



British
Orthopaedic
Association

Spring 2014

Dedicated to the memory of
Captain Noel Godfrey Chavasse VC and Bar

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

Full Report available from:

<http://thechavassereport.com/Downloads.html>

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.



Case Study 1

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 a clear and guaranteed funding stream that can be accessed easily by serving as well as retired service personnel. It should be noted that improved effectiveness and efficiency will enable savings to be realised.

Although an **Armed Forces Clinical Reference Group (AFCRG)** has been established the needs for on-going specialist musculoskeletal care for forces personnel, whether serving or retired, and for the Volunteer Reserves on standby for call-up should be considered a high priority for treatment. We need to form a sub-group of the rehabilitation Clinical Reference Group (CRG) and specialist orthopaedic CRG to deliver this. Routine care would be funded by the Clinical Commissioning Groups (CCGs) in NHS England, and by NHS Wales and NHS Scotland with provision guaranteed according to the principles of the Covenant.

To re-launch a strengthened and more authoritative Covenant between the NHS and the Armed Forces that guarantees timely, high quality care. This must also include the volunteer reserve. NHS Scotland has reminded its healthcare workforce of its responsibilities towards veterans, England and Wales should do the same.

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

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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.