43 Force Health Protection Aspects of Medical Planning

This chapter is split into two parts:

Part 1: Directive. This part provides the direction that must be followed to help you comply with (keep to) health and safety law, Government and Defence policy.

Part 2: Guidance. This part provides the guidance and good practice that should be followed and will help you to keep to this policy.

Contents

Amendment Record

This chapter has been reviewed by the Directorate of Defence Safety (DDS) together with relevant subject matter experts and key safety stakeholders. Any suggestions for amendments **should** in the first instance be directed to the Defence organisation's Safety Centre/Team Group Mailbox and with their approval, sent to DDS at People-DDS-GroupMailbox@mod.gov.uk.

Version No	Date Published	Text Affected	Authority
1.0	10 Dec 25	Development of new FHP chapter incorporating the EIH process and High Ambient Air Pollution.	DDS

Terms and definitions

The following table sets out definitions of some key terms used in this chapter. The current general safety terms and definitions are provided in the Master Glossary of Safety Terms and Definitions which can also be accessed on GOV.UK.

Accountable person	The person whose terms of reference state that they are responsible for making sure there are suitable and sufficient systems in place to control health and safety risks in their unit, establishment, site or platform. This term is used in place of CO, HoE, OC, Station Commander and so on, or as decreed by the Defence organisations.
Chemoprophylaxis	This refers to the administration of a medication for the purpose of preventing disease or infection.
Commander	This is generally, a military person responsible for planning activities, supervising activities, and making sure that personnel under their area of responsibility are safe. This term refers to a role rather than the rank of Commander, and it can be a permanent or temporary role (for example, lasting for the duration of a training exercise). In parts of Defence this person could be referred to as a 'responsible person.'
Competent Person	A person who has the training, skills, experience, and knowledge necessary to perform a task safely, and is able to apply them. Other factors, such as attitude and physical ability, can also affect someone's competence. (See http://www.hse.gov.uk/competence/what-is-competence.htm for information on competence).
Environmental Health Practitioner (EHP)	Also known as Environmental Health staff or EH Personnel, referring to personnel trained in environmental and industrial hazard identification and management.

Environmental and Industrial Hazards (EIH)	Defence activities both in permanent establishments and operational environments are vulnerable to multiple health hazards that can constrain operational effectiveness, such as hazards arising from hazardous chemicals other than Chemical Warfare (CW) agents, pathogenic organisms other than those used as Biological Warfare (BW) agents, radiation hazards other than those arising from the use of nuclear weapons, and physical hazards such as dust, noise, asbestos and smokes.
Force Health Protection (FHP)	This is one of the ten instruments of military medical care in NATO Doctrine and **must** be considered during medical planning. It is defined as, 'All medical efforts to promote or conserve physical and mental well-being, reduce or eliminate the incidence and impact of disease, injury and death and enhance operational readiness and combat effectiveness of the forces'. (AJMedP-4 Allied Joint Medical Force Health Protection Doctrine). In UK military Doctrine FHP is defined within the 7 capabilities of care.
Force Health Protection Instruction (FHPI)	An FHPI is a document that provides instructions (directives and guidance) on the predominant health threats and their mitigation for activities typically in operational or deployment settings where there is a full medical plan. It is applicable to all service personnel, civil servants, cadets and in some cases service families.
Force Generation (FGen)	The process of providing suitably trained and equipped forces, and their means of deployment, recovery and sustainment to meet all current and future tasks, with required readiness and preparation times.
FHP capability	FHP capability is a combination of coordinated activity of selfcare, non-vocational providers, and vocational generalist and specialist providers aimed at promoting health and preventing injury and illness. Effective force health protection makes a critical contribution to the maintenance of combat power but requires coordinated activity across all layers of the pre-hospital care capability framework and the Force Health Protection capability of care. To optimise effect, force health protection capability (particularly specialist environmental health) **should** be deployed with initial theatre enablers to identify and mitigate risks to health prior to the arrival of the main force.
FHP provision	FHP support for the activity can range from provision of a FHPI and FHP brief, to deployment on the recce and / or activity. The FHPI will determine the level of health risk, and this will in turn inform the HSS plan and the level of FHP support required
Health Service Support (HSS) Planning	Also known as the medical plan. The HSS Plan will mitigate risks to life and mission, through Medical Force Preparation measures, prevention of Disease and Non-Battle Injury (DNBI) and timely response to medical incidents / emergencies by the provision of safe and effective care.
Manager	A person responsible for managing or supervising staff, planning activities and making sure that personnel under their area of responsibility are safe. This could be a permanent or temporary role, and in parts of Defence this person could be referred to as a 'line manager', a 'Responsible person', or a 'delivery manager'.

Operational Staff Work	Documents created by staff branches to define areas of an operation, which may include or annex the Force Health Protection Instruction (FHPI).

Must and should

Where this chapter says **must**, this means that the action is a compulsory requirement.

Where this chapter says **should**, this means that the action is not a compulsory requirement but is considered good practice.

Scope

The policy contained within this chapter:

a. applies to all those employed by Defence (military and civilian) including reservists and those under the age of 18 (for example recruits and apprentices).

b. applies to those working on behalf of, or under the supervision of Defence (for example, contractors or visitors).

c. applies to all Defence activities away from a permanent establishment, carried out in any location (UK or overseas).

d. is not written for young persons in the cadet forces[1], Defence-run schools, nurseries and so on; those organisations **must** maintain their own safety policies and governance and **must** provide statutory compliant infrastructure and appropriate safe systems of work. They may use material from this chapter as a reference, but where appropriate their respective policies **should** be adapted to meet the needs of young persons and to follow applicable Department for Education guidance or legislation.

Assurance

The application of the policy contained within this Chapter must be assured (that is, its use must be guaranteed). As part of their overall assurance activity, the commander, manager, or accountable person must make sure that this policy is followed and put into practice effectively. Assurance must be carried out in accordance with JSP 815 (Defence Safety Management System) Element 12 – Assurance.

Alternative acceptable means of compliance

This policy is mandatory across Defence, and the only acceptable means of compliance (AMC) is attained by following the directive set out in this chapter. However, there may be circumstances where a small number of military units may be permanently unable to comply with (keep to) parts of the policy. In such circumstances an alternative AMC process is set out in the JSP 375 Directive and Guidance.

Equality Analysis

The policy in this Chapter has been subject to an equality analysis in accordance with the Public Sector Equality Duty and Departmental Policy.

[1] Guidance for cadet forces is set out in JSP 814 (Policy and Regulations for Ministry of Defence Sponsored Cadet Forces).

Part 1: Directive

Introduction

1. All Operations and Defence Activity Other than Operations (DAOTO) can threaten the physical and mental health of military and civilian personnel (i.e. whole force concept[2]). Individuals in their permanently assigned location, have health risks managed through occupational health and safety at work policies and procedures. Force Health Protection (FHP) offers an application of the same principles in situations where individuals are deployed.

2. FHP is a Command responsibility and a component of Force Protection[3] that comprises 'all medical efforts to promote or conserve physical and mental well-being, reduce or eliminate the incidence and impact of disease, injury and death and enhance operational readiness and combat effectiveness of the forces'. There is overlap between FHP and Health and Safety in the legal duty of care and regulation, so they are treated similarly.

3. This chapter sets out the directives that **must** be followed and the guidance that **should** be followed for FHP to help Defence meet its legal obligations around health and safety. This policy is aligned with Health and Safety Executive (HSE) guidance and adapted for Defence contexts. It **must** be read alongside related Defence safety policies (see related documents of this chapter).

4. The policy within this chapter is focused on Force Health Protection aspects of Medical Planning and **should** be read in conjunction with the relevant medical policy which is signposted throughout the document. Annexes have been, and will be, added to this chapter over time that will expand upon Force Health Protection, as supplementary information that builds on the base policy within this chapter.

Background

5. Defence activities both in permanent establishments and operational environments are vulnerable to multiple health risks that can constrain operational effectiveness, such as biological (for example bacteria, fungi, viruses and so on), climatic (for example extreme temperatures), and human-made (for example Environmental and Industrial Hazards (EIH) and Chemical, Biological, Radiological and Nuclear (CBRN) threats).

6. FHP emphasises overlapping preventive measures as essential to mitigating health risks. This policy encourages the chain of command to adopt a layered approach; integrating and liaising with a variety of medical teams and considering environmental and behaviour modifications required to enhance operational effectiveness.

---

[2] The term 'Whole Force' encompasses deploying MOD civilians and contractors, who **must** be given the same consideration as Service personnel in the application of this policy.
[3] JSP 950: Medical Policy & AJP-4.10: Allied Joint Doctrine for Medical Support.

7. It **must** be noted that in the policy throughout this chapter and its associated annexes, the term 'environment' will be used. This is in relation to 'environmental health' and the way in which our working environment can have an impact on the health of personnel, not with regards to how Defence activities affect the environment. The policy that governs how Defence protects the environment is set out in JSP 418: Management of Environmental Protection in Defence.

Key health and safety legislation

8. Employers have a general duty under the Health and Safety at Work etc. Act (HSWA) 1974, Section 2, to ensure, so far as is reasonably practicable, the health, safety and welfare at work of all of their employees and, under Section 3, anyone else who may be affected by that work activity.

9. There is also a duty on employers under the Management of Health and Safety at Work Regulations (MHSWR) 1999 to carry out a suitable and sufficient assessment of the risks to the health and safety of their employees. As such, Defence requires commanders, managers and accountable persons to make sure that suitable and sufficient risk assessments are carried out in order to mitigate health and safety risks to the personnel under their area of responsibility and anyone else who may be affected by that work activity. Defence safety risk assessments **must** be carried out in accordance with Chapter 8 (Risk assessment and safe systems of work) of JSP 375 Volume 1.

10. The Secretary of State (SofS) for Defence Policy Statement on health and safety, sets out SofS's commitment for Defence to comply with all the applicable health and safety legislation when in the United Kingdom (UK). When overseas, 'we will comply with the laws of Host States, where they apply to us, and in circumstances where such requirements fall short of UK requirements, we will apply UK standards so far as is reasonably practicable to do so'.

Accountability

11. FHP encapsulates additional risks that although are not specifically mentioned in the MHSWR 1999 they **must** be assessed and managed. In accordance with the SofS Policy Statement, Defence **must** make sure that FHP risks (along with all other safety risks) are assessed and mitigated to reduce them to As Low As Reasonably Practicable (ALARP).

12. The following roles have a significant responsibility in ensuring that appropriate health service support is included in the overall activity plan:

a. **Commanders** retain ownership of, and responsibility for, their activity plans and all risks inherent in them. A Senior Planning Officer **must** be appointed to oversee the activity by the commander. The activity owner has the legal responsibility to make sure that a planned activity is carried out in a safe manner and that all residual risks are ALARP. The commander or manager **must** make sure that suitable and sufficient risk assessments are carried out and recorded, as set out in Chapter 8 (Safety risk assessment and safe systems of work) of JSP 375 Volume 1. A formal auditable trail of delegation to the named individuals **must** be retained. For activities defined as deployments both this policy and JSP 815 Annex C must be applied. Commanders and planners are responsible for integrating the requirements of both, with particular attention on duty of care and risk escalation.

b. **Activity (Risk) owner - General Safety Risk Management.** For every activity there shall be a nominated Activity (Risk) Owner who is accountable and responsible for directing an activity and who has the final decision on authorising the activity. This is often aligned with the Delivery Duty Holder where Duty Holding is in place.

c. **Activity Deliverer**. This is the person who is responsible for the safe planning and delivery of activity on behalf of the Activity Owner.

d. **Activity Lead**. The Activity leads are the persons responsible for the safe conduct of the task / elements of the task on behalf of the Activity Owner / Deliverer.

e. **Activity Planning Staff** are to be directed to undertake the Health Service Support (HSS) planning which is an integral part of the overall planning for the activity. Planning staff are to seek support and oversight from CMA medical staff at the earliest opportunity.

f. **Competent Medical Authority (CMA) and medical staff** are responsible for providing regulatory oversight, quality assurance and professional advice on medical elements of planning. While they should not lead the writing of the plan, their role includes ensuring all risks are considered with appropriate mitigation measures, clinical safety standards are met and advising where regulatory compliance may be at risk. Further details on the role of the CMA is set out in JSP 950 Lft 5-2-8.

Policy Statements

13. The commander or manager **must** make sure that this policy is followed and put into practice effectively. Assurance **must** be carried out (as set out above).

14. The Policy Statements below are Defence directives on FHP and **must** be followed. However, there may be some exceptional circumstances where it may not be possible to fully comply with all the FHP requirements, for example during combat or sudden changes to operational plans. Where this is the case the commander, manager or those with delegated responsibility for FHP **must** record their decisions within the risk assessment documentation as soon as is practicable and as dictated by the operational circumstances. Commanders and managers **must** elevate the risks through their chain of command at the earliest opportunity in line with their Defence organisation's elevation process.

a. **Policy Statement 1**. Commanders and managers **must** make sure that a suitable and sufficient assessment of FHP risks is carried out where a CMA endorsed medical plan is required for Defence activity.

b. **Policy Statement 2**. A proportionate Force Health Protection Instruction (FHPI) **must** be produced where an assessment of FHP risks has been undertaken.

c. **Policy Statement 3**. Commanders or managers **must** make sure that the control measures identified in the assessment of FHP risks are put in place SFAIRP and followed to reduce the risks to ALARP.

d. **Policy Statement 4**. Commanders or managers **must** make sure that the hazards and mitigation measures are effectively communicated to the personnel who are likely to be affected.

Policy Statement 1
Commanders and managers **must** make sure that a suitable and sufficient assessment of FHP risks is carried out where a CMA endorsed medical plan is required for Defence activity.

15. The planning of Health Service Support (HSS), or medical planning, is an integrated part of the overall planning process for Defence and thus is Command led. It is the responsibility of commanders and managers to make sure that, through the Safe System of Work (SSW) and safe operating envelope they take all reasonable measures to maintain the health of the personnel under their command.

16. FHP is an essential element of any medical plan and therefore **must** be considered as part of all medical plans. In practical terms, FHP is the identification and assessment of likely health hazards and the preventative measures that need to be taken to stop Defence personnel becoming sick or injured, as such it is closely aligned to health and safety.

17. Medical plans, endorsed by a CMA[4], are required for Defence activities that include, but are not limited to, operations, exercises, Defence engagement activity, duty travel, overseas assignment, Defence Activity Other than Operations (DAOTO), Military Assistance to Civilian Authorities (MACA) in the UK (for example, flooding), adventurous training, battlefield studies and duty sports activities. Further information on medical plans can be found in JSP 950, Lft 5-2-8, CMA Policy.

18. Routine Defence activity throughout the UK or the strategic base does not require a CMA endorsed medical plan unless it is considered that the planned activity poses a reasonably foreseeable Risk to Life (RtL).

19. FHP, medical and all other risks are owned by the Activity (Risk) Owner. As such, the assessment of FHP risks **must** be considered as a part of the overarching risk assessment for the activity which **must** be carried out in accordance with Chapter 8 (Safety risk assessment and safe systems of work) of JSP 375, Volume 1. The overarching risk assessment **should** be recorded on the MOD Form 5010 (please see guidance notes), but alternatives specified by a Defence organisation's Safety and Environmental Management Systems (SEMS) may be used.

20. The suitable and sufficient assessment of FHP risks **must** be undertaken by a competent person[5] usually nominated by the CMA for the activity. A whole hazard approach **should** be taken when assessing FHP risks based on time, place, activity and person. To be suitable and sufficient, the competent person **must** consider information from multiple sources when conducting the assessment. This is not limited to but may include:

a. Open and closed source country health information.

b. Generic travel medicine advice.

c. Lessons identified, recce reports, local epidemiology and EIH assessments and previous Post Exercise Reports (PXRs).

[4] See JSP 950 Vol 5 Ch 2 Part 1 Lft 5-2-8.
[5] A Subject Matter Expert (SME) in FHP. For most activity this is functionally delivered by Environmental Health Practitioners and Officers with support and oversight from other healthcare specialists in particularly Public Health.

21. An EIH assessment **must** be considered for all new activity or where EIH have not previously been recorded to inform the assessment of FHP risk.

Policy Statement 2
A proportionate Force Health Protection Instruction (FHPI) **must** be produced where an assessment of FHP risks has been undertaken.

22. When there is a medical plan, the FHPI[6] informs commanders and those participating in an activity of the health risks, the individual / communal control and mitigation measures that **should** be implemented, including pharmaceutical intervention, (for example, vaccines and chemoprophylaxis (such as antimalarial medication)). Where mitigation measures are not implemented the risk **must** be understood by the risk owner.

23. The scope and detail of the FHPI is proportionate to the risk and there will be varying formats of the FHPI based on that risk. For example, a short version (plan on a page) could be produced for a single person staying in a hotel for a meeting in a European city, or a long version (multiple pages) of the FHPI for complex activity in a high-risk area (for example personnel undertaking jungle warfare training where the FHP measures are many and interconnected). The type of FHPI required to articulate the risk of an activity will be determined by the CMA.

24. The CMA would normally delegate the production of the FHPI to competent persons, usually relevant sS Environmental Health Practitioners. All enduring FHPIs for fixed locations where personnel are established **must** be reviewed periodically based on risk or as per sS Policy. Bespoke FHPIs will be required for each new activity or deployment based on time, place, activity and person.

25. All FHPIs produced within Defence **must** be subject to an assurance process which could include both audit of compliance and assessment of the information contained within them. The CMA is responsible to make sure that an appropriate assurance process is in place

Policy Statement 3
Commanders or managers **must** make sure that the control measures identified in the assessment of FHP risks are put in place and followed to reduce the risks to ALARP.

26. FHP risk is the same as all other risk and where a control or mitigation measure has been identified, it **must** be planned for and put in place before an activity starts as set out in Chapter 8 (Safety risk assessment and safe systems of work) of JSP 375, Volume 1. In preparing for activity the commander or manager **must** make sure that the:

a. Management controls and supervision are in place for the mitigation measures.

b. Provision and supplying of FHP material and equipment (for example, mosquito nets, insect repellents, treated clothing, sun cream and so on) is assured.

[6] In some OSW the FHPI may be an annex to the med plan/medical directive.

c. FHP measures for the Force Preparation (FPrep) and Force Generation (FGen) of individuals are in place prior to deployment or the start of the activity. Where the risk assessment and FHPI recommends the offer of pharmaceutical intervention (for example, vaccination or chemoprophylaxis for malaria) the chain of command **must** inform the medical staff / medical centre[7] undertaking the force preparation and generation of who requires the intervention and what the recommended intervention is. The higher formations are responsible for assuring this process.

d. The Commander **must** also consider providing sufficient information to all personnel undertaking the planned activity in cases where multiple Defence Primary Health Care (DPHC) medical centres are being used, this **could** be mounting instructions with a copy of the FHPI or risk assessment which details the recommended interventions.

Policy Statement 4
Commanders or managers **must** make sure that the hazards and mitigation measures are effectively communicated to the personnel who are likely to be affected.

27. Commanders and managers **must** effectively communicate hazards and the control measures / mitigation strategies to personnel. FPrep information should be extracted from the risk assessment and disseminated formally to deploying personnel, including augmentees. This aligns with the requirements detailed in various health and safety policy standards.

28. With health information make every contact count to change or reinforce health behaviours. This principle emphasises the importance of using every interaction to provide health information and protect health.

29. Commanders or managers **should** consider more than one communication methodology such as FHP briefs, online training, Reception, Staging, Onward Movement, and Integration (RSOI), induction briefs, FHPI/risk assessment distribution, poster and leaflet campaign and so on.

30. FHP measures and risk control **must** be reinforced during activities to confirm ongoing compliance and protection of health.

[7] The FHPI is the authority to vaccinate or provide chemoprophylaxis for a planned activity. Other vaccinations may be required iaw JSP 950 Lft 7-1-1 Annexes A - D.

Part 2: Guidance

This part provides the guidance and good practice that **should** be followed to help you comply with this policy and how to deliver FHP.

Plan activities

Policy Statement 1
Commanders and managers **must** make sure that a suitable and sufficient assessment of FHP risks is carried out where a CMA endorsed medical plan is required for Defence activity.

1. **Introduction.** Commanders and managers **must** make a suitable and sufficient assessment of FHP risks when planning activities. The FHP risk assessment **must** support the overarching risk assessment for the activity which **must** be carried out in accordance with Chapter 8 (Safety risk assessment and safe systems of work) of JSP 375, Volume 1. The MOD Form 5010 is the recommended template for recording risk assessments.

2. FHP risk assessments consider areas not typically included in standard health and safety assessments. For instance, they consider the potential spread of communicable diseases within a military population, as well as environmental and situational factors such as climate, pollution, and the built environment that may influence health outcomes.

3. **Medical planning**. An assessment of FHP risk is mandatory for all activity where a medical plan is required[8]. The CMA (or delegated authority) will review the medical plan and advise the CoC about medical risk, to support decision making. This assessment[9] is made across the **seven capabilities of care**[10].

4. The CMA **should** be informed about the planned activity, as early as possible, ideally 120 days before the activity begins. Primarily to ensure that any necessary pharmaceutical interventions are administered before departure with sufficient time for immunological protection. Additionally, it enables the involvement of specialists, such as public health experts, environmental health practitioners, occupational health professionals, toxicologists, and infectious disease consultants, as required.

[8] sS policy is found at ACSO 3215, RNTM-06-007/25 , 2025DIN06-012.
[9] In the Army, this is known as Health Risk Assessment (HRA); in the RN, a Health Impact Assessment (HIA); and in the RAF, a Health Threat Assessment (HTA).
[10] The 7 capabilities of care are: Force Health Protection (FHP), Primary Health Care (PHC), Pre-Hospital Emergency Care (PHEC), Deployed Hospital Care (DHC), Medical Evacuation (MEDEVAC), Medical Command, Control, Communications, Computers, and Intelligence (C4I), and Medical Logistics (Med Log).

Identify hazards and evaluate the risks

5. **Suitable and sufficient**. The suitable and sufficient assessment of FHP risks **must** be undertaken by a competent person usually nominated by the CMA for the activity. A whole hazard approach **must** be taken when assessing FHP risks based on:

a. **Time**. Understanding the length of potential exposure to FHP hazards is important as an individual may have prolonged exposure (for example, >1 month or longer), or a short exposure (for example, attending a conference). Seasonal variation may greatly impact hazards (for example, the wet season seeing an increase in the mosquito population).

b. **Risk group (Person)**. Some vulnerable persons are more susceptible to FHP hazards than the general population and require additional measures to be in place, which may include exclusion.

c. **Activity**. A predominately office-based role is likely to face less FHP hazards to SPs working outside (for example, jungle training). This **should** also be coupled closely to time on task and risk of exposure.

d. **Place**. In the same country/region, rural areas may have different risks to urban areas. For example; vector controls may be in place in an urban centre, so risk is reduced, but similar controls may not be in place if travelling to a rural area so risks are increased.

6. To be suitable and sufficient the assessment **must** contain information from multiple sources which may include but is not limited to:

a. **Open and closed source country health information**. Academic papers, epidemiological and outbreak reports, and Defence intelligence products amongst others provide health information to inform the assessment of FHP risk. It is worth noting that some closed source intelligence products may require higher levels of security clearance to access.

b. **Generic travel medicine advice**. There are many travel medicine resources available providing generic advice; although they are suitable for travel health they may require review for military activity, particularly in remote environments or where exposure to diseases not typically encountered by vacation travellers is expected.

c. **Lessons identified, recce reports, local epidemiology and Environmental and EIH assessments and previous PXRs**. Previous military and current on-site experience will inform the assessment of FHP risk. Of particular importance is the EIH Assessment.

7. **EIH Assessment**. An EIH assessment **must** be conducted for all new activity or where EIH hazards have not previously been recorded. An EIH assessment is a record of the environmental and industrial hazards found in a location and is used to support the assessment of FHP risk. Guidance on EIH assessments and how these are conducted is at Annex A.

Communication

Policy Statement 2
A proportionate Force Health Protection Instruction (FHPI) **must** be produced where an assessment of FHP risks has been undertaken.

8. **Introduction**. The FHPI informs commanders and those participating in activity of the health risks and the individual and communal control and mitigation measures that need to be taken, including pharmaceutical intervention for example vaccines and chemoprophylaxis such as antimalarial medication. The FHPI develops the assessment of FHP risk into more expansive direction and guidance rather than being fully articulated on the MOD Form 5010 as well as providing a record of threats, controls and mitigation.

9. Generally, the CMA (or delegated person) would task the production of the FHPI to a competent person, which is always from the respective sS Environmental Health Practitioner. The assessment of FHP risk and the FHPI **should** be reviewed periodically and for each new activity or deployment based on time, place, activity and person and dynamically when events dictate such as when:

a. a change in policy;

b. an accident or incident has occurred;

c. there is a notable change in the planned Defence Activity (for example; changes in activity time, place, or personnel and so on);

d. there is reason to believe insufficient risk mitigation exists, either through change to key personnel, activity tempo, duration of current assessment or other environmental considerations;

e. there is a significant change to travel advice, or a significant new health threat identified; or

f. the deployed force can be exposed to additional threats during periods off-duty or stand down within the activity.

10. **Full or Short FHPI**. The CMA (or delegated person) would determine the scope and detail of the FHPI, proportionate to the risk. Different Defence organisations and the sS will have varying tolerances to FHP risk. For example, a short version - such as ‘plan on page’ – may be appropriate for a single person staying in a hotel for a meeting in a European city. In contrast, a longer version would be required for more complex activities in high-risk areas, such as a larger group undertaking jungle warfare training, where the FHP measures are numerous and interdependent).

11. **Activity Information Required for FHPI Request**. Activity lead planners are to provide the competent person drafting the FHPI the following activity information:

a. **Location**. Which country and area (if known) are you deploying to or travelling through? Health threats vary within countries and regions (for example, the malaria risk in Botswana) and a refined assessment is required to ensure that the most accurate and practicable advice is given. Additionally, accommodation and other Real Life Support standards will vary (for example hotel accommodation may be lower risk than host nation military facilities or training areas).

(1) Planners should be aware that the entry requirements of some countries will change dependant on which country a person is arriving from. For example, Yellow Fever, Polio and MenACWY Vaccination Certificates may be required if arriving from a country with these endemic diseases or if held in an airport during a connecting flight for >12 hours, whereas if coming from the UK this would not be a requirement. Further entry requirement advice is available from the FCDO website[11].

b. **Activity**. What is the main activity? What are the main food, water and accommodation arrangements? Are there any likely visits to other countries or movement around the country? The activities undertaken by the deploying personnel are likely to present different risks (for example, an AT expedition will present different health threats to military engineering operations in the same country). Moving around the country may pose different health threats.

c. **Population at Risk**. What is your population at risk, including any at risk groups or civilian staff. Although the health threats will remain consistent regardless of the number of personnel exposed, the size of the deploying population may determine the range of control measures to be adopted. For example, a company exercise may require bio-security direction for vehicle disinfection whereas a STTT may not.

d. **Duration**. What is the duration and dates of this activity? The length of time spent on a deployment may influence the most appropriate control measures, particularly important if health risks vary due to seasonal changes.

12. **FHPI Process**. A FHPI **should** be used to inform the medical planning process and is a key document when writing a medical plan. The FHPI can only be effective if generated early in the process rather than as an afterthought at a later stage. The FHPI process is as follows:

a. Seek Force Health Protection advice at the earliest opportunity in the planning phase by contacting the CMA or delegated persons for the activity. Requests for an FHPI will normally be through the sS Environmental Health Practitioner. Requests for FHPI may be automated in some organisations.

b. A competent person (usually sS Environmental Health Practitioner) will undertake an assessment of FHP risk. Additional advice may be sought from other SMEs (for example a consultant in public health or tropical medicine).

c. Once the FHP risk has been assessed, an FHPI will be generated and assured by public health and/or appropriate formation Environmental Health Team. Where a reconnaissance visit for the activity is occurring, an interim FHPI may also be generated that will be augmented through information collected during the recce (for example EIH assessment).

d. The FHPI is submitted via the CMA (or delegated person) for assurance as part of the assessment of the medical plan. The activity risk holder **should** agree the assessment of FHP risk and FHPI (tolerate) or where the duty holder disagrees, they **should** terminate, treat, transfer or take the residual risk and record.

e. The FHP risk control and mitigation measures are to be in place and reviewed throughout the activity.

[11] Foreign travel advice - GOV.UK

13. **FHPI format**. There is no common format of a FHPI between the sS as they are bespoke documents to meet the needs of the formation and subject to sS Operational Staff Work (OSW) guidance. The FHPI **should** be split into two areas:

a. **Medical force preparation**. This should include (but not an exhaustive list); Vaccinations and chemoprophylaxis requirement, minimum medical employment standard (MES), dental standards, medical flags that may restrict deployment (for example, asthma in an area of poor air quality, more information can be found at Annex B to this chapter), advice to pregnant personnel and those on routine medication.

b. **Health threats and controls and mitigation**. The FHPI **should** state the identified threats and the mitigation measures that **must** be employed to reduce the risk. Examples of topics that may be covered by the FHPI include:

(1) **Communicable Diseases**. Vector-borne, airborne, ingestion and contact disease threats considered and preventative measures including vaccination requirements stated.

(2) **Climatic Injury**. Mitigation measures will be in accordance with JSP 375 Volume 1 Chapter 41 and Chapter 42.

(3) **Environmental and Industrial Hazards (EIH)**. Direction and guidance on the risk assessment and management of EIH and potential exposures of personnel to hazardous substances is contained in Annex A.

(4) **Flora and Fauna and Venomous, Feral and Wild Animals**. Relevant advice on the mitigation of wild / venomous animal risks with the location of health care facilities providing anti-venom (and its make and provenance) **should** be considered in locations where venomous species are deemed a significant risk.

(5) **Bio-security Measures**. Where necessary, the FHPI will provide clear direction on any bio-security requirements for aircraft, vehicles, shipping containers and equipment returning to UK, in accordance with JSP 800 Leaflet 25.

(6) **Suitably Qualified and Experienced Person (SQEP)**. FHP SQEP personnel (Environmental Health Practitioners) and / or unit trained personnel (Combat Health Advisor / Combat Health Duties[12]) should be either articulated within the FHPI or other OSW.

(7) **Food and Water**. Mitigation measures will seek to reduce incidences of gastro-intestinal diseases and illness due to contaminated supplies. Assessment of the potability of HN water supplies should be considered.

(8) **Personal and Communal Hygiene**. Specific advice when potentially operating in austere conditions.

(9) **Post-deployment Health Requirements**. Some deployments may require post tour health measures (for example, post tour illness, zika virus advice).

[12] **Army.** Deployable units are required to maintain appropriate Combat Health Duties (CHD) trained personnel. Currently 1 x CHD person per Major sub-unit or 1 per Minor unit and 1 x CHA per unit are required (JSP 950 Leaflet 3-3-3 Pest Management Policy, ACSO 3248 Annex A – Appointment Training Table). Dependant on the level of risk, nature of deployment and level of readiness, the required numbers may be higher.

Control measures

Policy Statement 3
Commanders or managers **must** make sure that the control measures identified in the assessment of FHP risks are put in place and followed to reduce the risks to ALARP.

14. FHP risk is the same as all other risk and where control measures have been identified they **must** be planned for and put in place before an activity starts, as set out in Chapter 8 (Safety risk assessment and safe systems of work) of JSP 375, Volume 1. In preparing for an activity the commander or manager **must** make sure that the:

a. Management and supervision are in place for the control measures and the mitigation.

b. Provision and supplying FHP material and equipment (for example, mosquito nets, insect repellents, treated clothing, sun cream etc) is assured.

c. FHP measures for the FPrep and FGen of individuals are in place prior to deployment or the start of the activity.

15. Hazards and risks identified in the FHPI and their subsequent controls or mitigations **should** be extracted and cited on the master risk assessment by the CoC for the activity for which the med plan is being generated. For individual augmentees and others such as reservists, they will be responsible to ensure their CoC is made aware of any risks and mitigations measures, and these should be clearly cited in the medical section of the Admin instruction/OSW for the planned activity.

16. **Pharmaceutical Intervention**. Notification to medical staff / medical centre that pharmaceutical intervention (for example, vaccination or chemoprophylaxis[13]) has been recommended for an activity is a Command or force generation function. The competent person undertaking the drafting of the FHPI or the CMA is unlikely to be sighted of all personnel deploying. Commanders or managers **must** provide to the respective Medical Centre(s) undertaking the medical preparation a nominal roll of those deploying and appropriate information and direction (which will detail pharmaceutical intervention). This will allow for necessary planning prior to deployment.

17. Where an individual presents to a medical centre requiring pharmaceutical intervention without prior notification or a copy of the appropriate OSW being available, the medical centre is not authorised to administer vaccines beyond routine immunisations, and may decline to provide vaccinations for specific operational activities. Due to the security surrounding some deployments personnel may attend and request vaccination without being able to share details of the location or activity. If further advice is required, healthcare personnel should contact the Defence Public Health Unit (DPHU) single point of contact (SPOC) in the first instance, who will engage with the relevant CMA for authorisation. Vaccination refusals should be managed IAW policy[14].

[13] JSP 950 Lft 7-1-1
[14] JSP 950 Vol 7 Ch 1 Part 1 Lft 7-1-1

Policy Statement 4
Commanders or managers **must** make sure that the hazards and mitigation measures are effectively communicated to the personnel who are likely to be affected.

18. Commanders and managers **must** effectively communicate hazards and their mitigation strategies to personnel ASAP once known and understood. This aligns with the requirements detailed in various health and safety policy standards.

19. With health information make every contact count to change or reinforce health behaviours. This principle emphasises the importance of using every interaction to provide health information and protect health. Commanders or managers can fulfil this by one or more of the following:

a. Distributing copies of the FHPI or risk assessment to those deploying. This will support the Medical Force Preparation of deploying personnel by informing and confirming with primary healthcare staff what pharmaceutical intervention is required. It will also ensure personnel are aware of any additional clothing items and equipment that will be required to support FHP and mitigate risk.

b. Arrange pre-deployment FHP Briefs (FHPB). These presentations inform deploying personnel about health threats and the controls to mitigate risks[15]. These are arranged through the CMA and/or HSS Staff. The FHPB may be delivered in various formats; including face to face, online or through the online learning platform.

c. Arrival FHP brief or induction training as part of Reception, Staging, Onward Movement, and Integration (RSOI) processes.

Retention of records

20. All records relating to published FHPIs and HIAs/HSS documentation, RSOI nominals and presentations **must** be retained in accordance with Chapter 39 (Retention of Records) of JSP 375, Volume 1.

Related documents

21. The following documents **should** be consulted in conjunction with this chapter:

a. JSP 375, Volume 1:

(1) Chapter 2 - Military and Civilian Workplace Safety

(2) Chapter 5 - First Aid

(3) Chapter 8 - Safety Risk Assessment and Safe Systems of Work

(4) Chapter 16 - Safety Occurrence Reporting and Investigation

(5) Chapter 36 - Asbestos

(6) Chapter 39 - Retention of Records

(7) Chapter 41 - Heat Illness Prevention

(8) Chapter 42 - Cold Injury Prevention

[15] The FHPI or OSW may require this for all deploying on named operations or other activity.

b. Other MOD Publications;

(1) JSP 815 - Defence Safety Management System

(2) JSP 392 - Management of Radiation Protection in Defence

(3) JSP 567 - Contractor Support to Operations (CSO)

(4) JSP 661 - Health and Wellbeing

(5) JSP 822 - Defence Training & Education Policy and Guidance

(6) JSP 950 - Medical Policy

(7) Joint Policy and Doctrine