GIRFT
GETTING IT RIGHT FIRST TIME

VETERAN AWARE

Improving Veterans MSK Rehabilitation Final Report

June 2022

Contents

Foreword

NHS England and NHS Improvement (NHSEI) has embedded the principles of the Armed Forces Covenant into its constitution. This means veterans, and indeed all the armed forces community, should enjoy the same standard of, and access to, healthcare as any other UK citizen in the area they live. They should continue to have access to high quality healthcare when and if required.

The first duty of the UK Government is the defence of the realm. Our armed forces fulfil that responsibility on behalf of the Government, sacrificing civilian freedoms, facing danger and, sometimes, suffering serious injury or death as a result of their duty. Families also play a vital role in supporting the operational effectiveness of our armed forces. In return, the whole nation has a moral obligation to the members of the Royal Navy, the Army and the Royal Air Force, together with their families. They deserve our respect, support, and appropriate and timely clinical interventions.

My vision remains the same as embodied in the Armed Forces Covenant, namely that those who have served and who later become veterans should face no disadvantage in the provision of healthcare services. Special consideration should be given, where appropriate, to those who have given most, such as the seriously injured.

The commonest reason for medical discharge from the armed forces is related to MSK injuries either during 'force generation' or during active service. As an orthopaedic surgeon at The Royal National Orthopaedic Hospital, I have been part of a team that have seen and treated both serving personnel and veterans with injuries to their knees, hips, shoulders and backs. Serving personnel as part of their treatment plan were able to access the armed forces services for MSK disorders which are world-class. This was confirmed from the findings of the Chavasse report (2014), where it was clear that care pathways for serving personnel were of an exemplar nature. Beyond that however and in the case of veterans, there was significant variation and disadvantage identified in the diagnosis and treatment pathways for MSK disorders as well as significant variation in available MSK rehabilitation services. I felt that we needed to address this.

Recognising the commitment of our veterans however, meant that through positive engagement with rehabilitation service providers and broader services during the past year, we have, we believe, established that there is the will and ability to make significant improvements in patient outcomes through a fresh approach. I would like to thank Maisy Provan and Sarah Baker for their commitment and hard work during this project. Despite COVID-19, they have been able to propose a new model of care, which in addition to rethinking the rehabilitation environment will deliver vastly improved MSK rehabilitation care across NHS England. This will impact all veterans who require MSK rehabilitation and improve care for all NHS patients.

I remain convinced that by improving MSK rehabilitation service for our veterans it will raise standards for all our patients that use the NHS. Let's now help the UK Government by doing our duty in making the UK the best place in the world to be a veteran.

Professor Tim Briggs
Chair of the VCHA and the GIRFT Programme
Colonel (Hon) 202 Field Hospital (Midlands) RAMC

Introduction from the author

Leading this review of MSK rehabilitation services for veterans has been a great opportunity to meet with clinicians up and down the country, in a wide variety of settings, from MSK rehab units and pain services to community and primary care. It was a pleasure to hear and learn from the experience of physiotherapists, occupational therapists, psychologists, specialist nurses, consultants and managers, who work in these services every day.

We also consulted closely with the wider community of professional societies, academia, charities and veterans themselves, who gave us valuable insights in focus groups and interviews.

One of the first questions we had to answer was on the scope of the project. Why look at all veterans differently to the wider population when it comes to MSK rehabilitation? While some will have serious service-related injuries, others will have injuries, conditions and physical health needs that are very similar to any other patient presenting to their GP or outpatient appointment.

This is true, up to a point. However, it does not take account of the complex intersection of challenges that relate back their experience in the forces, which may include mental health issues, difficulties transitioning to civilian life, or problems with housing and employment. All of these factors can complicate their experience of health services, requiring a different approach to achieve recovery.

Our stakeholders asked us to focus on all veterans, whether their rehab needs are complex or routine, service-related or not. Wider changes to rehab services for all MSK patients were not within our scope. However, it has been recognised that there is a lot of overlap and would be delighted if some of the changes we have recommended for veterans could also improve services for everyone with MSK rehabilitation needs.

On our site visits and virtual meetings, we heard inspiring examples of good practice – some of which are highlighted as case studies in the report. But we also heard frustration at the current state of services. Some staff told us that rehab felt like a neglected service with fewer facilities and resources than in the past, while veterans told us of a lack of co-ordinated care and a risk of getting lost in the system. There was a general feeling that rehabilitation was over-medicalised with a fairly rigid one-size-fits-all approach that is overdue for change.

Our recommendations are focused on rethinking our model of care to be more person-centred and holistic. While services would be better co-ordinated, with earlier triage and more MDT involvement in many cases, more patients would be managed in the community. Veterans would also have greater control over their own care and easier access to a range of services, from socially prescribed activities to self-management apps and tools, to help them back to full functionality and a more productive, enjoyable life.

We would like to thank everyone who has contributed to putting this report together and those who have given valuable feedback on it, informing our thinking and recommendations. We hope that it will help to drive improvement and deliver better outcomes for patients in the years ahead.

Maisy Provan

Maisy Provan

Maisy Provan is a physiotherapist and a captain in the British Army Reserves, serving with the Royal Army Medical Corps (RAMC). She has worked in two NHS acute trusts, in Oxford and Brighton, and has a wide range of experience in rehabilitation in the NHS. She now works for the Royal National Orthopaedic Hospital (RNOH) leading on the Veterans' Rehabilitation Project under the governance of NHS England. Alongside her work, she is studying for an MSc in Trauma Science at the University of Birmingham.

Executive summary

Musculoskeletal conditions are the most common medical reason for discharge from the armed forces[1]. Many of the injuries sustained in combat can result in loss of limbs requiring amputation and prosthetics. Exposure to complex loads during training and active service can also cause biomechanical deficits which leads to a high level of hip and groin pain.[2]

These issues may develop into long-term health problems. When transitioning from the armed forces, veterans lose access to gold standard musculoskeletal (MSK) rehabilitation. During their service, they are covered by the Defence Medical Service run by Ministry of Defence (MOD), an occupational-based healthcare system with excellent purpose-built facilities and no waiting lists or complicated referral systems, in which the medical staff understand the types of injuries and illnesses that arise from active service.

On leaving the service, veterans with MSK injuries or conditions find themselves in a very different world. They have to access and navigate NHS services, which can be difficult, especially for those with chronic ongoing needs that relapse periodically and deteriorate with time.

Education and awareness

There are few MSK rehabilitation services for veterans that recognise their physical and mental health needs, and relatively low awareness of veterans and their needs among NHS Trusts. On our site visits, we found that many clinicians on the ground didn't have much awareness about veterans and whether they had veterans as patients.

Identifying veterans in the health system

When a service leaver registers with a GP, the GP has to request the patient's medical notes from the MOD – they are not automatically transferred. When veterans change GPs, their veteran status is often not communicated to the new practice. The result is that many GPs do not know which of their patients are veterans. Veterans told us this carries through when they are referred to other services in secondary and community care.

NHS staff, from the GPs to the hospital ward clerk or receptionist to the treating clinician, need education to raise their awareness of veterans as a distinct patient group. As a minimum, they need to know to ask patients if they have served in the armed forces and record the response on the system, while respecting their right not to disclose.

A need for co-ordinated care

Many of the veterans we spoke to with MSK injuries and conditions cited poor co-ordination as a barrier to good healthcare. We heard a common complaint that they had to repeat the same information over again to multiple staff or services. Many felt they were left to co-ordinate their own care. They found this particularly difficult, without knowing the structure or functions of NHS services and the different roles of medical staff and allied health professionals (AHPs).

The role of the Veterans Trauma Network (VTN)

The VTN is a virtual network of clinicians in 12 major trauma centres, therapists, Op Courage and charity representatives. It provides a centralised, multidisciplinary approach to treatment and referrals for those with complex service-related injuries, making sure that veterans are directed to the right services. However, it does not need to see, nor can it see every veteran.

The role of the Veterans Covenant Healthcare Alliance (VCHA)

The VCHA aims to accredit every trust within the NHS to become Veteran Aware. This will allow the majority of veterans to be seen within their local NHS services where trusts are aware of veterans needs and are committed to provide their care. This will allow the local co-ordination of care but utilising the VTN services when required.

1 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1001267/UK_service_personnel_medical_discharges__financial_year_2020_21.pdf

2 Cassidy, RP. and Coppack, RJ. et al, BMJ Military Health 2021 http://dx.doi.org/10.1136/bmjmilitary-2020-001588

A veterans' health passport

Some veterans expressed a desire for a health passport, which would contain all the relevant information, which they could carry with them to each new appointment. It allows patients to turn up and hand over their story to different health professionals without having to repeat themselves.

Our recommendations

- All trusts should become Veteran Aware.
- All NHS staff should have basic veteran awareness training, which should be included in the induction package for new staff and then form part of mandatory training requirements. Dedicated Armed Forces Champions should be appointed in each health service.
- Patients should be asked if they have ever served in Her Majesty's Armed Forces when they register with a GP or present in hospital. Their status must be recorded on NHS systems in both primary and secondary care to promote appropriate joined-up care and provide a baseline of data to enable improvements.
- Veterans should have a designated key worker as a single point of contact in primary care.
- A veterans' passport should be developed giving veterans a patient-held document that summarises their health history, which they can hand over at each new appointment.

Improving MSK rehabilitation services for veterans

Variation in rehabilitation services

Services for amputees

Disablement service centres, including Murrison centres, provide multidisciplinary support for amputees. These services are nationally-funded and generally provide good quality care, including ongoing rehabilitation, for veterans across the country for as long as they need it. However, we saw evidence of variation in these services. Some trusts offered ringfenced time slots for veterans while others did not give dedicated slots but did make longer appointments. Peer support was available for amputees in some places, but not in others.

Other MSK veteran services

For veterans with other complex physical health issues the VTN provides multidisciplinary assessment and helps to get them to see the right person at the right place for their needs. However, nationally there is no co-ordinated approach or network to manage patients with MSK rehab needs.

Some of the veterans we spoke to said rehabilitation follow-up and support was uncoordinated in their local area or did not match their needs. In some cases, it was non-existent. This may relate, in part, to the fact that all MSK rehabilitation is commissioned locally and is not always joined up with centralised services.

Lack of vocational rehabilitation

In our site visits and meetings, we saw a general lack of vocational rehabilitation in the NHS for all patients, veteran and non-veteran alike, which is associated with a lack of funding and capacity to provide these services. The focus was much more on re-abling people to do things like walking or climbing stairs, rather than rehabilitating them back to a higher functioning level. Mind-body interaction is a key player in rehabilitation, especially for veterans whose experiences in active service can be devastating – and yet the two are still so often treated separately.

Regional variations

Veterans with MSK health conditions tend to live in areas where there are large army or naval bases, cities in the north and rural areas of England. However, accessing MSK rehabilitation services can be difficult. For example, many veterans live in Cornwall, where there are only two NHS trusts. Rehab services are often provided in satellite clinics which can be hard to get to. Staff retention issues mean it can be difficult to get regular appointments or waiting lists become longer due to the lack of staff.

Variation in pain services

Pain is often the number one concern for veterans with service-related injuries and chronic MSK conditions. We found significant variation in how pain services are organised. In different trusts, they may sit with rehabilitation, in a separate pain management unit, or under a different speciality, such as rheumatology. Waiting times in many areas are high. Issues we identified in our site visits and meetings include:

- Appropriately skilled staff are often not available to deliver treatment.
- MDT working is limited or teams are not joined up.
- Pain services are not well integrated with other services which means patients face longer waits when they are referred for specialist advice.
- Pain management programmes, which use education and group practice sessions to help people manage their pain and everyday activities better, are not being used to optimum effect.

A proposed new model of care

We believe that the existing model of care is not working and needs to be rethought with the veteran at the centre, using a variety of approaches, based on individual needs and goals. The changes we are proposing are broadly in line with the initial work of the Best MSK Health Collaborative[3], a new NHS England initiative to improve services for all MSK patients and 'build back better' post-pandemic.

Early triage and referral

When people who are identified as veterans present with MSK injuries they should be referred to their local Veteran Aware hospital trust for an initial holistic assessment to determine their needs. The vast majority would be managed locally, with most care delivered in the community and within the local rehabilitation network or a regional rehabilitation unit, such as the veterans rehabilitation unit now being built at the Royal National Orthopaedic Hospital (RNOH). Occasionally, a referral to the VTN may be required if there are complex issues, which can link them to the right treatment or service, whether that's a further medical intervention, a rehabilitation centre, a community service or a veteran's charity.

Centring care for chronic conditions in the community

Veterans with chronic conditions told us they would like to see more care delivered in primary care with GPs working alongside first contact practitioners (FCPs) – who are generally physiotherapists – practice nurses and community rehabilitation. Local co-ordination could include social prescribing to activities or activity-based recovery programmes offered by veterans charities.

Taking rehabilitation away from the traditional environment and into settings such as leisure centres could also help them to integrate in their community and develop peer-to-peer support networks – aiding confidence and supporting recovery.

3 Rebuilding MSK services – a longer-term vision for MSK health | NHS Confederation

Strengthening MDTs for complex patients

If the case is complex, MSK veterans should have a full wrap around MDT assessment to allow a pathway to be created specifically to the individual's needs. MDTs should be located under one roof rather than having to go to different places at different times to see different members of the same team. This would also promote closer working between team members and enable more 'corridor conversations' and ideas for improvement.

There is a need for a wider range of AHPs to be included in MDTs. Some rehabilitation services rely exclusively on physiotherapists, who may not be able to achieve full functional and vocational rehabilitation without the input of occupational therapists, psychologists, social prescribers and others.

Early referral to specialist centres

A short intensive burst of rehabilitation delivered at the time when it is most needed can help people recover function faster, rebuild their lives and ultimately save on later outpatient and inpatient care costs. Their needs can then be managed more easily in the community with less need for specialist intervention. Commissioning groups should reconsider their cost benefit analysis and allow trusts to consider this option in the best interests of patients.

Staff recruitment and retention

Low staffing levels are a major contributing factor to gaps and variations in MSK rehabilitation services. We found from our visits and survey results that in many areas, rehab units are staffed solely by physiotherapists. There's a general need to put more effort into regional recruitment and retention to keep existing staff and attract a wider range of AHPs to support effective rehabilitation.

Our recommendations

- A minimum of two outcome measures should be used for MSK rehabilitation, chosen specifically to meet and reflect patient goals and needs. Services should regularly review performance against these measures and make improvements as needed.
- MSK rehabilitation services for veterans should aim for full vocational rehabilitation rather than limited re-ablement, with clearly defined goals and expectations set out in a rehabilitation plan agreed with each patient.
- People presenting with MSK injuries in primary care, who are identified as veterans, should be referred to an MDT for a personalised and holistic rehabilitation needs assessment, including physical, cognitive and psychological functioning.
- Rehabilitation for veterans with chronic, but not acute, MSK conditions should be managed in the community, with access to multidisciplinary care and a variety of services, such as gyms, classes and social prescribing, depending on individual need.
- Veterans with complex and disabling conditions should have their ongoing care managed by MDTs in line with NICE recommendations. MDTs should include physiotherapy, occupational therapy, psychology and conditioning specialists. MDTs should consider involving MSK rehabilitation centres who have a reputation for specialised rehabilitation services. They can also link into the Veteran Trauma Network (VTN) for patients with complex needs if service related and they cannot be managed locally. This will provide an additional level of treatment and support if needed.
- NHS trusts should look to attract a wider range of allied health professionals to join MSK rehab MDTs and make more allocated time for CPD and training. Staff should feel involved in quality improvement processes so they can help deliver changes within the service that they work in.

Supporting long term recovery

Like most people living with MSK conditions, veterans want to get back to a level of functioning that enables them to live a good life, doing work that gives them purpose and activities that they enjoy. The health system should be providing people with the tools and support they need to achieve these aims, not just during treatment, but also after they have been discharged.

Social prescribing to activities and hobbies

Veterans' charities have long recognised the benefits of activity-based rehabilitation. Many of their programmes are based on helping people learn sports and hobbies and guiding them to get the maximum health benefits from them. NHS rehabilitation for veterans should link more closely with these charities to promote long term independence and autonomy in managing MSK conditions.

Supporting veterans to self-manage their conditions

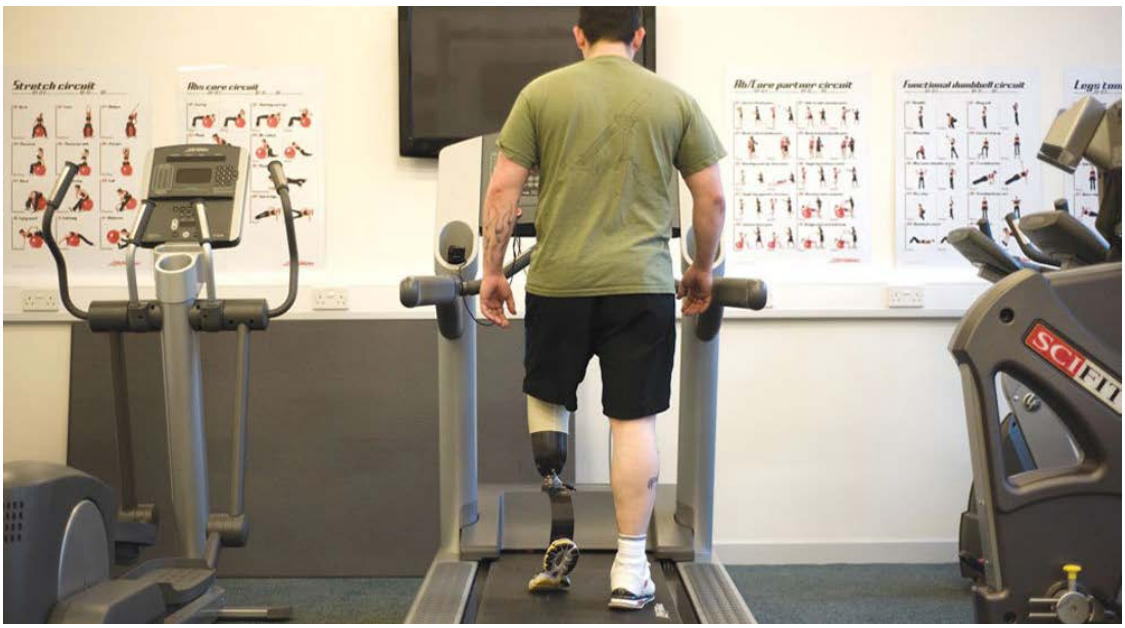
In our focus groups with veterans, they told us that they are not listened to. There is too much emphasis 'on a medicalised approach, doing things to them and not with them'. They should be empowered to manage their own care in ways that are meaningful to them and can lead to long term behaviour change.

Approaches that we found to be successful include:

- Apps and digital resources that guide patients through a program of exercises and allow them to track their progress, boosting motivation.
- Online educational resources that help people learn more about their condition and how to practice safe and effective self-care.
- Ongoing access to gyms and leisure centres where patients can continue to build strength, confidence and peer support.
- The ability to re-access rehabilitation services if needed without the need for another referral.

Our recommendations

- Social prescribing should be used to help veterans take control of their own long-term rehabilitation, develop vocational skills and foster long term social connections.
- Veterans with mild and chronic MSK disorders should be supported to self-manage their conditions long term through education, digital resources and access to facilities such as gyms and leisure centres, with the freedom to access rehab services when needed without another referral.



Method and approach

About the Veterans Rehabilitation Project

The Veterans Rehabilitation Project was established in 2021 to undertake a review of musculoskeletal (MSK) rehabilitation services currently available to veterans across England. Its aim was to identify gaps and variations in provision, highlight best practice, and develop recommendations for improvement.

The project was funded through the NHS England and Improvement Armed Forces Commissioning Group and hosted through the Royal National Orthopaedic Hospital (RNOH) under the leadership of Professor Tim Briggs.

It aligns with the work of the Veterans Covenant Healthcare Alliance (VCHA) (see page 32) and forms part of the wider NHS England and Improvement Armed Forces Programme.

Background

The Chavasse Report[4], published in 2014 by Professor Briggs, highlighted the need to improve veteran healthcare. The report acknowledged the lack of rehabilitation for armed forces veterans once discharged compared to world-class rehab centres within the armed forces including Headley Court and now the Defence and Medical Rehabilitation Centre (DMRC) in Loughborough.

Among its recommendations, the report proposed setting up NHS rehabilitation units from learning about the defence rehabilitation centres. As a result, the Government awarded £2 million to help set up the first veteran rehab centre at the RNOH in Stanmore. This is currently under construction and will open in late 2023. It will be the first of its kind and have dedicated MSK inpatient beds for veterans as well as offering an outpatient MSK programme.

The Veterans Rehabilitation Project was also informed by Professor Briggs' work on the Getting It Right First Time (GIRFT) programme. The unwarranted variation in NHS MSK services was clear through visits to all trusts in England.

> *'As former members of the finest armed forces in the world, our military veterans have demonstrated values, skills, commitment and willingness to make the ultimate sacrifice for others. They have always, and continue, to provide a rich contribution to society, and the overwhelming majority of our veterans thrive. It is right that we as a nation – government, charities, business and the wider public – support and empower those who have served us in our armed forces. We have a long history of doing this in the UK, and it remains our duty to support those who step up to serve this country. But it also presents a wider opportunity to make a difference. Veterans, young and old, offer a wealth of experience, skills and knowledge that are vital for civil society.'*
>
> **Professor Tim Briggs**

Project scope

The scope was set out by the Armed Forces Directorate and Professor Briggs. The review covered the provision of rehabilitation and pain services for veterans with MSK issues, including amputees. The scope was asked to include all veterans not just those with service related injuries. The Impacts of psychological health on physical rehabilitation was also considered within the veteran cohort. Neurological and respiratory-related conditions were out of scope.

4 The Chavasse Report – Timothy Briggs www.thechavassereport.com

Why we need better MSK rehabilitation services for veterans

Musculoskeletal conditions are the most common medical reason for discharge from the armed forces[5] and the leading contributor to disability worldwide.[6]

In general, veterans suffer higher impact MSK injuries than the general population. During the wars in Afghanistan and Iraq, more than 50% of personnel referred to defence rehabilitation had an injury severity score (ISS) above 35 – a scale where 75 means an injury is not survivable. This compares with the majority of NHS patients who have an ISS of between 16 and 24.[7]

Many of the injuries sustained in combat result in loss of limbs requiring amputation and prosthetics. Exposure to complex loads during 'force generation' and active service can also cause biomechanical deficits which leads to a high level of hip and groin pain.[8] Other prevalent MSK issues among veterans include:

- osteoarthritis
- spinal and neurological disorders
- knee pain
- back and neck issues
- lower back pain
- bone and joint injuries

These issues may develop into long-term health problems, often compounded by mental health issues, which can result from the trauma associated with service-related injuries. MSK and mental health are closely interlinked among veterans and need to be addressed together to achieve the best outcomes.

Why look at veterans differently to other MSK patients?

Some veterans, especially those with injuries and conditions that are not service related, have the same physical health needs as the wider MSK population with similar injuries and conditions.

However, they can face specific challenges that relate back their experience in the forces, including mental health issues and the added physical demands they placed on their bodies. They may face difficulties transitioning to civilian life, including problems with housing and employment, which complicate their access to and experience of health services. Their experiences of active service and associated life changes may be central to understanding their injuries and potential for recovery.

Therefore, even when their physical problems are the same as others, their overall healthcare needs may be different and they may require a different approach to achieve the same outcomes. This is why non-service-related injuries and conditions were included within the scope of this report.

However, we are aware that the needs of many veterans intersect closely with those of the wider MSK population – and that what we recommend for veterans may also benefit people facing similar issues. Throughout this project we have been aware of this potential impact. If the improvements we recommend for veterans are implemented and carried over to other MSK patients, patients across the NHS could also benefit from better joined up services and new models of care.

5 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1001267/UK_service_personnel_medical_discharges__financial_year_2020_21.pdf

6 World Health Organization Musculoskeletal conditions (who.int)

7 RJ Russell et al 2011. The role of trauma scoring in developing trauma clinical governance in the Defence Medical Services – PMC (nih.gov)

8 Cassidy, RP. and Coppack, RJ. et al, Biomechanical and clinical outcomes in response to inpatient multidisciplinary hip and groin rehabilitation in UK military personnel. BMJ Military Health 2021 http://dx.doi.org/10.1136/bmjmilitary-2020-001588

The changes we are proposing are broadly in line with the initial work of the Best MSK Health Collaborative[9], a new NHS England initiative to improve services for all MSK patients and 'build back better' post-pandemic.

'As a veteran and a healthcare professional that provides rehabilitation, I think it is an imperative that veterans receive timely and appropriate rehabilitation for injuries and conditions due to service long after they leave. We must have centres that provide excellent rehabilitation to ensure that veterans can thrive after injury with facilities fit for purpose. Excellent care does not end at the camp gates.'

David Williams, Physiotherapist and Veteran

Methodology

Rehabilitation clinicians Maisy Provan (physiotherapist) and Sarah Barker (occupational therapist) reviewed rehabilitation services across England, including community, outpatient and inpatient programmes, with a particular focus on MSK, pain management and the psychological effects of injury.

They studied the models developed at units currently providing rehabilitation to serving personnel and veterans, and looked for variations and examples of best practice that would help to drive up standards of care. The team networked across England to bring together NHS, charity, private and MOD services as well as meeting with academics conducting research into the veteran community.

Site visits and meetings

As part of the review process, the team undertook 262 engagements with clinicians throughout 2021. In the initial phase of the project, meetings took place virtually, but as the year progressed, the team was able to make more site visits and meet staff face-to-face. Staff who attended included, but were not limited to, physiotherapists, occupational therapists, psychologists, specialist nurses, consultants and service managers.

During each session, the team presented the project aims and asked participants about their service, how it operates, patient journeys, what works and doesn't work, opportunities for improvement, and what changes would make the greatest difference, both now and in the long term.

See Appendix, page 50, for the full list of meetings and visits.

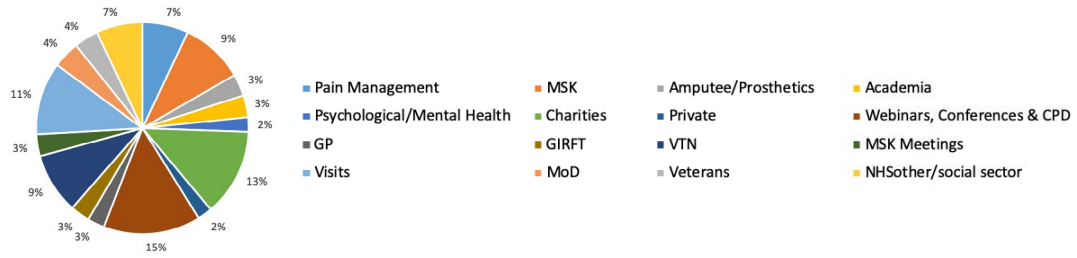
Lived experience – engaging with veterans and stakeholders

The team engaged with veterans in a series of focus groups and one-to-one interviews, to understand their experiences as ex-service personnel and as patients using current rehabilitation services. The review was primarily concerned with MSK rehabilitation service providers in secondary and community care. However to understand more about the healthcare journey from first presentation the project team also spoke to a number of GPs, first contact practitioners (FCPs) and social prescribers in primary care. (see Appendix, page 50 for details).

9 Rebuilding MSK services – a longer-term vision for MSK health | NHS Confederation https://www.nhsconfed.org/articles/rebuilding-msk-services-longer-term-vision-msk-health

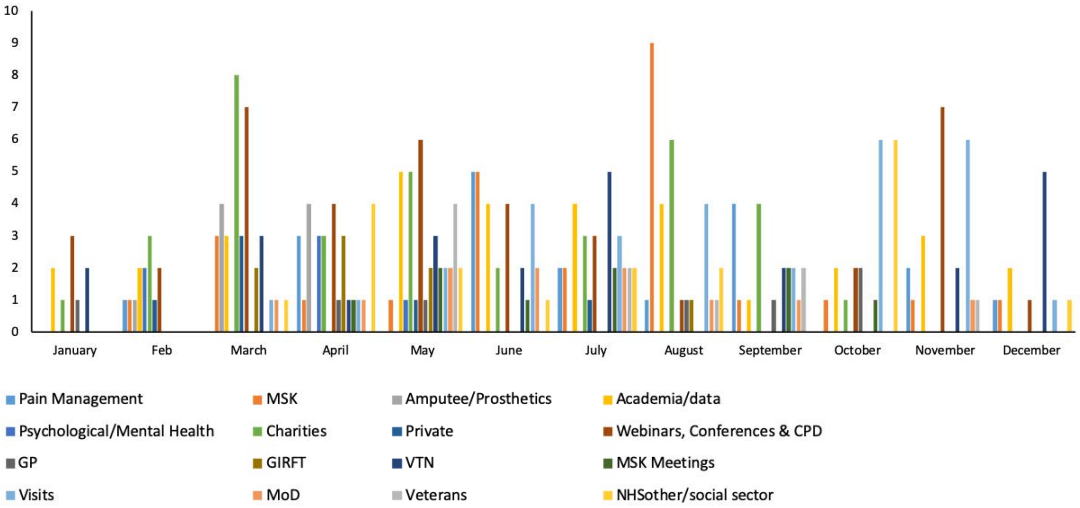
Figure 1: engagement with service providers and stakeholders by area/sector

Overall Engagement of the Veterans Rehabilitation Project



Engagement within NHS Sectors

Figure 2: engagement with service providers and stakeholders by month



Review of supporting evidence

The Veterans Rehabilitation Project team reviewed a range of documents, studies and guidelines on rehabilitation interventions, and compared them to current clinical practice. These included:

- NICE Guidelines
- Previous NHS reports on rehabilitation
- British Society of Rehabilitation studies and documents
- British Pain Society reports and guidance
- Chartered Society of Physiotherapy recommendations
- Versus Arthritis reports

Governance and oversight

The project was guided by a stakeholder group including:

- Professor Tim Briggs, Chair of the VCHA, National Director of Clinical Improvement NHS E/I
- Alison Treadgold, Head of Armed Forces Health (Operations)
- Andy Bacon, Head of Armed Forces Policy and Strategy
- Beth Lambert, Veterans Trauma Network Programme Manager
- Kate Parkin, Lead of the Sussex Armed Forces Network
- NHS England and NHS Improvement

The group met monthly to give feedback and oversight. This included scoping what services currently existed and what pathways were in place.

A reference group was also created to strengthen external review and contribute ideas for the project. The group, which met every six weeks, included:

- Miss Alex Crick, NHS Consultant Plastic Surgeon at Salisbury NHS Foundation Trust
- Helen Harvey, NHS Clinical Manager at Bristol Murrison Centre
- Pete Le-Feuvre, Military Physiotherapist and PhD student
- John Doyle, Lead Allied Health Professional, Royal National Orthopaedic Hospital (RNOH)
- Matt Fossey, Associate Director and Professor at Anglia Ruskin University
- Brian Chenier, Prosthetics support officer from Blesma

Evidence and data collection

Most NHS trusts and GP practices do not flag or record veterans on their systems. This means there is very little data collected about them as a distinct patient group, about their conditions, treatment or outcomes.

Therefore, the majority of data that informed this review came from qualitative interviews. These were meetings with services and clinicians to gain insight into what was happening on the ground, and what is needed going forward, using set questions for comparison, followed by analysis of the themes that emerged from meetings.

Online survey

An online survey was created to gather quantitative data about some of the existing NHS services. Responses were received from a variety of related services across England, including MSK rehabilitation, neuro rehabilitation, pain, orthopaedic and psychology, in hospitals and the community. The level of response to the online survey was poor overall and therefore the data was of limited use in drawing conclusions and formulating recommendations.

What is rehabilitation?

The Veterans Rehabilitation Project defines rehabilitation as maximising a person's physical and mental capacity and returning them to a level of physical, social and psychological function where they are able to realise their own potential.

It is a process depending on the patient's condition and needs rather than one form of treatment. It can involve restoring movement, muscle strength and capacity to walk and exercise, as well as reducing pain and symptoms.

For some, function and quality of life may mean being able to walk to the shop, for others it might be contributing to family life, while for others it may be completing a physical challenge or returning to employment.[10] Goals are always dependent on the individual, their recovery trajectory and the stage of their condition.

Rehabilitation is achieved through a process of person-centred assessment, treatment and management with ongoing evaluation. The person and their family or carers are supported to improve their physical health, cognitive function, participation in society, and quality of life.

This can have benefits for society as a whole, promoting positive lifestyle behaviours, helping people return to employment or volunteering, and enhancing the communities in which they live.

10 Tesco, L. 2009. Quality of life measurement: one size fits all. Rehabilitation medicine makes no exception. Journal of Medicine and the Person 7(1):5-9 https://www.researchgate.net/publication/225634172_Quality_of_life_measurement_one_size_fits_all_Rehabilitation_medicine_makes_no_exception

The veteran population and current services

The veteran population

The veteran population includes everyone who has served in the armed forces, both regular and reservist. Spouses, partners and children are also viewed as members of the armed forces community and may be affected by the physical and mental health of their veteran family member and the health services provided to them.

There are an estimated 2.4 million veterans in Great Britain, making up an estimated 5% of household residents aged 16 and over.[11] It is estimated there are up to 5.4m spouses, partners, widowers and child dependants of veterans.

The average length of time veterans serve in the armed forces is 10 years.

- Almost 90% of the veteran population are men and around 10% are women.
- Around 60% of veterans are over-65 and 40% are of working age.
- Some veterans are as young as 17 having served only a short time in the armed forces.[12]

Who is a Veteran?

A veteran is anyone who has served in the British Army, the Royal Navy, the Royal Marines or the Royal Air Force, as either a regular or reservist, for at least a day, as well as merchant mariners who have seen duty on military operations. Current reservists who are not mobilised also have the status of veteran until they return to active service.

A range of experiences

The age range among veterans reflects very different experiences of the armed forces, from those who served in Iraq, Afghanistan or Northern Ireland, to those who have never deployed on military duties. Some older veterans will have done national service in the 1950s and 60s and younger veterans may have left the service after a few weeks or months.

Military service has both positive and negative effects on health. The British military has a reputation for high levels of physical fitness. In general, military personnel are likely to be healthier and fitter than civilians of the same age in the earlier years of service as a result of the rigorous demands of military training and service, often termed the 'healthy solider effect'.[13]

Long-term care needs

However, the long-term impact of active service can take its toll as service personnel put higher demands on their bodies than most civilians, especially on the musculoskeletal (MSK) system. Armed forces veterans who need rehabilitation tend to have suffered higher impact MSK injuries that the general population and have greater rehabilitation and support needs. They may develop a range of MSK and chronic pain conditions[14], that may continue over a long period[15].

11 Office for Veteran Affairs (OVA). 2020. Veteran Factsheet 2020. ONLINE [Accessed 05/07/2021]: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/874821/6.6409_CO_Armed-Forces_Veterans-Factsheet_v9_web.pdf

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

13 Hinojosa, Activity-Limiting Musculoskeletal Conditions in US Veterans Compared to Non-Veterans: Results from the 2013 National Health Interview Survey. PLoS One. 2016; 11(12): e0167143. doi: 10.1371/journal.pone.0167143i

14 Goulet, J.L. et al. 2016. The musculoskeletal diagnosis cohort: examining pain and pain care among veterans. Pain. 157 (8): 1696-1703.

15 Higgins, D. et al. 2020. The Relationship Between Body Mass Index and Pain Intensity Among Veterans with Musculoskeletal Disorders: Findings from the MSD Cohort Study. Pain Medicine. 1;21(10):2563-2572.

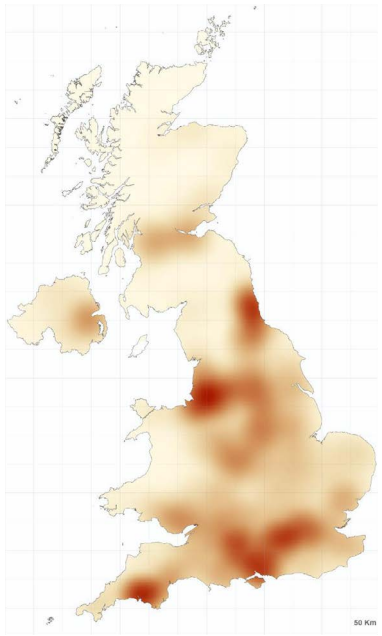
As discussed in 'About the Veterans Rehabilitation Project' page 11, veterans can face mental and physical challenges that relate back their experience in the forces, and experience problems adapting to civilian housing and employment, which complicate their access to and experience of health services.

Although healthier earlier in life, they begin to fall behind their civilian counterparts during the middle years on some MSK outcomes. Veterans aged 35–49 are significantly more likely than non-veterans to report problems with:

- Back or neck related conditions (34% vs 23% of same-age civilians)
- Leg or feet related conditions (33% vs 20%)
- Arm or hand related conditions (22% vs 13%)[16]

Some veterans may also suffer the consequences of a heavy drinking and smoking culture in the armed forces in later life, although this impact is likely to reduce among newer veterans as awareness of the effect of lifestyle on health grows.

Figure 3: Heat Map showing the geographical density of MSK veterans in receipt of MoD disability payments in Great Britain[17]



2.4m
veterans living in Great Britain[18]

10 years
average time veterans have served in the armed forces

16 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1001267/UK_service_personnel_medical_discharges__financial_year_2020_21.pdf

17 The provision of rehabilitation services for MSK armed force veterans in the UK and constituent countries, final report 2015 www.phast.org.uk

18 https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/874821/6.6409_CO_Armed-Forces_Veterans-Factsheet_v9_web.pdf

Current MSK rehabilitation services for veterans

Under the Armed Forces Covenant[19], which became law in 2021, veterans with health conditions that are related to their military service should not suffer any disadvantage in accessing NHS services and are entitled to 'special consideration' subject to clinical need. A large proportion of them are likely to be entitled to specialist MSK services. The new Armed Forces Act (2021) also makes it a legal requirement that statutory authorities have 'due regard' for the health needs of veterans.

However, we found that there are very few MSK rehabilitation services for veterans that recognise their physical and mental health needs, and relatively low awareness of veterans and their needs among NHS Trusts. The research also found that there are very few MSK rehab services for NHS patients.

Only 20% of those who answered our survey, which was sent to all NHS MSK rehab providers via VCHA Regional Leads, said they had specific services for veterans. These are mostly for amputees and provide specialist continuing services for veterans who were fitted with prosthetic limbs as a result of injuries during active service.

In most cases, veterans access the same MSK rehab services as the general population with little or no differentiation of them, their injuries or mental health needs. This can lead to poor engagement with their healthcare and cause them to get lost in the system – see Smoothing the transition to civilian healthcare, page 23.

Online survey – Do you provide any specific services for veterans?

Services for amputees – the Veterans Prosthetics Panel (VPP) and disablement service centres

The NHS is funded to provide high-quality prosthetic limbs to veterans through the VPP. This centrally-held funding is available to all veterans who are eligible either because they have lost a limb during military service or lost a limb due to injury caused in service. Dedicated slots are held open for veterans in some hospitals, including a network of disablement service centres (DSCs) specially equipped for veterans.

In 2013 nine DSCs received Murrison funding and are now known as Murrison centres.[20] Patients can access specialist services without waiting when they need it, including long-term ongoing care and replacement of prosthetic limbs when required.

The Defence and Medical Rehabilitation Centre (DMRC)

DMRC is a major MOD-run clinical rehabilitation centre for armed forces personnel and some veterans, located at Stanford Hall near Nottingham. Opened in 2018, it replaces the previous MOD rehab centre at Headley Court, Surrey. Currently only veterans with complex prosthetics can access services at DMRC.

The Veterans' Orthopaedic Service

This special service, based at the Robert Jones and Agnus Hunt Orthopaedic Hospital in Shropshire, provides hip and knee replacement surgery for veterans with arthritic lower limb problems. The surgical service is run by Lt Col Carl Meyer, Orthopaedic Surgeon and Army Reservist with 202 Field Hospital, and the therapy service by Noel Harding, military veteran. Veterans travel from across England to access this service. However, most then return to their local area which may not have an understanding of their service history and therefore their specific rehabilitation needs.

19 About – Armed Forces Covenant https://www.armedforcescovenant.gov.uk/about/
20 https://www.gov.uk/government/news/11-million-funding-boost-to-improve-nhs-care-for-war-veterans

The Veterans Trauma Network (VTN)

The VTN is a network of specialist clinicians linked to 12 trauma centres located at NHS trusts across England. The network deals with veterans who have complex physical healthcare issues as a direct result of their time in service. Once a referral is received, the VTN holds a virtual multidisciplinary team (MDT) meeting to develop a treatment plan and pathway.

Independent providers

In some areas of the country, the NHS commissions organisations from the private sector to provide rehabilitation services. This might happen where the local NHS does not have the capacity to deliver higher level ongoing rehabilitation to meet a specific patient need, ranging from outpatient occupational therapy to full functional rehabilitation in a residential centre.

Veterans' charities

Service charities play a vital role, including delivering care and support, driving research to better understand the needs of the veteran population, and providing advocacy for the armed forces community.

They help veterans to access existing NHS services, co-ordinate their care, and navigate the health system to achieve better outcomes and provide support for veterans' mental health, which is often closely linked to their physical condition. In some cases, they may also help to fund private rehabilitation care where a specific need can't be met by the NHS.

Some of the more prominent charities providing services for veterans' needs include:

Blesma

Works with amputees and people who can no longer functionally use their limbs. They help advocate for patients and sometimes attend hospital appointments with them, helping veterans explain their issues to NHS staff. https://blesma.org/

Royal British Legion

Runs the Battleback Centre, which helps wounded, injured and sick serving personnel and veterans return to duty or civilian life. This is a recovery centre and does not provide physical rehabilitation. https://www.britishlegion.org.uk/get-support/physical-and-mental-wellbeing/recovery-centres

Help for Heroes

Provides a veterans' clinical service, including help with coordinating care, as well as mental health and sports recovery programmes. It used to run four regional recovery centres but these have been replaced with a nursing and services providing occupational therapy in the community. https://www.helpforheroes.org.uk/get-support/physical-health-support/

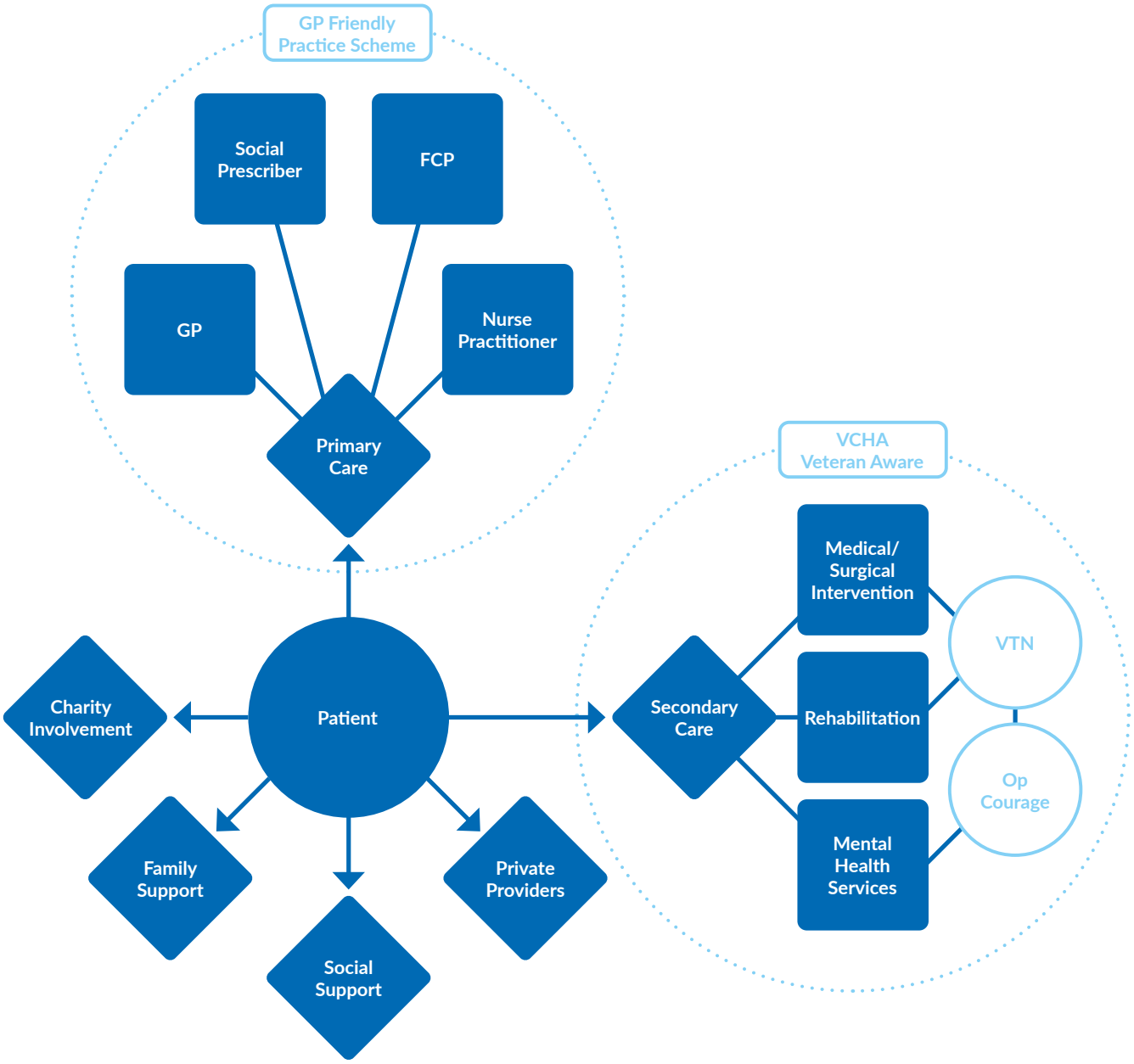
Defence Medical Welfare Service (DMWS)

Provides advice and support to armed forces and veterans when they are receiving treatment in hospital, helping them navigate their healthcare pathway. Also works with the VTN in a peer support role with veterans. https://dmws.org.uk/

There are also numerous smaller charities that provide rehabilitation support for veterans recovering from injuries through a range of outdoor pursuits and activities. Some of these are featured later in this report (see page 44).

Overall, the services that charities provide, while very welcome, are not joined up across the country. Although the connections between NHS and charities are improving, they are still not fully developed. Charities do not provide the whole package of physical rehabilitation services and are not a substitute for NHS provision.

Figure 4: Rehabilitation sits within a network of services that can all potentially contribute to veterans' recovery including primary and community care, mental health services and veterans' charities, supported by accreditation schemes such as Veteran Aware for hospitals and the veteran friendly GP scheme (see page 28), as shown below. However, many veterans find it difficult to know what's available to them and to access and navigate this landscape.



Veteran services around the world

There is wide variation in healthcare for veterans in other countries. Some have little or no specific provision, while others have far more than is available in England. For example, in the USA there are dedicated veteran hospitals that specialise in treating service-related illness and injury, although this is in the context of a system which does not normally provide free access to healthcare. Canada, Australia and France are also known for having good services for veterans. In recent years, Israel has also invested heavily in treatment pathways and strategies for defence rehabilitation post-military service.

Smoothing the transition to civilian healthcare

When people leave the armed forces, it can be a difficult transition. They often feel a sense of loss or bereavement. It can seem like not only losing a job, but leaving behind a family, comradeship, housing and people who can empathise and 'speak their language'.

For those with service-related injuries, they are also losing access to gold standard musculoskeletal (MSK) rehabilitation. During their service, they are covered by the Defence Medical Service run by Ministry of Defence (MOD). This is an occupational-based healthcare system, designed to get people back into active service. The difficulty of transitioning from this service was highlighted in the Chavasse report as a problem that needed fixing.

MOD rehabilitation services

Rehabilitation in defence is very different from the NHS. Services are built around the expectation of recovery and the functional requirements for the person's role in the military. The Defence Medical Service offers intensive inpatient stays with a structured rehabilitation programme, as well as a residential rehab programme.

All care is provided through multidisciplinary teams (MDTs), including physiotherapists, occupational therapists and exercise rehabilitation instructors (ERIs). Physiotherapists and ERIs are available at every stage from first presentation in primary care. A wider team may be involved depending on the complexity of the patient's injuries, and the support they need – this may include social work, mental health, prosthetics, speech and language therapy or other support.

Physical rehabilitation work is often done in groups to build a sense of shared ambition and responsibility among patient groups, as well as providing a ready-made source of peer support.

Defence rehabilitation is open-ended and not time constrained. For as long as patients continue to improve, the service will continue to support them. This could include an intensive inpatient stay at the Defence and National Rehabilitation Centre (DNRC), followed by ongoing physio or exercise-based rehabilitation at their local primary care facility, or at a regional rehabilitation unit.

MOD tiered approach

Primary Care Rehabilitation Facilities (PCRFs): are the base layer in defence rehabilitation. Generally located in medical centres, they case manage and treat minor and some moderate MSK injuries. They consist of a physiotherapist and exercise rehabilitation instructor (ERI). PCRFs also manage some service personnel with chronic conditions.

Regional Rehabilitation Units (RRUs): these units provide medical opinion and treatment for patients with moderate MSK injuries, as well as secondary care rehab. RRUs have a Multidisciplinary Injury Assessment Clinic (MIAC) consisting of a GP specialising in sports and exercise medicine (SEM) or an SEM consultant, a physio and ERI. Some RRUs also have access to podiatry.

Continued on the next page...

MOD tiered approach continued

Defence and Medical Rehabilitation Centre (DMRC), Stanford Hall: the DMRC offers specialist rehabilitation spilt into sections: neuro, trauma, and force regeneration team. It takes a whole MDT approach with physiotherapists, occupational therapists, ERIs, psychologists, medical doctors and prosthetist.

The core principles of military rehabilitation are:

- early assessment
- use of the MDT
- active case management
- functional exercise-based rehabilitation
- rapid access to further specialist opinion
- a focus on vocational outcome.

MOD rehabilitation relies upon effective case management with a clear pathway to ensure that ensure that each patient gets the right specialist opinion and treatment at the right place at the right time to get them quickly back to duty.

Service leavers slipping through the cracks

The Defence Medical Service (DMS) offers excellent purpose-built facilities and no waiting lists or complicated referral systems. The medical staff are a mixture of military and civilian themselves and understand the types of injuries and illnesses that arise from active service. As patients, service personnel are motivated to get better and rejoin their colleagues, which drives compliance with their rehabilitation programmes.

On leaving the service, veterans with MSK injuries or conditions find themselves in a very different world. They have to access and navigate NHS services, which can be difficult for those used to the forces rehabilitation infrastructure. This is especially problematic for those with chronic ongoing needs, or service-related issues that relapse periodically and deteriorate with time, making them difficult to manage without support.

Health literacy issues

Some veterans may have low health literacy, so they may struggle to understand health information and what is being asked of them, or how to make choices about their healthcare. They may be used to following orders and find it difficult in situations where they have to make complex decision about their healthcare themselves.

They may find it difficult to seek help or explain their issues to NHS staff, who may have a low awareness or understanding of the strains that military service has put on their bodies and the physical and mental health issues that result from that.

Reluctance to see a GP

We found from our conversations with veterans that many delay seeking care for their conditions, which may deteriorate as a result. They often try to 'push through the pain', don't want to burden the NHS or hope the problem will go away on its own. Rather than going to their GP, some veterans wait until things are so bad that they end up at the emergency department.

This was reflected in our survey of NHS MSK services. The services that responded received a larger proportion of referrals (43.3%) from emergency or other hospital departments than from GPs (36.7%).

Online survey – What is your most common referral source?

Mental health issues

Many veterans with service-related injuries also suffer from mental health issues, including PTSD, which may be directly related to the trauma associated with those injuries. This further complicates their engagement with NHS services.

More needs to be done to overcome these barriers. A joint approach between health services and Operation Courage, the NHS mental health service for people leaving the armed forces, as part of transition training, could help to reduce the stigma of having to seek help, which holds many veterans back.

Getting lost between services

Likewise, a greater awareness among GPs of both the physical and mental health needs of veterans, might lead to both being treated at the same time rather than just referring to one service and being bounced between one and the other.

We heard from some veterans who felt that they were caught in a Catch 22, unable to access or engage with physical rehabilitation services because their mental health issues had not been resolved, yet unable to comply with their mental health treatment because they were still suffering significant physical pain or incapacity. These patterns were also reflected in some clinic letters from Veteran Trauma Network (VTN) MDTs.

Some of these patients are at risk of getting lost between mental health and MSK services and entering a downward spiral. However, the VTN is working with Operation Courage and the services charities to establish stronger links and we are hopeful that veteran experiences will improve in the near future.

'Those who serve in the Armed Forces, whether regular or Reserve, those who have served in the past, and their families, should face no 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.'

Armed Forces Covenant

A lack of co-ordinated care

Many of the veterans we spoke to with MSK injuries and conditions cited poor co-ordination as a barrier to good healthcare. They described their experiences of using NHS services as a 'convoluted process' and reported feeling 'abandoned' and 'bounced from pillar to post' because their needs are too complex.

The issues start with the transferring of medical notes from the Ministry of Defence (MOD) to GPs, where there is a high level of inconsistently at the moment. Some GPs we spoke to did not seem to be aware of veterans' medical history. Veterans told us this carries through when they are referred to other services. Some veterans do not have a good relationship with their GP and can struggle with the health system because GPs are the gatekeepers to secondary care and other services. These issues are being addressed through the Royal College of General Practitioners (RCGP) veteran friendly accreditation programme – see page 28.

Feedback on navigating the health system

Experiences of using and navigating NHS services were often described as 'traumatising'.

- Some mentioned poor communication between different NHS departments and services, which they found frustrating. This led to a common complaint that they had to repeat the same information over again to multiple staff or services.
- Many felt they were left to co-ordinate their own care. They found this particularly difficult, without knowing the structure or functions of NHS services and the different roles of medical staff and allied health professionals (AHPs).
- For some, there was a lack of explanation or follow through, which they felt was overwhelming and frustrating.
- There was also frustration about the high turnover of staff, as veterans built up relationships and rapport with staff members who left. Some felt that, though everyone said they worked as a team, in reality they didn't.
- By contrast, veterans spoke highly of the rehabilitation and treatment they received during their time in service, with particular praise for the occupational therapists.

The need for a single point of contact

Veterans felt as though they needed a point of contact to co-ordinate their care, especially those with chronic or long-term MSK conditions.

Co-ordination by a key worker has been shown to work for people with other chronic conditions. For example, people with diabetes are assigned to a diabetes nurse in the community who is their main point of contact. This allows other clinicians to focus their time and attention on treating patients while patients feel they have an advocate who is looking out for their best interests.

However, key worker care co-ordination is currently not generally available for anyone with MSK injuries or pain conditions. In its absence, many veterans turn to forces charities to support them and help them navigate the health system and to advocate on their behalf. The Warrior Programme and the Royal British Legion were two charities that were highlighted as doing this well. As outlined in the recently issued Defence Holistic Transition Policy[21], veterans should not have to rely on charities to support their transition to the NHS or receive an adequate standard of care.

The role of the VTN

The VTN is a virtual network spread across England of predominantly military clinicians in major trauma centres, therapists, Op Courage and charity representatives. It provides a centralised multidisciplinary approach that co-ordinates treatment and referrals for those with complex service-related injuries, making sure that veterans are directed to the right services. It is working with services charities to establish a single point of contact to co-ordinate care for those patients.

The majority of veterans with MSK needs can be seen locally in their Veteran Aware trusts. But we must be able to co-ordinate their care with rehabilitation services, both local and regional, where required, and use the VTN when needed.

21 JSP 100 Pt 1 & Pt 2 (V1.1 Apr 21); https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/979344/JSP100_Parts1And2__V1.1_Apr_21_.pdf

A veterans' health passport

Some veterans expressed a desire for a health passport, which would contain all the relevant information, which they could carry with them to each new appointment – this is in line with NICE guidelines[22] on rehabilitation planning and is reflected in our recommendations.

This idea has been trialled in Stockport in a project jointly sponsored by the council and local NHS. It allows patients to turn up and hand over their story to different health professionals without having to repeat themselves. The trial has had some success using a pdf/printed form and there are plans to fully digitise and roll it out to other areas of England. However, these plans have been delayed due to issues with funding. There is scope for it to become an Armed Forces Health and Social Care Record.

Transition experiences – Ali's story

In 2008, at aged 28, Ali was diagnosed with osteoarthritis in her lower back as a result of multiple deployments and undertaking loaded boot marches carrying up to 15kg in weight, as well as combat physical training sessions. She also had knee surgery in 2018 while in the military and suffered bilateral wrist pain towards the end of her career. In 2020 when she reported the wrist issue to her medical officer, she was advised to contact her GP as she was coming to the end of her military service.

Ali was left with multiple health challenges. She cannot lift a kettle and struggles to maintain personal care. She also experienced mental health issues, originally diagnosed in 2010 and compounded by her physical health conditions, and received some support after discharge from the Department of Community Mental Health (DCMH) and the veterans' Transition Intervention and Liaison Service (TILS).

However, with her medical transfer from the MoD to the NHS, she says she 'felt abandoned'. She found she had to repeat her story many times to multiple clinicians and found this frustrating. She has had multiple issues with her GP practice, which did not have her MoD medical records. She felt they did not look at her medical history. A GP at the practice advised her to get help from a private healthcare provider.

She has had issues accessing appropriate physiotherapy and with referrals to other specialists to the extent that she has had to seek private treatment. Difficulties with changes to processes and poor communications have left her feeling anxious and with more pain. Ali said she had no option due to her debilitating pain but to co-ordinate her own referrals. Lack of progress getting a referral for her wrist problems led to her having a private MRI scan in January 2021, which showed osteoarthritis.

Ali now has private healthcare with BUPA as they favourable rates for veterans. She has received treatment for bursitis in her elbow and x-rays identifying arthritis in her hands and feet through BUPA. She has also had support from Versus Arthritis.

Her experience in the NHS has made her feel that her basic needs have not been met.

She felt like no-one wanted to know her story and feels that if people can't see a problem, it doesn't exist.

Particular concerns

- transfer of care is a difficult process
- repeating her story has been a cause of frustration
- poor communication between services
- having to co-ordinate her own healthcare
- notes not transferred from MoD to GP
- GP not looking at medical history

22 NICE Guideline, Rehabilitation after traumatic injury, Developing a rehabilitation plan 1.4.3 www.nice.org.uk/guidance/ng211

Education for NHS staff and veterans

Some of the issues with co-ordination of care could be resolved if there was greater awareness of veterans in the health system. This would enable healthcare professionals to make better links with veterans' services, both NHS and charities. On our site visits and meetings with NHS trusts around the country, we found that many clinicians on the ground didn't have much awareness about veterans and whether they had veterans as patients.

Our sister team the Veterans Covenant Healthcare Alliance (VCHA) did a mystery shopping exercise in some trusts and found that the simple question 'Have you ever served in the British Armed Forces?' is not routinely asked.

Identifying veterans in the health system

When a service leaver registers with a GP, a letter is automatically generated informing the GP that their new patient has been under the care of the Defence Medical Services. However, GPs have to request the patient's medical notes from the MOD – they are not automatically transferred. When veterans change GPs, their veteran status is often not communicated to the new practice.

The result is that many GPs do not know which of their patients are veterans. This is important because when GPs refer veterans for hospital treatment, they may need to include in their referral letter a statement around whether the health condition is related to the patient's military service. The RCGP is working on raising awareness within primary care and providing a more seamless pathway for veterans accessing NHS services.

Asking patients if they've served

It is clear that NHS staff, from the GPs to the hospital ward clerk or receptionist to the treating clinician, need education to raise their awareness of veterans as a distinct patient group. As a minimum, they need to know to ask patients if they have served in the armed forces and record the response on the system, while respecting their right not to disclose.

Ideally, they should also be asking follow-up questions about their circumstances, housing, employment and mental health, which may all have changed when they left the armed forces and may be linked to their physical condition.

Giving staff some education will help them to build a rapport with veterans and ultimately provide a better service. Many of the clinicians we spoke to on our site visits said how useful it would be to have some staff training and a resource library to learn more about the armed forces community.

'Veterans have a right to be treated by culturally competent staff, and it is important that NHS workers avoid stereotypes in treatment – positive or negative. So many healthcare interactions need a good therapeutic relationship to succeed – and this will be determined by how confident the healthcare worker feels with veterans, and whether the veteran feels well understood. Failing to train NHS staff in veterans' issues means likely wasted time and effort.'

Dr Jeremy Gaunlett-Gilbert, Principal Clinical Psychologist, Royal National Hospital for Rheumatic Diseases and Research Lead at the Bath Centre for Pain Services

Managing service leavers' expectations

Veterans also need education about the structure of the NHS and the roles of different staff. Management of expectations is key when veterans have come from the Defence Medical Services (DMS). There can be a sense of entitlement, which leaves them frustrated and disappointed with the everyday realities of the NHS.

The MOD has begun doing some work in this area. It now provides transition courses for service leavers which explain how some NHS services work and what will be available to them. However, something is needed to fill the gap for veterans who left before these courses were introduced and who are still having problems adjusting to the civilian health system or have ongoing health literacy issues.

It is essential that DMS interact and communicate with NHS services to ensure seamless transition, especially for those with significant on-going rehabilitation needs, otherwise many of the gains made whilst serving could be lost. Integrated Personal Commissioning for Veterans Network (IPC4V) has already helped to bridge this gap for those with complex and enduring physical, neurological and mental health conditions.[23]

Raising awareness of veterans in the NHS

Several organisations are working to improve levels of awareness, including accreditation programmes for hospitals and GPs. We support these efforts and propose that accreditation should be accelerated to cover all NHS trusts and GP practices in England.

VCHA Veteran Aware accreditation

The Veteran Covenant Healthcare Alliance (VCHA) is a group of NHS providers, currently 115, – including acute, mental health, community, and ambulance trusts – who aspire to be exemplars of the best care for the armed forces community, including veterans. The group has launched Veteran Aware accreditation to improve awareness of the needs of veterans in the NHS. Each Veteran Aware-accredited trust must show that it:

- understands and is compliant with the Armed Forces Covenant
- has a clearly designated Veterans' Champion
- supports the UK Armed Forces as an employer
- has established links to appropriate nearby veteran services
- has staff trained and educated in the needs of veterans
- raises awareness of veterans
- identifies veterans to ensure they receive appropriate care
- refers veterans to other services as appropriate

Each Trust is reaccredited every three years against an agreed standard of which includes examples of improved veteran care.

Veteran-friendly accreditation for GP services

The RCGP is working with NHS England and NHS Improvement to accredit GP practices as 'veteran friendly'. Nearly 1,000 GP practices in England are accredited through this programme, which provides practices with an information pack to help increase their understanding of the health needs of veterans, and the services available to them.

Accreditation lasts for three years, and requires that practices commit to:

- asking patients registering with the surgery if they have ever served in the British Armed Forces
- coding this information on the GP computer system
- having a clinical lead for veterans in the surgery, who can be a nurse or paramedic

'Becoming a veteran accredited GP practice is quick and simple and sends a really powerful message to your veteran patients that you understand and care'

Robin Simpson, Brigadier (Retd) RG Simpson FRCGP, RCGP Veterans Champion

23 https://www.england.nhs.uk/personalisedcare/upc/ipc-for-veterans/

Recommendations

1 All trusts should become Veteran Aware.

2 All NHS staff should have basic veteran awareness training, which should be included in the induction package for new staff and then form part of mandatory training requirements. Dedicated Armed Forces Champions should be appointed in each health service.

3 Patients should be asked if they have ever served in Her Majesty's Armed Forces when they register with a GP or present in hospital. Their status must be recorded on NHS systems in both primary and secondary care to promote appropriate joined-up care and provide a baseline of data to enable improvements.

4 Veterans should have a designated key worker as a single point of contact in primary care.

5 A veterans' passport should be developed giving veterans a patient-held document that summarises their health history, which they can hand over at each new appointment.

Improving MSK rehabilitation services for veterans

As discussed in The veteran population and current services, page 16, there are few NHS MSK rehabilitation services that address veterans' specific physical and mental health needs.

Variation in rehabilitation services

Services for amputees

Disablement service centres, including Murrison centres, provide multidisciplinary support for amputees. These services are nationally-funded and generally provide good quality care, including ongoing rehabilitation, for veterans across the country for as long as they need it. Some veterans with complex prosthetics that were issued while they were still serving return to the Defence and Medical Rehabilitation Centre (DMRC) for ongoing management of these prosthesis.

We saw evidence of variation in services for amputees in our site visits and meetings. Some trusts offered ringfenced time slots for veterans while others did not give dedicated slots but did make longer appointments. Peer support was available for amputees in some places, but not in others.

Other MSK veteran services

For veterans with other complex physical health issues the Veterans Trauma Network (VTN) – see page 19 – provides multidisciplinary assessment and helps to get them to see the right person at the right place for their needs. However, they do not provide rehabilitation services directly and must refer patients with MSK rehab needs on to other services.

The veterans we spoke said they were willing to travel in order to access specialist services where the staff understood 'what they had been through' and were trained to deal with service-related injuries and health problems. However, veterans stated that when they returned to their local area, rehabilitation follow-up and support was uncoordinated or did not match their needs. In some cases, it was non-existent.

Some of these issues relate to the fact that all MSK rehabilitation is commissioned locally and is not always joined up with centralised services. Veterans who lived on the borders of two different commissioning areas expressed frustration in accessing appropriate rehabilitation services because they were on the wrong side of the boundary line.

Ad hoc services relying on individuals

Apart from the limited circumstances described above, the majority of veterans with MSK rehabilitation needs must access NHS services in the same way as any other patient. There is often no awareness of their veteran status and no attempt to address their physical health needs in the context of their service history, or the mental and social challenges they face as a result.

We saw some excellent examples of veteran-specific care in our site visits and meetings – some of which are featured in case studies in this section. But they were relatively few and tended to rely on the effort and enthusiasm of individual staff, often veterans themselves, rather than as part of an established care pathway. In some trusts, ad hoc services have been spearheaded by veterans or concerned partners and family members.

Veteran Aware accreditation

The Veterans Covenant Healthcare Alliance (VCHA) has been set up to raise awareness of veterans and the armed forces community within NHS trusts. The aim is that all NHS Trusts will be aware of veterans and their responsibilities towards them by March 2023. This will allow care to be delivered locally where possible and to a set standard.

There are currently 115 NHS trusts signed up to the VCHA Veteran Aware Accreditation scheme, more than 54% of all NHS trusts across England. The rate at which trusts have joined is increasing. However, in our survey carried out in Autumn 2021 the majority of those who responded (62%) said their trust was still not accredited. In those that were, we found that change is slow to happen on the ground. We believe that this was significantly impacted by the single focus of trusts on the COVID-19 pandemic. At that time, many staff in MSK units were not aware of the accreditation, what it meant or which of their patients were veterans.

This is now changing as the accreditation programme progresses and the NHS restores normal services, with more yearly service reviews and requirements to evidence good practice. The VCHA is now recording evidence of the impact of accreditation on patient care through patient stories and evidence from trusts. It is aiming for achieve accreditation of all NHS trusts in England by 2023. For more information visit https://veteranaware.nhs.uk

Online survey – Is your service VCHA accredited?

Variation in pain services

Pain is often the number one concern for veterans with service-related injuries and chronic MSK conditions. It is a life-limiting factor that all successful rehabilitation must address.

We found significant variation in how pain services are organised. In different trusts, they may sit with rehabilitation, in a separate pain management unit, or under a different speciality, such as rheumatology. Waiting times in many areas are high with veterans, living with chronic pain, among those waiting up to two years for treatment.[24]

There is also wide variation in service delivery across the country.[25] Trusts variously offer pain clinics, pain management programmes or pain rehabilitation, and these services differ in their set-up, staffing and resources. These findings broadly echo the British Pain Society's Pain Audit Report[26].

The main issues we identified in our site visits and meetings include:

- Appropriately skilled staff are often not available to deliver treatment.
- MDT working is limited or teams are not joined up.
- Pain services are not well integrated with other services which means patients face longer waits when they are referred for specialist advice.
- Information on pain is not delivered in a way that many patients can grasp the essentials.
- The work has not been done to assess the impact of improved pain management on other aspects of the healthcare system.
- We were told there is little or no national oversight or regional leadership to promote quality specialised pain care.[27]

24 Ellis, B. Et al. 2021. Chronic Pain in England: Unseen, Unequal and Unfair. Verus Arthritis. ONLINE [Accessed 05/07/2021]: https://www.versusarthritis.org/media/23739/chronic-pain-report-june2021.pdf

25 https://www.britishpainsociety.org/static/uploads/resources/files/FPM-Core-Standards-2021.pdf; British Pain Society. 2013. The National Pain Audit Third Report focus on safety and outcomes. [ONLINE] Available at: www.britishpainsociety.org/static/uploads/resources/files/members_articles_npa_2013_safety_outcomes.pdf [Accessed 18 November 2021].

26 https://www.britishpainsociety.org/static/uploads/resources/files/members_articles_npa_2012_1.pdf

27 Ham, C. et al. 2016. Improving Quality in the English NHS A strategy for action. The kinds fund. ONLINE [Accessed 22/10/2021]: https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/Improving-quality-Kings-Fund-February-2016.pdf

The role of pain management programmes

Pain management programmes use education and practice sessions, usually in group sessions, to help people with persistent pain to manage their pain and everyday activities better. They are usually managed within an MDT, with a focus on a biopsychosocial approach that is suited to the needs of individuals.

While only some of these programmes have so far demonstrated efficacy, there is evidence that they can help some patients. They give people tools such as mindfulness training to help them self-manage, as well as developing interests and challenges to distract from the pain, drawing on self-motivation. Such approaches are especially suited to veterans who tend to respond well to physical challenges and goal setting.

However, we found that pain management programmes are not being used to optimum effect. One of the key comments we heard was 'stop letting everything else fail before accessing the service'. It was felt that pain management programmes were seen as a last resort and staff wished they had received referrals earlier.

Some areas of the country offer escape pain programmes – an evidence-based MSK pain rehab programme – in NHS settings or local leisure centres. This allows people to re-integrate into the community while having rehabilitation in a non-medical environment. But this is not available everywhere.

MSK rehabilitation in the NHS

How MSK rehabilitation services are provided varies across England. In some places it is all provided in hospital under one roof, in others it is divided between hospitals, GP practices and community services.

A majority of the services we reviewed were hospital-based and run by physiotherapists in outpatient departments. Patients are either referred via their GP or through secondary care, with some self-referrals allowed depending on local practice.

Most units were set up with physiotherapy plinths or couches, with services provided on a one-to-one basis, with few classes or group activities providing peer support. Most patients have an initial 45-60-minute assessment, with up to five 30-minute follow-up appointments.

Gaps in multidisciplinary teams (MDTs)

Multidisciplinary working was limited with a narrow range of medical and allied health professionals (AHPs) on MSK rehabilitation teams, or members of MDTs located in different sites and buildings so that they were not easily available.

Few services offered occupational therapy and even fewer had psychologists as part of the MSK rehab team. Often it was not possible to refer patients to a psychologist in another part of the hospital. Patients were signposted to services without a managed referral to ensure they got the help they needed.

Variations in community care

Rehabilitation can be provided in the community through local clinics or GP practices – with healthcare workers coming into people's homes where needed. This helps patients who are immobile or find it hard to access hospital services.

However, we found that the community rehabilitation model is not well developed. Rehab is provided in the home, and services are often designed around re-abling elderly people after falls. Staff may not be equipped to support patients who need full functional rehabilitation, or those with specific needs.

Continued on the next page...

Restricted access to specialist centres

Specialist rehabilitation centres are intended to provide intensive rehabilitation care outside of an acute hospital for people with a disabling condition – to enable them to recover function and regain a level of independence long term.

We found that these were almost exclusively for patients with neurological and spinal disorders, and they are not the set up for people with chronic MSK conditions.

Regional variation

Patients with complex MSK and neurological problems who cannot access specialist centres may be referred for an intensive block of specialist rehabilitation at a private rehabilitation centre or hospital. But this is entirely dependent on local CCGs commissioning the service.

Within the NHS, we found that the facilities and services available for MSK rehabilitation depended on where people live. Some services offer exercise classes for patients with osteoarthritis, upper limb and back pain, but in some places patients are directed to online exercises or leaflets with exercise instructions.

Some MSK rehab units had a gym but many did not. Some had a class space in which education sessions can be run. A few had hydrotherapy pools. In some places we visited, there were pools but they were closed or out of use.

There is considerable variation in the kinds of services that were commissioned depending on area and cost. For example, a short stay with rehabilitation in a private nursing home might be a relatively cost-effective option in Newcastle but prohibitively expensive in London and the South East.

A need for investment and prioritisation

We heard from MSK rehabilitation teams that the service is often an afterthought. Many described it as a 'broken system'. They told us that rehabilitation facilities such as gyms and equipment have been cut in recent years where trusts were looking for budget savings or seeking space for beds or offices. This reduces the capacity to offer a full range of rehabilitation services.

It can be hard to justify investment in rehabilitation facilities and resources as improvement in patients can be slow and requires a large amount of patient compliance. Often it does not result in visible cost savings in the short term, other than a slight reduction in some GP and outpatient appointments.

However, we think this misses the bigger picture. One of the major factors in poor MSK health is physical inactivity.[28] The cost to the NHS is estimated at £0.9 billion a year. A small fraction of that amount could make a huge difference to MSK services and staffing levels.

Staff training and retention

In our meetings and site visits we heard that staffing levels were generally low with high numbers of vacancies in some areas. This leads to staff being under pressure and feeling that they aren't able to provide the full scope of service they would like to. Appointment times are generally short, waiting times long and staff are under pressure to discharge patients quickly. We were told that there isn't time for proper in-service training and continuing professional development (CPD).

28 Public Health England. March 2021. Musculoskeletal Health: applying All Our Health. ONLINE [Accessed 05/07/2021]: https://www.gov.uk/government/publications/musculoskeletal-health-applying-all-our-health/musculoskeletal-health-applying-all-our-health

Other barriers to veteran rehabilitation

As discussed in Smoothing the transition to civilian healthcare, page 22, we identified gaps in awareness and understanding between health professionals and veterans, which can be a barrier to effective rehabilitation services.

- Clinicians often don't have a strong understanding of the military community and the problems that veterans can face. Veterans can often come with complex presentations and can require time to unpack things – for example, the circumstances of their injury, whether they have been medically discharged, employment and housing status and family situation. It's important for clinicians to think widely about all aspects of a patient's life that might affect their ability to engage with treatment and return to function.
- There's a lack of veteran champions in trusts, which means that staff often don't know who to turn to if they have a question about a veteran. This may improve as the Veteran Aware accreditation programme takes root.
- Engagement – if veterans don't feel listened to, they will often disengage with their rehabilitation. Getting veterans on board with their treatment is vital to inspire self-motivation and ensure compliance.
- Veterans may not understand the roles of different professionals in the NHS and may not seek medical help. They may have issues with language and literacy.

Some of these issues can be addressed by better training and education as proposed in Recommendation 1.

Barriers to measuring impact

Veteran status is not recorded on NHS systems and this lack of data makes it hard to assess or quantify what trusts are doing or evidence the effectiveness of any programmes that do exist. This means that commissioners cannot justify further investment, or judge how much money to allocate, even where anecdotally, an initiative appears to be working well.

As of now, the only way to identify veterans is by correlating patient names with data from the Armed Forces Pension and Compensation Schemes, or from the 2021 Census – the first to ask about past service in the military. While these are potentially useful information sources for commissioning groups, they are clearly unrealistic day-to-day in busy NHS services.

As proposed in Recommendation 2, we think that asking patients whether they have served in the military and recording this status on patient records, is a necessary first step towards improving services for veterans. It will help us to identify them in the health system, understand their specific health needs, and provide a baseline of data to plan improvements in care.

Outcome measures also need to be carried out for veterans so the data can give us meaningful insights into how patients are doing.[29] These could be based on performance data with comparison of results before and after treatment. Along with the use of patient-recorded outcome measures (PROMS) and quality of life questionnaires to evaluate the impact of the intervention.

Measures should be adapted locally to ensure they reflect the needs and goals of patients in each service. Services need to be regularly reviewed against outcome measures to make sure that interventions are helping patients.

Regional variations

The heat map on page 17 shows the distribution of veterans with MSK health conditions across the UK. They tend to be clustered in areas where there are large army or naval bases, cities in the north and rural areas of England. This reflects the tendency of service personnel to return to where they grew up or to places they lived while serving. However, these places are not always well located for MSK rehabilitation services.

29 NICE Guideline, Rehabilitation after traumatic injury, Monitoring progress against the rehabilitation plan 1.5.10 www.nice.org.uk/guidance/ng211

For example, many veterans live in Cornwall, where there are only two NHS trusts. Rehab services are often provided in satellite clinics which can be hard to get to. Staff retention issues mean it can be difficult to get regular appointments or waiting lists become longer due to the lack of staff. In other counties where these problems exist, trusts can lean on neighbouring services. But this is very difficult in Cornwall because of its geography.

Virtual appointments and follow-ups can be offered but in many cases physical presentation is essential to properly assess people's injuries and needs (see Learnings from COVID-19, page 36).

Rehabilitation experiences – Mark's story

Mark served in the military in the 1980s and was medically discharged suffering from knee pain, which he has self-managed ever since.

In 2019, he began to develop pain in his lower back, which also went down to his knee and leg. He had a spinal decompression procedure to release a nerve. After the operation, he had no further physiotherapy support. He was given crutches and sent home. He felt there was a lack of explanation and follow up.

He had some occupational therapy to help manage chronic pain but this was largely ineffective. He has also been referred to the private Edward VII hospital in London, which offers pain therapy on a charitable basis.

He experienced ongoing mobility issues and was using a walking frame indoors and a mobility scooter and/or crutches when out and about. His GP referred him for community therapy, which was helpful but was stopped because of COVID-19.

During this time his knees also began to get worse and he is now receiving physiotherapy for low impact strengthening. His mental health also deteriorated and he has self-referred to the Transition Intervention and Liaison Service (TILS). He also contacted the Royal British Legion Charity and they guided him to the mental health support provided by Help for Heroes and the Warrior Programme.

Particular concerns

- Therapists try and find ways to discharge patients early without considering long-term needs.
- Lack of communication and review of changes in health and adapting to new needs and goals.
- Lack of education about what is out there for ex-service personnel.
- Difficult to find an appropriate gym to help with his back pain.

A proposed model of care for MSK veterans

It is clear from our review of MSK rehabilitation services in England that the NHS is not meeting the needs of all veterans. Services and facilities are patchy, subject to a postcode lottery of commissioning and local practice. There is inadequate communication between the MOD and the NHS and between GPs and secondary care. Clinicians are often unaware of whether patients are veterans, and of their experiences and medical history.

There are gaps in MDTs and veteran care is largely uncoordinated. In many cases, their specific care needs are not being met. Many feel they are being failed, especially when compared with the services delivered by the Defence Medical Service.

Care is good for amputees and there are well-established services for those with brain and spinal injuries. No well-established care pathways were found for other veterans with MSK injuries and conditions, although some physical health pathways are now being developed. There is very little focus on those with deconditioning who are not maintaining daily activity levels and may only need some health coaching and functional strengthening and movement work.

In our site visits and meetings, we saw a general lack of vocational rehabilitation in the NHS for all patients, veteran and non-veteran alike, which is associated with a lack of funding and capacity to provide these services. The focus was much more on re-abling people to do things like walking or climbing stairs, rather than rehabilitating them back to a higher functioning level.

Mind-body interaction is a key player in rehabilitation, especially for veterans whose experiences in active service can be devastating – and yet the two are still so often treated separately.

We believe that the existing model of care is not working and needs to be rethought with the person at the centre, using a variety of approaches, based on individual needs and goals. The services we visited that used more holistic methods, including social prescribing, had the best results and feedback from veterans – see Supporting long-term recovery, page 43.

The changes we are proposing here are broadly in line with the initial work of the Best MSK Health Collaborative[30], a new NHS England initiative to improve services for all MSK patients. As such, they would also help the wider population of people with MSK rehabilitation needs, who are badly served by the current arrangements.

Learnings from COVID-19

COVID-19 demonstrated the need for efficient, effective rehabilitation services. When the pandemic began and beds were needed, rehabilitation support was vital to get patients mobile and discharged safely. Likewise, the emergence of long COVID demonstrated the need for rehabilitation to prevent deconditioning and improve patient flow and recovery.

As the pandemic progressed, many units were forced to shut their doors. This challenged clinicians to find new ways to support patients, through pain consultations and blended treatment approaches, with some considering social prescribing and alternative methods to support patients.

These changes have brought some welcome flexibility into the system and an increased openness to new ways of working. However, this was counterbalanced by the withdrawal of face-to-face services for all except the most serious cases – in an area of care where physical presentation is often essential. We have heard anecdotally that this led to an increase in recent hospital appointments and A&E attendances as patients delayed treatment or their symptoms were not picked up.

The need for a fresh approach

Existing MSK rehabilitation care for most veterans is based on a model of initial appointment and follow-ups, followed by discharge to the GP, often without adequate tools to self-manage or co-ordinate ongoing care.

It's a fairly rigid, one size fits all approach. Among the services we visited, there was a widespread feeling that it was overdue for change. Clinicians should be able to offer more person-centred rehabilitation, recognising that some people may only need some advice on exercise while others will need more targeted interventions.

Among veterans there was a feeling that NHS services are over-medicalised. They should stop doing things to and for them, and start doing things with them. There should be scope for more vocational rehabilitation to restore the strength, skills and confidence needed for higher level activities such as driving, sports and hobbies.

Assessments should include asking patients about their personal history, work, hobbies and interests, usual activities and motivations, in line with NICE guidelines, to get a clearer picture of what will help them to recover.[31] This is part of routine practice for allied health professionals (AHPs) but sometimes gets overlooked because there are not enough AHPs or there is pressure to discharge patients early to free up capacity.

30 Rebuilding MSK services – a longer-term vision for MSK health | NHS Confederation

31 NICE Guideline, Rehabilitation after traumatic injury, MDT team rehabilitation needs assessment 1.2.8 www.nice.org.uk/guidance/ng211

'There is a clear need to radically challenge the entrenched NHS model of pathology-driven, medicalised MSK delivery. We are unwittingly creating institutionalised dependency rather than rehabilitation to functional freedom. From the very start of the patient's journey, we need to focus on patient-led functionality, with staff and settings that segue seamlessly with the patient's independent goal and activity community. In an ideal world, the veteran wouldn't know when their rehab 'finished', rather just blending back into their active lifestyle'

Dr Chris Ireland, GP with a specialist role in sports and exercise medicine, Cornwall

Rewiring traditional care pathways

Unlike surgery and other medical treatments, rehabilitation does not flow neatly from one step to the next. The number of variables in rehabilitation cases and the diversity of patient goals mean linear pathways very rarely apply between patients.

Two people might be referred for what looks like the exact same thing on paper but their injuries and experiences, backgrounds, functional mobility, strength, social situation and employment, will all affect the length of time and what services they may need during their rehabilitation.[32] These extenuating factors are very important for veterans whose experiences of active service and associated life changes may be central to understanding their injuries and potential for recovery.

Different patients will have different needs, aspirations and goals and will achieve things in different timescales. They have to be active participants in their treatment, which relies heavily on engagement and compliance. NICE guidelines state that short term and long term goals should be agreed with each person, based on what's important to them, what they value and find most meaningful.[33]

The pathway should fit around the patient rather than the patient fitting into the pathway. Our proposed model is therefore more like a web of services rather than a pathway. It would allow veterans to access the services that are relevant to them while empowering them to take control over their own health and wellbeing, interlinking with veteran charities as needed.

It would de-medicalise treatment where possible and locate the centre of care back into the community, with more co-production of care and joint working between primary, secondary and community services. This could help to take some of the pressure off busy hospitals by diverting patients who would benefit more from a gym class or an outdoor activity-based course.

Early triage and referral

One of the issues we found was that veterans were not being thoroughly assessed after presentation in primary care. Often GPs do not have the skills, time or understanding of veteran experiences and injuries to be able to carry out an effective initial assessment.

Those with service-related injuries may be referred through the VTN, which provides a holistic multidisciplinary assessment with referral to appropriate services. But, as stated earlier, the VTN is capacity constrained. It cannot see every veteran with service-related issues and does not see veterans whose health problems are not as a direct result of their service.

In everyday practice, many veterans are referred for an assessment by a physiotherapist working on their own, without the support of other specialists. This often results in delays in effective treatment, people being caught up in waiting lists, leading to deterioration.

32 Bennell KL, Nelligan R, Dobson F, et al. Effectiveness of an internet-delivered exercise and pain-coping skills training intervention for persons with chronic knee pain. Ann Intern Med 2017; 166: 453–462.

33 NICE Guideline, Rehabilitation after traumatic injury, Setting rehabilitation goals 1.3.1 www.nice.org.uk/guidance/ng211

When people , who are identified as veterans, present with MSK injuries they should be referred to their local Veteran Aware Hospital Trust for immediate triage. If their case is complex, they should have a full wrap around MDT assessment to allow a pathway to be created specifically to that individual veteran's needs. The vast majority would be managed locally, with most care delivered in the community – see below.

If the patient presents with complex needs, as a result of their service then a referral to the VTN may be required, which can link them to the right treatment or service, whether that's a further medical intervention, a rehabilitation centre, a community service or a veteran's charity. In the future there will be the option for complex veterans to be referred to one of the planned veteran rehabilitation units which will have links into the National Rehabilitation Centre (NRC).

The local MDT should complete a personalised and holistic rehabilitation needs assessment, including physical, cognitive and psychological functioning – similar to the assessment currently provided for some patients by the VTN.[34]

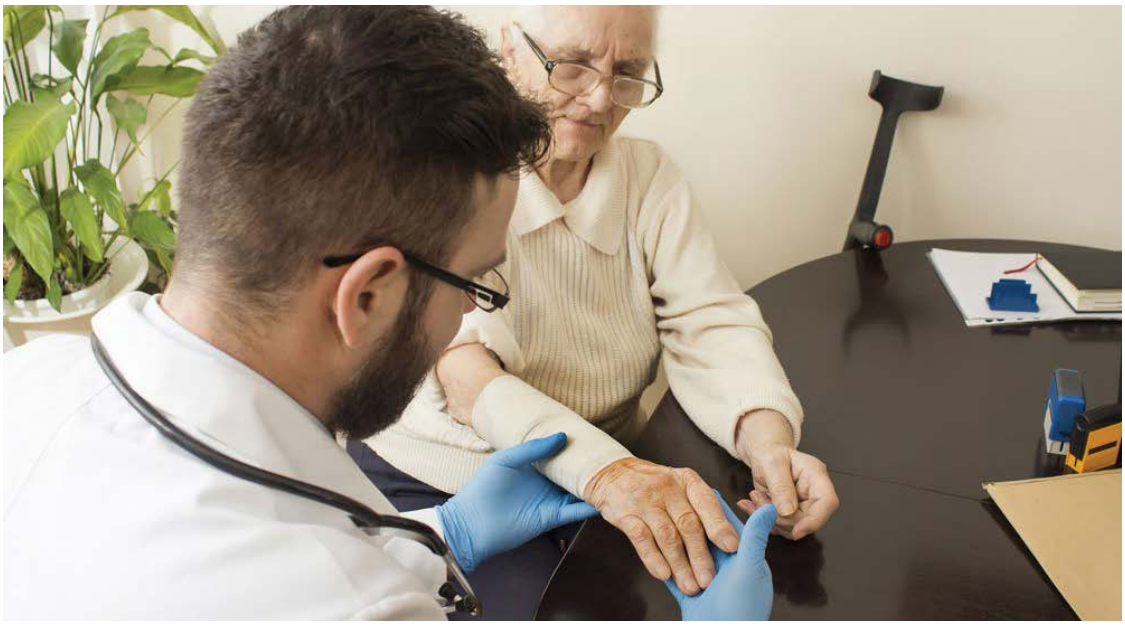
Centring care for chronic conditions in the community

Veterans with chronic conditions told us they would like to see more care delivered in primary care with GPs working alongside first contact practitioners (FCPs) – who are generally physiotherapists who have links to community rehabilitation.

This is in line with the direction of travel under the Best MSK programme, which is rethinking how MSK services, including rehabilitation, are delivered. Best MSK has already developed a toolkit for primary and community care to guide referral practice and support patient self-management where appropriate, and is committed to working with the voluntary sector, independent sector and lived experience partners.

Local co-ordination could help to promote higher quality care both within the primary and community care settings and through social hubs such as gyms, with potential for social prescribing to activities or activity-based recovery programmes offered by veterans charities – see page 19. This could reduce the need for secondary care and locate more care closer to where patients live.

Most patients with chronic MSK conditions could be managed in the community if this kind of wraparound support was available, with local rehabilitation champions to advocate for their needs, detailed care plans with clearly defined goals and expectations[35], and links to social prescribing and specialist care depending on individual needs.



34 NICE Guideline, Rehabilitation after traumatic injury, MDT team rehabilitation needs assessment 1.2.1 www.nice.org.uk/guidance/ng211

35 NICE Guideline, Rehabilitation after traumatic injury, Developing a rehabilitation plan and making referrals 1.4 www.nice.org.uk/guidance/ng211

Best practice example:

Providing joined up care for veterans in pain

Primary Integrated Community Services, Nottingham

This community-based pain service supports people with chronic pain conditions across a wide area from Nottingham to Newark, with a regular cohort of veterans with MSK injuries.

Patients can be referred via their GP or a hospital consultant. They have a biopsychosocial assessment after triage, which assesses mood and mental health concerns from the outset. This is important for veterans, who may experience anger and loss of role having been discharged from the armed forces, and find it difficult to pace their recovery.

Patients receive one-to-one support from a pain practitioner, supported by an MDT which includes physiotherapy, occupational therapy, nursing, psychology, pharmacy, wellbeing practitioners and cognitive behavioural (CBT) therapy. The team meets monthly to discuss all complex patients.

A six-week pain management programme called 'Moving on from pain' is based in local leisure centres. It is based on giving people the tools to self-manage and enabling them to re-integrate in the community with education and peer support. Mindfulness, CBT and Tai Chi are available as part of the programme.

Following discharge, patients are able to self-refer back within a year for any flare-ups. They are encouraged to contact the service directly rather than to go back to the GP. The team keeps a number of SOS slots in clinical diaries for this purpose.

Rethinking the rehabilitation environment

Taking rehabilitation away from the traditional environment would be a good first step in giving patients more control over their care. For example, at the Royal National Orthopaedic Hospital (RNOH) in Stanmore patients can use the leisure centre on site as part of the rehab programme.

Veterans we spoke to who used this service reported that it helped them to integrate in their community and develop peer-to-peer support networks – aiding confidence and supporting recovery. Patients often then would come back and use the facilities at the leisure centre once they had been discharged.

The escape pain programme works on a similar model in both NHS and leisure centres. This encourages independence and autonomy over health and wellbeing. MSK rehab services could work with local authorities to access their leisure centres for ongoing rehabilitation, possibly as part of the new integrated care system (ICS) structures.

Rehabilitation rooms and areas within hospitals and rehabilitation centres should be redesigned to make them feel less medicalised and more like places in the community.

Strengthening MDTs for complex patients

A frequent comment we heard from veterans with complex MSK conditions was a desire to have all members of the MDT under one roof rather than having to go to different places at different times to see different members of the same team. This would also promote closer working between team members and enable more 'corridor conversations' and ideas for improvement.

As discussed above, there is also a need for a wider range of AHPs to be included in MDTs in line with NICE guidelines.[36] Some rehabilitation services rely exclusively on physiotherapists, who may not be able to achieve full functional and vocational rehabilitation without the input of occupational therapists, psychologists, social prescribers and others. A wider team would help patients to move through their journey quicker rather than waiting for further referrals.

36 NICE Guideline, Rehabilitation after traumatic injury, MDT team rehabilitation needs assessment 1.2.4 www.nice.org.uk/guidance/ng211

There is a strong body evidence to support the clinical and cost effectiveness of MDT rehabilitation, while including a range of AHPs has been shown to improve person-centred care.[37] AHPs are also crucial in identifying patients' rehab needs, improve the process of care and meeting key performance indicators.[38]

The NHS could look to the example of organisations including the MOD, the Fire and Rescue Service and police forces, who all use AHPs with expertise in sports and exercise and conditioning to support employees through rehabilitation.

Best practice example:

Creating a hub with services all under one roof

Lancashire Teaching Hospitals NHS Foundation Trust

Preston Specialist Mobility Centre is a one-stop shop which offers rehabilitation alongside prosthetics, orthotics, wheelchair services and maintenance therapy.

It offers unlimited access for war veterans and deals with many complications from surgery and illness in the veteran population, including amputees. There are several routes to access services – patients may be referred from their GP or a consultant, they can self-refer or transfer from another specialist rehabilitation centre.

The hub has an on-site gym and a welcoming family atmosphere where veterans can meet others in their situation and build peer support networks. After an initial triage assessment, patients receive a holistic assessment by the physiotherapist, occupational therapist, psychologist and pain team. The centre also offers a repair service for prosthetic limbs.

We heard excellent feedback from veterans on the hub. One travelled from Liverpool to be able to access its services. Another commented on the quality of the communication and the MDT ethos, which means that all her needs were being met, having been frustrated by her NHS treatment before coming to the Preston.

Early referral to specialist centres

As discussed above, we currently we don't have any options in England for NHS-led intensive residential rehabilitation for those with MSK injuries that are not seriously disabling. NICE guidelines recommend an intensive rehabilitation course of up to three weeks for complex patients if this would have a significant impact in improving function.[39]

Access to this kind of care is generally restricted to those with neurological or spinal injuries. However, we think that this is counterproductive. A short intensive burst of rehabilitation delivered at the time when it is most needed can help people recover function faster, rebuild their lives and ultimately save on later outpatient and inpatient care costs. Their needs can then be managed more easily in the community with less need for specialist intervention.

Research shows that early transfer to specialist centres and more intense inpatient rehabilitation is more cost effective – they have a higher short-term costs for greater longer term gains.[40] Commissioning groups should reconsider their cost benefit analysis and allow trusts to consider this option in the best interests of patients.

The RNOH veteran MSK rehabilitation service

Currently under construction with an opening planned for late 2023, the new veteran rehabilitation unit at the Royal National Orthopaedic Hospital (RNOH) will be the first veteran rehabilitation unit of its kind. It will have 4–6 dedicated Veteran beds to encompass MSK rehabilitation as well as helping to manage chronic pain and psychological issues. There will also be a holistic outpatient service, with links into the chairty sector.

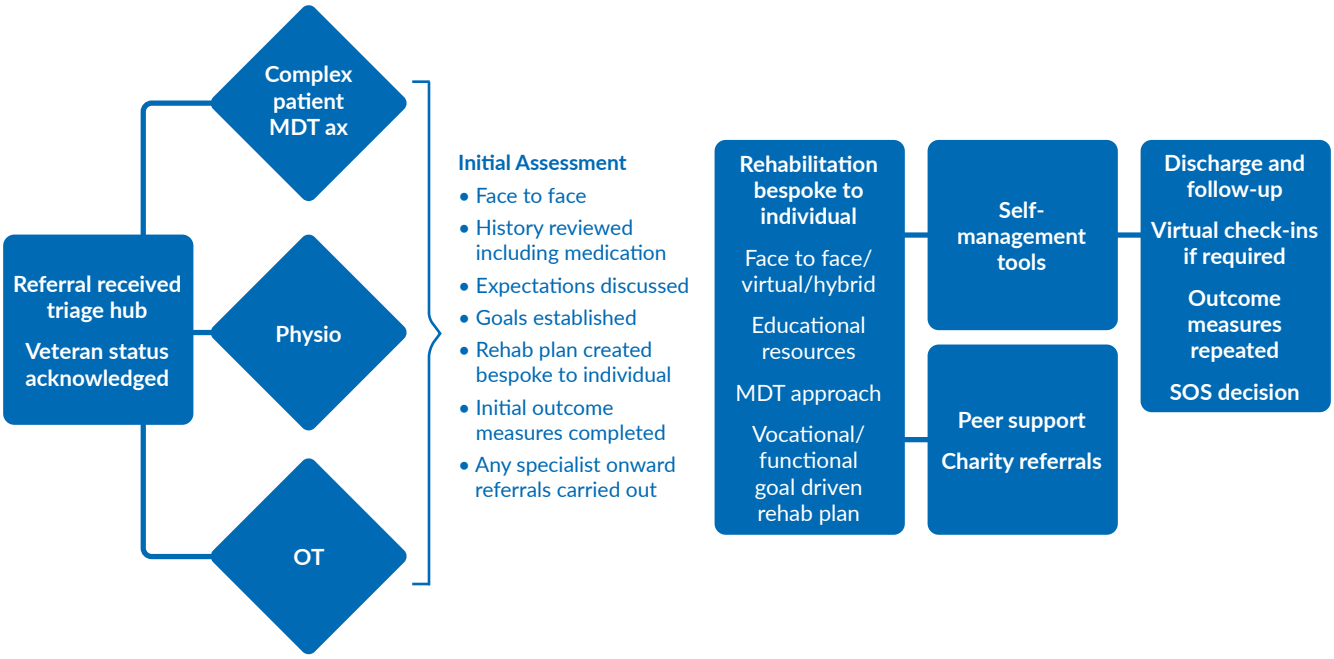
37 https://www.england.nhs.uk/wp-content/uploads/2017/01/ahp-action-transform-hlth.pdf

38 https://www.longtermplan.nhs.uk/wp-content/uploads/2019/01/nhs-long-term-plan-june-2019.pdf

39 NICE Guideline, Rehabilitation after traumatic injury, Intensive rehabilitation 1.5.3 www.nice.org.uk/guidance/ng211

40 https://www.bsrm.org.uk/downloads/specialised-neurorehabilitation-service-standards--7-30-4-2015-pcatv2-forweb-11-5-16-annexe2updatedmay2019.pdf

Figure 5: An illustration of the patient journey through MSK rehabilitation in our proposed model



Staff recruitment and retention

As discussed above (A snapshot of MSK rehabilitation in the NHS, page 32) low staffing levels are a major contributing factor to gaps and variations in MSK rehabilitation services. We found from our visits and survey results that in many areas, rehab units are staffed solely by physiotherapists.

With the banding system of the NHS, AHPs can live anywhere in the country outside London and earn the same amount of money. There's a general need to put more effort into regional recruitment and retention to keep existing staff and attract a wider range of AHPs to support effective rehabilitation.

On our site visits, we heard a preference for non-hierarchal management where everyone 'gets stuck in'. There was a much greater appreciation for those in team lead positions when that person still had a clinical caseload. The units that were doing well also tended to offer staff more opportunity to develop professionally with protected time for continuing professional development (CPD).

The Defence Medical Service rehabilitation units were a good example of a workspace that people want to be a part of and find professionally attractive. We found that staff had opportunities for development, CPD time set aside, and had more time to spend without patients without the pressure to discharge early. The occupational focus also means patients were more motivated and engaged.

Recommendations

6 A minimum of two outcome measures should be used for MSK rehabilitation, chosen specifically to meet and reflect patient goals and needs. Services should regularly review performance against these measures and make improvements as needed.

7 MSK rehabilitation services for veterans should aim for full vocational rehabilitation rather than limited re-ablement, with clearly defined goals and expectations set out in a rehabilitation plan agreed with each patient.

8 People presenting with MSK injuries in primary care, who are identified as veterans, should be referred to an MDT for a personalised and holistic rehabilitation needs assessment, including physical, cognitive and psychological functioning.

9 Rehabilitation for veterans with chronic, but not acute, MSK conditions should be managed in the community, with access to multidisciplinary care and a variety of services, such as gyms, classes and social prescribing, depending on individual need.

10 Veterans with complex and disabling conditions should have their ongoing care managed by MDTs in line with NICE recommendations. MDTs should include physiotherapy, occupational therapy, psychology and conditioning specialists. MDTs should consider involving MSK rehabilitation centres who have a reputation for specialised rehabilitation services. They can also link into the Veteran Trauma Network (VTN) for patients with complex needs if service related and they cannot be managed locally. This will provide an additional level of treatment and support if needed.

11 NHS trusts should look to attract a wider range of allied health professionals to join MSK rehab MDTs and make more allocated time for CPD and training. Staff should feel involved in quality improvement processes so they can help deliver changes within the service that they work in.

Supporting long term recovery

As discussed earlier in this report, there is too much focus in rehabilitation on narrow re-ablement and too little focus on long-term functional and vocational rehabilitation.

Treatment very often consists of an assessment and a few follow-up appointments. After that patients are left to cope on their own, until the next crisis sees them coming back with through the revolving door.

Like most people living with MSK conditions, veterans want to get back to a level of functioning that enables them to live a good life, doing work that gives them purpose and activities that they enjoy. Veterans in our focus groups expressed feelings of wanting to live a life they value with economic benefit to society, where they know how to contribute.

The health system should be providing people with the tools and support they need to achieve these aims, not just during treatment, but also after they have been discharged.

Empowering veterans to achieve their goals

Successful long-term rehabilitation requires a commitment from the individual themselves. It often needs a change in beliefs and lifestyle – as well as constant motivation to keep going and working to achieve goals. The rehabilitation journey doesn't stop on discharge. The challenge is how do we inspire people to change and instil behaviours and habits that stick.

Social prescribing to activities and hobbies

Military training makes veterans highly responsive to physical challenge, recreational sports and activities. Often the thing that makes the greatest difference to their long term recovery is being linked to a hobby they can practice on their own or joining an activity group based in their community.

One example we heard of during our site visits and meetings was of a woman in Cornwall suffering chronic pain and mental health problems. A social prescriber used the patient's personalised care budget to buy her a second-hand wetsuit that cost £20. The patient was then able to go wild swimming daily. Her pain and mental health both improved as a result of this one small action.

Similar impacts have been reported from people joining local walking groups, learning horticulture and gardening, rock climbing, and arts and crafts. The key aspect of this is patient ownership – the greatest benefit comes from the person doing something for themselves from which they get satisfaction, meeting like-minded people and feeling part of society.

Veterans' charities have long recognised the benefits of activity-based rehabilitation. Many of their programmes are based on helping people learn sports and hobbies and guiding them to get the maximum health benefits from them. NHS rehabilitation for veterans should link more closely with these charities to promote long term independence and autonomy in managing MSK conditions.

HighGround provides horticultural therapy for service personnel treated at the Defence and Medical Rehabilitation Centre (DMRC) at Stanford Hall and rural weeks for veterans and reservists. This provides an opportunity for patients to get 'stuck in' and bring themselves back to nature while improving both physical and mental wellbeing.

Battle Back part of the Royal British Legion charity, runs multi-activity sports recovery courses at the Battleback Centre in Shropshire, providing challenge to veterans to spur recovery.

Veterans' Growth provides horticultural therapy specifically for veterans experiencing mental health issues.

Battling On uses the best practices of green space intervention coupled with the camaraderie of like-minded veterans to help tackle issues from low self-esteem and confidence to PTSD.

HorseHeard uses equine-facilitated learning as a way to improve emotional health and wellbeing, coaching people to be in the moment and helping develop action plans for the future through therapeutic intervention.

Rock2Recovery uses active adventure and water pursuits to trigger positive change and self-recovery.

'I'd never heard of HorseHeard before and quite sceptical on how a horse could help with my PTSD. How wrong was I, the fact that a horse could pick up on my emotions and help me begin to understand and learn how to control my emotions and anger and let those emotions go and become calmer, and during this pandemic the mechanisms I learnt at HorseHeard has gone a very long way to keeping me alive and not wanting to commit suicide'

Marianna Mitchell, forces veteran

Example:

Supporting recovery through horticulture

HighGround and Veterans' Growth charities

HighGround delivers horticultural therapy service for injured service personnel and veterans at the DMRC. Weekly sessions, held in its dedicated greenhouses and outdoor rehabilitation space, help patients get back on their feet.

Skills learned in the sessions include improving standing tolerance and endurance, increasing fine motor skills and cognitive processing, improving confidence and self-esteem and social interaction.

Being outdoors in the fresh air away from the clinical side of rehab in a safe, peaceful environment, and taking part in meaningful activity, encourages mindfulness and has a positive impact on mental health. HighGround also helps patients develop leisure interests and vocational opportunities and has also recently released adaptive gardening guidelines.

Veterans Growth', in East Sussex, focuses on veterans living with mental health issues including PTSD. It offers horticulture-based therapy in 12 weekly sessions. Veterans are usually referred from the Transition Intervention and Liaison Service (TILS) and therapy is designed to compliment other forms of treatment.

Participants receive a mix of one-to-one therapy and group activity. The courses aim to reduce participants' levels of stress, anxiety, depression and isolation through physical activity, developing new skills and making long term social connections.

Supporting veterans to self-manage their conditions

Veterans with MSK injuries and conditions are experts in their own health. They experience the pain and discomfort every day. They know what works and what doesn't work, the things that trigger flare-ups and the activities to avoid when it's at its worst.

In our focus groups with veterans, they told us that they are not listened to. There is too much emphasis 'on a medicalised approach, doing things to them and not with them'. Healthcare professionals need to get better at listening to what they are saying and supporting them to help themselves.

The techniques that veterans learn in clinical rehabilitation settings are not easy to transfer to their daily life. They should be empowered to manage their own care in ways that are meaningful to them and can lead to long term behaviour change.

NICE recommends[41] providing a tailored package of online education and learning materials for people after a traumatic injury, which could include information on:

- movement and physical activity
- energy conservation and pacing
- sleep
- activities of daily living
- work, social activities and hobbies
- nutrition and diet
- pain management and medicines
- wound healing
- mental health
- local and national sources of information

Approaches that we found to be successful include:

- Apps and digital resources that guide patients through a program of exercises and allow them to track their progress, boosting motivation. We found these were being used in some rehab units and were thought to be helpful, especially where patients could continue to access them after discharge.
- Online educational resources that help people learn more about their condition and how to practice safe and effective self-care.
- Ongoing access to gyms and leisure centres where patients can continue to build strength, confidence and peer support.
- The ability to re-access rehabilitation services if needed without the need for another referral.

Active waiting lists

Active waiting lists and pre-reading resources have also been shown to be useful in developing autonomy and a mindset of self-care. Patients who are waiting for treatment are given information and guidance relevant to their MSK condition to help learn about that condition or on healthy lifestyle choices or options available in terms of physical activity, nutrition and wellbeing.

This approach is used in fire and rescue services rehabilitation. For example, if a patient is waiting for treatment for chronic pain, they receive information on pain management techniques or mindfulness.

41 NICE Guideline, Rehabilitation after traumatic injury, Guided self-managed rehabilitation 1.5.7 www.nice.org.uk/guidance/ng211

Preventing re-occurrence

As discussed above, giving people back their confidence and ability to participate in society whether that be through paid employment or through carrying out a hobby they enjoy, benefits not only that individual but wider society.

It can help prevent re-occurrence of MSK-related health issues and help people live better without the need for hospital treatment. The more people are supported to put their own self-recovery first the greater the longer-term benefits for society as a whole.

Instilling good habits and behaviours long term can also help people address problems such as obesity, which is common among veterans with chronic MSK disorders[42] and can be a trigger for recurring presentations. People in this situation should be offered long term support to maintain activity levels and manage their weight as part of ongoing rehabilitation.

Recommendations

12 Social prescribing should be used to help veterans take control of their own long-term rehabilitation, develop vocational skills and foster long term social connections.

13 Veterans with mild and chronic MSK disorders should be supported to self-manage their conditions long term through education, digital resources and access to facilities such as gyms and leisure centres, with the freedom to access rehab services when needed without another referral.

42 Higgins, D. et al. 2020. The Relationship Between Body Mass Index and Pain Intensity Among Veterans with Musculoskeletal Disorders: Findings from the MSD Cohort Study. Pain Medicine. 1;21(10):2563-2572. Hilton, L. Hempel, S. Ewing, B.A. et al. Mindfulness meditation for chronic pain: systematic review and metanalysis. Ann Behav Med 2016; 51: 199–213.

Future work

Following publication of this Report, we intend to begin a pilot implementation phase, rolling out our recommendations for veteran rehabilitation at chosen sites across the country. We have already received expressions of interest from trusts who want to be part of this.

A further review will look at the evidence from the pilot that could help to inform better rehabilitation practice for people with MSK disorders in the wider population, under the stewardship of Profession Tim Briggs, National Director of Clinical Improvement, and working closely with Andrew Bennet (NCD in MSK) and the Best MSK programme.

We will also advocate for more rigorous evaluation of rehabilitation interventions, so that resources can be focused on giving the most effective treatments to those who will derive the most benefit, and better training for all clinicians working in this area. Training programmes should be developed in close collaboration with all the relevant professional groups and specialties.

In order to maximise the long-term benefits of rehabilitation, we also think that work is needed to address the broader contributing factors to MSK health, including:

- Public health interventions to reduce the future risks of developing MSK conditions.
- Better understanding of the risk factors for longer-term disability with clear routes for the early assessment and intervention for those with severe progressive conditions or severe pain in particular.
- Better use of information systems and technologies and better design of public buildings and private housing to promote independence and self-respect.

Long term objectives and aspirations

As discussed earlier in this report, rehabilitation gyms and facilities have been cut in many areas of the country, or been turned into space for beds or offices. Reinvestment into gyms, patient shared areas, hydro pools, outdoor patient spaces would all reap massive returns.

At the Royal National Orthopaedic Hospital (RNOH) in Stanmore the first veteran rehabilitation unit, part of a larger rehabilitation unit for NHS patients is under construction with a planned opening in late 2023. It will be the first of its kind. The unit will bring together MSK and pain rehabilitation services with psychological support and will have the trust's Murrison prosthetic centre on site.

Based on the results of this pilot, the long-term future may see a network of regional rehabilitation centres that can flex between outpatient and residential set ups, where complex patients with chronic MSK injuries conditions can go for intensive therapy to kick start their rehabilitation and recovery journeys. These should work seamlessly on a tiered basis with primary care and community-based services, which will provide the majority of rehabilitation needs.

The completion of VCHA Accreditation across all NHS trusts in England will also help, along with the GP scheme. As awareness increases, this will ultimately lead to improvements in care and people living better for longer with their conditions, with less need for presentation at A&E or hospitalisation.

Acknowledgements

We'd like to thank everyone who contributed to the development of this report, starting with Professor Tim Briggs who initiated the project and who continues to guide its delivery.

We're grateful to the many colleagues in rehabilitation services across the country who took part in our site visits and meetings for contributing their insights and experience, and to the veterans who participated in focus groups and one-to-one discussions.

We're also indebted to our stakeholder group: Professor Tim Briggs, Alison Treadgold, Andy Bacon, Beth Lambert, Kate Parkin, and NHS England and NHS Improvement. And to our reference group of Dr Alex Crick, Helen Harvey, Pete Le-Feuvre, John Doyle, Matt Fossey and Brian Chenier.

The research and review process was carried out by Sarah Barker and Maisy Provan. Our data analyst was Ed Bramley-Harker. The report was edited by Andorif, editor William Higgins.

Appendix

Full list of meetings, site visits and participants.

Service	*Names Person & Role*	*Type*
York St John University	Nick Wood Business development manager (Armed Forces and uniformed services)	Virtual
DMWS	Paul Gaffney Beverly Young Abby Dryden Jessica Liston	Virtual
Positive Transition	Tim Jones Veteran & App developer	Virtual
RCGP	Dr Robin Simpson Veteran Covenant Lead for Royal College of GPs	Virtual
Norfolk Community Healthcare	Linda Long Lead Physiotherapist	Virtual
Police Rehabilitation Centre in Harrogate	Sarah Ward Lead Physiotherapist	Virtual & face to face
Police Rehabilitation Centre in Goring	Ian Barron Physiotherapist	Virtual & face to face
Norfolk Community Health and Care NHS Trust	Lynne Fanning Head of Clinical Education and Research	Virtual
Hobbs Neurological Rehabilitation	Helen Hobbs Physiotherapist Jen Mellows Speech and Language Therapist Rachel Occupational Therapist	Virtual & face to face
Midlands and East Veterans TILS	David Powell Regional Lead	Virtual
Solent NHS Mental Health	Andrew Spencer Armed Forces Lead Manager	Virtual
Fire Fighters Charity	Nicola Pattern Physiotherapist & Clinical Lead	Virtual & face to face
Injured Jockeys Fund	Jayne Matthews Oaksey House Practice Manager & IJF Governance Lead	Virtual & face to face
Addenbrookes Pain Service	Elsje De Villers Physiotherapist	Virtual
KCL	Amos Sims Nurse & Researcher	Virtual
RNOH	David Baxter Spinal Consultant & serving army doctor	Virtual
Bristol Enablement Centre	Helen Harvey Clinical Lead and Podiatrist	Virtual & face to face

MOD	Peter Le Feuvre Military Physiotherapist	Virtual
Elysium Healthcare	Julie Hayley Manager Pauline Matthews & Kirsty Allison Occupational Therapist Nicholas Dougherty Physiotherapist	Virtual & face to face
Blesma	Brian Chenier Prosthetics Support Officer	Virtual
GIRFT	Dr Sridevi Kalidindi GIRFT Clinical Lead for Mental Health	Virtual
London Spinal Cord Injury Centre RNOH	Emma Linley – Clinical Specialist Occupational Therapist and Team Lead Benita Hexter – Clinical Specialist and Lead Physiotherapist	Face to face
Norfolk & Norwich NHS	Leanne Millar Occupational Therapist	Virtual
UK ROC	Carolyn Young NHS E & I	Virtual
Dorset NHS DSC	Tim Randell Physiotherapist	Virtual
Plymouth NHS DSC	Gary Parett Physiotherapist	Virtual
Salisbury NHS Trust	Dr Alex Crick Plastic surgeon specialising in lower limb reconstruction. Runs the War Injuries Clinic for both serving personnel & veterans.	Virtual & face to face
B.A.S.I.C Brain & Spinal Injuries Charity	Peter Emms Fundraising & Communications Sylvia Moss Physiotherapist	Virtual & face to face
Royal British Legion	Elizabeth Colliety Public Affairs and Policy Team	Virtual
High Ground	Anna Baker Cresswell Charity Founder	Virtual
Guys & St Thomas' DSC	Amy Jones Physiotherapist & Clinical Lead	Virtual
Academic	Tom Kersey PhD student researching pain in veterans	Virtual
Birmingham NHS DSC	Jos Van Mulken Physiotherapist	Virtual
Hampshire hospitals NHS foundation trust	Dr Dominic Aldington Pain consultant (ex-army)	Virtual
Royal Derby NHS DSC	Karen Clark Physiotherapist	Virtual
Poole ABI Rehabilitation Service	Mark Smith Liz Parish Occupational therapist	Virtual

Finchale Group	Jacqui Nicolson	Telephone
Oxford NHS Trust DSC	Sarah Holden Specialist prosthetic Physiotherapist	Telephone
Norfolk & Norwich NHS Trust	Laura Butler Lucy Reeve Occupational Therapist	Virtual
Portsmouth NHS DSC	Chantel Ostler Physiotherapist Sam Metcafe Manager	Virtual
Specialist Mobility Centre Preston NHS	Dr Fergus Jepson Rehabilitation Consultant	Virtual & face to face
Dorset NHS	Andrew Gritt Armed Forces Welfare Service	Virtual
MOD/NHS – Frimley Park	Col Alan Mistlin MOD/NHS consultant in rheumatology and rehabilitation	Virtual
Leeds NHS Trust	Karen Hardwick Trauma psychologist	Virtual
Salford NHS	Lorraine Moore Pain Physiotherapist	Telephone
GIRFT – General Medicine	Phillip Dyer Darren Best	Virtual
Veterans Growth	Jason Stevens Veteran & Charity Founder	Virtual
Norfolk County Council CCG	Merry Halliday Andrew Hayward	Virtual
South Tees NHS DSC	Rachael McManus Sally Smith	Virtual
Bowley Close NHS DSC Guys & St Thomas'	Lisa Ferguson Counsellor/psychotherapist	Virtual
Robert Jones & Agnes NHS Hospital	Noel Harding Physiotherapist	Virtual & face to face
Battleback Centre – Royal British Legion	Chris Joynson Centre manager	Virtual & face to face
GIRFT	Keith Gray & Adrian Hopper	Virtual
GIRFT	Dr Martin Allen Respiratory Clinical Lead	Virtual
Dorset CCG	Rob Munrow Senior programme lead, primary and community care team, primary care network lead for the Armed Forces public patient voice advisory group for NHS England	Virtual
Suffolk County Council	Jim Brown	Virtual
Walton Centre	Stephen Mullin Consultant Clinical Neuropsychologist	Virtual
NHS	Dr Sue Patterson ED consultant	Virtual

Portsmouth	Keith Malcom Armed Forces Covenant Lead Nurse Jan Hodgkinson DMWS	Virtual
Best MSK Health Collaborative	Jane Hart Programme Director	Virtual
Leeds Beckett University	Chris Kay Senior Research Fellow	Telephone & Virtual
Black stork Charity	Janet Morrison CEO	Virtual
Academic Department of Military Rehabilitation (ADMR), DMRC Stanford Hall – MOD	Russell Coppack Clinical Research Manager	Virtual
Academic – Visiting professor at Oxford Brookes university	Derick Wade Rehabilitation consultant	Virtual
RNOH-Pain service	Nicola Clancy Physiotherapist	Face to face
GIRFT – ED	Dan Bowden ED Consultant	Virtual
Warrior Programme	David Corthorn Veteran	Virtual
Academic – Anglia Ruskin University, Veterans and Families Institute for Military Social Research	Matt Fossey Associate Professor and Director	Virtual
Addenbrookes Hospital and University of Cambridge	Sue Robinson Consultant in Emergency Medicine & Associate lecturer	Virtual
Edgeware Health	Ed Bramley-Harker	Virtual
UNITS Study	Dr Mary Keeling – Senior Research Fellow – Visible Difference and Military Conflict Research & Sarah Evans – Research Associate Centre for Appearance Research	Virtual
Escape Pain	Isabel Rodrigues de Abreu – Education & Events Manager, project lead Michael Hurley – Clinical director of the health innovation programme, Physiotherapist by background. Franchesca Thompson – Orthopaedic Research UK Project Lead	Virtual
Walking with the Wounded	Heather Saunders Head of Employment	Virtual
Penzance – GP	Dr Boutler GP and reservist (RAMC) and veterans champion	Virtual
RNOH – NHS	John Doyle Physiotherapist & AHP Lead	Virtual & face to face
MOD	Air Commandant Rich Withnall	Virtual
East Lancashire Hospitals NHS Trust	Rachel Loftus Community and Intermediate Care Division	Virtual

Help for Heroes	Carol Betteridge Naval Veteran	Virtual & face to face
RNOH – Prosthetics	Jennifer Fulton – Physiotherapist John Sullivan & Morren – Prosthetist	Face to face
Darlington Pain Service	Verity Joyce Physiotherapist	Virtual & face to face
University Hospitals of Derby & Burton – MSK outpatients	David Williams Physiotherapist & veteran	Virtual & face to face
GIRFT – NHS	Bernadette Knight VCHA Regional Lead	Virtual
MOD	Anne Segalini Lead Occupational Therapist at Stanford Hall	Virtual
NHS E&I South West	Juliet Ferris Veterans and IPC	Virtual & face to face
University Hospitals of Derby & Burton – MSK Group outpatients & vocational rehab	Sarah Holt Lead Occupational Therapist	Virtual & face to face
Birmingham Community Healthcare NHS Foundation Trust	Hayley Price Physiotherapist	Virtual
MOD – Regional Rehabilitation Unit (Larkhill)	Andrew Taylor Civilian Physiotherapist	Virtual
Veterans Welfare Service	Emma Jones	Telephone
MOD – Regional Rehabilitation Unit	Rob Canfer RAF physiotherapist	Virtual
TILS	Andrew Millard Occupational therapist & veteran	Virtual
RNOH – Pain service	Greg Booth Physiotherapist & researcher	Virtual
University Hospitals of Derby & Burton	Lara Raworth – project improvement team	Virtual
Cabinet Office	David Richmond Independent Veterans Advisor to UK Government Ministers, Veteran, Help for heroes	Virtual
Loughborough University	Femindah Mieur Researcher – health psychology	Virtual
King Edward Vii Pain Team	Claire Fear – Nurse Suzanne Brook – physiotherapist Jannie Van Der Merwe – clinical psychologist	Virtual
Battling On	Rick Stead – Business Manager Derek Easton – Project Manager Sean Fraser – Veterans Programme Co-Ordinator Nikki Markham – Founding Director	Virtual & face to face
Bowra Foundation	Helen Patrick Operations Manager	Virtual
Physiquie	Andy Thomas CEO	Virtual

St George's NHS Trust	Stephen Friend Consultant Physiotherapist Paul Marshall-Taylor Occupational Therapist Ben Bowling Physiotherapist	Virtual & face to face
Loughborough University	Mark Lewis Dean of school and Professor of MSK Biology	Virtual
Sussex Partnership	Sally York Primary Care Lead, FCP & Spinal Advanced Practice Physiotherapist	Virtual
Camden MSK	Jonathan Hersey Programme Lead	Virtual
GP – Barnwell, Cambridge	Dr Rachel Harmer	Virtual
MACP	James Rogers Professional Network Officer for MACP	Virtual
NHS Solent –MSK Team	SallyAnn Smith – Clinical Manager Catherine Heather – MSK Pain Ops Lead	Virtual
Horse Heard	Heather Hardy – Trustee & Facilitator Vicky Bennett – CEO Alison Mary Barlow	Virtual
Guys & St Thomas'	Sarah Austin – Managing Director Integrated and Specialist Medicine Billy Kelly – Armed Forces Lead	Virtual
MSK Best Collaborative	Fortnightly meetings	Virtual
Nottingham's Primary Integrated Community Service Ltd	Paula Banbury Pain team lead	Virtual & face to face
Rehab consultant at Salford & president of the BSRM	Krystyna Walton	Virtual
Active Plus Cornwall	Danny Daniel – Manager Pete Fox – Lead Instructor Pete Jackson – Instructor Chris Mayer – Instructor Lucy Richards – Project & Compliance Manager: Health Works for Cornwall Richie – Operations Manager	Virtual & face to face
Battleback Staff	Chris Joynson – Operations Manager Capt Christopher Knight – 2IC Ceri Williams – coach Laura Simpson – coach Lyndon Chatting-Walters – coach	Face to face & virtual
Guys & St Thomas'	Jack Grodon MSK Clinical specialist physiotherapist	Virtual
MOD	Dean Holder OC at Tedworth House	Virtual & face to face
NHS & Elite sports	Dr Chris Tomlinson Consultant in Sports & Exercise Medicine	Virtual
St Andrews Therapy Department, Mid and South Essex NHS Foundation Trust	Rachel Wiltshire – Lead Therapist for Burns, Plastics and Hand Therapy	Virtual

Cornwall MSK NHS	Maria Stickland – Senior Operational Manager Morissa Livett – MSK Clinical Lead	Virtual
Living Well with Pain, Northumbria NHS	Sarah Woods Clinical Psychologist	Virtual
BNTVA – The charity for Atomic Veterans	Ceri McDade Chair	Virtual
Academic	Adrian Needs Principal Lecturer in Forensic Psychology at the University of Portsmouth	Virtual
Bury NHS Trust	Pain Team Anna Dalton – Mental Health Services Bury – strategic and opps lead for longterm conditions Psychological medicine David Thompson – physiotherapist, MSK and pain	Virtual
Royal United hospital's Bath NHS foundation trust	Gina Sergeant Head of therapies and professional lead AHP Dr Jeremey Gaunlett-Gilbert Clinical psychologist in the pain team	Virtual & face to face
UK ROC	Lynne Turner Stokes Herbert Dunhill Chair of Rehabilitation. Director, Regional Rehabilitation Unit, Northwick Park Hospital. KCL Professor	Virtual
Newcastle NHS	Nicola Stephens Physiotherapist Lisa Robinson Specialist Pain Nurse	Virtual
Katie Piper Foundation	Johanne Harrison Head of patient services	Virtual
Arthritis and Musculoskeletal Alliance (ARMA)	Sue Brown CEO	Virtual
British Society of Rehabilitation Medicine Salford Royal NHS	Krystyna Walton Rehabilitation consultant & President of the BSRM	Virtual
Royal Cornwall Hospital – NHS	Dr Michael Butler Orthopaedic Surgeon & Veteran	Face to face
Royal Cornwall Hospital – NHS	Dr Nigel Rayner Dr Chris Ireland Both GPs who also run the MSK interface service	Face to face
RJAH – NHS	Lt Carl Meyer Orthopaedic Surgeon and army reservist	Telephone
Cornwall NHS	Andy Craze & Marc Walsh Armed Forces Social Prescribers	Face to face
Defence Transition Services	Kate McCloughlin Officer in Charge	Virtual
Supporting Wounded Veterans	Ryan Knight Team Leader – Pain Resilience Programme	Virtual

Versus Arthritis	Sarah Clarke Health Service Improvement Manager	Virtual
Remaker UK	Humphrey Maddan Veteran and company Owner	Virtual
NHS England & Improvement	Dr Alf Collins Pain specialist	Virtual
Barts Health NHS Trust	Cat Hilton Physiotherapist & researcher	Virtual
Royal National Orthopaedic Hospital	Anthony Gilbert Physiotherapist & researcher	Virtual
Charted Society of Physiotherapy	Julie Blackburn Physiotherapist & Professional Advisor	Virtual
VTN Wales	Bethan Hughes Programme Manager	Face to face
Veterans Project Scotland	Keri Magee Veteran and Project Lead	Virtual
Think Therapy	Helen Merfield Nurse & Veteran Steph Fleet Occupational Therapist	Virtual
NHS Digital	Ian Ramsey Programme Manager	Virtual
Barts and The London School of Medicine and Dentistry. Queen Mary University of London	Jaqueline Rapport Teaching Fellow: MSc in Trauma Sciences. Academic and Pastoral Advisor	Virtual

Virtual Webinars/ Conferences	
FiMT – in their shoes	Jan 2021
Kings Fund – Developments in the NHS	Jan 2021
Kings Fund – Trust & Transparency in healthcare	Feb 2021
Blue Light Conference	Feb 2021
KCL Conference	March 2021
Kings – virtual healthcare	March 2021
Brighton Council Military Meeting	March 2021
FiMT – Transition of serving people and families	March 2021
Health Innovation Exchange: innovation in rehabilitation Event	March 2021
Together we can make a difference – Sussex Armed Forces Network • Champions Training • Mental Health • LGBT + • Women • Carer & Family • Physical Health (Face to face conference)	 February & May 2021 April 2021 May 2021 September 2021 November 2021 January 2022
Brain Health: Online Webinar Series	May 2021
Crowdcast: Shellshock series	June 2021
MSK: Improvement and Innovation	July 2021
Military Human Training. Nick Wood, York St John University	July 2021

FCP Higher Education Webinar	August 2021
GP Teaching: Veterans Medicine (Presented at)	October 2021
Poppy Conference	November 2021
British Trauma Society Conference	November 2021
Therapies Research & Audit Forum RNOH	November 2021
UNITS Dissemination Event	November 2021
Culture & Leadership Conference (British Army)	December 2021