and definitions

This Snapshot summarises themes and issues relating to physical health and healthcare provision for the Armed Forces 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.

Armed Forces-relevant terms and their definitions can be found [here](#). The following terms are particularly important:

- The term **transition** is used to describe the period of (re)integration into civilian life from the Armed Forces. For the purposes of this Snapshot, it starts from the point in Service at which personnel start their resettlement process, and can continue for several years from discharge.
- **Resettlement** describes the formal processes and procedures by which transition is managed, and the formal support provided to Service leavers during transition. It starts with the activation of the resettlement process and continues until the end of resettlement provision.
- The term **Early Service Leaver (ESL)** covers those who get the minimum statutory resettlement support. ESLs are defined by the [Ministry of Defence](#) as “Service leavers who are discharged (a) compulsorily from the trained strength or untrained strength and lose entitlement to resettlement provision ... they would otherwise have because of the circumstances of their discharge (e.g. Compulsory Drugs Test failures); (b) at their own request from the trained strength or untrained strength, having completed less than four years’ Service.”
- The term **veteran** is defined by the [Ministry of Defence](#) as anyone who has “served for at least a day in HM Armed Forces, whether as a Regular or a Reservist.”
- 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) So progress can be monitored, all serving WIS personnel in the Army are logged in the Wounded Injured and Sick Management System database (WISMIS).

## 2. Methods

A review was undertaken of the available UK evidence relating to the physical health and healthcare provision of Service 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. Of particular use in the writing of this summary were data reports produced by the Ministry of Defence, the websites of the Scottish, Welsh and Northern Irish devolved Governments and the UK Government [informational webpage](#), all of which outline structures of healthcare support from and collaboration between the Defence Medical Services (DMS) and the [National Health Service](#) (NHS) for each nation. A significant source of information for charitable provision for veterans’ physical health was the [Armed Forces Charities’](#)

[Physical Health Provision](#) report from the [Directory of Social Change](#). The [Veterans & Families Research Hub](#) was also an invaluable source of relevant literature.

### 3. Healthcare Provision for the Armed Forces Community

#### Commitment to Armed Forces Healthcare

The Armed Forces Covenant sets out the commitment made by the UK Government to provide healthcare to the Armed Forces community. The [Covenant](#) states that the Armed Forces 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 Armed Forces, subject to clinical need’.

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; 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.

#### 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 Armed Forces (Regular and Reserve) and civilian populations, including veterans and their families. Whilst Armed Forces (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 Armed Forces community, including for Reservists not on active duty and when individuals have acquired veteran status. There are also pathways for which the MOD and NHS can provide effective joint care (see [‘Healthcare Provision’](#) for further information). Furthermore, as will be explored in this Snapshot, in the UK, charitable organisations are (mainly for veterans and their families) often a supporting arm to this partnership and provide substantial amounts of their resources and support, particularly in respect of physical health support for those who have been seriously injured whilst in Service and where injuries result in the need for continuing post Service care for veterans. It is [reported](#) that Service charities spent at least £103 million on provision for armed forces physical health in 2016.

In an attempt to coordinate efforts to uphold the Covenant between the multiple players 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 Armed Forces personnel with complex and

enduring physical, neurological and mental health conditions that are attributable to injury whilst in 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 says the outcome for health and wellbeing should be that "[a]ll veterans enjoy a state of positive physical . . . health and wellbeing, enabling them to contribute to wider aspects of society."

### **UK-wide Healthcare**

The aforementioned [Covenant report](#) also draws attention to country-specific initiatives across the UK. The Scottish Veterans Commissioner released a [significant report](#) in 2018 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 need to incorporate veterans' needs into national initiatives from the Scottish Government, such as into plans to establish a National Trauma Network. This Network will mirror the existing [Veterans Trauma Network in England](#). Scotland have yet to designate their Major Trauma Centres. In response to this report, a [follow-up report](#) from the Scottish Government accepted the Commissioner's recommendations and from 2018 the Scottish Government is developing a "distinctive Scottish approach" to veterans' healthcare.

The Scottish Government currently funds the [Veterans First Point Network](#), provided as part of the NHS in Scotland. The Veterans First Point Network offers a point of contact for veterans and their families who require support for a range of needs, including support for their physical health. It is reported that investment will be provided for this service until 2020 by the Scottish Government and NHS Scotland.

In Wales, there are also plans to integrate a Veterans Trauma Network into the Welsh Major Trauma Centre system in 2019. Wales has an MOD Fast-Track Pathway for Service personnel, providing secondary and specialist care and prioritising treatment for personnel who are actively serving but are currently graded as medically not deployable.

In Northern Ireland, the 'Armed Forces Liaison Forum' ensures equitable access to health and social care services by members of the Armed Forces, families and veterans, where there are specialised needs. General healthcare needs are met through GP services local to military establishments.

Within [NHS Improvement](#) provision, [accreditation](#) has been introduced for 'Veteran Aware' hospitals that meet the criteria for offering the best care to veterans. This initiative is part of the Veterans Covenant Hospital Alliance (VCHA). A new [manifesto](#) for the VCHA was released in February 2019; 25 hospitals have so far been accredited, with the next goal set to have 75 NHS providers accredited by the end of 2019. This is due to be extended to other types of provision (for example, Mental Health, Ambulances, Community services). In a similar vein to Veteran Aware hospitals, GPs can sign up to become accredited as 'veteran friendly' under a [national scheme introduced in 2018](#), to improve medical care and treatment for former Armed Forces personnel. The scheme is backed by NHS England

and the Royal College of General Practitioners (RCGP). It has been [reported](#) and [publicised](#) that General Medical Services GP forms ([GMS1 form](#)) have been amended nationally to include a question regarding the identification of veterans by GPs, to facilitate access to healthcare priority treatment.

## 4. Physical Health Provision whilst in Service

### 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 Service personnel so they are medically 'fit for task'. The DMS is staffed by 11,000 Service personnel (7,500 Regular and 3,500 Reserve) and 2,200 civilian personnel, and provides healthcare to the 144,900 (as [reported](#) October 2018) 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, such as on permanent military bases and in areas of conflict.

The DMS treat personnel in the UK, overseas and at sea. The provision of 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 this 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 (PRUs), also located in the UK and Germany; services can also be delivered on deployment by field hospitals. PRUs provide an intermediate level of treatment, with those needing more complex treatment attending the [Defence Medical Rehabilitation Centre](#) (DMRC).

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 new location.

### Service-Specific Provision

The [Army Medical Service](#) (AMS) provides 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](#), [Royal Army Veterinary Corps](#), [Royal Army Dental Corps](#) and [Queen Alexandra's Army Nursing Corps](#). The AMS contributes the largest numbers of staff to the DMS and runs the majority of 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](#).

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](#).

### **NHS Statutory Arrangements**

Physical healthcare provision for the Armed Forces 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 Armed Forces community, including veterans and their families, can access NHS services. NHS England is responsible for all secondary and community health services for the Armed Forces 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 Armed Forces community in devolved nations exists it will be included in this Snapshot. It is important, however, to note that there is not as much widely available information, reporting or research on NHS provision for the Armed Forces in devolved nations.

NHS [commissioning intentions](#) for the Armed Forces community 2017 – 2019 state the physical health priorities to be: access to high quality services that meet the Covenant commitment; improved access to NHS screening programmes; a focus on prosthetics and continuing healthcare; and the implementation of the [Integrated Personal Commissioning for Veterans Framework](#).

An NHS England [report](#) recognises the statutory duty of the NHS to commission services for the Armed Forces community and this is always under review. The current version of the [NHS Constitution](#) specifically references the Armed Forces Covenant and therefore allows the NHS to provide 'priority services' for the Armed Forces community, where the Constitution prohibits such commissioning. The NHS is required to [commission](#) certain services for members of the Armed Forces 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](#) and is defined in [Section 15 of the Health and Social Care Act 2012](#).

### **MOD/NHS Partnership**

To inform decisions regarding the commissioning of clinical services, the MOD produces statistics on the number of Armed Forces and entitled civilian personnel with a DMS registration. The [latest figures](#) show 170,554 with a DMS registration, a decrease of 1.3% from the year previous, which sits in line with the changing size of the Armed Forces "required by the MOD to achieve success in its military tasks."

There is a [Partnership Agreement](#) between the MOD and NHS England which outlines the commissioning of health services in England for the Armed Forces. There are Ministry of Defence Hospital Units (MDHUs), which are military healthcare facilities embedded within NHS Trusts and

civilian hospitals. There are five MDHUs located in the UK. There is also the [Royal Centre for Defence Medicine](#) (RCDM) located in Queen Elizabeth Hospital, [University Hospitals Birmingham NHS Foundation Trust](#), Birmingham. The RCDM provides medical support to military operational deployments, as well as providing secondary and specialist care for members of the Armed Forces. 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, including abroad. Following medical treatment, many transfer to the DMRC. The RCDM is also a training centre for Defence personnel and focuses on medical research. Furthermore, the influence of Armed Forces 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.

The [location](#) of the new DMRC is close to both the [RCDM](#) and the [University Hospitals Birmingham NHS Foundation Trust](#) and there are hopes that this will help to enable the joined up care, involving multiple healthcare professionals, needed to deliver complex rehabilitation.

### **Charitable Healthcare Provision for the Armed Forces Community**

Charities play a substantial role in physical healthcare initiatives for the serving Armed Forces community (Post Service charitable support for veterans is discussed [here](#)). Physical health charitable providers promote the recovery, fitness and good health of the Armed Forces, 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 Armed Forces, 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 Armed Forces charity sector) providing support for the physical health needs of the Armed Forces population. This support encompasses “services which promote the recovery, fitness and general good health of the Armed Forces 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 Armed Forces 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.

## 5. The Physical Health of the Serving Armed Forces

Overall, in 2017, the UK Regular Armed Forces (selected for good health at the time of recruitment) were at a significantly lower risk of dying compared to the UK general population. More specifically, MOD statistics suggest that the Regular Armed Forces were at a 78% decreased risk of dying as a result of a disease related condition, and at a 39% 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 Armed Forces 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 Armed Forces, it is reported that 52% of injuries sustained (including Armed Forces personnel and MOD Civilian employees) occurred during training and that the rate of injury is higher for untrained than trained personnel.

### 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 Battle injuries. Non-Battle injuries included climatic injuries, land transport accidents, slips, trips, falls and bites/allergic reactions.

The increased use of Improvised Explosive Devices (IEDs) changed the nature of combat and saw personnel requiring complex medical care for blast injuries, thus demanding a change in physical healthcare provision going forward. One such injury sustained by Service personnel is loss of limb/s through traumatic or surgical amputation. The peak number of IED events involving UK personnel were recorded in 2009-2010, coinciding with high tempo operation in Helmand Province in Afghanistan.

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). A patient's NOTICAS classification may change as they advance through treatment. There are further NOTICAS reporting categories used to specify a number of types of casualty 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 Very Seriously Injured, 23% Seriously Injured, 19% Incapacitating Injury/Illness and 19% Unlisted Casualties. From 2013-2016, of the 636 personnel who attended an Inpatient clinic at the Defence Medical Rehabilitation Centre, 47% remained in Service, 37% were Medically Discharged and 16% had left Service for reasons other than Medical Discharge.

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 made for 'complex trauma' or 'neuro'; 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.

## 6. Transition and Resettlement

### Medical Discharge

Service personnel who sustain physical injuries, such as lose limbs (in reality a small population) are able to 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. In practice, this ethos can be inconsistently applied and non-discharge may be complicated by other factors. 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 Armed Forces. 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. Upon discharge, the healthcare needs of ex-Service personnel are provided for under the NHS, within the healthcare system provided to the general population.

During a five-year time period (2013-2018) there were 176 UK Service personnel who sustained a traumatic or surgical amputation as a result of injuries or illness. Of these, one quarter have been medically discharged. For those UK Service personnel who served in Afghanistan (2001-2018), 297 sustained injuries lead to traumatic or surgical amputation. Of these, three quarters have been medically discharged. For those UK Service personnel who served in Iraq (2003-2018), 32 sustained injuries which lead 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, 1,769 Army, 486 Naval Service and 196 RAF personnel were medically discharged.

Certain demographic groups were significantly more likely to medically discharge: females in the Naval Service and RAF, Other Ranks (i.e. personnel from any of the three Services who are not Officers, for example, warrant officers, non-commissioned officers and ordinary soldiers with the rank of private or regimental equivalent), Royal Marines in the Naval Service and Untrained Personnel in the Army (Untrained in the Army is defined as personnel who have not completed Phase 1 training). With regards specifically to physical health, the main causes of medical discharges 2017-2018 were musculoskeletal disorders and injuries. These disorders and injuries led to 56% of Naval Service, 57% of Army and 46% of RAF medical discharges.

Medically discharged personnel who leave the Armed Forces prior to completion of their contract may be entitled to additional payments as part of their military pension. The Armed Forces Compensation Scheme (AFCS) compensates for claims from personnel and veterans where injury and illness have been caused or made worse by Service. Figures show that 53% of all injury/illness awards were for musculoskeletal (MSK) disorders.

## 7. The Physical Health of Veterans and their Families

### Healthcare Provision in the UK

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

This veteran-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.

### Healthcare Provision in England

In England, the Veterans Trauma Network (VTN – established 2016) provides specialist care to veterans with traumatic injuries and utilises the NHS Major Trauma Centres, and several acute and specialist trusts, to deliver life-long reconstructive trauma and associated care, and has also been able to use its specialist professional skills to support the wider population in domestic terrorist and trauma events, as well as supporting other 'blue light' service patients. The VTN is an NHS England service, but works in close partnership with the DMS and several charities, such as RBL, Blesma, Blind Veterans UK and Style for Soldiers, in supporting veterans, their referral and their pre/post-operative rehabilitation. The VTN supports research, has strong links to mental health trauma services, and is fully integrated with the veteran's GP. NHS Wales are launching their VTN in 2019 and NHS Scotland are hoping to do so by 2020.

### Healthcare Provision in Scotland

The Scottish Government sets out provision for the wider Armed Forces and veterans, including a veteran's right to priority healthcare treatment, in the report Renewing Our Commitments. There are Armed Forces & 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. For example,

NHS Inform gives specific advice on physical injuries, such as [amputation](#). Veterans First Point (as [introduced previously](#) in this Snapshot) helps veterans and their families with a number of issues they may face in adapting to civilian life, including with their physical health. Veterans First Point run 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](#). It is also worth noting that [Veterans Scotland](#) gathers together resources and advice from a number of organisations that support veterans in key areas, including with their physical health needs; the [Veterans-Assist](#) website makes these resources searchable.

### 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 Armed Forces 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 module '[Veterans' health and wellbeing](#)' 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 understanding better the specific health and wellbeing issues that veterans and their families may face.

For the context of healthcare provision in Wales, it should also be noted that a significant healthcare service for veterans in Wales is [Veterans' NHS Wales](#), but since this service focuses on mental health it will be explored in a future Snapshot on the mental health of veterans and their families.

### 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 in Northern Ireland 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 wider online information that details 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 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."

### 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 Armed Forces culture and a more nuanced understanding of the potentially 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. GPs in turn commented that they needed more information on how to assess veterans and to where they could refer veterans.

A 2014 [report](#) drew attention to data that suggested more than a third of GPs did not know the priority/disadvantage criteria for veterans, as per the Covenant stipulation, and those that did know had received the information through the media.

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 concludes that there is a need to make improvements to commissioning practices for veterans.

In an effort to increase the visibility of veterans within civilian healthcare provision, [from 2018](#) the information collected on GP registration forms includes further details of veterans, which will be used to allow healthcare professionals to identify personnel, veterans and their families and establish areas of need.

It is similarly [suggested](#) that civilian nurses providing primary care need educational preparation to understand the specific needs of veterans, as nurses will often be an important first point of contact for veterans accessing healthcare. This [paper proposes](#) 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 links 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 so 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. Having acknowledged this, 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 within healthcare professions, to gain insight into Armed Forces culture and use this knowledge to tailor relevant support for veterans and their families.

### **Charitable Healthcare Provision for veterans**

Charitable support for the Armed Forces community, as [introduced above](#), often continues for veterans and in many cases there are even more prominent examples of charitable support for the veteran community. A recent [report](#) states that veterans are the most common recipients of physical health 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.

Beyond clinical care and time spent at the DMRC, recovery and rehabilitation often takes place at [Recovery Centres](#) run by [Help for Heroes](#) or at home, with access to NHS outpatient services. Recovery Centres are located in key locations across the UK; [Phoenix House](#) at the Catterick Garrison for the North of the UK; [Chavasse VC House](#) at the Colchester Garrison for the East of the UK; [Tedworth House](#) in the South of the UK; the [Recovery Centre](#) at the Devonport Naval Base in the West of the UK; in Wales, there is a Help for Heroes [Community Recovery Team](#) coordinating support.

Charities provide ongoing support to WIS veterans when the individual transitions back into their everyday home environment, for example, 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 Armed Forces 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 over 60% of charities deliver a nursing or care home service themselves.

For veterans who want to find out what support is offered by charities to meet physical health needs, [Veterans' Gateway](#) coordinates and signposts to available support, raising awareness of Service-charity provision across the UK. This coordination of support and signposting from Veterans' Gateway also includes signposting to NHS services.

[Research](#) found that there is extensive collaboration between charities and other voluntary sector organisations to deliver care and support to veterans, and between charities themselves – over three-fifths of charities partnered with other voluntary sector organisations.

There is recognition in [recent veteran population data](#) that a significant proportion of the veteran community is ageing. It is [reported](#) that 63% of veterans are aged 65 and over. Many Service charities make a point of including, promoting to, and in some cases directly focussing on, older veterans. The [Defence Medical Welfare Service](#) looks after the older veteran community and makes a specific point of differentiating the medical care they provide for the older veteran community.

### **The Physical Health of Veterans**

There is [no difference in the self-reported general health](#) of veterans and non-veterans. For example, 35% of veterans and 36% non-veterans aged 16-64, and 18% of veterans and 19% 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. [Research](#) published in 2016 similarly asserts that veterans are physically robust and have the same health complaints as the general population, and there is no higher prevalence of cancer in the veteran community than in the general population. [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.

Some of the most 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. These findings were acknowledged as being consistent with the higher rates of military smoking, as [reported previously](#) as a result of prior research.

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 (45%) to have ever smoked. Furthermore, *female* veterans of working age (50%) 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 (55%) compared to retirement age female non-veterans (42%). Veterans of working age who had previously smoked were [significantly more likely](#) to report suffering from chest and breathing problems. [Research](#) shows a higher percentage of veterans compared with non-veterans developed lung cancer (0.79% vs 0.64%) and other smoking-related cancers (1.31% vs 1.09%). However, the same research showed that the risk of lung cancer decreased among younger veterans.

A [report](#) suggests that the veteran population experience 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) – many other causes of hearing loss, such as birth complications, infectious diseases, genetic predispositions and head injuries, would have rendered the individual unsuitable to undertake military Service in the first place. This is supported by a [review of research studies](#) published in 2017, which reinforces that noise-induced hearing loss (NIHL) is a significant and major health issue affecting the Armed Forces 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.

The Scottish Veterans Commissioner [identifies](#) the main severe and lasting physical conditions faced by veterans as being multiple and complex injuries, such as those caused by blast injuries, notably Traumatic Brain Injury, amputation, burns, internal injuries, hearing/sight loss and spinal cord injuries. General physical health concerns for veterans are identified as being for amputees, for those with mobility issues, musculoskeletal disorders and injuries (MSDs), those managing chronic pain, and for those with severe sensory impairment (hearing and/or sight loss), such as tinnitus.

### **Physical Health of Veterans Case Study**

Across the preceding decade there has been increased publicity, media exposure and reporting around the physical health needs of veterans, and in particular around the reporting and media attention given to WIS veterans with amputations. Events such as the [Invictus Games](#) have increased international recognition of WIS veterans and given a higher profile, for example within television broadcasting of sporting events, to those amputees using prosthetic devices.

An illustrative case study of these gradual changes in UK understanding of and provision for WIS veterans is that of amputees using prosthetics. A [report](#) released in June 2011 called for improvement

in care and provision for WIS veterans, in particular for amputees. The report made recommendations that would sit in line with the Government's commitment to the Covenant and it was suggested that recommended changes would in turn benefit the wider amputee community. The Veterans' Prosthetics Panel (VPP) was established in 2012 in response to the report's recommendations and in October 2011, the UK Government announced an investment of up to 15 million pounds to improve prosthetics for military veterans who had lost a limb as a result of serving their country. The Department of Health & Social Care introduced a number of specialist prosthetic and rehabilitation centres for amputee veterans across the country.

A later report built on the ideas of the 2011 report and detailed the standard of NHS provision for WIS veterans, drawing attention to the basic but functional prosthetic limbs provided by the NHS, which did not at that time include prosthetics equipped with the latest technology, notably prosthetics with Microprocessor Knees (MPKs). The report suggested that redistribution of funding would guarantee all serving personnel and veterans injured in Service would be able to upgrade to the latest prosthetics technology. The report states that NHS Scotland had already followed this lead. In 2013, there was notable media coverage of the UK Government's decision to allow veterans with Service-attributable injuries to access prosthetics with Microprocessor Knees (MPKs), known colloquially as 'bionic legs'. The work of Service charity Blesma was key in pushing for and helping to implement this change in entitlement. The Veterans' Prosthetics Panel (VPP), in England, now provides appropriate (including MPK) prosthetics, as well as replacements and associated rehabilitation, through a number of locally-based NHS Disablement Service Centres.

### **The Family Context**

The Families Federations take on a significant amount of work in coordinating support, assistance and advocacy for the wider Armed Forces community, including veterans and their family members. There are Families Federations for the Army, Royal Air Force and Royal Navy.

A 2014 review commissioned by Blesma (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. This review shows that there is evidence within the general healthcare literature suggesting the involvement of family caregivers is important for the success of a patient's rehabilitation. However, the review ultimately recognised a need at that time to increase awareness of and provision for the families and carers of veterans.

Recent research brings new evidence and emphasis to the importance of assessing how families cope when a veteran is recovering from injury and differentiates between the needs of the veteran and family member involved in the caring relationship. This in turn suggests 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 General Practitioners and Nurses, need greater awareness and training regarding the potential specific needs of veterans.

[Research](#) published in 2017 finds that family members caring for WIS personnel would appreciate “proactive, direct and sustained communication from support service providers,” and suggests that ‘family care coordinators’ would be of benefit to provide continuous and consistent care to families.

More attention has also been brought to the physical health of children of Armed Forces or veteran families who may be young carers. A [project report](#) identified that young carers from Armed Forces families may be particularly vulnerable, as they also have to contend with other factors of military life, such as mobility and the need to relocate and change schools, and the impact of deployment on their wellbeing. However, in balance, the report also points out that these young carers can be resilient, adaptable and proud of their family’s way of life.

A significant proportion of Armed Forces charities provide physical health support for the wider Forces community, including family members. It was [recorded in a recent report](#) that 57.9% of charities make provision for spouses/partners and 49.6% support dependents and serving personnel. 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. Government-led initiatives are often delivered in partnership with third sector organisations and the Service Family Federations; for example, the MOD’s [Defence Recovery Capability](#), which is delivered in partnership with [Help for Heroes](#) and [The Royal British Legion](#).

## 8. Conclusion

This Snapshot outlines physical healthcare provision for the Armed Forces community, including veterans and wider family members, and outlines some of the key physical health concerns for the Armed Forces. It is worth noting that the mental health of the Armed Forces community should be considered in parity with physical needs, but this Snapshot concentrates on physical health only. 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 certain combat roles, which mean some serving personnel and veterans will require ongoing specialised care.

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

Physical healthcare provision for the Armed Forces (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 Wounded, Injured and Sick (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; for example, some NHS hospitals have input from medical professionals with specialised Defence-related training who have the knowledge to treat particular types of combat injuries (for example, through the VTN). In relation to physical healthcare, charities make a significant contribution to the Armed Forces

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, and 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 and the MOD aims to provide joint initiatives across the full range of health needs for the Armed Forces 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 the support that exists. 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.

### Key Sources and References

Armour, C., Waterhouse-Bradley, B., Walker, E. and Ross, J., 2017. Supporting & Serving Military Veterans in Northern Ireland. Project report for the Northern Ireland Veterans' Health and Well-Being Study. Available at: <<https://www.vfrhub.com/article/supporting-serving-military-veterans-northern-ireland/>>.

BBC News, 2013. 'Bionic legs' for military amputees. [online] 19 February. Available at: <<https://www.bbc.co.uk/news/uk-politics-21497473>>.

Briggs, T., 2014. *The Chavasse Report: The Evidence*. Available at: <<https://www.vfrhub.com/article/the-chavasse-report-the-evidence/>>.

Bergman, B. P., Mackay, D. F., Morrison, D. and Pell, J. P., 2016. Smoking-related cancer in military veterans: retrospective cohort study of 57,000 veterans and 173,000 matched non-veterans. *BMC Cancer*, 16(311). doi: 10.1186/s12885-016-2347-5. Available at: <<https://www.vfrhub.com/article/smoking-related-cancer-in-military-veterans-retrospective-cohort-study-of-57000-veterans-and-173000-matched-non-veterans-scotland/>>.

Bergman, B. P., Mackay, D. F. and Pell, J. P., 2018. Peripheral arterial disease in Scottish military veterans: a retrospective cohort study of 57,000 veterans and 173,000 matched non-veterans. *Journal of Public Health*. doi:10.1093/pubmed/fdy046. Available at: <<https://www.vfrhub.com/article/peripheral-arterial-disease-in-scottish-military-veterans-a-retrospective-cohort-study-of-57-000-veterans-and-173-000-matched-non-veterans-scotland/>>.

Bergman, B. P., Macdonald, E. B., Mackay, D. F. and Pell, J. P., 2019. Healthy workers or less healthy leavers? Mortality in military veterans. *Occupational Medicine*. doi: 10.1093/occmed/kqz023. Available at: <<https://www.vfrhub.com/article/healthy-workers-or-less-healthy-leavers-mortality-in-uk-military-veterans/>>.

Burgess, J. E., Gall, M., Orr, S. and Kilbey, S., 2017. Formation of Defence Primary Healthcare: a new way of delivering firm base primary healthcare. *Journal of the Royal Army Medical Corps*, 163(2). Available at: <<https://www.vfrhub.com/article/formation-of-defence-primary-healthcare-a-new-way-of-delivering-firm-base-primary-healthcare/>>.

Cooper, L., Andrew, S. and Fossey, M., 2016. Educating nurses to care for military veterans in civilian hospitals: An integrated literature review. *Nurse Education Today*, 47, pp. 68-73. Available at: <<https://www.vfrhub.com/article/educating-nurses-to-care-for-military-veterans-in-civilian-hospitals-an-integrated-literature-review-2/>>.

Department of Health and Social Care, 2011. *Improved prosthetics services for military veterans*. *Gov.uk Announcements*, [online] 21 October. Available at: <<https://www.gov.uk/government/news/improved-prosthetics-services-for-military-veterans>>.

Department of Health and Social Care, 2014. *The Mandate - A mandate from the Government to NHS England: April 2014 to March 2015*. Available at: <[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/383495/2902896\\_DoH\\_Mandate\\_Accessible\\_v0.2.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/383495/2902896_DoH_Mandate_Accessible_v0.2.pdf)>.

Department of Health and Social Care, 2015. *The NHS Constitution for England*. Available at: <<https://www.gov.uk/government/publications/the-nhs-constitution-for-england/the-nhs-constitution-for-england>>.

Directory of Social Change, 2018. *Focus On: Armed Forces Charities' Physical Health Provision*. Available at: <<https://www.vfrhub.com/article/focus-armed-forces-charities-physical-health-provision/>>.

Fossey, M. and Hacker Hughes, J., 2014. *Traumatic Limb Loss and the Needs of the Family – Current Research: Policy and Practice Implications*. [pdf] Blesma. Available at: <<https://www.vfrhub.com/article/traumatic-limb-loss-and-the-needs-of-the-family-current-research-policy-and-practice-implications/>>.

Gauntlett-Gilbert, J. and Wilson, S., 2013. Veterans and chronic pain. *British Journal of Pain*, 7(2), pp. 79-84. Available at: <<https://www.vfrhub.com/article/veterans-chronic-pain/>>.

Gov.uk, 2018. *The Strategy for our Veterans*. Available at: <<https://www.vfrhub.com/article/uk-veterans-strategy-2018/>>.

Gov.uk Legislation, 2012. *Health and Social Care Act 2012*. [online] Available at: <[www.legislation.gov.uk/ukpga/2012/7/section/15/enacted](http://www.legislation.gov.uk/ukpga/2012/7/section/15/enacted)>.

Hynes, C. and Thomas, M., 2016. What does the literature say about the needs of veterans in the areas of health? *Nurse Education Today*, 47, pp. 81-88. Available at: <<https://www.vfrhub.com/article/literature-say-needs-veterans-areas-health/>>.

Institute of Applied Health Research, 2017. *Existing evidence on noise induced hearing loss and tinnitus in the military and other occupational groups*. Available at: <<https://www.vfrhub.com/article/existing-evidence-on-noise-induced-hearing-loss-and-tinnitus-in-the-military-and-other-occupational-groups/>>.

McGill, G., Wilson, G., Hill, M. and Kiernan, M. D., 2019. Utilisation of the principles of the Armed Forces Covenant in NHS Trusts and Clinical Commissioning Groups across England: a freedom of information investigation. *BMJ Open*, 9(1). Available at: <<https://www.vfrhub.com/article/utilisation-of-the-principles-of-the-armed-forces-covenant-in-nhs-trusts-and-clinical-commissioning-groups-across-england-a-freedom-of-information-investigation/>>

Ministry of Defence, 2011. *The Armed Forces Covenant*. Available at: <<https://www.vfrhub.com/article/the-armed-forces-covenant/>>.

Ministry of Defence, 2016. *Defence Medical Rehabilitation Centre, Headley Court – Inpatient (Ward) Attendance*. Available at: <<https://www.vfrhub.com/article/defence-medical-rehabilitation-centre-headley-court-inpatient-ward-attendance/>>.

Ministry of Defence, 2016. *Improvised Explosive Device (IED) events involving UK personnel on Op HERRICK in Helmand Province, Afghanistan*. Available at: <<https://www.vfrhub.com/article/improvised-explosive-device-ied-events-involving-uk-personnel-on-op-herrick-in-helmand-province-afghanistan/>>.

Ministry of Defence, 2016. *Types of Injuries Sustained by UK Service Personnel on Op HERRICK in Afghanistan, 1 April 2006 to 30 November 2014*. Available at: <<https://www.vfrhub.com/article/types-of-injuries-sustained-by-uk-service-personnel-on-op-herrick-in-afghanistan-1-april-2006-to-30-november-2014/>>.

Ministry of Defence, Department of Health and Social Care, NHS England and Lancaster, M., 2016. *Better care package for severely injured veterans*. Gov.uk Announcements, [online] 13 July. Available at: <<https://www.gov.uk/government/news/better-care-package-for-severely-injured-veterans>>.

Ministry of Defence, 2017. *Annual Population Survey: UK Armed Forces Veterans residing in Great Britain, 2016*. Available at: <<https://www.vfrhub.com/article/annual-population-survey-uk-armed-forces-veterans-residing-in-great-britain-2016/>>.

Ministry of Defence, 2018. *Amputation Statistics 1 April 2013 – 31 March 2018*. Available at: <<https://www.vfrhub.com/article/amputation-statistics-1-april-2013-31-march-2018/>>.

Ministry of Defence, 2018. *Annual Medical Discharges in the UK Regular Armed Forces*. Available at: <<https://www.vfrhub.com/article/annual-medical-discharges-in-the-uk-regular-armed-forces-2/>>.

Ministry of Defence, 2018. *Bi-annual NHS Commissioning Population Statistics 1 October 2018*. Available at: <[https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment\\_data/file/758008/20181119 - Bi-annual NHS Commissioning Population Statistics 1 October 2018.pdf](https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/758008/20181119_-_Bi-annual_NHS_Commissioning_Population_Statistics_1_October_2018.pdf)>.

Ministry of Defence, 2018. *Census 2011: Working age UK Armed Forces Veterans residing in England and Wales*. Available at: <<https://www.vfrhub.com/article/census-2011-working-age-uk-armed-forces-veterans-residing-in-england-and-wales/>>.

Ministry of Defence, 2018. *Deaths in the UK Regular Armed Forces: Annual Summary and Trends over Time 1 January 2008 to 31 December 2017*. Available at: <<https://www.vfrhub.com/article/deaths-in-the-uk-regular-armed-forces-annual-summary-and-trends-over-time-1-january-2008-to-31-december-2017/>>.

Ministry of Defence, 2018. *MOD Health and safety Statistics: Annual Summary & Trends Over Time 2013/14 – 2017/18*. Available at: <<https://www.vfrhub.com/article/mod-health-and-safety-statistics-annual-summary-trends-over-time-2013-14-2017-18/>>.

Ministry of Defence, 2018. *The Armed Forces Covenant Annual Report 2018*. Available at: <<https://www.vfrhub.com/article/the-armed-forces-covenant-annual-report-2018/>>.

Ministry of Defence, 2018. *UK Armed Forces Compensation Scheme Annual Statistics 6 April 2005 to 31 March 2018*. Available at: <<https://www.vfrhub.com/article/uk-armed-forces-compensation-scheme-annual-statistics-6-april-2005-to-31-march-2018/>>.

Ministry of Defence, 2018. *UK Armed Forces Quarterly Service Personnel Statistics 1 October 2018*. Available at: <<https://www.vfrhub.com/article/uk-armed-forces-quarterly-service-personnel-statistics-1-october-2018/>>.

Ministry of Defence, 2019. *Population Projections: UK Armed Forces Veterans residing in Great Britain, 2016-2028*. Available at: <<https://www.vfrhub.com/article/population-projections-uk-armed-forces-veterans-residing-in-great-britain-2016-to-2028/>>.

Ministry of Defence and NHS England, 2018. *Partnership Agreement Between Ministry of Defence and NHS England for the Commissioning of Health Services for the Armed Forces*. Available at: <<https://www.england.nhs.uk/wp-content/uploads/2018/11/mod-nhs-england-partnership-agreement.pdf>>.

Murrison, A., 2011. *A better deal for military amputees*. Available at: <<https://www.vfrhub.com/article/a-better-deal-for-military-amputees/>>.

NHS England, 2016. *Armed Forces and their Families Commissioning Intentions – 2017/18 to 2018/19*. Available at: <<https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2016/10/armed-forces-comms-intent-1617-1819.pdf>>.

NHS England, 2019. *Armed Forces Personnel in Transition: Integrated Personal Commissioning for Veterans (IPC4V)*. [online] Available at: <<https://www.vfrhub.com/article/armed-forces-personnel-in-transition-integrated-personal-commissioning-for-veterans-ipc4v-2/>>.

NHS Improvement, 2018. *Veteran Aware Hospitals*. [online] Available at: <<https://improvement.nhs.uk/resources/veteran-aware-hospitals/>>.

Scottish Government, 2018. *Scottish Government Support for Veterans and the Armed Forces Community in Scotland*. Available at: <<https://www.vfrhub.com/article/scottish-government-support-for-veterans-and-the-armed-forces-community-in-scotland/>>.

Scottish Veterans Commissioner, 2018. *Veterans' Health & Wellbeing: A distinctive Scottish Approach*. Available at: <<https://www.vfrhub.com/article/veterans-health-wellbeing-a-distinctive-scottish-approach/>>.

Simpson, R. G. and Leach, J., 2015. The General Practitioner and the military veteran. *Journal of the Royal Army Medical Corps*, 161(2). Available at: <<https://www.vfrhub.com/article/general-practitioner-military-veteran/>>.

The Children's Society, 2017. *Young Carers in Armed Forces Families: Evidencing the need*. Available at: <<https://www.vfrhub.com/article/young-carers-armed-forces-families/>>.

The Royal British Legion, 2014. *Lost Voices*. Available at: <<https://www.vfrhub.com/article/a-royal-british-legion-report-on-hearing-problems-among-service-personnel-and-veterans/>>.

Verey, A., Keeling, M., Thandi, G., Stevelink, S. and Fear, N., 2016. UK support services for families of wounded, injured or sick Service personnel: the need for evaluation. *Journal of the Royal Army*

*Medical Corps*, 162(5), pp. 324-325. Available at: <<https://www.vfrhub.com/article/uk-support-services-for-families-of-wounded-injured-or-sick-service-personnel-the-need-for-evaluation/>>.

Verey, A., Keeling, M., Thandi, G., Stevelink, S. and Fear, N., 2017. Support needs and experiences of family members of wounded, injured or sick UK service personnel. *Journal of the Royal Army Medical Corps*, 163(6). Available at: <<https://www.vfrhub.com/article/support-needs-and-experiences-of-family-members-of-wounded-injured-or-sick-uk-servicepersonnel/>>.

Veterans and Families Institute for Military Social Research, 2018. *Caring and Coping: the Family Perspective on Living with Limb Loss*. Available at: <<https://www.vfrhub.com/article/caring-and-coping-the-family-perspective-on-living-with-limb-loss/>>.

Welsh Government, 2017. *Welsh Health Circular*. Available at: <<https://www.veteranswales.co.uk/images/Pdfs/WHC-2017-41-Armed-Forces-Covenant-Healthcare-Priority-for-Veterans.pdf>>.