

Tracking Op HERRICK (Afghanistan) VSI/SI Operational Casualties: 1 January 2008 to 31 December 2010

4 May 2011

Issued By:

Defence Analytical
Services and Advice
(DASA)
Spur 7 B Block
Enslough
Bath
BA1 5AB

Enquiries

Press Office:
020 721 83253

Statistical Enquiries:

Dr Kate Harrison
Head of Health Information
DASA
Tel: 01225 468456
kate.harrison@dasa.mod.uk

Internet:

<http://www.dasa.mod.uk>

DASA Welcome Feedback

If you have any comments
or questions about this
publication or about DASA
statistics in general, you
can contact us as follows:

E-mail:

[DASA-enquiries-
mailbox@mod.uk](mailto:DASA-enquiries-mailbox@mod.uk)

Visit the DASA website
(www.dasa.mod.uk)
and complete the feedback
form.

INTRODUCTION

1. This report is the third in a series producing statistical information on patients that were very seriously injured (VSI) or seriously injured (SI) on Operation HERRICK (Afghanistan) between 1 January 2008 and 31 December 2010 as listed on the initial Notification of Casualties (NOTICAS) signal. It complements and expands upon the fortnightly publication of operational casualty and fatality statistics which include counts of Service personnel VSI or SI.
2. This report **does not** include patients that were very seriously ill or seriously ill on Operation HERRICK (Afghanistan) between 1 January 2008 and 31 December 2010 as listed on the initial Notification of Casualties (NOTICAS) signal, in line with the fortnightly publication of operational casualty and fatality statistics.
3. This report has been provided in response to the increasing number of requests for information about injured UK Service Personnel. The requests vary from requesting more detail on the injuries sustained to understanding the long-term outcome of those injured.
4. The MOD are committed to making information on Operational Casualties public but have to draw a line between how much information is provided regularly in the public domain and information which compromise operational security of UK Armed Forces Personnel or which risks breaching an individual's right to medical confidentiality. This report along with the quarterly release of the Op HERRICK and Op TELIC Amputation Statistics is supporting the MOD's commitment to release information wherever possible.
5. The findings in this report first focus on the casualty care pathway in theatre in Afghanistan, including admittance to the field hospital, the length of time in the field hospital and how many of these were aeromedically evacuated to the UK. The report then presents information on the casualty care pathway once they were returned to the UK. This includes:
 - Where they were initially admitted on return to the UK and the length of time at that first location.
 - Medical locations where the casualties received further specialist treatment.
 - The number of VSI/SI casualties that were amputees.
 - The number of pathways closed and the overall length of the care pathway from initial injury to the date the care pathway was closed (or the date of download from the Defence Patient Tracking System (DPTS) for open pathways).
 - The number of casualties that return to medically fully deployable or medically limited deployable.
 - The number of casualties who have been discharged from Service.
 - The number of casualties who have registered a claim for compensation and who have been awarded compensation under the Armed Forces and Reserve Forces Compensation Scheme (AFCS).

KEY POINTS

6. In 2008, there were 65 personnel with an initial NOTICAS classification of VSI or SI on Operation HERRICK (27 were VSI, 38 were SI). 60 (92%) of these were the result of hostile action, 5 (8%) were the result of operational accidents.

7. In 2009, there were 157 personnel with an initial NOTICAS classification of VSI or SI on Operation HERRICK (82 were VSI, 75 were SI). 147 (94%) of these were the result of hostile action, 10 (6%) were the result of operational accidents.
8. In 2010, there were 154 personnel with an initial NOTICAS classification of VSI or SI on Operation HERRICK (80 were VSI, 74 were SI). 144 (94%) of these were the result of hostile action, 10 (6%) were the result of operational accidents.
9. This totals 376 personnel with an initial NOTICAS classification of VSI or SI on Operation HERRICK between 1 January 2008 and 31 December 2010 (189 were VSI, 187 were SI). Of the 376 personnel, 139 (37%) were identified as amputees at 31 March 2011, 136 of which were the result of hostile action.
10. All of the 376 casualties were admitted to a field hospital in Afghanistan. The length of stay at the field hospital varied between less than a day to six days, with an average (median) length of stay of one day. Seven patients were discharged from the field hospital and returned to unit in theatre. The remaining 369 casualties were aeromedically evacuated to the UK for treatment (one of these was initially aeromedically evacuated to the American Hospital in Landstuhl, Germany).
11. As the main receiving unit for military casualties evacuated from an Operational theatre; the Royal Centre for Defence Medicine (RCDM) received 366 of the 369 casualties in the UK (one casualty was treated in Germany initially and upon returning to the UK was then treated at the RCDM and two patients were returned to unit to be treated at Primary Health Care).
12. After finishing their first in-patient or out patient episode at RCDM the 364^a patients (363 received by RCDM and one received by RCDM via Germany) have gone on to either receive further treatment at RCDM or to receive treatment at other specialist care locations.
13. As at 1 March 2011, 113 (30%) of the 376 personnel with an initial NOTICAS classification of VSI or SI on Operation HERRICK between 1 January 2008 and 31 December 2010 had closed pathways, indicating that no further specialist care was required, 13^b of these 113 personnel had subsequently redeployed on Operation HERRICK and/or Operation TELIC.
14. As at 1 March 2011, 17 (15%) of the 113 personnel with a closed pathway were no longer in service. The remaining 359 personnel (96 with closed pathways, 263 with open pathways) remain in Service. For the 17 personnel no longer in Service:
 - 16 had a closed pathway on the DPTS indicating that no further specialist care was required and had then been discharged from Service.
 - One personnel had a closed pathway on the DPTS and was returned to duty after recovering from his injuries then later died in an unconnected incident.
15. As at 1 March 2011, the latest Medical Deployability Standard (MDS) recorded, for the 96 personnel who were still in Service with a closed pathway:
 - 33 were medically fully deployable (MFD)
 - 17 were medically limited deployable (MLD)
 - 34 were medically non deployable (MND)
 - 12 had no MDS recorded after their injury on DMICP
16. As at 31 December 2010, 300 (80%) of the 376 personnel had claimed for compensation under the AFCS. This resulted in a total of 383 claims, which includes multiple and/or additional claims for some individuals. Currently individuals have up to seven years from the date of their injury to make a claim and as such, the remaining 76 individuals who have yet to claim may still do so in the future.
17. Of those who claimed under the AFCS, a total of 249 have been awarded compensation for an injury or illness caused by Service. The remaining 51 casualties who registered a claim are still awaiting the outcome of their AFCS claim.

^a Three patients have been excluded as they had not completed their first in-patient episode at RCDM.

^b Excludes Service personnel that returned to Unit in theatre after sustaining their injury (VSI/SI) and includes one personnel who redeployed and died in an unconnected incident.

CONTENTS

Data, Definitions and Methods	4
Very Seriously Injured (VSI) and Seriously Injured (SI).....	4
Operation HERRICK	4
Operation TELIC	4
Roulemont.....	4
Data sources	5
Statistical Methods	5
Medical Care Pathway	6
Specialist Treatment Locations.....	6
Number of Personnel Very Seriously Injured or Seriously Injured	8
Amputees	15
Care Pathway Length and Closed Pathways	15
Discharged Personnel.....	17
Current Joint Medical Employability Standard (JMES) for Personnel with Closed Pathways.....	17
Armed Forces Compensation Scheme	17
Discussion and Future Developments	19
Data Sources	20
Specialist Treatment Locations.....	24

Data, Definitions and Methods

Very Seriously Injured (VSI) and Seriously Injured (SI)

18. The VSI and SI categories are defined by Joint Casualty and Compassionate Policy and Procedures. They are not strictly 'medical categories' but are designed to give an indication of the severity of the injury to inform the next of kin and the chain of command.

19. Casualties are listed as VSI and SI in the Notification of Casualty (NOTICAS). NOTICAS is the name for the formalised system of reporting casualties within the UK Armed Forces. It sets in train the MOD's procedure for informing next of kin. The MOD's Joint Casualty and Compassionate Policy and procedures set out the guidance under which a NOTICAS report is to be raised. NOTICAS takes precedence over all but the most urgent operational and security matters.

20. This report **does not** include patients that were very seriously ill or seriously ill on Operation HERRICK (Afghanistan) between 1 January 2008 until 31 December 2010 as listed on the initial NOTICAS signal, in line with the fortnightly publication of operational casualty and fatality statistics.

21. The NOTICAS reports raised for casualties contain information on how serious medical staff in theatre judge their condition to be. This information is used to inform what the next of kin are told. "VSI" and "SI" are the two most serious categories into which personnel can be classified:

- Very Seriously Injured or VSI is the definition used where the injury is of such severity that life or reason is imminently endangered.
- Seriously Injured or SI is the definition used where the patient's condition is of such severity that there is cause for immediate concern, but there is no imminent danger to life or reason.

22. The NOTICAS system is initiated very early in the patient's admission to the field hospital, the classification of a casualty will change as time progresses. The initial signal listing of VSI or SI may in some cases be followed by an updated less serious listing if the case appeared worse on admission than transpires. This report only includes casualties with an initial NOTICAS listing of VSI or SI.

23. The Ministry of Defence publishes the VSI and SI casualty statistics for Operation HERRICK every two weeks, two weeks in arrears. These can be obtained from the DASA website: www.dasa.mod.uk

Operation HERRICK

24. Operation HERRICK is the name for UK operations in Afghanistan which started in April 2006. UK Forces are deployed to Afghanistan in support of the UN authorised, NATO led International Security Assistance Force (ISAF) mission.

25. **Operation Panther's Claw** was preceded by several other operations carried out by British and Afghan government forces with the purpose of "taking and holding ground" in Helmand Province prior to the Afghanistan elections in 2009.

Operation TELIC

26. Operation TELIC is the name for UK operations in Iraq which started in March 2003 and finished in July 2009. UK Forces were deployed to Iraq to support the Government's objective to remove the threat that Saddam posed to his neighbours and his people and, based on the evidence available at the time, disarm him of his weapons of mass destruction. The Government also undertook to support the Iraqi people in their desire for peace, prosperity, freedom and good government.

Roulement

27. A roulement in Afghanistan comprises a six month time period from April to October or October to April. Some of the results in this report are presented by these time periods representing the summer and winter deployments. Each six month time period is assigned a sequential number, the time periods covered by each roulement are:

- HERRICK 4: 15 April 2006 to 14 October 2006
- HERRICK 5: 15 October 2006 to 14 April 2007
- HERRICK 6: 15 April 2007 to 14 October 2007
- HERRICK 7: 15 October 2007 to 14 April 2008
- HERRICK 8: 15 April 2008 to 14 October 2008
- HERRICK 9: 15 October 2008 to 14 April 2009
- HERRICK 10: 15 April 2009 to 14 October 2009
- HERRICK 11: 15 October 2009 to 14 April 2010

- HERRICK 12: 15 April 2010 to 14 October 2010
- HERRICK 13: 15 October 2010 to 14 April 2011

Amputee

28. An amputee is defined as live UK Service personnel who have an injury coded in the Joint Theatre Trauma Register (JTTR) as Amputation (traumatic), partial or complete, for either upper or lower limbs using the Abbreviated Injury Scale (AIS) Dictionary 2005 (Military Edition), and live UK Service personnel who had a surgical amputation performed either at the field hospital or at a UK hospital (the majority of these will be at the Royal Centre for Defence Medicine). A traumatic or surgical amputation can range from the loss of part of a finger or toe up to the loss of entire limbs. Only amputees with a initial NOTICAS listing of VSI or SI have been included in this report.

Data sources

29. The information provided in this report includes Naval Service Personnel (includes the Royal Navy and the Royal Marines), Army Personnel including those from the Gibraltar Regiment, RAF Personnel and Reservists.

30. The information has been compiled from a number of sources:

- Notification of Casualty (NOTICAS)
- Field Hospital Admissions from J97 Returns and Operational Emergency Department Attendance Register (OpEDAR)
- The Joint Theatre Trauma Registry (JTTR)
- The Defence Patient Tracking System (DPTS)
- DASA's Mental Health Returns Database
- DASA's Medical Discharge Database
- Compensation and Pension System (CAPS)
- Joint Personnel Administration (JPA)
- Defence Medical Information Capability Programme (DMICP).

31. Detailed information on these datasets and how they were used in this report is contained in **ANNEX A**.

Pseudo-anonymisation

32. Prior to analysis data sources have been linked using a pseudo-anonymisation process. The individual identifiers were stripped from datasets and replaced by a pseudo-anonymiser, generated, effectively, by an automated sequential numbering system. The key to the system is that it recognises previous occurrences of a given Service number and allocates the same pseudo-anonymiser on each occasion. The pseudo-anonymisation process can only be reversed in exceptional circumstances controlled by the Caldicott Guardian under strict protocols.

Statistical Methods

33. Information on length of stay and length of pathways has been presented as a median average with an inter-quartile range, rather than a mean average and standard deviation as these statistics are affected less by outliers.

- a. The median is the value in the centre of the data set when they are arranged from smallest to largest.
- b. A quartile is any of three values (first/lower quartile, second quartile (median), third/upper quartile) that divides the sorted (from smallest value to largest value) dataset into four equal parts. The lower quartile is the value that at which 25% of the values in the dataset will be below. The upper quartile is the value that at which 75% of the values in the dataset will be below.
- c. The inter-quartile range is the range in which the middle 50% of the data points fall (i.e. the distance between the lower and upper quartile). The longer the inter-quartile range the wider the spread of data.
- d. An outlier is a value lower than the lower quartile or higher than the upper quartile.

34. The Non-Parametric Mann-Whitney U Test for Independent samples has been used to test if the distribution of time from injury to treatment at a particular treatment location is different for VSI and SI patients. The same test has also been use to test if the distribution of length of admission time is different for VSI and SI patients.

Medical Care Pathway

35. **Figure 1** presents an example of a *typical* medical care pathway for a UK Service Personnel VSI or SI whilst on Operation HERRICK.

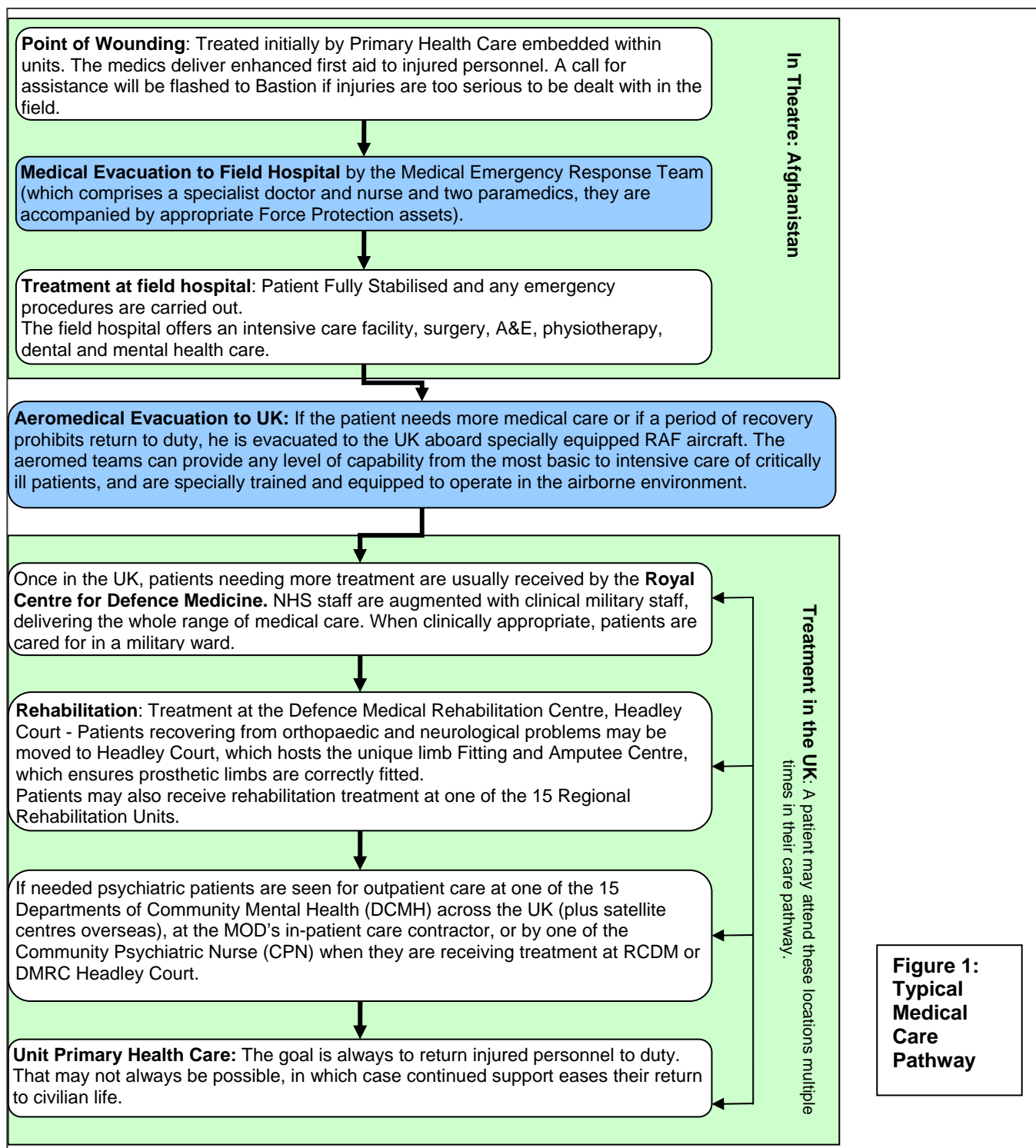


Figure 1: Typical Medical Care Pathway

Specialist Treatment Locations

36. More detailed Information on the Specialist Treatment locations included in this report is contained in **ANNEX B**.

FINDINGS

37. **Figure 2** presents a summary of the VSI/SI patient treatment pathway for those injured between 1 January 2008 and 31 December 2010.

**Role 2/3 Field Hospital Admission
NOTICAS Signal Initial Listing VSI or SI
(Median Length of Stay: 1 day)
376 (189 VSI, 187 SI)**

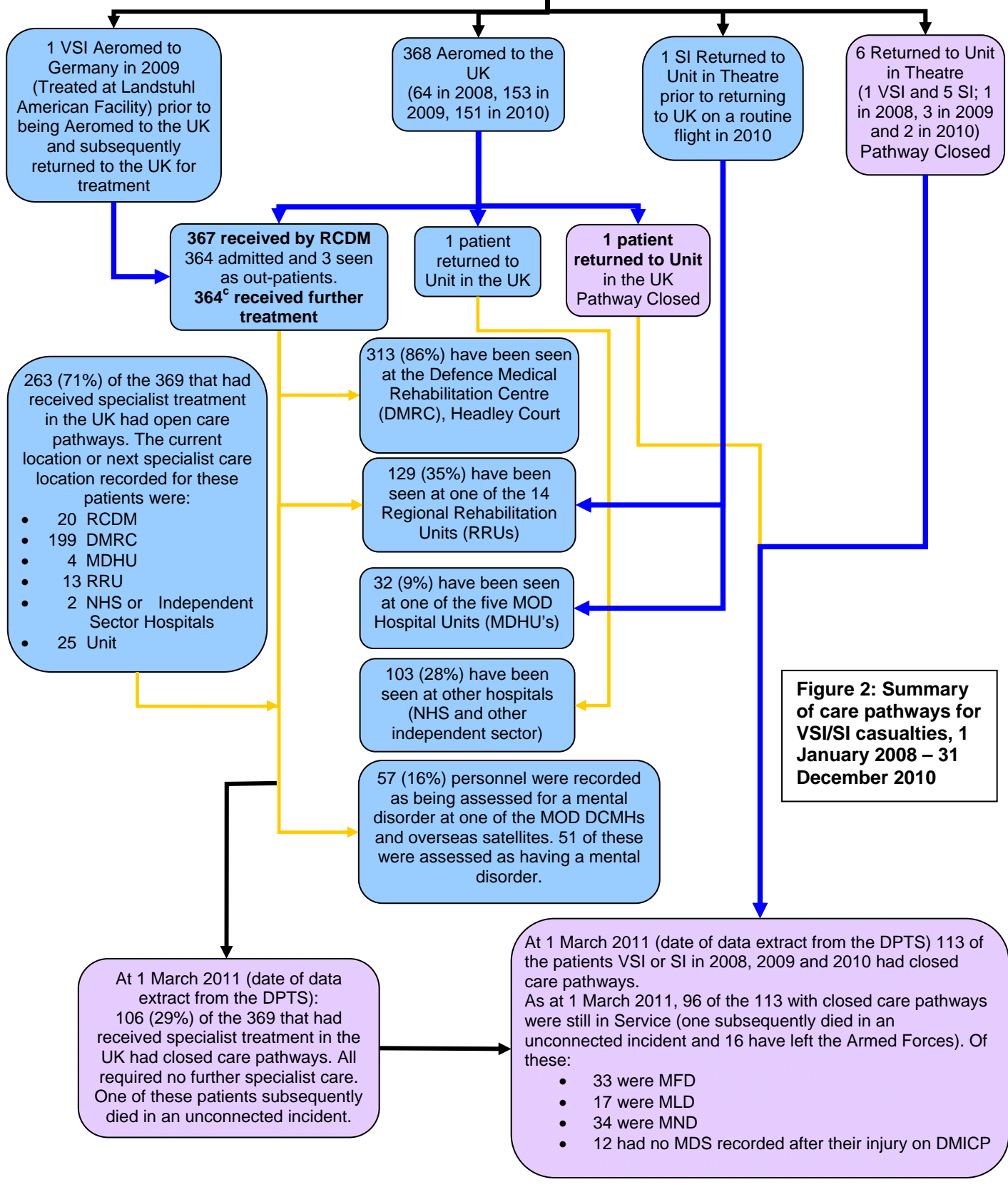


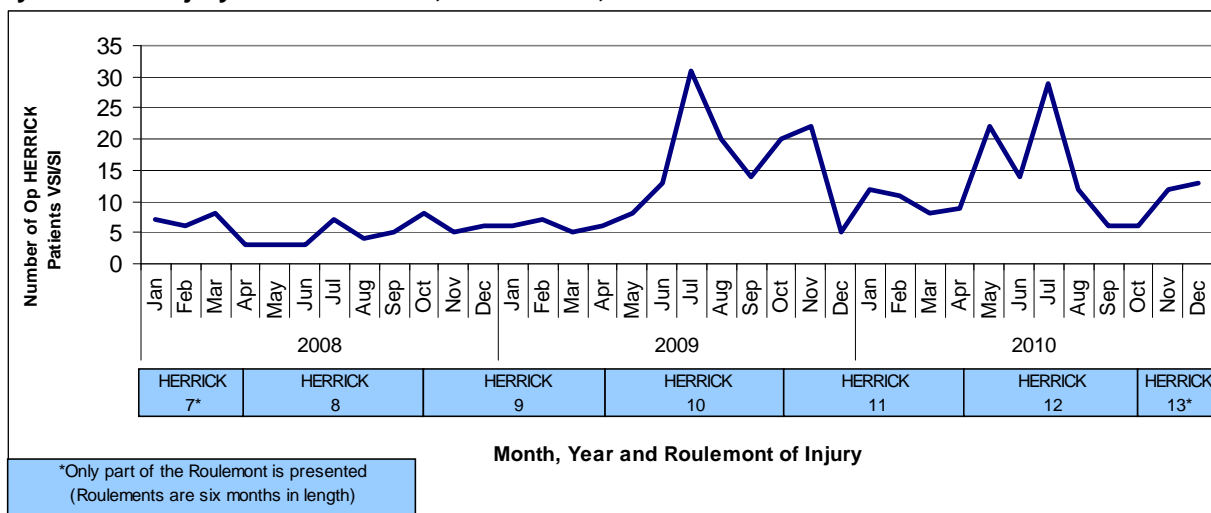
Figure 2: Summary of care pathways for VSI/SI casualties, 1 January 2008 – 31 December 2010

^c Three patients have been excluded, as at 1 March 2011 they had not completed their first in-patient episode at RCDM.

Number of Personnel Very Seriously Injured or Seriously Injured

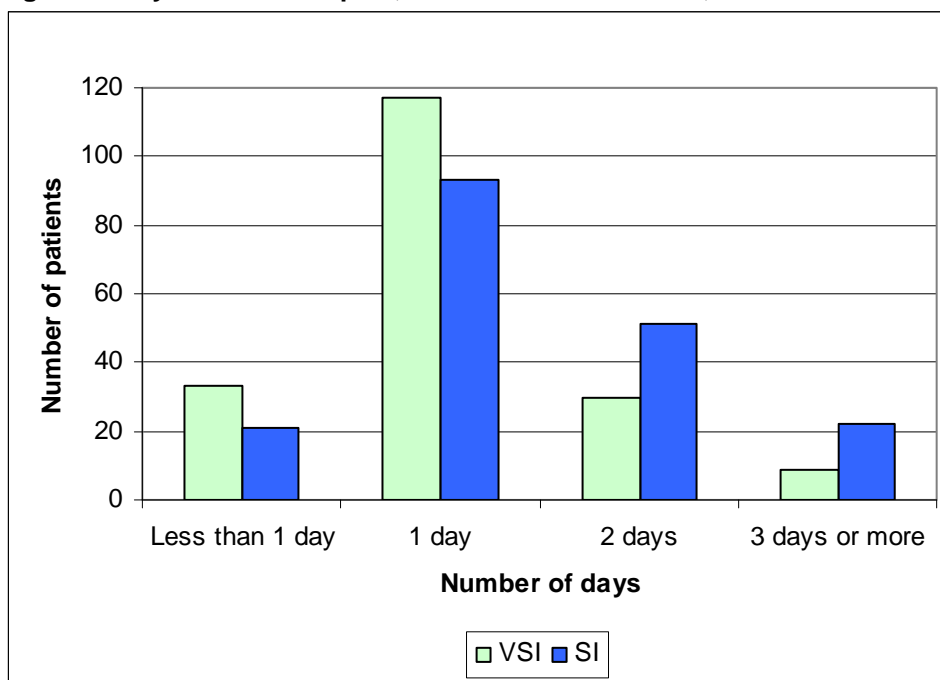
38. In 2008, there were 65 personnel with an initial NOTICAS classification of VSI or SI on Operation HERRICK (27 were VSI, 38 were SI). 60 (92%) of these were the result of hostile action, 5 (8%) were the result of operational accidents.
39. In 2009, there were 157 personnel with an initial NOTICAS classification of VSI or SI on Operation HERRICK (82 were VSI, 75 were SI). 147 (94%) of these were the result of hostile action, 10 (6%) were the result of operational accidents.
40. In 2010, there were 154 personnel with an initial NOTICAS classification of VSI or SI on Operation HERRICK (80 were VSI, 74 were SI). 144 (94%) of these were the result of hostile action, 10 (6%) were the result of operational accidents.
41. This totals 376 personnel with an initial NOTICAS classification of VSI or SI on Operation HERRICK between 1 January 2008 and 31 December 2010 (189 were VSI, 187 were SI). Of the 376 casualties, 42 were Naval Service personnel (includes Royal Navy and Royal Marines), 327 were Army personnel and seven were Royal Air Force personnel.
42. **Figure 3** presents the number of personnel with an initial NOTICAS classification of VSI or SI on Operation HERRICK by month of injury and roulement. The fluctuations seen are largely due to Operational tempo and the rise on HERRICK 10 (summer 2009 tour) was largely due to Operation Panther's Claw.

Figure 3: Personnel with an initial NOTICAS classification of VSI or SI on Operation HERRICK by month of injury and Roulement, 2008 – 2010, Numbers



43. Of the 376 personnel with an initial NOTICAS classification of VSI or SI on Operation HERRICK between 1 January 2008 and 31 December 2010, 139 (37%) were identified as amputees as at 31 March 2011, 136 of which were the result of hostile action. The 139 amputees are a subset of those reported in the Quarterly Op HERRICK and Op TELIC Amputation Statistics produced by DASA and published on the DASA website (www.dasa.mod.uk). There are a couple of reasons why some of the amputees were not recorded as VSI/SI in 2008, 2009 or 2010:
 - their injury occurred in an earlier time period and the amputation was a surgical amputation that occurred in 2008, 2009 or 2010;
 - their injuries resulted in an initial NOTICAS listing of 'Incapacitating Injury' or 'Unlisted injury' as the injuries were not of such severity that life or reason is imminently endangered (VSI) or of such severity that there is cause for immediate concern, but there is no imminent danger to life or reason (SI) (as some of the amputees include personnel who have lost a finger or toe).
44. All of the 376 casualties were admitted to a field hospital in Afghanistan. The length of stay at the field hospital varied from less than one day to six days, with an average (median) length of stay of one day. The length of stay in the field hospital will have been based on individual circumstances, before leaving the field hospital the casualty will have been fully stabilised and any emergency procedures will have been carried out. **Figure 4** presents the length of stay of those admitted to the field hospital.

Figure 4: Days¹ in field hospital, VSI and SI, 2008 – 2010, Numbers



¹ Dates into and out of the field hospital are recorded as date only and not date and time, therefore if a patient arrived and departed on the same day this would be recorded as less than a day. If a patient arrived one day and departed the following day this would be recorded as 1 day.

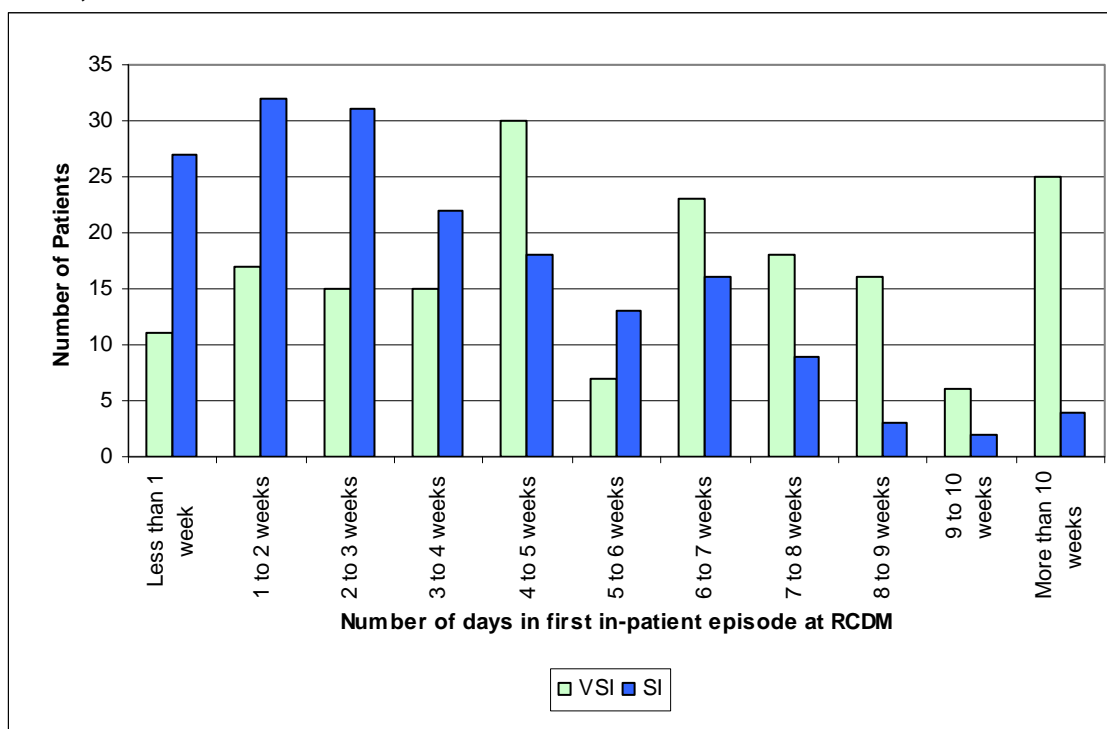
45. Seven patients (initial listing as one VSI and six SI) were treated in the field hospital and then returned to unit in theatre. These patients may have had conditions that were less serious than originally judged or the treatment may have been readily available in the field hospital and the casualties did not require aeromedical evacuation to the UK.
46. Of the remaining 369 patients, 368 were returned to the UK for treatment (via an aeromed flight) and one was returned (via an aeromed flight) to the US hospital in Germany for initial treatment for one month and then later returned to the UK for treatment. When patients require aeromedical evacuation they will be given appropriate degrees of Priority so that if the aircraft space is limited the more urgent patients may be evacuated before those with conditions less serious. Of the 369 patients:
 - 209 (57%) were returned as priority 1 – Urgent: These are patients for whom speedy evacuation is necessary to save life or limb, to prevent complication of serious illness or to avoid serious permanent disability. Priority 1 patients will normally be returned to the UK within 24 hours.
 - 96 (26%) were returned as priority 2 – Priority: These are patients who require specialised treatment not available locally and who are liable to suffer unnecessary pain or disability unless evacuated to the UK within 48 hours.
 - 64 (17%) were returned as priority 3 – Routine: These are patients whose immediate treatment requirements are available locally but whose prognosis would definitely benefit by air evacuation on routine flights. Most return to the UK within 3-4 days.
 - Occasionally patients, particularly those of greater dependency may wait longer than 7 days in order to maximise fitness to fly and to reduce any risks associated with their movement by air. Such deferment would result from purely clinical considerations.

VSI/SI Personnel returned to the UK for treatment

First Location of Specialist Care

47. As the main receiving unit for military casualties evacuated from an operational theatre, the Defence Patient Tracking System (DPTS) recorded that the Royal Centre for Defence Medicine (RCDM) received 366 of the 369 VSI and SI patients returned to the UK for treatment. Of the three not recorded on the DPTS as being received by RCDM:
- One casualty was treated in Germany initially and upon returning to the UK was then treated at the RCDM. This casualty has been removed from this section as he would skew the treatment times; however they have been included in the subsequent sections.
 - One casualty was returned to unit, receiving treatment/care at primary health care. This patient was listed as SI as they were involved in an incident, with more than one casualty and the unit determined it was important to return the individual to the UK as soon as possible.
 - One casualty was returned to unit, receiving treatment/care at primary health care. This casualty was later seen at a NHS (Independent Sector) hospital so has been included in subsequent sections.
48. At RCDM, National Health Service (NHS) staff, augmented with clinical military staff, deliver the whole range of medical care. Serious casualties need and receive advanced levels of care across a wide range of medical disciplines that can only be found in a major trauma hospital. When clinically appropriate, patients are cared for in a military ward.
49. 363 of the 366 casualties received by RCDM were admitted as in-patients (excludes casualty initially treated in Germany). **Figure 5** presents the length of stay of their first episode of care which varied between 1 day (less than one week) and 218 days (31 weeks), with an average (median) of 29 days (4-5 weeks), and an inter-quartile range of 34 days (lower quartile of 15 days and an upper quartile of 49 days).

Figure 5: Length of stay at first in-patient episode at RCDM (weeks), VSI or SI NOTICAS, 2008 – 2010, Numbers^{1,2}



¹ For the weekly categories, 1 to 2 weeks includes patients at RCDM for 1 or more weeks but less than 2 weeks.

² Three of the 363 patients admitted as an in-patient at RCDM have been excluded as they have not yet been discharged from their first episode of care, leaving 360 patients represented in this graph.

50. The distribution of the length of stay at the first episode as an in-patient at RCDM was significantly different for VSI and SI patients^d. The average (median) length of stay of VSI patients (41 days, (5 to 6 weeks); inter-quartile range of 34 days (lower quartile of 24 days and an upper quartile of 58 days)) was longer than for SI patients (21 days (2 to 3 weeks); inter-quartile range of 24 days (lower quartile of 12 days and an upper quartile of 36 days)).
51. The distribution of the length of stay at the first episode as an in-patient was significantly different for those injured as a result of hostile action and those injured as a result of non-hostile action^d. The average (median) length of stay of patients injured as a result of hostile action (31 days (4 to 5 weeks); inter-quartile range of 33 days (lower quartile of 16 days and upper quartile of 49 days)) was longer than for patients injured as a result of non-hostile action (10 days (1 to 2 weeks); inter-quartile range of 11 days (lower quartile of 6 days and upper quartile of 17 days)). This is likely to be due to the complexity of conditions suffered by some of the casualties who were injured as a result of hostile action.

Subsequent Locations of Specialist Care

52. After finishing their first in-patient or out-patient episode at RCDM the 364^e patients (363 aeromed straight to the UK, (360 admitted as in-patients and three seen as out patients) and one patient who was treated in Germany first) have gone on to either receive further treatment at RCDM or to receive treatment at other specialist care locations.

Royal Centre for Defence Medicine

53. As at the 1 March 2011 (date of data extract from the DPTS):
- 181 (50%) of the 364 patients had received subsequent treatment as an in or out-patient at **RCDM**, 86 of which were admitted as an in-patient more than once.
 - 17 (5%) of the 364 patients were receiving treatment at RCDM or were awaiting their next episode at RCDM. (In addition three patients were still receiving treatment in their first in-patient episode at RCDM).

Defence Medical Rehabilitation Centre (DMRC), Headley Court

54. As at 1 March 2011 (date of data extract from the DPTS), 313 (86%) of the 364 patients have received subsequent treatment at DMRC, Headley Court. Patients may move straight from their in-patient or out patient care at RCDM to DMRC or they may have a period of time on sick leave to enable time to heal before starting rehabilitation or they may be seen at one of the Regional Rehabilitation Units before requiring treatment at DMRC.
55. All patients attending DMRC are initially seen by a team of experts from different medical fields who together agree on the course of treatment. The team includes specialist medical officers, nurses, fitness instructors, physiotherapists, occupational therapists, speech and language therapists, cognitive therapists and social workers. The team also help prepare the casualties for a gradual return to active duty where possible.
56. Of the 311 that have attended DMRC:
- 254 (82%) were seen as in-patients, 207 of these 254 individuals were admitted as an in-patient more than once.
 - 291 (94%) were seen as out patients.
 - 76 (24%) were seen as residential patients.

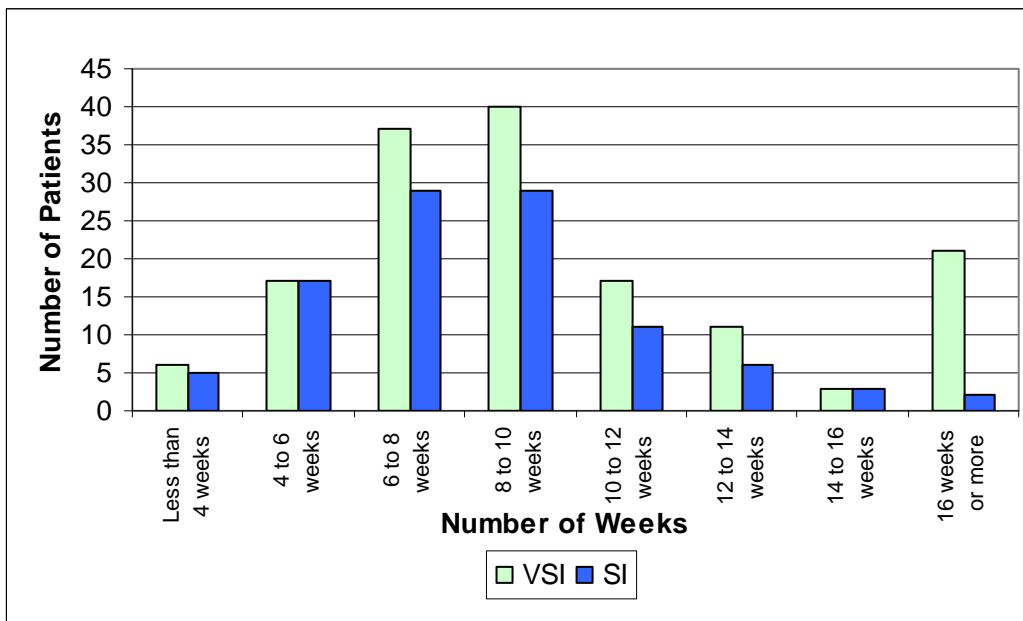
Length of time between Injury and In-Patient Admissions

57. **Figure 6** presents the length of time between injury and the first episode of care at DMRC, Headley Court.

^d Difference in distributions tested using The Mann Whitney Wilcoxon statistic for independent samples at the 5% significance level.

^e Three patients have been excluded as they had not completed their first in-patient episode at RCDM

Figure 6: Length of time between injury and first episode of care at DMRC, initial VSI or SI NOTICAS, 2008 – 2010, Numbers¹



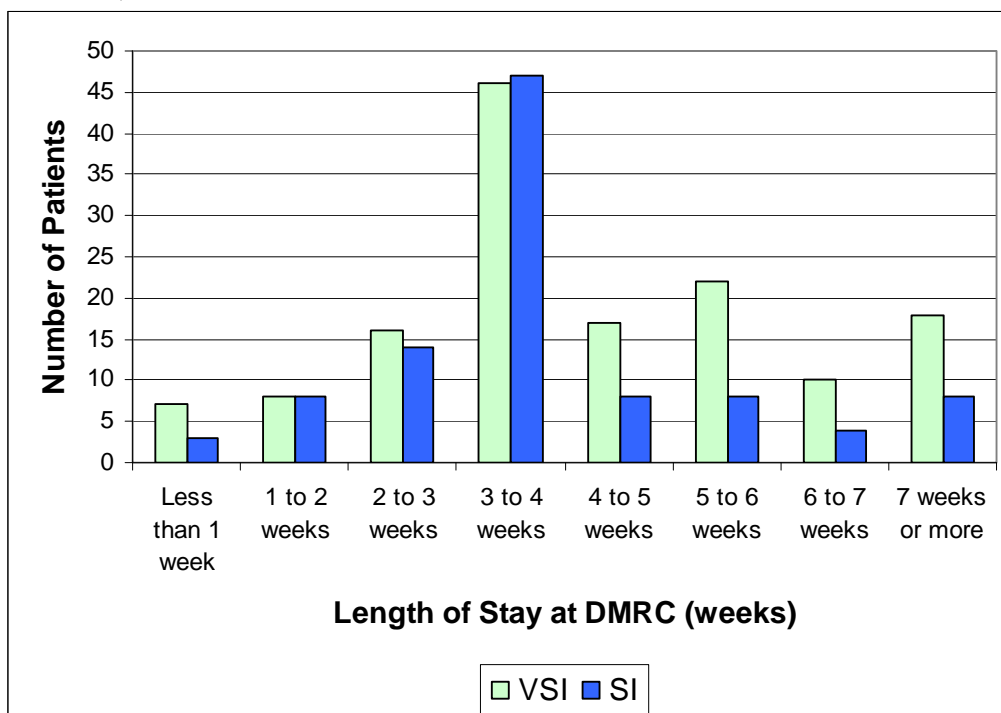
¹ For the weekly categories, 4 to 6 weeks includes patients whose time between injury and arrival at their in-patient episode at DMRC is 4 or more weeks but less than 6 weeks.

58. The length of time between injury and first episode of care varied between 12 days (less than 4 weeks) and 570 days (16 weeks or more), with an average (median) of 61 days (inter-quartile range of 28 days (lower quartile 47 days to upper quartile 75 days)). Therefore increases in VSI/SI patients in theatre should initially be seen on average approximately 8 to 9 weeks later at DMRC, Headley Court.
59. The first in-patient admission shows the smallest variation in the length of time between injury and admission. There are a few outliers in this data with some patients taking considerably longer than average to arrive at DMRC from their date of injury. Of these outliers, the majority were VSI patients indicating that they may need lengthier specialist care or longer recovery time prior to being admitted for rehabilitation. Subsequent admissions are more variable in nature (with larger inter quartile ranges) than the first admission:
- On average (median) the second in-patient admission occurs 17 weeks after injury, eight weeks after first admission.
 - The third in-patient admission occurs 24 weeks after injury, seven weeks after second admission.
 - The fourth in-patient admission occurs 32 weeks after injury, eight weeks after third admission.
 - The fifth in-patient admission occurs 40 weeks after injury, eight weeks after fourth admission.
 - The sixth in-patient admission occurs 48 weeks after injury, eight weeks after fifth admission.
 - The seventh in-patient admission occurs 61 weeks after injury, 13 weeks after sixth admission.
 - The eighth in-patient admission occurs 68 weeks after injury, seven weeks after seventh admission.

Length of In-Patient Admissions

60. **Figure 7** shows that the median length of stay of first admission for both VSI and SI in-patients at DMRC was 3 to 4 weeks (10 patients were excluded from analyses as they have not yet been discharged from their first in-patient episode at DMRC).

Figure 7: Length of Stay of First Admission to DMRC (Headley Court), initial VSI or SI NOTICAS, 2008 – 2010, Numbers^{1 2}

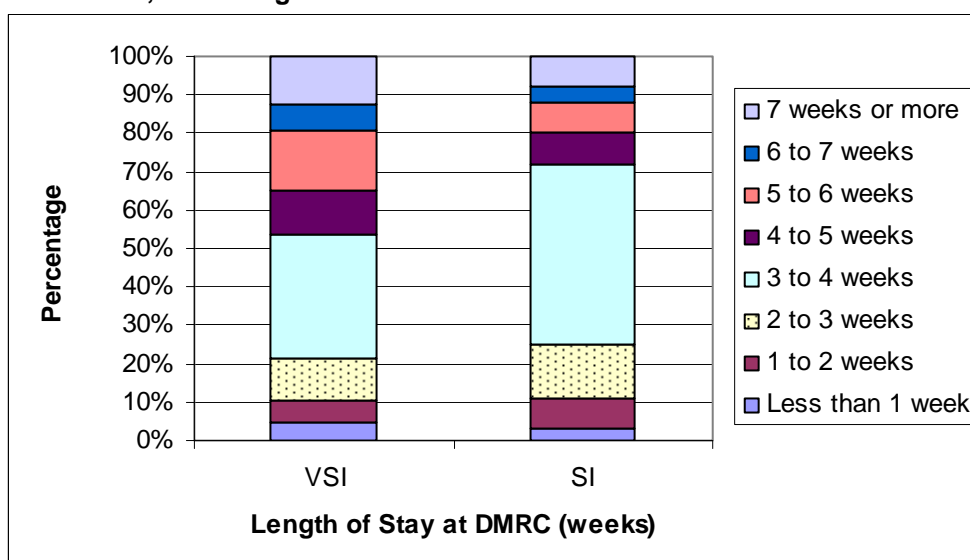


¹ For the weekly categories, 1 to 2 weeks includes patients at DMRC for 1 or more weeks but less than 2 weeks.

² 10 of the 254 patients admitted as an in-patient at DMRC have been excluded as they have not yet been discharged from their first episode of care, leaving 244 patients represented in this graph.

61. **Figure 8** shows that the distribution of first in-patient length of stay at DMRC was significantly different for VSI and SI patients^f. The average (median) length of stay for VSI patients (25 days, (3 to 4 weeks); inter-quartile range of 15 days (lower quartile of 23 days and an upper quartile of 38 days)) was longer than for SI patients (24 days (3 to 4 weeks); inter-quartile range of nine days (lower quartile of 21 days and an upper quartile of 30 days)).

Figure 8: First In-patient length of stay at DMRC (Headley Court), initial VSI or SI NOTICAS, 2008 – 2010, Percentage¹

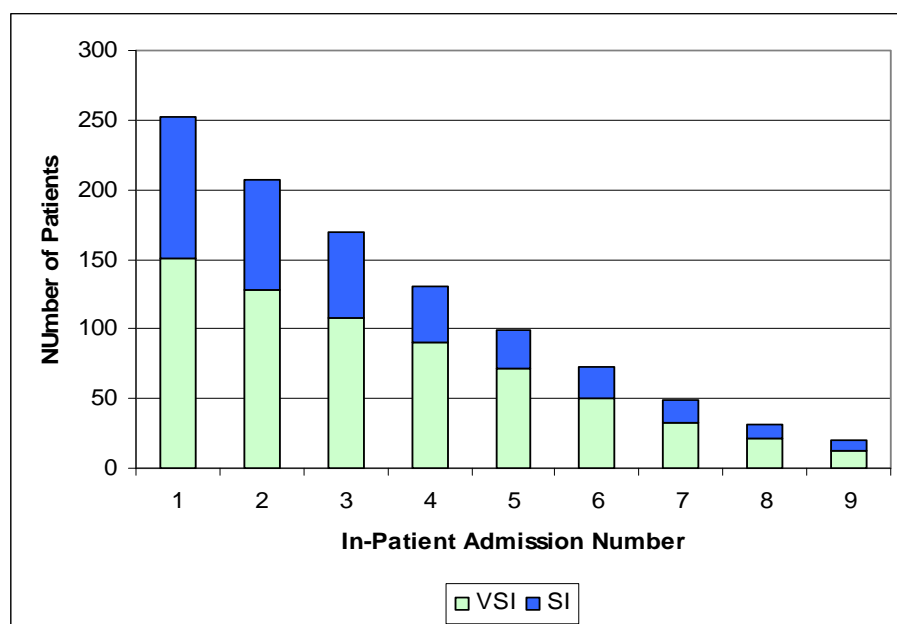


¹ 10 of the 254 patients admitted as an in-patient at DMRC have been excluded as they have not yet been discharged from their first episode of care at DMRC, leaving 244 patients represented in this graph.

^f Difference in distributions tested using The Mann Whitney Wilcoxon statistic for independent samples at the 5% significance level.

62. On average the first in-patient admission was the longest admission for these 244 patients (254 patients less the 10 patients not discharged from their first in-patient episode of care) with a median admission length of 24 days. There were some outliers in this data with two patients spending considerably less time than average at their first in-patient admission (approximately one day) and a number of patients spending considerably longer than average at their first in-patient admission (more than 50 days). It appears to be both VSI and SI in-patients that occur in these extreme values indicating that first in-patient length of stay is dependent on individual circumstances.
63. The median length of stay for each subsequent admission (admission number is incremental, first in-patient episode is admission 1, second in-patient episode is admission 2 etc) is less than the first but remains relatively stable at around 19 days.
64. **Figure 9** presents the number of in-patient admissions by VSI and SI classification. The number of in-patients admitted decreases with every admission; of the 254 in-patients:
- 207 (81%) went on to have a second admission,
 - 169 (67%) went onto have a third admission,
 - 130 (51%) went on to have a fourth admission,
 - 99 (39%) went on to have a fifth admission,
 - 73 (29%) went on to have a sixth admission,
 - 49 (19%) went on to have a seventh admission
 - 31 (12%) went on to have an eighth admission,
 - 20 (8%) went on to have a ninth admission,
 - 29 (Less than 12%) of all first in-patient admissions go on to have ten or more admissions.
- The current maximum number of in-patient admissions is 15 (admissions 10 - 15 do not appear on the graph due to small numbers). However, these numbers are likely to change as many patients have yet to complete their care pathway.
65. The distribution of the number admissions was significantly different for VSI and SI patient.⁹ The average (median) number of admissions for VSI patients (four admissions; inter-quartile range of four (lower quartile of two and an upper quartile of six)) was higher than for SI patients (three admissions; inter-quartile range of three (lower quartile of two and an upper quartile of five)). This may reflect the more severe injuries that are sustained by VSI patients that require additional in-patient rehabilitation admissions.

Figure 9: In-Patient Admissions to DMRC (Headley Court), initial VSI or SI NOTICAS, 2008 – 2010, Numbers



66. As at 1 March 2011 (date of data extract from the DPTS), 199 (55%) of the 364 patients were currently receiving treatment at DMRC or awaiting their next episode of care at DMRC.

⁹ Difference in distributions tested using The Mann Whitney Wilcoxon statistic for independent samples at the 5% significance level.

Regional Rehabilitation Units (RRUs)

67. As at 1 March 2011 (date of data extract from the DPTS):

- 129 (35%) of the 364 patients had received subsequent treatment at one of the 14 RRUs. Of these 129; 125 had been seen at a multi-disciplinary assessment clinic (MIAC) and 40 had been treated on rehabilitation courses (28 had been on one three week course and 12 had been on two three week courses).
- One patient who was SI and returned to unit in theatre and returned to the UK on a routine flight subsequently received treatment at a RRU. This patient was seen at a MIAC.
- 13 of the 365 patients (364 aeromed and completed treatment at RCDM and one returned on a routine flight) were currently receiving treatment at an RRU or awaiting their next episode at an RRU.

Other Locations

68. As at 1 March 2011 (date of data extract from the DPTS):

- 32 (9%) of the 364 patients had received subsequent treatment at one of the five **Ministry of Defence Hospital Units**.
- Four of the 364 patients were currently receiving treatment at a MDHU or awaiting their next episode at a MDHU.

69. As at 1 March 2011 (date of data extract from the DPTS):

- 103 (28%) of the 364 patients had received subsequent treatment at **another hospital** (including NHS and Independent Sector Hospitals). In addition, one patient who was aeromed from Op HERRICK and returned to unit to receive treatment/care at primary health care subsequently received treatment at a NHS/Independent Sector Hospital.
- Two of the 365 patients (364 aeromed and completed treatment at RCDM and one returned on an aeromed, received treatment at unit and later seen at a NHS hospital) were currently receiving treatment at **another hospital** or awaiting treatment at **another hospital**.

70. As at 31 December 2010 (latest date for which mental health data is available)

- 57 (16%) of the 364 patients had been seen for assessment as new patients at the MOD's **DCMHs and overseas satellites**, after their date of injury. Of these 57 personnel, 51 were assessed as having a mental disorder. Of the 51 personnel:
 - 46 were assessed with a neurotic disorder
 - Fewer than five were assessed with a mood disorder
 - Fewer than five were assessed with an other mental disorder
- Fewer than five of the 364 patients were admitted to the MOD's in-patient contractor for mental health.

Amputees

71. As highlighted earlier 139 (37%) of the 376 VSI/SI casualties in 2008, 2009 and 2010 were identified as amputees by 31 March 2011, 136 of which were the result of hostile action.

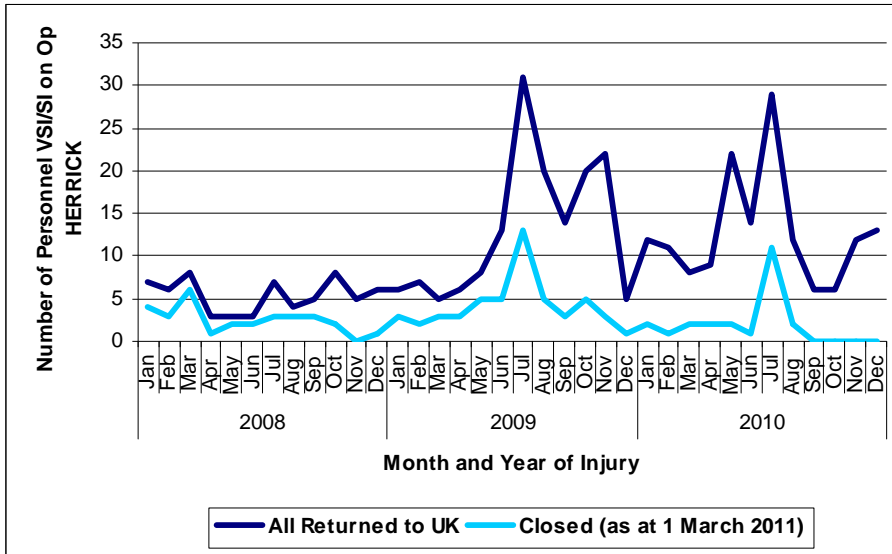
72. As at 1 March 2011, 131 (94%) of the 139 amputees had open care pathways, indicating that they were still receiving specialist care. Of the 139 amputees:

- All had been treated at RCDM (all 139 were seen as in-patients and 64 were seen as out-patients).
- 133 had been treated at DMRC, 132 were seen as in-patients, 133 were seen as out-patients and 21 were seen as residential patients. All 133 were seen at more than one type of appointment.
- 23 had received treatment at a RRU; all 23 were seen at a multi-disciplinary assessment clinic and two were treated on a rehabilitation course.
- 56 had received subsequent treatment at another hospital (including NHS, Independent Sector Hospitals and Ministry of Defence Hospital Units).

Care Pathway Length and Closed Pathways

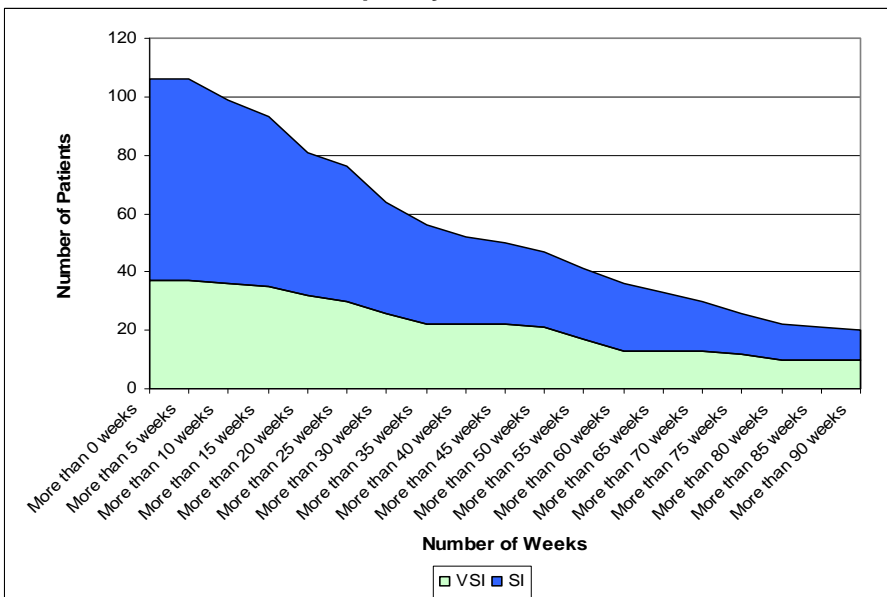
73. **Figure 10** presents the number of personnel returned to the UK for specialist treatment with an initial NOTICAS classification of VSI or SI on Operation HERRICK by month of injury and the number of these personnel with closed pathways as at 1 March 2011.

Figure 10: Personnel with an initial VSI or SI NOTICAS, 2008 – 2010, returned to the UK by month of injury and closed care pathways, numbers



74. As at 1 March 2011 (date of data extract from the DPTS), 263 (71%) of the 369 VSI/SI patients returned to the UK for treatment in specialist care had open care pathways, **Figure 10** highlights that many of those injured between 2008 and 2010 still have open care pathways. The remaining 106 had closed pathways indicating that no further specialist care was required (37 VSI and 69 SI; 30 who were injured in 2008, 53 who were injured in 2009 and 23 who were injured in 2010).
75. One of the 106 patients with a closed pathway subsequently had a new pathway initiated (nine months after the original closed pathway) as a result of their previous injury (SI). Two of the 106 patients, who required no further specialist follow-up for a VSI and SI were returned to duty, one later died in an unconnected incident and one was returned via aeromed for the same injury sustained in the original VSI incident and treated in Primary Health Care. At 1 March 2011 all three of these pathways were closed.
76. **Figure 11** presents the length of care pathway as a cumulative frequency graph for the 106 patients returned to the UK for specialist care with **closed** pathways, calculated using the time between injury and date of pathway closure. For the patient with a subsequent pathway initiated only the length of time of the initial pathway has been calculated.

Figure 11: Length of care pathway for closed pathways (weeks), initial VSI or SI NOTICAS, 2008 – 2010, Cumulative Frequency



77. The length of **closed** care pathways varied between 39 days (between 5 and 6 weeks) and 1,290 days (between 184 and 185 weeks), with an average (median) of 279 days (between 39 and 40 weeks) and an inter-quartile range of 365 days (lower quartile 151 days (between 21 and 22 weeks) and upper quartile 516 days (between 73 and 74 weeks)).
78. Please note, there are some patients with **open** care pathways who injured at the start of 2008 and thus at the 1 March 2011 (date of data extract from the DPTS) these pathways were over 37 months in length.
79. The analysis on length of care pathway is currently limited due to the small proportion of those who were VSI/SI on Op HERRICK in 2008, 2009 and 2010 with closed treatment pathways. This will be updated in future reports to enable a better understanding of the length of time that these patients are in treatment.
80. The graphs and commentary produced in this section only included those personnel returned to the UK for Specialist Care. There were an additional six personnel with an initial NOTICAS of VSI or SI whose pathways were closed in theatre, one service person whose pathway was closed once they had returned to the UK who did not receive any specialist care (these seven personnel were excluded from this section as they would skew the trends presented). In total **113** personnel out of the **376** with an initial NOTICAS listing of VSI or SI had a **closed care pathway**.
81. As at 1 March 2011, 13^h of the 113 personnel with closed care pathways had subsequently redeployed on Operation HERRICK and/or Operation TELIC.

Discharged Personnel

82. As at 1 March 2011, 17 (15%) of the 113 personnel with a closed pathway were no longer in Service. The remaining 359 (96 with closed pathways, 263 with open pathways) remain in Service. Of the 17:
- 16 had a closed pathway in the DPTS indicating that no further specialist care was required and had then been discharged from Service.
 - One personnel had a closed pathway in the DPTS and was returned to duty after recovering from his injuries then later died in an unconnected incident.
83. If a decision has been taken to medically discharge an individual from the Military the specific Defence Medical Services health team who have been caring for that individual will begin a liaison with appropriate civilian healthcare providers (e.g. General Practitioner / Primary Health Care Team / civil mental health team / NHS Trust) to ensure the transfer of care and patient history takes place.
84. Additionally the MOD have specialist health social workers who manage the individual's wider resettlement issues, liaising with relevant civil agencies such as local housing authorities, financial authorities, service welfare and charitable organisations; again to endeavour that the individual's transfer into the civilian environment is as smooth and as seamless as possible.

Current Joint Medical Employability Standard (JMES) for Personnel with Closed Pathways

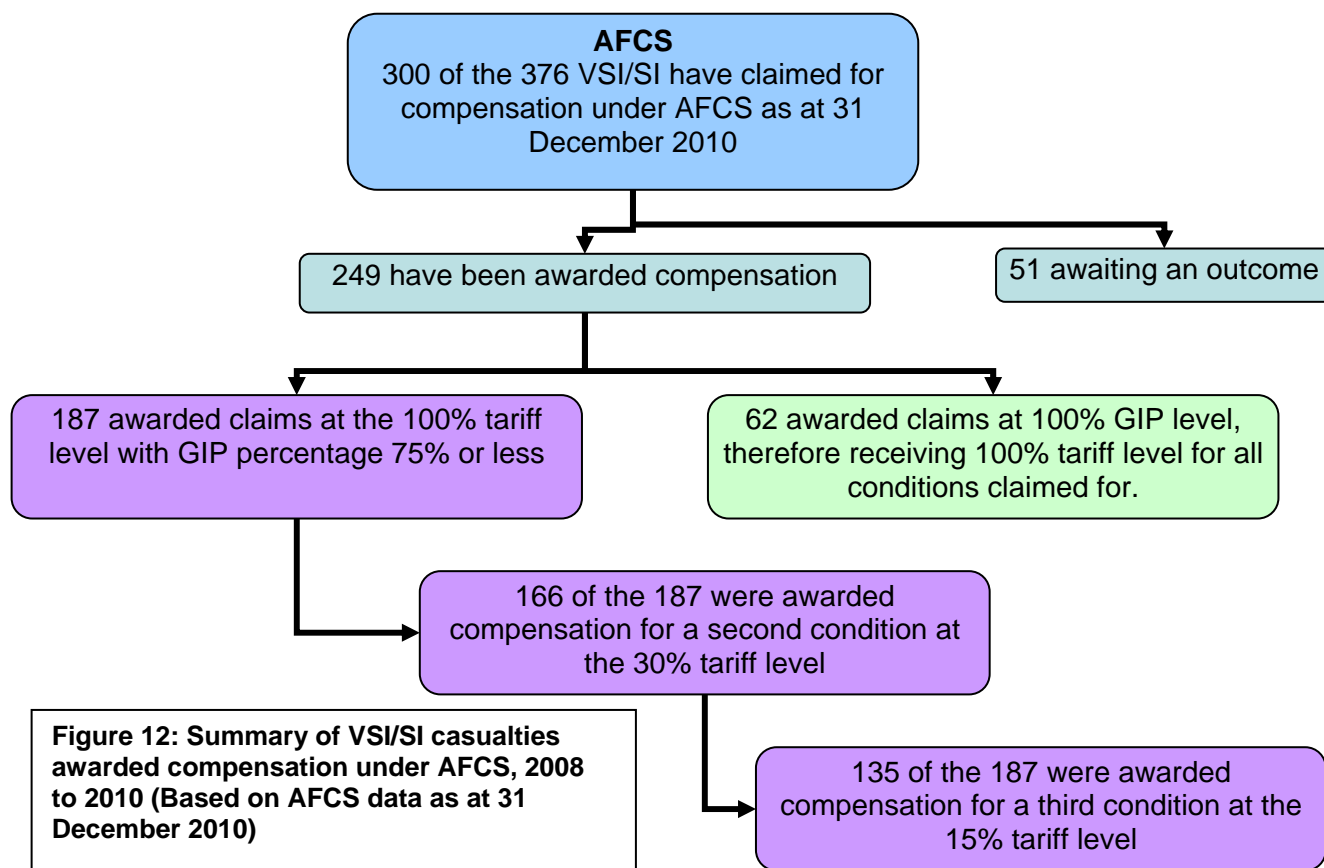
85. As at 1 March 2011, the latest Medical Deployability Standard (MDS) recorded, for the 96 personnel who were still in Service with a closed pathway, (excluding the 17 patients described in paragraph 82):
- 33 were medically full deployable (MFD)
 - 17 were medically limited deployable (MLD)
 - 34 were medically non deployable (MND)
 - 12 had no MDS recorded after their injury on DMICP

Armed Forces Compensation Scheme

86. As at 31 December 2010 (latest date for which AFCS data is available), 300 (80%) of the 376 casualties had claimed for compensation under the Armed Forces and Reserve Forces Compensation Scheme (AFCS). This resulted in a total of 383 claims, which includes multiple and/or additional claims for some individuals. Currently, individuals have up to seven years from the date of their injury to make a claim and as such, the remaining 76 individuals who have yet to claim may still do so in the future.

^h Excludes Service personnel that returned to Unit in theatre after sustaining their injury (VSI/SI) and includes one personnel who redeployed and died in an unconnected incident.

87. Individuals awarded at tariff levels 1-11 will receive a Guaranteed Income Payment (GIP), which is an index-linked, tax-free payment, in addition to their lump sum amount. Individuals awarded at tariff levels 12-15 will receive a lump sum amount only.
88. Where multiple claims are awarded under the AFCS, the most severe condition is awarded 100% of the tariff amount for that condition. The second most severe condition is awarded 30% of the tariff amount for that condition and the third most severe is awarded 15% of the tariff amount for that condition. Subsequent conditions are not allocated an award amount. The exception to this is when an individual is awarded at tariff levels 1-11 and is also allocated a GIP percentage of 100%. In these cases, all awarded conditions will receive 100% of the tariff amount.
89. As at 31 December 2010, 249 of the 300 individuals who had claimed under the AFCS had been awarded compensation for an illness or injury related to their Service.
90. Of the 249 individuals awarded, 62 were allocated a 100% GIP percentage and therefore received 100% of the tariff amount for all claimed conditions. The two categories of conditions most frequently awarded for these 62 individuals were 'injury, wounds and scarring' and 'amputations'.
91. Of the 249 individuals awarded, 187 were awarded compensation for an injury or illness related to their Service at 100% of the tariff level (with a GIP percentage of 75% or less). Of these, 166 individuals were also awarded for a further condition at 30% of the tariff level, and 135 were also awarded for a further condition at 15% of the tariff level.
92. As at 31 December 2010, there was no outcome recorded on CAPS for the claims of the 51 remaining VSI/SI casualties who had registered claims under the AFCS.



Notes on AFCS data:

1. Conditions are assessed against a tariff of injuries table where the lower numerical values (i.e. 1-4) reflect the more severe conditions that are awarded at the highest tariff level. Full details of the tariff can be found at <http://www.veterans-uk.info/pdfs/afcs/tariff.pdf>.
2. All claims counted in this report occurred after the date of injury. The claim made under AFCS may not be attributable to their VSI or SI sustained on Op HERRICK.

Discussion and Future Developments

93. A large proportion of the casualties that had a classification of VSI or SI on the initial NOTICAS signal still remain in specialist care, with only 30% of patients completing their care pathway.
94. To fully understand the length of time that VSI/SI patients are in treatment and the broad long term outcome measures (including the number returned to unit, those medically discharged or those re-deployed), DASA will continue to track the remaining 70% of patients with open pathways and will add subsequent patients with a NOTICAS classification of VSI or SI on Op HERRICK. DASA will update this report every six months.

Data Sources

NOTICAS

Notification of Casualty (NOTICAS) is the name for the formalised system of reporting casualties within the UK Armed Forces. It sets in train the MOD's next of kin informing procedure. The MOD's Joint Casualty and Compassionate Policy and procedures set out the guidance under which a NOTICAS report is to be raised. NOTICAS takes precedence over all but the most urgent operational and security matters.

The NOTICAS reports raised for casualties contain information on how seriously medical staff in theatre judge their condition to be. This information is used to inform what the next of kin are told. "VSI" and "SI" are the two most serious categories into which personnel can be classified:

- a. Very seriously injured/ill or VSI is the definition we use where the injury/illness is of such severity that life or reason is imminently endangered.
- b. Seriously injured/ill or SI is the definition we use where the patient's condition is of such severity that there is cause for immediate concern, but there is no imminent danger to life or reason.

The VSI and SI categories are defined by Joint Casualty and Compassionate Policy and Procedures. They are not strictly 'medical categories' but are designed to give an indication of the severity of the injury to inform the next of kin and the chain of command.

The NOTICAS was used to identify those personnel whose initial listing was VSI or SI during 2008, 2009 and 2010. In these figures we have excluded individuals categorised as VSI or SI whose condition was identified to be caused by illness.

The number of Service personnel VSI or SI as a result of Op HERRICK is published fortnightly, a fortnight in arrears, and can be found on the DASA website (www.dasa.mod.uk).

Field Hospital Admissions from J97 Returns and OpEDAR

In 2008, 2009 and 2010 there was a UK Field Hospital at Camp Bastion where the more seriously ill and injured were treated. This has an intensive care and high-dependency facility, as well as surgical, medical, A+E, physiotherapy, and dental, mental health, x-ray, CT scanner and laboratory facilities.

DASA receive information on the patients who are admitted to the UK Field Hospital at Camp Bastion from the J97 Returns. This J97 return also includes those patients admitted to the following two locations:

- The HQ of Multinational Brigade (South) in Kandahar also maintained a Field Hospital which provides support for ISAF and Coalition personnel. This facility includes additional capabilities to that of the Role 2 including specialist diagnostic resources and specialist surgical and medical capabilities.
- In Kabul, UK Personnel may be admitted to either the French or Greek Field Hospital. There is also a US facility which provides physiotherapy and dentistry. In total, the UK deploy some 300 medical staff to support the operation.

DASA also receive information on admissions and attendances at the UK Field Hospital at Camp Bastion from the Operational Emergency Attendance Register (OpEDAR)).

These two data sources have been used to report on length of stay in the field hospital and outcome from that admission.

Whilst most of the data is captured via drop down menus, some fields, including diagnosis, are free text, thus the quality of medical information captured is variable.

The OpEDAR system records all patients who have attended or have been admitted through the A&E department of a UK Operational hospital. The treatment classification broadly groups the data by injury treatment type. OpEDAR captures information at the initial assessment. It is possible for this to change over the course of treatment or for a patient to have multiple conditions; however, this information is not captured.

Amputation Data

The VSI/SI casualties in Afghanistan in 2008, 2009 and 2010 were linked with amputation data which are compiled from four sources:

- The Joint Theatre Trauma Register (JTTR), which commenced during 2003 to improve the care of the seriously injured patient from the point of injury to the point of discharge from hospital treatment.
- The Complex Trauma Database managed by the Defence Medical Rehabilitation Centre, Headley Court which commenced in June 2008 to record information on patients receiving in-patient care on the complex trauma ward.
- The Prosthetics Database managed by the Defence Medical Rehabilitation Centre, Headley Court which commenced in June 2006 to record information on patients fitted with a prosthetic limb(s).
- The Defence Patient Tracking System (DPTS) which commenced on 8 October 2007. The DPTS was set up to enable the capture of tracking data for aeromedically evacuated patients at the place where healthcare is being delivered along the care pathway.

An amputee is defined as live UK Service personnel who have an injury coded in the JTTR as Amputation (traumatic), partial or complete, for either upper or lower limbs using the Abbreviated Injury Scale (AIS) Dictionary 2005 (Military Edition), and live UK Service personnel who had a surgical amputation performed either at the field hospital or at a UK hospital (the majority of these will be at the Royal Centre for Defence Medicine). A traumatic or surgical amputation can range from the loss of part of a finger or toe up to the loss of entire limbs.

Live personnel are defined as those being discharged from hospital after receiving treatment for the injuries that resulted in an amputation(s).

The data from the JTTR is cross referenced with the Complex Trauma Database, the Prosthetics Database and the DPTS. Doctors may recommend and/or patients may elect to have an amputation at any point during their care pathway, thus any additional live UK Service personnel identified as an amputee from these data sources have been included in this report.

The number of amputations sustained as a result of Op HERRICK are released on a quarterly basis, one month in arrears, on the DASA website (www.dasa.mod.uk).

The Defence Patient Tracking System (DPTS)

The DPTS was set up to monitor the progress of Armed Forces patients undergoing specialist treatment in the UK to ensure that their care is delivered promptly and coherently, and to coordinate clinical, administrative and welfare aspects of their support. The DPTS was set up as previously this information was not stored centrally. This data source has therefore been used to track the VSI/SI casualties through their specialist care pathway.

The DPTS is not a medical or welfare record system; medical records are held on the Defence Medical Information Capability Programme (Primary Health Care) and by the National Health Service (Secondary Health Care); welfare records are held in single Service welfare databases. The DPTS is not an authoritative record of personnel and demographic details, these details are held on Joint Personnel Administration system.

The number of patients treated at RCDM and DMRC as a result of Op HERRICK are released on a monthly basis, one month in arrears, on the DASA website (www.dasa.mod.uk).

Mental Health Returns

DASA receive and collate mental health returns covering all new episodes of care of Service Personnel to the MOD's Departments of Community Mental Health (DCMHs) for outpatient care, and new admissions to the MOD's in-patient care contractor. The DCMH staff record the initial psychiatric assessment during a patient's first appointment, based on presenting complaints. The information is provisional and final diagnoses may differ as some patients do not present the full range of symptoms, signs or clinical history during their first appointment. The psychiatric assessment data are categorised into three standard groupings of common mental disorders used by the World Health Organisation's International Statistical Classification of Diseases and Health-Related Disorders 10th edition (ICD-10).

A number of patients present to DCMHs with symptoms that require the treatment skills of DCMH staff, whilst not necessarily having a specific and identifiable mental disorder. In the Results section, these cases are referred to as “assessed without a mental disorder”.

Records submitted were excluded from the main analysis if they were duplicates or repeat attendances in the same episode of care. Civilian or non-UK military personnel are not covered by this report.

A rigid pseudo-anonymisation process, and other measures preserving patient confidentiality, has enabled full verification and validation of the DCMH returns, importantly allowing identification of repeat attendances.

This data source has been used to identify the VSI/SI patients that have attended a DCMH or in-patient care contractor as a new referral after the date of their injury.

The number of Service personnel referred to the MOD’s DCMHs for outpatient care, and new admissions to the MOD’s in-patient care contractor are released on a quarterly basis, three month in arrears, on the DASA website (www.dasa.mod.uk).

Compensation and Pension System (CAPS)

The Compensation and Pension System (CAPS) holds the data regarding the Armed Forces and Reserve Forces Compensation Scheme (AFCS). The AFCS came into force on 6 April 2005 to pay compensation for injury, illness or death attributable to Service that occurred on or after that date. It replaced the previous compensation arrangements provided by the War Pensions Scheme and the attributable elements of the Armed Forces Pensions Scheme.

Injury benefits include a tariff-based lump sum payment to compensate for injury and, where appropriate, to provide payment to assist with the immediate costs of disablement. For more severe injuries (tariffs 1-11), a further sum is paid in the form of a Guaranteed Income Payment (GIP), which consists of regular payments to provide a continuous income stream. For the first time, a claim can be made and awarded while still in Service, although when a GIP is awarded in-Service, its payment is deferred until the individual has left Service.

Lump Sums: A tax-free lump sum payment is paid to a Service or ex-Service person as compensation for an injury or illness that is predominantly caused or made worse by Service. The tariff has 15 levels with a lump sum amount attached to each level; the lower numerical values (i.e. 1-4) reflect the more severe conditions that are eligible for higher monetary awards. Full details of the tariff can be found at <http://www.veterans-uk.info/pdfs/afcs/tariff.pdf>. Lump sums may be awarded as a result of an in-Service claim, a medical discharge claim or a post Service claim. The table below shows the tariff level amounts.

Tariff Level	Amount (£)
1	570,000
2	402,500
3	230,000
4	172,500
5	115,000
6	92,000
7	63,825
8	48,875
9	34,100
10	23,100
11	13,750
12	9,075
13	5,775
14	2,888
15	1,155

Guaranteed Income Payments: A Guaranteed Income Payment (GIP) is payable when an award has been made and the illness or injury is in tariff levels 1 to 11. A GIP is a tax free monthly payment intended to be paid as compensation for loss of earnings capacity so is not payable whilst in-Service. Therefore if a GIP is awarded as the result of an in-Service claim it will be deferred until the claimant has left the Services. Once awarded, a GIP is payable for life and uprated annually in line with inflation to the Retail Price Index (RPI).

Tariff levels 1 to 11 are divided into four bands and they refer to the percentage used to calculate the annual amount of the GIP; 100% for Band A (tariff levels 1-4), 75% for Band B (tariff levels 5-6), 50% for Band C (tariff levels 7-8) and 30% for Band D (tariff levels 9-11).

In February 2010, the review of the AFCS, announced last year by the Defence Secretary, was completed. The main areas that need some adjustment to ensure the Scheme delivers as effectively as it can are:

- a. **Multiple injuries:** every person who sustained multiple injuries arising from a single incident will now receive some recognition for each injury.
- b. **GIP calculations:** the average number of promotions that an injured Service person may have achieved that they are no longer able to as a result of their injury will be reflected in the tax-free index-linked GIP that those with serious injuries receive.
- c. **Lump sum amounts:** all lump sum levels, with the exception of the top amount, will be increased.
- d. **Time limits increase:** time limits to claim will be increased and a new 'fast' payment introduced so claimants can receive some compensation without having to go through the whole claim process.

All those who have already made a claim will benefit from the Review and will be contacted once their case has been reviewed. This will happen after the changes have been implemented through new legislation, which is likely to be early 2011, with claims being re-visited throughout 2011.

This data source was used to identify how many of the VSI/SI casualties have registered claims under the AFCS, and the outcome of the claim. Individuals were included in the figures if the date of their claim was registered on CAPS was on or after their date of incident.

The number of claims registered and awarded under the AFCS are reported on a quarterly basis, three months in arrears, on the DASA website (www.dasa.mod.uk).

Joint Personnel Administration (JPA)

JPA (the Armed Forces personnel system) has been used to identify if the Service personnel remains in Service and to identify if an individual has been re-deployed once their care pathway is complete (using JPA move and track).

Defence Medical Information Capability Programme

DMICP is the source of electronic, integrated healthcare records for primary healthcare and some MOD specialist care providers. This source has been used to obtain an individual's medical deployability status (MDS) after injury, which provides an indication of their Medical Deployability status. Once downgraded, Service personnel will be assessed as Medically Fully Deployable (MFD), Medically Limited Deployable (MLD) or Medically Non-Deployable (MND).

Specialist Treatment Locations

Hospital Treatment

The Royal Centre for Defence Medicine (RCDM)

1. Since 2001, the Royal Centre for Defence Medicine (RCDM), based at the University Hospital Birmingham Foundation Trust (UHBFT), has been the main receiving unit for military casualties evacuated from an operational theatre. In the Birmingham area, military patients can benefit from the concentration of five specialist hospitals (including the new Queen Elizabeth Hospital) to receive the appropriate treatment. The Queen Elizabeth Hospital is at the leading edge in the medical care of the most common types of injuries (e.g. polytrauma) our casualties sustain, and the majority of casualties will be treated there, but others may be transferred to another hospital (in Birmingham or elsewhere) if that is where the best medical care can be given.

Ministry of Defence Hospital Units (MDHUs)

2. There are five Ministry of Defence Hospital Units (MDHUs) where Defence Medical Services personnel work alongside civilian colleagues in NHS hospitals. As well as contributing to the care provided by these hospitals, they gain the depth and range of experience necessary to be able to administer first class treatment when deployed on Operations. When clinically appropriate, military patients are kept together and treated by military staff at these units. They are located at: Deriford, Frimley Park, Peterborough, Portsmouth and Northallerton.

National Health Service (NHS) and Independent Sector Hospitals

3. Patients may also receive treatment at other NHS hospitals or independent sector hospitals. This may occur if the patient requires treatment at a particular specialist unit or to be nearer their home.

Rehabilitation

4. If military patients require further rehabilitation care following initial hospital treatment, they may be referred to the Defence Medical Rehabilitation Centre (DMRC) at Headley Court in Surrey, which provides advanced rehabilitation and includes in-patient facilities. Less serious cases may go on to one of MOD's 15 Regional Rehabilitation Units (RRUs) in the UK and Germany, which provide accessible, regionally based assessment and treatment, including physiotherapy and group rehabilitation facilities.

Psychiatric Treatment

5. Psychiatric patients in the UK Armed Forces are seen for out-patient care at one of the 15 Departments of Community Mental Health (DCMH) across the UK (plus satellite centres overseas), at the MOD's in-patient care contractor, or by one of the Community Psychiatric Nurse (CPN) when they are receiving treatment at RCDM or DMRC Headley Court. Mental health services are configured to provide community-based mental health care in line with national best practice, providing assessment and treatment consistent with the guidelines and standards set by the National Institute for Health and Clinical Excellence and the National Service Frameworks.
6. The DCMHs are staffed by Community Mental Health Teams comprising psychiatrists and mental health nurses based on the catchment area population of the DCMH, with access to clinical psychologists and mental health social workers.
7. Until 1st March 2009, in-patient care has been provided regionally in specialised psychiatric units under a contract with the Priory Group. In November 2008 it was announced that the South Staffordshire and Shropshire NHS Foundation Trust network (in partnership with 5 other Foundation Trusts and one NHS Scotland Trust) has been awarded a three year contract for the provision of in-patient mental health services. The transfer of inpatient care from Priory Group occurred from 1st March 2009, at which point Priory Group ceased to admit patients. To ensure appropriate procedures were in place by 1st March 2009, selected patients were admitted to the South Staffordshire and Shropshire NHS Foundation Trust network from January 2009.