

# Tracking Op HERRICK (Afghanistan) VSI/SI Operational Casualties: 2008 and 2009

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## INTRODUCTION

1. This report is the first in a new series producing statistical information on patients that were very seriously injured (VSI) or seriously injured (SI) on Operation HERRICK (Afghanistan) in 2008 or 2009 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) in 2008 or 2009 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 TELIC and Op HERRICK 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 and the length of their care pathway.
  - 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 medically fully deployable or medically limited deployable.
  - The number of casualties medically discharged with the principal cause leading to discharge.
  - 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. This totals 222 personnel with an initial NOTICAS classification of VSI or SI on Operation HERRICK in 2008 and 2009 (109 were VSI, 113 were SI). Of the 222 personnel, 73 were identified as amputees at 31 December 2009, 71 of which were the result of hostile action.
9. All of the 222 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. Four patients were discharged from the field hospital and returned to unit in theatre. The remaining 218 casualties were aeromedically evacuated to the UK for treatment (one of these was initially aeromedically evacuated to the American Hospital in Landstuhl, Germany).
10. As the main receiving unit for military casualties evacuated from an Operational theatre; the Royal Centre for Defence Medicine (RCDM) received 216 of the 218 casualties in the UK (one patient was returned to unit to be treated at Primary Health Care, one casualty was treated in Germany initially and upon returning to the UK was then treated at RCDM).
11. After finishing their first in-patient or out patient episode at RCDM the 215<sup>a</sup> patients (214 received by RCDM and 1 received by RCDM via Germany) have gone on to either receive further treatment at RCDM or to receive treatment at other specialist care locations.
12. As at 1 April 2010, 220 of the 222 with an initial NOTICAS classification of VSI or SI on Operation HERRICK in 2008 and 2009 were still in Service. For the 2 personnel no longer in Service:
  - One had a closed pathway in the DPTS indicating that no further specialist care was required and had then been discharged from Service, their last MDS was Medically Fully Deployable.
  - 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.
13. As at 1 April 2010, 38 of the 220 VSI or SI still in Service had closed care pathways, indicating that no further special care was required. Three of these 38 personnel had subsequently redeployed on Operation TELIC and/or Operation HERRICK.
14. As at 1 April 2010, DMICP recorded for the 38 personnel who were still in Service with closed pathways, 23 were medically fully deployable (MFD), six were medically limited deployable (MLD), nine were medically non deployable (MND).
15. As at 31 December 2009, 133 of the 222 casualties had claimed for compensation under the AFCS. This resulted in a total of 164 claims, which includes multiple and/or additional claims for some individuals. Currently individuals have up to seven years from the date of their injury or onset of illness to make a claim and as such, the remaining 89 individuals who have yet to claim may still do so in the future.
16. Of those who claimed under the AFCS, a total of 93 have been awarded compensation for an injury or illness caused by Service. The remaining 40 VSI/SI casualties were awaiting the outcome of their AFCS claim.

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<sup>a</sup> Two patients have been excluded as they had not completed their first in-patient episode at RCDM.

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## Data, Definitions and Methods

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

17. 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.

18. 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.

19. This report **does not** include patients that were very seriously ill or seriously ill on Operation HERRICK (Afghanistan) in 2008 or 2009 as listed on the initial NOTICAS signal, in line with the fortnightly publication of operational casualty and fatality statistics.

20. 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.

21. 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.

22. 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](http://www.dasa.mod.uk)

### Operation HERRICK

23. 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.

24. **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.

### Operation TELIC

25. 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

26. 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

### **Amputee**

27. 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**

28. 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. 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).

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

### **Pseudo-anonymisation**

30. 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**

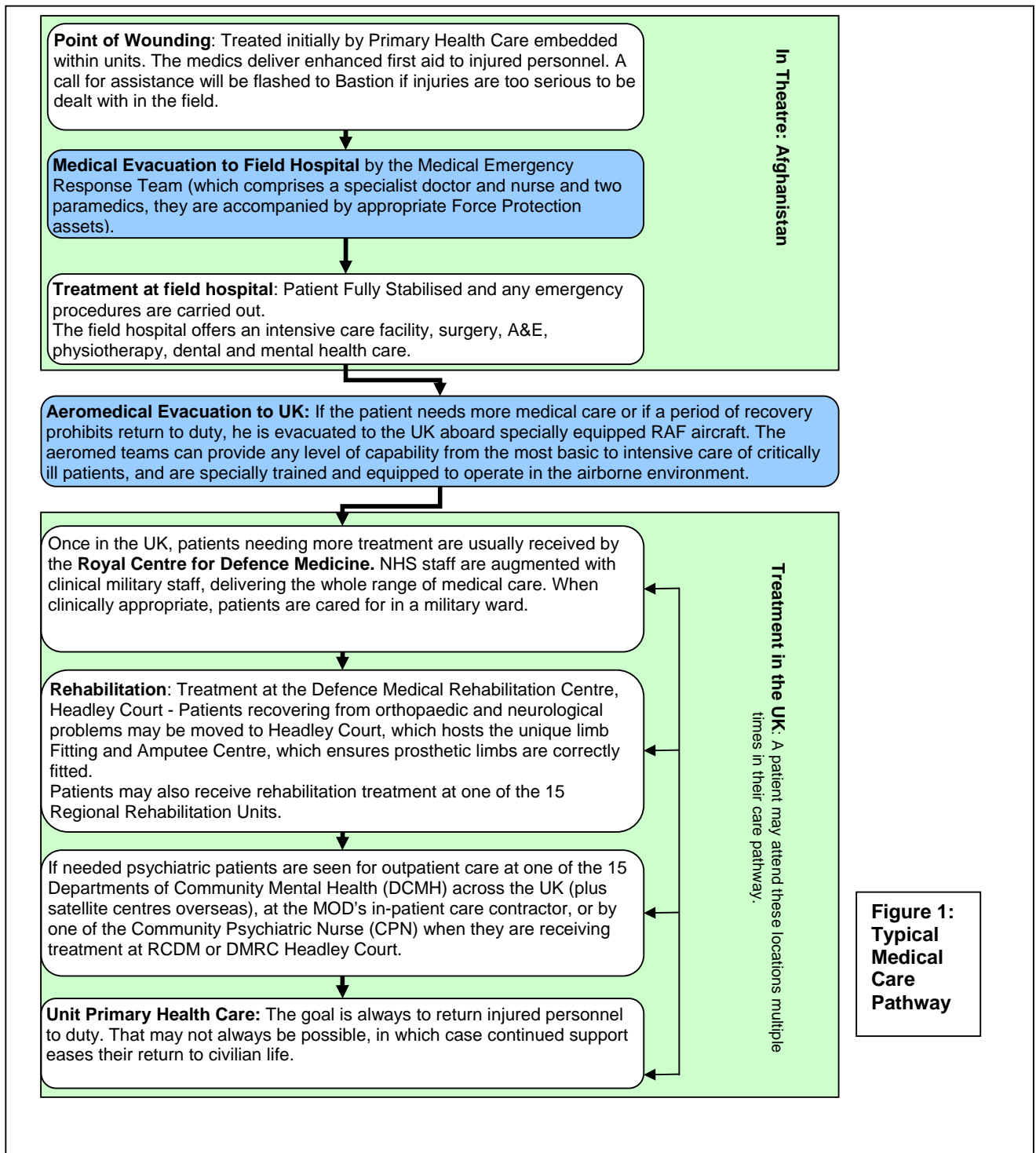
31. Information on length of stay and length of pathways has been presented as a median average with an inter-quartile range, rather than a mean average and standard deviation as these statistics are affected less by outliers.

- The median is the value in the centre of the data set when they are arranged from smallest to largest.
- 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.
- 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.
- An outlier is a value lower than the lower quartile or higher than the upper quartile.

32. 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 used to test if the distribution of length of admission time is different for VSI and SI patients.

### Medical Care Pathway

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



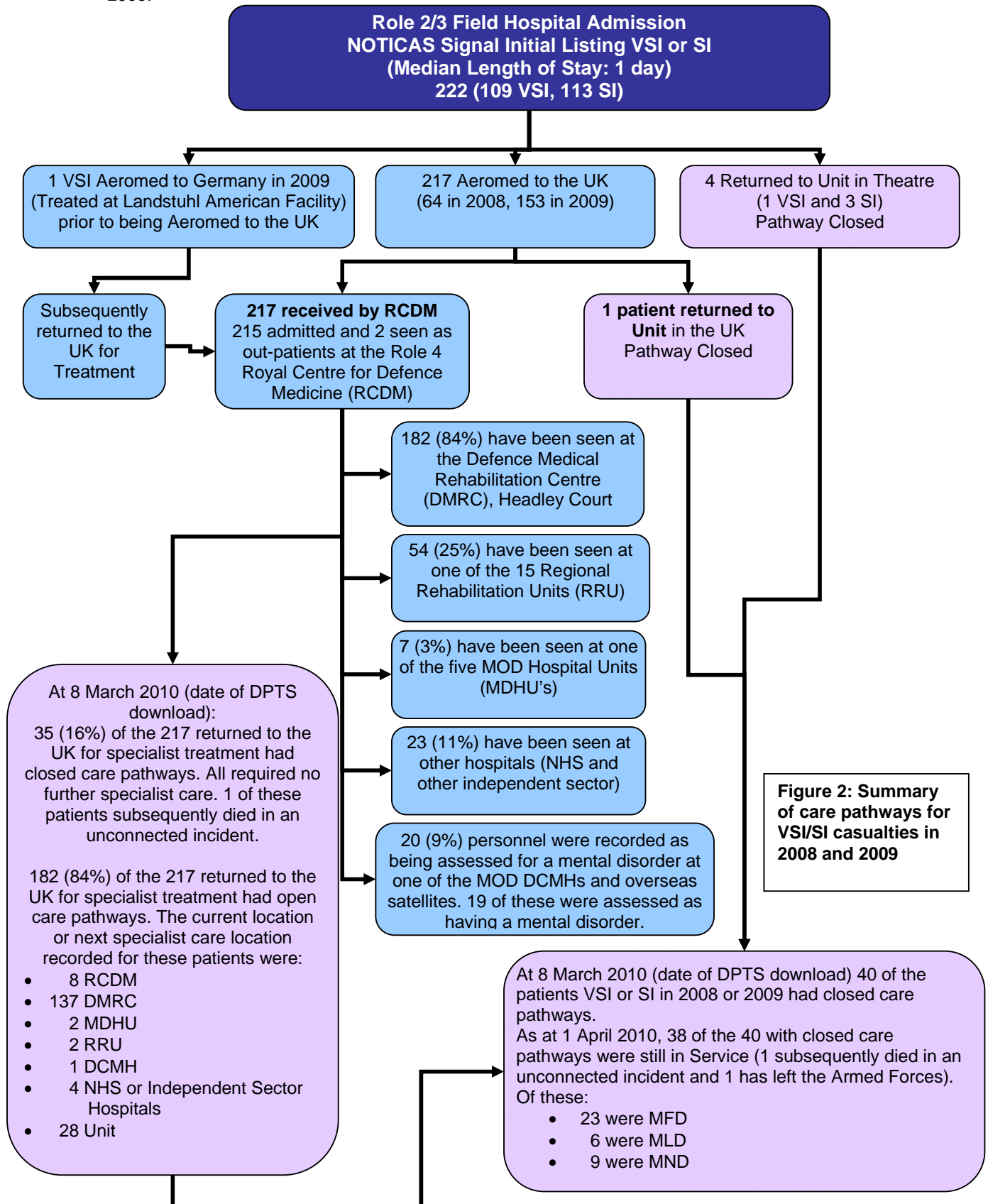
**Figure 1:**  
**Typical**  
**Medical**  
**Care**  
**Pathway**

### Specialist Treatment Locations

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

**FINDINGS**

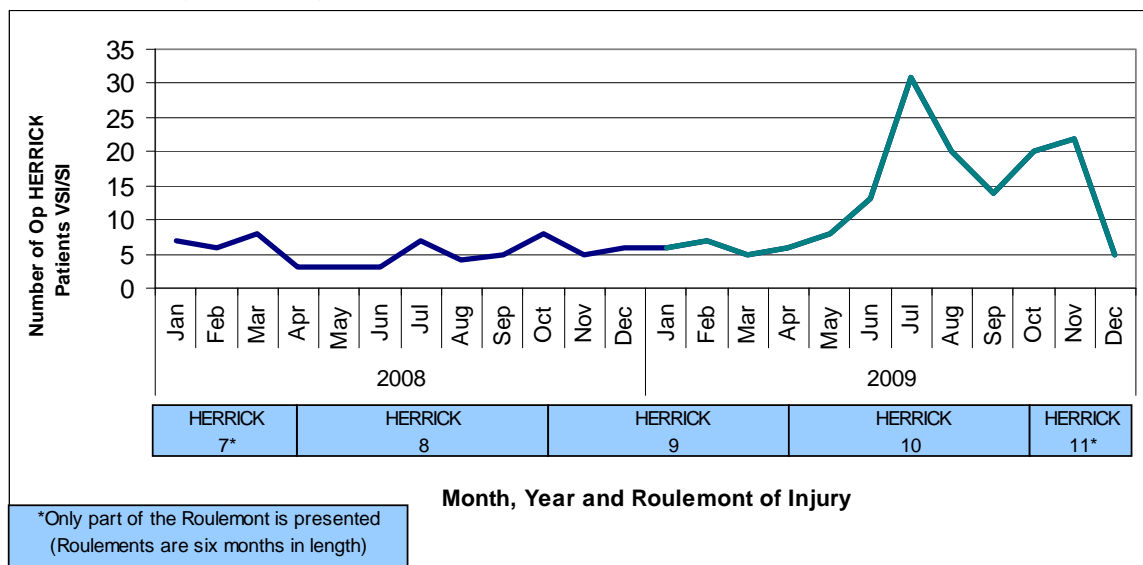
35. **Figure 2** presents a summary of the VSI/SI patient treatment pathway for those injured in 2008 and 2009.



### Number of Personnel Very Seriously Injured or Seriously Injured

36. 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.
37. 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.
38. This totals 222 personnel with an initial NOTICAS classification of VSI or SI on Operation HERRICK in 2008 and 2009 (109 were VSI, 113 were SI). Of the 222 casualties, 31 were Naval Service personnel (includes Royal Navy and Royal Marines), 185 were Army personnel and 6 were Royal Air Force personnel.
39. **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.

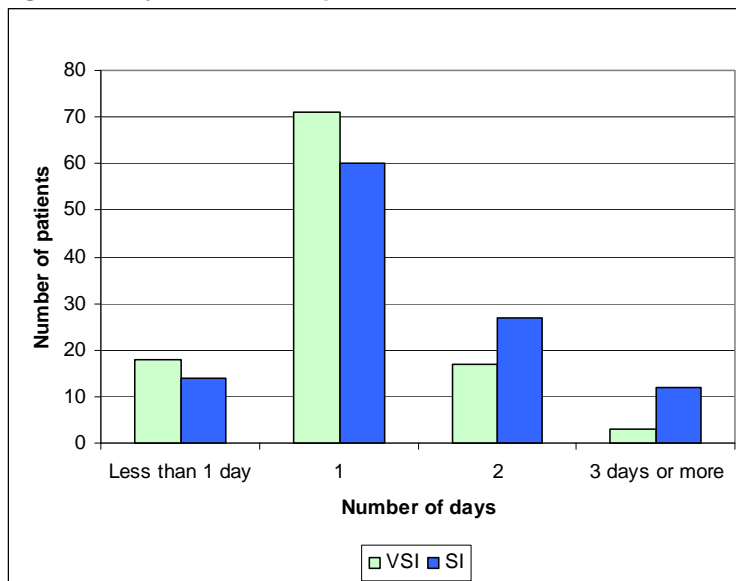
**Figure 3: Personnel with an initial VSI or SI NOTICAS, Operation HERRICK by month of injury and Roulement, 2008-2009, Numbers**



40. Of the 222 personnel with an initial NOTICAS classification of VSI or SI on Operation HERRICK in 2008 or 2009, 73 were identified as amputees as at 31 December 2009, 71 of which were the result of hostile action. As at the 31 December 2009, in 2008 and 2009 there were 85 surviving UK Service personnel from Op HERRICK whose injuries included a traumatic or surgical amputation, partial or complete, for either upper or lower limbs as reported in the Quarterly Op TELIC and Op HERRICK Amputation Statistics produced on the DASA website ([www.dasa.mod.uk](http://www.dasa.mod.uk)). There are a couple of reasons why the 12 amputees were not recorded as VSI/SI in 2008 or 2009:
  - their injury occurred in an earlier time period and the amputation was a surgical amputation that occurred in 2008 or 2009;
  - 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).
41. All of the 222 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 be based on individual circumstances, before leaving the field hospital the casualty will be fully stabilised and any emergency procedures will be carried out. **Figure 4** presents the length of stay of those admitted to the field hospital.



**Figure 4: Days\* in field hospital, initial VSI or SI NOTICAS, 2008 - 2009, Numbers**



\*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.

42. Four patients (initial listing as 1 VSI and 3 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.
43. Of the remaining 218 patients, 217 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 218 patients:
  - 120 (55%) 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.
  - 62 (28%) 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.
  - 36 (16%) 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**

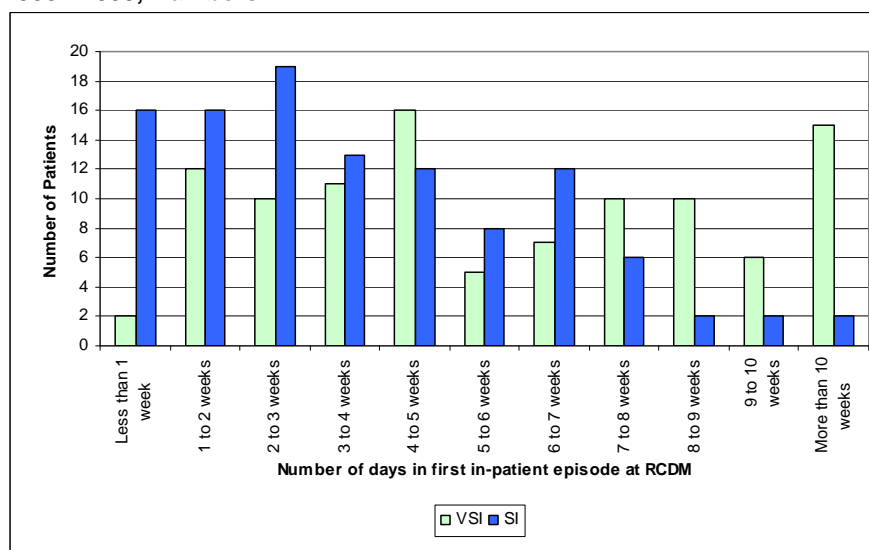
##### **First Location of Specialist Care**

44. As the main receiving unit for military casualties evacuated from an operational theatre, the DPTS recorded that the Royal Centre for Defence Medicine (RCDM) received 216 of the 218 VSI and SI patients returned to the UK for treatment. Of the 2 not recorded on the DPTS as being received by RCDM:
  - 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 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.

45. 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.
46. 214 of the 216 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 30 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), initial VSI or SI NOTICAS, 2008 - 2009, Numbers<sup>1,2</sup>**



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

<sup>2</sup> Two of the 214 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 212 patients represented in this graph.

47. 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<sup>b</sup>. The average (median) length of stay of VSI patients (37 days, 5 to 6 weeks; inter-quartile range of 36 days (lower quartile of 23 days and an upper quartile of 59 days)) was longer than for SI patients (22 days (3 to 4 weeks); inter-quartile range of 26 days (lower quartile of 12 days and an upper quartile of 38 days)).
48. 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<sup>b</sup>. The average (median) length of stay of patients injured as a result of hostile action (32 days (4 to 5 weeks); inter-quartile range of 35 days (lower quartile of 15 days and upper quartile of 51 days)) was longer than for patients injured as a result of non-hostile action (12 days (1 to 2 weeks); inter-quartile range of 15 days (lower quartile of 7 days and upper quartile of 22 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.

<sup>b</sup> Difference in distributions tested using The Mann Whitney Wilcoxon statistic for independent samples at the 5% significance level.

**Subsequent Locations of Specialist Care**

49. After finishing their first in-patient or out-patient episode at RCDM the 215<sup>c</sup> patients (214 treated straight from aeromed from Op HERRICK, 212 admitted as in-patients and two seen as out patients, and 1 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***

50. As at the 8 March 2010 (date of data extract from the DPTS):
- 86 (40%) of the 217 patients had received subsequent treatment as an in or out-patient at **RCDM**, 49 of which were admitted as an in-patient more than once.
  - 6<sup>c</sup> were awaiting their next episode of care at RCDM.

***Defence Medical Rehabilitation Centre (DMRC), Headley Court***

51. As at 8 March 2010 (date of data extract from the DPTS), 182 (85%) of the 215 patients have received subsequent treatment at the 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.

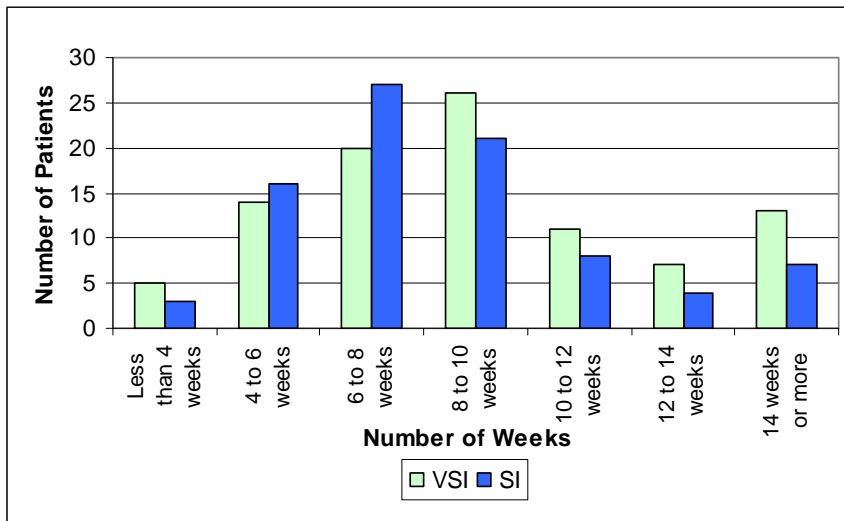
52. All patients attending DMRC are initially seen by a team of experts from different medical fields who together agree on the course of treatment. The team includes specialist medical officers, nurses, fitness instructors, physiotherapists, occupational therapists, speech and language therapists, cognitive therapists and social workers. The team also help prepare the casualties for a gradual return to active duty where possible.

53. Of the 182 attending DMRC:
- 147 (81%) were seen as in-patients, 107 of these 147 individuals were admitted as an in-patient more than once.
  - 164 (90%) were seen as out patients.
  - 37 (20%) were seen as residential patients.

*Length of time between Injury and In-Patient Admissions*

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

**Figure 6: Length of time between injury and first episode of care at DMRC, initial VSI or SI NOTICAS, 2008 - 2009, Numbers**



55. The length of time between injury and first episode of care varied between 12 days and 210 days, with an average (median) of 59 days (inter-quartile range of 26 days (lower quartile 45 days to

<sup>c</sup> Two patients have been excluded but included in Figure 2 as they had not completed their first in-patient episode at RCDM.

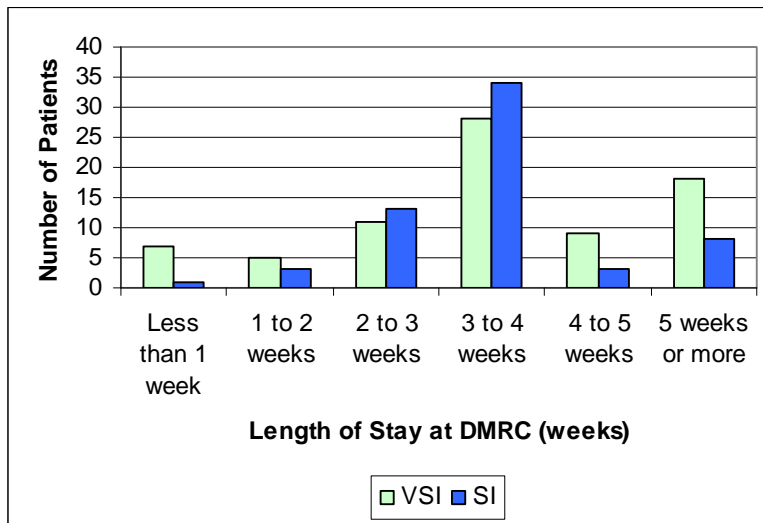
upper quartile 71 days)). Therefore new NOTICAS, including increases in NOTICAS with an initial listing of VSI or SI in theatre should initially be seen on average approximately 8 to 9 weeks later at DMRC, Headley Court.

56. 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, all but one were VSI patients indicating that they may need more lengthy specialist care 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 16 weeks after injury, eight weeks after first admission.
  - The third in-patient admission occurs 22 weeks after injury, six weeks after second admission.
  - The fourth in-patient admission occurs 27 weeks after injury, five weeks after third admission.
  - The fifth in-patient admission occurs 35 weeks after injury, eight weeks after fourth admission.
  - The sixth in-patient admission occurs 41 weeks after injury, six weeks after fifth admission.
  - The seventh in-patient admission occurs 47 weeks after injury, six weeks after fifth admission.
  - The eighth in-patient admission occurs 52 weeks after injury, five weeks after seventh admission.
  - The ninth in-patient admission occurs 61 weeks after injury, nine weeks after the eighth admission.

*Length of In-Patient Admissions*

57. **Figure 7** shows that the median length of stay for both VSI and SI in-patients first admission at DMRC was 3 to 4 weeks (seven 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 for First Admission to DMRC (Headley Court), initial VSI or SI NOTICAS, 2008 - 2009, Numbers<sup>1</sup>**

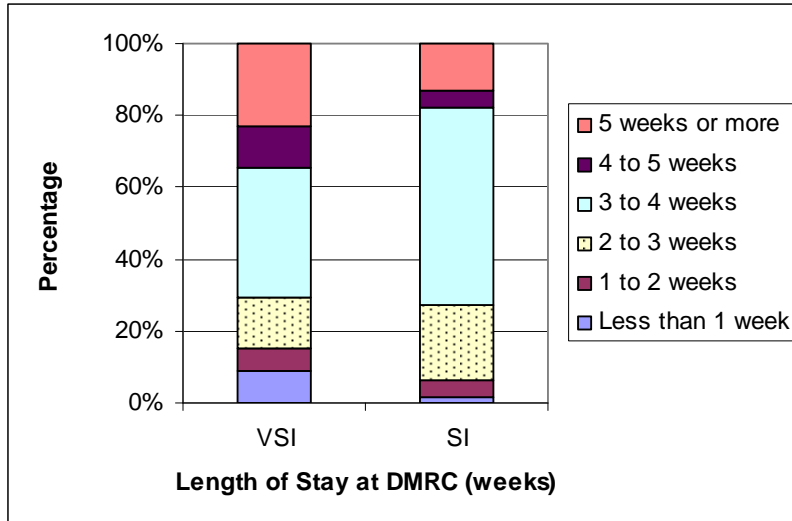


<sup>1</sup> Seven of the 147 patients admitted as an in-patient at DMRC have been excluded as they have not yet been discharged from their first episode of care, leaving 140 patients represented in this graph.

58. **Figure 8** shows that the distribution of in-patients first length of stay at DMRC is different for VSI and SI patients. Although the average (median) length of stay for both VSI and SI in-patients first admission at DMRC was 3 to 4 weeks, a higher proportion of VSI patients (than SI patients) had a length of initial stay longer than 3 to 4 weeks. However, the difference between these distributions was not significant<sup>d</sup>.

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

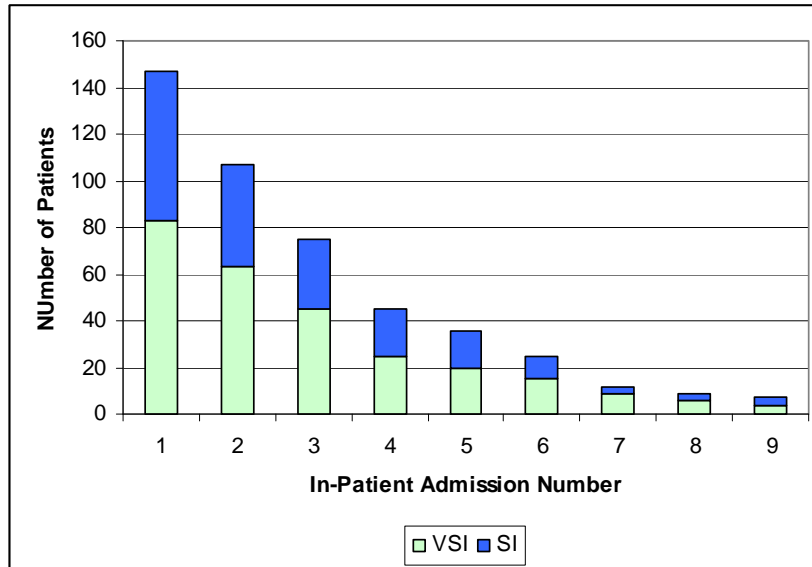
**Figure 8: Length of Stay for First Admission to DMRC (Headley Court), initial VSI or SI NOTICAS, 2008 - 2009, Percentage<sup>1</sup>**



<sup>1</sup> Seven of the 147 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 140 patients represented in this graph.

59. On average the first in-patient admission is the longest admission for these 147 patients with a median admission length of 24 days. There are 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 determined by individual circumstances.
60. 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 17 to 18 days.
61. **Figure 9** presents the number of in-patient admissions by VSI and SI classification. The number of in-patients admitted at each episode decreases with every admission; of the 147 in-patients, the maximum number of in-patient admissions was 11. The number of in-patients seen at subsequent admissions decreases with every admission. Of first in-patient admissions:
  - 73% go on to have a second admission,
  - 51% go onto have a third admission,
  - 31% go on to have a fourth admission,
  - 24% go on to have a fifth admission, and
  - 17% go on to have a sixth admission.
  - Less than 10% of all first in-patient admissions go on to have seven or more admissions.
 The current maximum number of in-patient admissions is 11. However, these numbers are likely to change as many patients have yet to complete their care pathway.
62. A larger proportion of VSI than SI in-patients go on to have further admissions (admissions 10 and 11 do not appear on the graph due to small numbers). 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 - 2009, Numbers**



63. As at 8 March 2010 (date of data extract from the DPTS), 137 patients were currently receiving treatment at DMRC or awaiting their next episode at DMRC.

**Regional Rehabilitation Units (RRUs)**

64. As at 8 March 2010 (date of data extract from the DPTS):

- 54 of the 215 patients had received subsequent treatment at one of the 15 RRUs. Of these 54; 51 have been seen at multi-disciplinary assessment clinic and 18 have been treated on one of the three week rehabilitation courses (two patients have been on a rehabilitation course twice).
- Two patients were currently receiving treatment at an RRU or awaiting their next episode at an RRU.

**Other Locations**

65. As at 8 March 2010 (date of data extract from the DPTS):

- Seven patients had received subsequent treatment at one of the five **Ministry of Defence Hospital Units**.
- 23 patients had received subsequent treatment at **another hospital** (including NHS and Independent Sector Hospitals).
- 20 were recorded as having been seen for assessment as new patients at the MOD's **DCMHs and overseas satellites**, after their date of injury. Of these 20 personnel, 19 were assessed as having a mental disorder. None of the VSI/SI personnel were admitted to the MOD's in-patient contractor for mental health.

**Amputees**

66. As highlighted earlier 73 of the 222 VSI/SI casualties in 2008 and 2009 were identified as amputees by 31 December 2009, 71 of which were the result of hostile action.

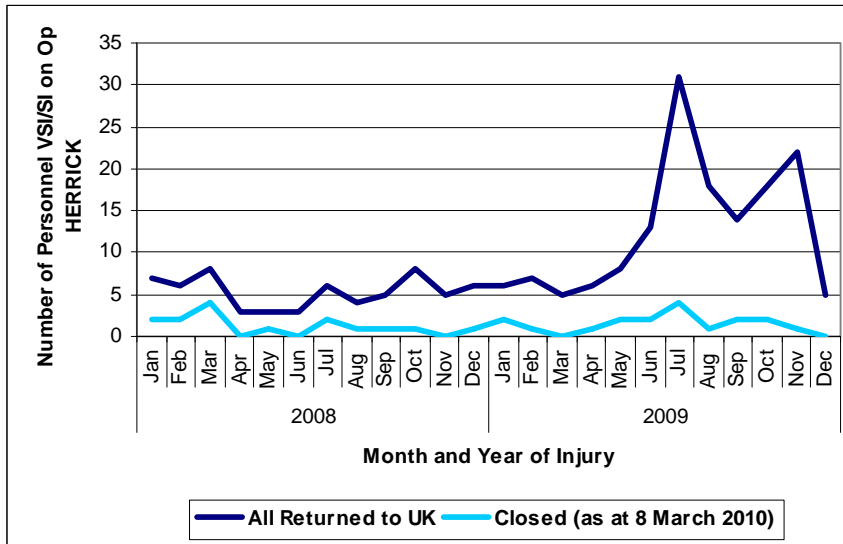
67. As at 8 March 2010 all of the 73 amputees had open care pathways, indicating that they were still receiving specialist care. As at 8 March 2010, of the 73 amputees:

- All had been treated at RCDM (all 73 were seen as in-patients and nine had also been seen as out-patients).
- 70 had been treated at DMRC (two of the amputees not yet treated had appointments scheduled in the next month (April 2010) at DMRC), 69 were seen as in-patients, 69 were seen as out-patients and seven were seen as residential patients. All 70 were seen at more than one type of appointment.
- Five had received treatment at a Regional Rehabilitation Unit; all five have been seen at a multi-disciplinary assessment clinic and one has been treated on a rehabilitation course.
- 10 had received subsequent treatment at another hospital (including NHS, Independent Sector Hospitals and Ministry of Defence Hospital Units).

### Care Pathway Length and Closed Pathways

68. **Figure 10** presents the number of personnel returned to the UK for 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 8 March 2010.

**Figure 10: Personnel with an initial NOTICAS initial VSI or SI NOTICAS, 2008 – 2009, returned to the UK by month of injury and closed care pathways, numbers**

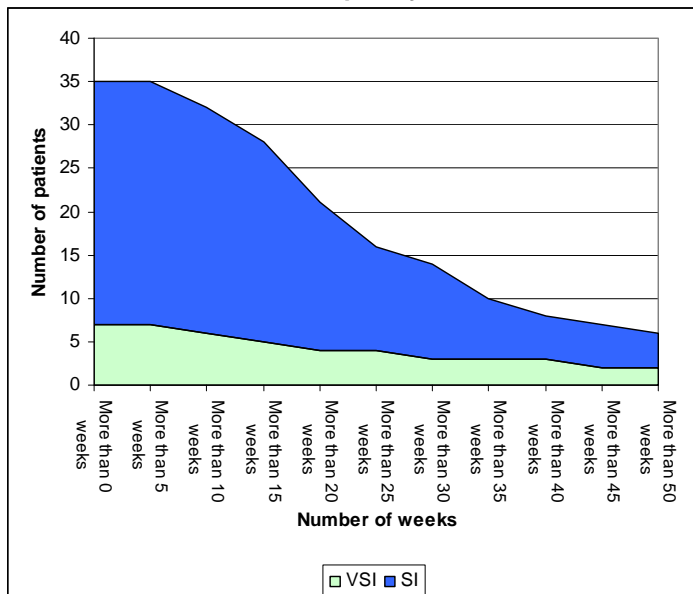


69. As at 8 March 2010 (date of data extract from the DPTS), 182 of the 217 VSI/SI patients returned to the UK for treatment in specialist care had open care pathways, **Figure 10** highlights that many of those injured at the beginning of 2008 still have open care pathways. The remaining 35 had closed pathways indicating that no further specialist care was required (7 VSI and 28 SI; 15 who were injured in 2008 and 20 who were injured in 2009).

70. One of these 35 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). Another one of these 35 patients, who required no further specialist follow-up for his SI was returned to duty and later died in an unconnected incident.

71. **Figure 11** presents the length of care pathway as a cumulative frequency graph for the 35 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 – 2009, Cumulative Frequency**



72. The length of **closed** care pathways varied between 41 days (between 1 and 2 months) and 623 days (between 20 and 21 months), with an average (median) of 157 days (between 5 and 6 months) and an inter-quartile range of 171 days (lower quartile 110 days (between 3 and 4 weeks) and upper quartile 275 days (between 9 and 10 weeks)).
73. However, there are some patients with **open** care pathways who injured at the start of 2008 and therefore as at the 8 March 2010 (date of data extract from the DPTS), these pathways were over 25 months in length.
74. The analysis on length of care pathway is currently limited as only a small proportion of those who were VSI/SI on Op HERRICK in 2008 and 2009 have closed treatment pathways. This will be updated in future reports to enable a better understanding of the length of time that these patients have been in treatment.
75. The graphs and commentary produced in this section only included those personnel returned to the UK for Specialist Care. There were an additional four personnel with an initial NOTICAS of VSI or SI whose pathways were closed in theatre and one patient whose pathway was closed once they had returned to the UK who did not receive any specialist care (these five personnel were excluded from this section as they would skew the trends presented). In total **40** personnel out of the **222** with an initial NOTICAS listing of VSI or SI had a **closed care pathway**.

#### **Discharged Personnel**

76. As at 1 April 2010, **220 of the 222** with an initial NOTICAS classification of VSI or SI on Operation HERRICK in 2008 and 2009 were still in Service. For the 2 personnel no longer in Service:
- One had a closed pathway in the DPTS indicating that no further specialist care was required and had then been discharged from Service, their last MDS was Medically Fully Deployable.
  - 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.
77. 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.
78. 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**

79. As at 1 April 2010, DMICP recorded for the 38 personnel who were still in Service with closed pathways (excluding the two patients described in paragraph 76):

- 23 were medically fully deployable (MFD)
- six were medically limited deployable (MLD)
- nine were medically non deployable (MND)

80. As at 1 April 2010, three of the 38 personnel who were still in Service with closed pathways had subsequently redeployed on Operation TELIC and/or Operation HERRICK.

### **Armed Forces Compensation Scheme**

81. As at 31 December 2009, 133 of the 222 casualties had claimed for compensation under the Armed Forces and Reserve Forces Compensation Scheme (AFCS). This resulted in a total of 164 claims, which includes multiple and/or additional claims for some individuals. Currently, individuals have up to seven years from the date of their injury or onset of illness to make a claim and as such, the remaining 89 individuals who have yet to claim may still do so in the future.

82. For injury or illness, the AFCS provides an immediately-available tax-free lump sum for pain and suffering, the size of which reflects the severity of injury or illness. There are 15 tariff levels with associated lump sum awards which currently range from £1,155 to £570,000.

83. For serious injuries and illness, AFCS also provides an income stream known as the Guaranteed Income Payment (GIP). This is a tax-free, index-linked monthly payment from discharge until death. The GIP is an enhancement to an individual's ill-health pension, paid in recognition of the fact that the injury or illness was sustained as a result of service. The scale of the payment is based on the severity of injury, and age and salary at discharge.

84. A review of the AFCS has been conducted by Lord Boyce and the recommendations were reported in February 2010. Lord Boyce recommended an increase in: the GIP to reflect likely promotions foregone as a result of injury; all lump sum amounts apart from the maximum £570,000; the maximum award available for mental illness; and the time limit from point of injury or onset of illness to make a claim from five to seven years. Further recognition will also be given to multiple injuries arising from a single incident.

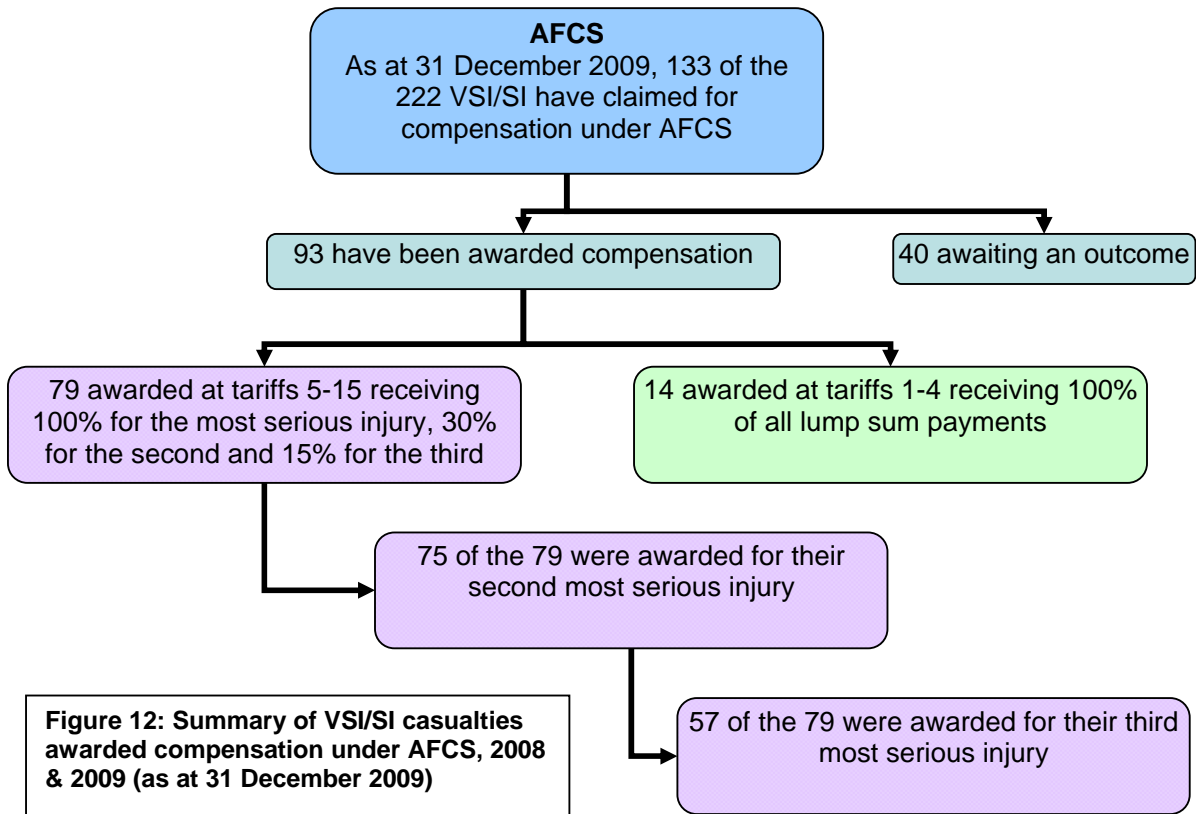
85. The Scheme currently pays 100% of all lump sum amounts to individuals in the most seriously injured category (tariff levels 1-4) who suffer multiple injuries arising from a single event. For others, awarded at tariff levels 5-15 the Scheme pays 100% for the most serious injury, 30% for the second, and 15% for the third. Once the recommendations from Lord Boyce's Review have been implemented in new legislation in 2011, all injuries caused by Service, not just the most serious three, will attract some compensation under AFCS.

86. As at 31 December 2009, 93 of the 133 individuals who have claimed under the AFCS have been awarded compensation for an illness or injury caused by their Service.

87. Of the 93 individuals awarded, 14 were at tariffs 1-4 and so the individuals received 100% of all the lump sum payments.

88. Of the 93 individuals awarded, 79 were at tariffs 5-15 and so the individuals received 100% for the most serious injury, 30% for the second and 15% for the third. Of the 79 individuals awarded at tariffs 5-15 who received 100% for their most serious injury, 75 were awarded for a further condition at 30% of the tariff level, and 57 were also awarded for a further condition at 15% of the tariff level.

89. As at 31 December 2009, the remaining 40 VSI/SI casualties were awaiting the outcome of their AFCS claim.



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**

90. 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 15% of patients completing their care pathway.
91. 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 85% 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 and 2009. 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](http://www.dasa.mod.uk)).

### Field Hospital Admissions from J97 Returns and OpEDAR

In 2008 and 2009 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.

### JTTR Amputation Data

The Joint Theatre Trauma Registry (JTTR) has been searched for cases which match the following criteria:

- Live UK Service personnel who have an injury coded 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 have had a surgical amputation performed either at the field hospital or at a UK Field Hospital.
- Incidents between 1 Apr 06 and 31 Dec 09 as a result of operations in Afghanistan and/or Iraq.

The results from this search have been cross referenced with information held in the Defence Patient Tracking Cell at the Defence Medical Rehabilitation Centre Headley Court. This was then linked with the VSI/SI casualties in Afghanistan in 2008 and 2009 to identify those who have suffered either a traumatic or surgical amputation; this could range from the loss of part of a finger or toe up to the loss of an entire limb(s).

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](http://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 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](http://www.dasa.mod.uk)).

#### *Mental Health Returns*

DASA receive and collate mental health returns covering all new referrals 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).

DASA publishes a quarterly report (a quarter in arrears) on Mental Health for UK Armed Forces Personnel. These reports can be obtained from the DASA website: [www.dasa.mod.uk](http://www.dasa.mod.uk)

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](http://www.dasa.mod.uk)).

#### *Medical Discharges*

DASA maintain a database on Service Personnel who have left Service as a result of a medical discharge with the principal cause leading to discharge. Medical discharges are the result of a number of specialists (medical, occupational, psychological, personnel, etc) coming to the conclusion that an individual is suffering from a medical condition that prevents their continued service in the Armed Forces. Statistics based on these discharges do not represent measures of true morbidity or pathology. At best they indicate a minimum burden of ill-health in the Armed Forces. Furthermore, the number and diversity of processes involved with administering a medical discharge introduce a series of time lags, as well as impact on the quality of data recorded.

The information on cases was sourced from electronic personnel records and manually entered paper documents from medical boards. The primary purpose of these medical documents is to ensure the appropriate administration of each individual patient's discharge. Statistical analysis and reporting is a secondary function.

Although Medical Boards recommend medical discharges they do not attribute the principal disability leading to the board to Service. A Medical Board could take place many months or even years after an event or injury and it is not clinically possible in some cases to link an earlier injury to a later problem which may lead to a discharge. Decisions on attributability to Service are made by the Service Personnel and Veterans' Agency.

This data source has been used to identify if any of the VSI/SI in 2008 and 2009 have been subsequently Medically Discharged and the principal reason leading to discharge.

The number of medical discharges are released on an annual basis in UK Defence Statistics (UKDS). These can be found on the DASA website ([www.dasa.mod.uk](http://www.dasa.mod.uk)) in Chapter 3 (Tables 3.17 to 3.19).

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 next year, 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](http://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 board after injury, which provides an indication of their Medical Deployability status. Once boarded, 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 outpatient 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.