FOCUS ON

Armed Forces Charities' Physical Health Provision

2018

Rhiannon Doherty
Anthony Robson
Stuart Cole

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directory of social change

In association with
Cobseo The Confederation of Service Charities
VS Veterans Scotland

Funded by
FiMT forces in mind trust
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Foreword

Being physically healthy is something that many take for granted, especially given our free access to health care in the UK. While not many people would accept physical injury or harm as a potential risk in their career, members of our armed forces do so on a regular basis. This is no small risk to accept and the reality of such a sacrifice can be overwhelming.

It is important, however, to recognise that a career in the armed forces is not inevitably followed by poor health; in fact, some Service personnel leave at the peak of physical fitness. Nevertheless, others experience life-changing injuries during their Service careers. Such injuries have repercussions beyond the physical, inflicting an enormous impact on how an individual recovers and returns to military duty or re-adjusts to civilian life.

The Armed Forces Covenant ensures that veterans should receive priority treatment from the NHS, where it relates to a condition which results from their service in the armed forces. Yet, armed forces charities' physical health provision often occupies an important space, which lies outside the remit of NHS support. Such services play an important role in the recovery process and undoubtedly contribute to the good health and well-being of beneficiaries.

The term 'physical health provision' often conjures images of clinical procedures, hospitals and doctors, but this report shows that in reality, physical health provision is much broader and more difficult to define. Charities often take more holistic or non-clinical approaches to physical health provision, which frequently merge with other areas of provision, such as housing, employment and social inclusion.

This report is the first to shine a light on forces charities operating within the sphere of physical health. There are 121 charities working in this space – a small proportion of the overall armed forces charity sector (10%), serving, according to charities researched, at least 250,000 members of the armed forces community.

Charities have played an integral role in establishing health-care initiatives such as the Veterans' Trauma Network, on which Blesma and Blind Veterans UK serve as partners. There are now services such as NHS and MOD veterans' prosthetic services and Royal British Legion mobility and hearing funds, while collaboration between Help for Heroes, The Royal British Legion and the MOD sees that Service personnel are able to access Personnel Recovery Centres (PRCs) as part of their rehabilitation.

DSC are proud to extend our relationship with Forces in Mind Trust (FiMT), who we have partnered with since 2014 to produce insightful research on the armed forces charity sector. The aim of the *Focus On* series is not only to highlight the vital work our armed forces charities do for their respective beneficiaries, but also to create a better knowledge base for policymakers and these charities to continue to act in the best interests of our armed forces community.

Focus On: Armed Forces Charities' Physical Health Provision is the third of six thematic reports on armed forces charities to be published during 2017 and 2018 – it continues the series' delivery of unique insights and intelligence on this important sector.

Tom Traynor, Head of Research, Directory of Social Change

About the authors

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Rhiannon joined DSC in 2017 as a Researcher on DSC's Armed Forces Charities research project, where she contributes to the researching and writing of reports including *Focus On: Armed Forces Charities' Mental Health Provision* (2017).

Before joining DSC, Rhiannon volunteered for a range of charities including NDCS and Oxfam.

Rhiannon holds a BA (Hons) in English Literature and Communications. She also holds an MA in Politics and Mass Media from the University of Liverpool.

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Anthony joined DSC in 2017 as a Researcher on DSC's Armed Forces Charities research project. Along with undertaking research and writing of reports such as *Focus On: Armed Forces Charities' Mental Health Provision* (2017), Anthony also maintains the project's online database of forces charities.

Prior to joining DSC, Anthony volunteered as a high school Classroom Assistant and also as a member of the Merseyside Police Cadet scheme.

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STUART COLE

Stuart is the Research Manager for DSC's Armed Forces Charities project. Since joining DSC in 2015, Stuart has researched forces charities, producing reports including: *Focus On: Armed Forces Charities' Mental Health Provision* (2017); *Sector Insight: Armed Forces Charities in Scotland* (2016); and *Cobseo Members' Survey* (2015).

Before joining DSC, Stuart held an academic post in public health research, working on projects in partnership with the World Health Organization, Alcohol Research UK and the NHS. Stuart's work focused on violence, traumatic injury and alcohol consumption.

Stuart holds a BA (Hons) in Psychology and Sociology, an MSc in Applied Psychology, and a PGCE in Psychology. He is a qualified teacher and worked for five years as a psychology lecturer at a number of colleges and schools before moving into research.

Acknowledgements

The authors would like to thank all of the armed forces charities which provided invaluable information during the data-collection period of this research.

Special thanks go to Veterans Scotland, Cobseo, Help for Heroes, NHS England, The Royal Hospital Chelsea, Fisher House, Blesma, The Invictus Games Foundation and SSAFA for their support during the writing process.

About the Directory of Social Change

The Directory of Social Change (DSC) has a vision of an independent voluntary sector at the heart of social change. We believe that the activities of independent charities, voluntary organisations and community groups are fundamental to achieve social change. We exist to support these organisations in achieving their goals.

We do this by:

- Providing practical tools that organisations and activists need, including online and printed publications, training courses, and conferences on a huge range of topics
- Acting as a 'concerned citizen' in public policy debates, often on behalf of smaller charities, voluntary organisations and community groups
- Leading campaigns and stimulating debate on key policy issues that affect those groups
- Carrying out research and providing information to influence policymakers, as well as offering bespoke research for the voluntary sector

Since 2014, DSC has been commissioned by Forces in Mind Trust to produce research aimed at illuminating the armed forces charity sector. Now in its fourth year, the project was grown to include two *Sector Insight* (2014, 2016) reports and a searchable online database of armed forces charities, which exists as a free resource for members of the public.

DSC's *Focus On* reports are intended as short, easily digestible reports on individual areas of provision, which are intended to inform those who work within the charity sector, policymakers, media professionals and members of the public interested in the work of armed forces charities. DSC delivered two reports in 2017, entitled *Focus On: Armed Forces Charities' Mental Health Provision* and *Focus On: Armed Forces Charities' Education & Employment Provision*. This report focuses on forces charities which provide support for beneficiaries with physical health problems.

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For details of our research go to www.dsc.org.uk/research, or email research@dsc.org.uk.

Executive summary

DSC is committed to illuminating the vital work of armed forces charities. This report delivers an account of charities delivering physical health support to Service personnel and their families.

Physical health provision refers to services which promote the recovery, fitness and general good health of the armed forces community. It also includes services targeted specifically at WIS (wounded, injured and sick) beneficiaries. Generally, these services aim to improve their quality of life or transition to Civvy Street, for example in helping with housing, social inclusion or welfare services.

To address this remit, DSC devised the following research questions:

- How many forces charities provide physical health support for Service personnel and their families?
- How is physical health support delivered to beneficiaries?
- What standards of practice, collaboration and evaluation exist?

DSC found that forces charities offered a diverse variety of services, ranging from nursing care and grants for mobility aids, to adapted scuba diving. Many charities provided lifelong support for members of the armed forces community, regardless of whether their injury or illness was attributable to Service or not.

KEY FINDINGS

How many forces charities provide physical health support?

There are approximately 1,200 UK armed forces charities, one-tenth of which deliver physical health support.[1]

Which types of beneficiaries are supported?

The number of beneficiaries accessing health-care services indicates that there is a substantial demand for physical health provision spread over a relatively small number of charities (N=121).

- At least 250,000 beneficiaries accessed physical health support between 2016 and 2017.
- The amount was found to be seven times greater than those accessing education/employment support, and twenty-five times greater than those accessing mental health support within the same period.[2]
- Ex-Service personnel with Service-related injury/illness were the most common type of beneficiary, supported by 83% of charities.
- The most commonly supported injury/illness type was limited mobility (64%), followed by wounds (61%).

[1] For more information on how the total number of UK armed forces charities is calculated, please see page XIV.
[2] According to previous research conducted by DSC (Cole, S. et al., 2017 and Doherty, R. et al., 2017).

How much expenditure is dedicated to physical health provision?

Armed forces charities spent at least £103 million on physical health provision within the last year.

- Expenditure on physical health was more than three times greater than the amount dedicated to education/employment (£26 million) and mental health (£28 million) in 2016.[3]

Which types of services are provided?

Armed forces charities offer a wide range of physical health services, which included a combination of clinical and holistic approaches.

- The most commonly provided physical health services were recreation, adapted housing and sports/fitness programmes, delivered by 41%, 38% and 37% of charities respectively.
- In total, only 17% of charities delivered services which were administered by a health-care professional (referred to here as clinical services).

To what extent do charities engage in collaboration and partnership?

DSC found evidence of extensive collaboration within the voluntary sector, but partnership with external health authorities was rare.

- Over three-fifths (61%) of charities partnered with other voluntary sector organisations.
- Significantly fewer charities partnered with the NHS (17%), MOD Welfare services (17%) and MOD Health-care (14%) services.
- Charities providing clinical services themselves were three times more likely to partner with the NHS than charities which did not (38% v. 12% respectively).

What standards of practice exist?

Charities' adherence to best practice was especially relevant for those delivering clinical services themselves (N=20), the vast majority of which followed clinical care guidelines.

- In total, 90% of charities delivering clinical services themselves were registered with the Care Quality Commission (CQC) or national equivalents.

How do forces charities evaluate their services?

It is important that charities carry out routine evaluation of their services to ensure that they effectively assist their beneficiaries and respond to any gaps in provision.

- Less than half (45%) of charities carried out routine evaluation and monitoring.
- Questionnaires were the most common method of evaluation, undertaken by around one-third (33%) of charities who carry out routine evaluation.

[3] According to previous research conducted by DSC (Cole, S. et al., 2017 and Doherty, R. et al., 2017).

CONCLUSIONS AND RECOMMENDATIONS

- DSC's findings largely debunk the myth that there are too many forces charities. Of the approximately 1,200 armed forces charities registered in the UK, only 10% make provision for physical health. This means that there are only 121 organisations serving over 250,000 beneficiaries.

- Physical health provision accounts for a significantly larger subsection of the armed forces charity sector than mental health and education/employment, both in terms of the number of beneficiaries accessing support and the amount of charitable expenditure dedicated to delivering provision.

- Forces charities offered an extremely diverse range of services aimed at improving the physical health of beneficiaries, varying from clinical to holistic approaches. Charities responded to gaps in health-care provision, by delivering services not readily available on the NHS.

- Although charities collaborated extensively with one another, partnerships with external health authorities were not as common. Cross-sector collaboration should be encouraged in order to avoid duplication of effort, as well as to share resources and expertise.

- Although the majority of charities providing clinical services adhered to clinical care guidelines, in some cases details of registration with regulatory authorities were difficult to obtain. DSC recommends that charities more effectively communicate their adherence to guidelines, in order to promote public trust and better inform their beneficiaries.

- Additionally, DSC recommends that all charities should show greater commitment to measuring impact, which would help assess whether services were effective and would help identify any further gaps in provision.

Introduction

CONTEXT

The singular focus of this report is to provide an account of physical health provision offered by forces charities. Members of the armed forces community may access health support elsewhere, for example from the MOD, government schemes, local health authorities and welfare organisations. It is beyond the scope of this report to discuss each in detail. However, it is useful to briefly summarise some of the wider context surrounding military health care so as to better understand the environment in which Service charities operate.

Historically, charities have played a vital role in military health care, including several charities featured in this report. For instance, the Soldiers', Sailors' & Airmen's Families Association's (SSAFA) health-care provision can be traced back to the introduction of its nursing branch in 1892, later known as Alexandra nurses. The Royal Hospital Chelsea (also featured in this report) has been operating for over 330 years, initially established in 1682 to care for those 'broken by age or war' (The Royal Hospital Chelsea, 2017). Both charities continue to provide care to the armed forces community today.

In 2017, MOD health-care provision and charitable provision still intersected fairly often. The Defence Recovery Capability is a prime example of collaboration between the defence and charity sectors to aid the recovery of WIS (wounded, injured and sick) Service personnel. This MOD initiative is delivered in partnership with Help for Heroes and The Royal British Legion, with contributions from a host of other Service charities. It provides resources such as Individual Recovery Plans and Personnel Recovery Centres to help WIS personnel return to duty or transition to skilled, working civilian life. The Defence Medical Service (DMS) retains primary responsibility for the health care of Serving personnel. According to the 2016 *Continuous Attitudes Survey*, 80% of Serving personnel reported being satisfied with their medical care (MOD, 2017).

Upon leaving Service, responsibility for veterans' health care transitions to the NHS. The Armed Forces Covenant currently enshrines the right to priority treatment for ex-Service personnel, although eligibility is largely dependent upon attributable injury and clinical need. Notably, Lord Ashcroft's 2017 *Veterans' Transition Review : Third follow-up report* stated that in regards to transition for Service leavers in England, 'it is in the field of health that the most obvious progress has been made.' In particular, Ashcroft praises the Veterans Trauma Network, and The Covenant Hospital Alliance, a network of over 20 NHS acute hospitals and health boards in England seeking to become more 'veteran-friendly' (Ashcroft, 2017).

The 2017 *Covenant Annual Report* also highlighted a series of recent initiatives intended to increase awareness of armed forces health needs among medical professionals. Notable developments included the launch of a Veterans' Awareness Accreditation programme for GP practices in England, the widespread use of e-Learning packages by NHS staff, as well as Health Education England's ongoing commitment to developing and training Armed Forces Champions.

Throughout the rest of the UK, policymakers have reaffirmed their commitment to the Covenant via the introduction of new legislation and guidance. The Scottish Government recently introduced the Community Health Index in an attempt to more easily identify Serving personnel and their families. In Wales, new guidance has been issued to GPs and health-care professionals on priority treatment for veterans, while Northern Ireland's Health and Social Care (HSC) authorities continue to monitor NHS waiting times for military families.

The UK armed forces community is estimated to include over ten million individuals, some of whom may be wounded, injured and sick (NHS, 2015). Annual MOD statistics on medical discharge and pension claims provide a rough indication of how many Service personnel suffer from injury and illness. In total, 2,526 Service personnel were medically discharged within the last year, the main cause of which was musculoskeletal disorders (MOD, 2017). However, it remains largely unknown what proportion of the ex-Service community suffer

from non-Service related health problems, or who suffer from Service-related injuries which present later in life, beyond their military careers.

Research carried out by academics and charities has shed some light on the prevalence and types of injury/illness suffered by ex-Service personnel. For instance, The Royal British Legion's *2014 UK Household Survey of the ex-Service Community* found veterans to be twice as likely to have a long-term illness that limits their activity, compared to the general population (24% v. 13% respectively) (The Royal British Legion, 2014). On the other hand, findings from the MOD's *Annual Population Survey* in 2015 found no differences in the health conditions reported by veteran and non-veteran populations in the UK. The most prevalent long-term health conditions experienced by veterans were musculoskeletal and cardiovascular and respiratory problems (MOD, 2016).

At present, a definitive list of common health issues facing the Service community does not exist. This is largely due to the fact that academic studies on WIS Service personnel tend to focus on specialist areas, whether musculoskeletal injury (Briggs et al., 2014), traumatic amputation (Murrsion, 2011; Fossey et al., 2014), or visual impairment (Malcolm et al., 2014). Studies which examine health needs of the armed forces community more broadly, although insightful, have been typically limited to small sample groups. For example, the groups may cover the beneficiaries of one specific charity, veterans of a particular conflict or those serving within a limited time frame (The Royal British Legion, 2014; Greenberg et al., 2016; Fear et al., 2010). As occupational dangers and hazards vary enormously from one conflict to another, existing academic studies are limited in their representation.

This report finds that forces charities provide a vast array of physical health services, some of which are clinical and others which adopt a holistic approach. Physical health provision frequently extends into and merges with other areas of support, such as housing, social inclusion, employment and well-being. Service charities respond to a wide range of social issues arising either directly or indirectly as result of physical health issues. Forces charities' physical health services generally cater to a plethora of everyday health problems which in many cases are unrelated to Service experience, with many voluntary organisations providing 'support for life'.

FOCUS OF THE REPORT

This report aims to illuminate a small section of the armed forces charity sector providing physical health support for Service personnel and their families, some of whom may be WIS.

The term wounded, injured and sick (and its abbreviation, WIS) appears throughout the report. This term is frequently cited within academic writing and often embedded in the language of Service charities, although its definition varies considerably between the many charities and services in question. Within the context of this report, the term is employed in its broadest sense to include any member of the armed forces community who experiences physical health issues, whether attributable to Service or not.

The focus of this report is limited to 'physical health provision', which refers to services promoting the recovery, fitness and general good health of the armed forces community. It also includes services which are directed specifically at injured/ill beneficiaries, which serve more generally to improve their quality of life and well-being, or to support their transition to civilian life.

Physical health is an extremely broad subject. As such, forces charities' physical health services differ hugely, ranging across many examples of clinical and non-clinical approaches. There is inevitably significant overlap between areas of charitable provision as a result of comorbidity. For example, beneficiaries with musculoskeletal injuries may require accessible housing because of their reduced mobility.

The report thus takes into account not only traditional clinical services but a huge variety of non-clinical services which serve to promote beneficiaries' health and aid physical recovery. Among these examples are recreation, leisure, sport, fitness and adapted housing.

Mental health provision is excluded from DSC's definition of physical health provision and has previously been explored in DSC's 2017 report *Focus On: Armed Forces Charities' Mental*

Health Provision. However, there is an inevitable degree of overlap as provision for physical health and provision for mental well-being often go hand in hand.

To date, little data has been gathered on forces charities making provision for physical health. This report aims to tackle this shortfall of knowledge by examining how many charities operate within this space and which types of services they provide. It also explores financial expenditure, beneficiaries, cross-sector collaboration, evaluation and best practice, with the aim of delivering new insights into the work of forces charities.

It is beyond the scope of this report to investigate wider contextual factors underpinning Service personnel's ability to access health care. Nevertheless, some key contextual considerations are outlined in the 'Context' section on page XI. Additionally, this report does not make comments or value judgements on the effectiveness of current provision being made by charities. Instead, its purpose is to hold an objective mirror to this particular subsection of the armed forces charity sector.

The report examines organisations which meet DSC's definition of an armed forces charity and which make provision for physical health.[4] Undoubtedly, provision exists for health-care support throughout the wider charity sector, which beneficiaries can access regardless of any affiliation with the armed forces. However, this report will focus exclusively on those charities whose main purpose is to serve the armed forces community. DSC's definition of an armed forces charity is outlined in the section entitled 'DSC Classification of Armed Forces Charities', which can be found below.

TERMINOLOGY

For the purpose of this report, and in keeping with the language used in *Sector Insight* (2014 and 2016), the term 'ex-Service personnel' will stand to refer to any person who has served in the UK armed forces (for at least one day). 'Serving personnel' refers to individuals who are currently employed in the armed forces.

The term 'spouses/partners' refers to the partners of Serving personnel and ex-Service personnel and includes divorced or separated spouses as well as widows and widowers. The term 'dependants' refers to the children of Serving and ex-Service personnel. When referring to all of the above (ex-Service personnel, currently Serving personnel, their spouses and dependants), the term 'armed forces community' is employed.

As mentioned, the term WIS appears throughout the report. Within the context of this report, the term is employed in its broadest sense to include any member of the armed forces community who experiences physical health issues, irrespective of whether they are attributable to Service experience or not.

DSC CLASSIFICATION OF ARMED FORCES CHARITIES

The definition of an armed forces charity utilised for this report is applied as outlined in DSC's *Sector Insight 2016*:

> *'Charities that are established specifically to support past and present members of the armed forces and their families (the armed forces community). In this context, an armed forces charity must be able to apply this definition to their beneficiaries.'*
>
> *DSC, Sector Insight 2016*

When DSC published its first report on armed forces charities (*Sector Insight 2014*), the number of armed forces charities was reported as being approximately 2,200. Since 2014, the methodology for categorising armed forces charities has been refined to exclude charities whose direct beneficiaries are not members of the armed forces community. This exclusion therefore applies to 'cadet' charities, which accounted for 500 charities in *Sector Insight 2014*.

[4] For further information on DSC's definition of an armed forces charity, see 'DSC Classification of Armed Forces Charities', on this page (XIII).

Cadet charities were excluded on the basis that although they are – by their own admission – not firmly affiliated with the armed forces, and their beneficiaries (the cadets themselves) are not necessarily members of the armed forces community.

It is appreciated that certain heritage or memorial charities may not directly serve the armed forces community, and therefore a small number of heritage or memorial charities have been removed, with each being considered for inclusion on a case-by-case basis.

A further 500 association branches are represented in the report by their centralised organisations and corporate–body accounts. This methodology eliminates the possibility of 'double counting' financial resources from the branch accounts.

DSC will publish a *Focus On* report in 2018 that will provide a definitive figure of the size of the armed forces charities sector, which will include a comprehensive breakdown of its subsectors.

METHODOLOGY

DSC maintains a database containing information on approximately 1,200 armed forces charities, of which roughly 900 are registered with the Charity Commission for England and Wales (CCEW). A further 300 charities included in the database are registered in Scotland with the Office of the Scottish Charity Regulator (OSCR).

In order to identify charities which make physical health provision, DSC undertook a systematic keyword searching process of DSC's database, along with the CCEW, OSCR and Charity Commission for Northern Ireland (CCNI) databases. In order to be included in this report, charities were required to meet specific eligibility criteria, including specifying that physical health support was either their sole charitable object or one of their key charitable objects. Although many charities' objects broadly refer to physical health, DSC also looked for specific evidence of this beyond their official charitable objects and regulator classifications. This included charities making specific reference to programmes and services addressing issues related to physical health, funding other organisations to deliver these services on their behalf, or working with partners to meet such needs.

A number of forces charities generally state in their objects that they make provision for former members who find themselves in need, which includes the possibility of physical health care. Such charities are not included in this analysis unless evidence of provision can be identified by DSC in information provided by the charities, either online (via information submitted to the relevant charity regulator) or through contacting the charities in question.

In August 2017, DSC sent email requests to 121 charities inviting them to take part in a survey. This was followed up by a postal invitation to the survey, before a final reminder email was sent out in early September 2017. To bolster the survey data, follow-up phone calls were conducted with charities which had been unresponsive to survey invitations. As a result of this, 48.8% of the 121 charities identified as physical health-care charities (N=59) responded to the survey.

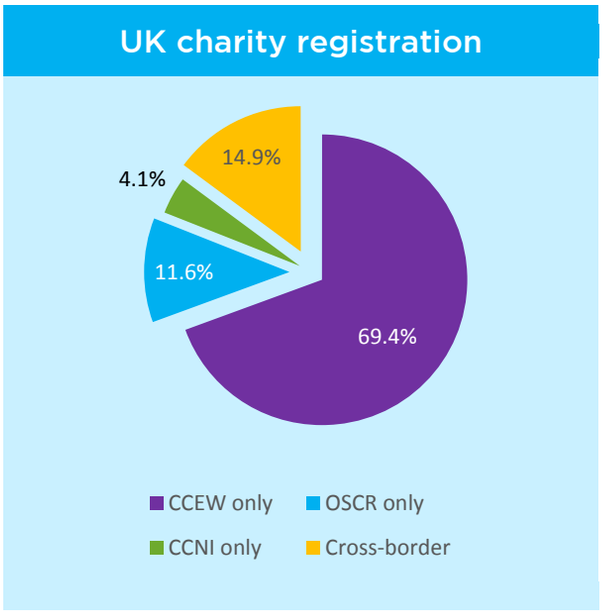
Researchers collected data on the remaining 51.2% of charities which did not respond to the survey (N=62). Relevant data was gathered from a wide range of sources, including charity commission information, charities' websites, annual accounts, impact reports and direct correspondence with charity representatives where possible. The 121 charities included in this research represent 10.1% of the approximate total number of UK armed forces charities (N≈1,200).

DSC is confident that the charities represented in this report are comprehensive and accurate as of the final data-collection and refinement date (17/10/2017). The possibility of charities being excluded from the report due to not being found by researchers is recognised. However, due to the rigour of the search process, this is considered to be unlikely.

Financial data utilised in this report was not gained through means of survey. It was taken from the latest available accounts and annual reports that were submitted to UK charity regulators. The majority (68.6%) of data utilised in this report comes from 2015/16 accounts, with 3.3% being from 2016/17 accounts and 19.8% from 2014/15 accounts. A total of 8.3% charities had no available accounts listed during the data-collection process, which was

predominantly because of charities not yet having been required to submit accounts due to their newly registered status.

Figure 1



DSC examined the split of charities by their registration with their respective charity regulators. Figure 1 shows a percentage split of the 121 charities featured in this data.

Charities registered exclusively with CCEW accounted for 69.4% (N=84) of charities.

Cross-border, which refers to charities registered with both CCEW and OSCR, accounted for 14.9% (N=18) of charities.

Charities registered exclusively with OSCR accounted for 11.6% (N=14) of charities.

Charities registered with CCNI accounted for 4.1% (N=5) of charities.

CHAPTER ONE

An overview of charities' physical health provision

1.1 INTRODUCTION

This chapter provides information and analysis on the nature and characteristics of physical health provision made by UK armed forces charities. As mentioned previously, physical health provision refers to services which promote the recovery, fitness and general good health of the armed forces community. It also includes services targeted specifically at WIS beneficiaries, which more generally aim to improve their quality of life or transition to Civvy Street. Examples of which may include housing, social inclusion or welfare services.

The chapter is divided into the following sections:

- Beneficiaries accessing support
- Charitable expenditure
- Chapter summary

1.2 BENEFICIARIES ACCESSING SUPPORT

1.2.1 Number of beneficiaries accessing support

Data collected by DSC provides a figure for the estimated number of beneficiaries accessing charities' physical health services within the last year.

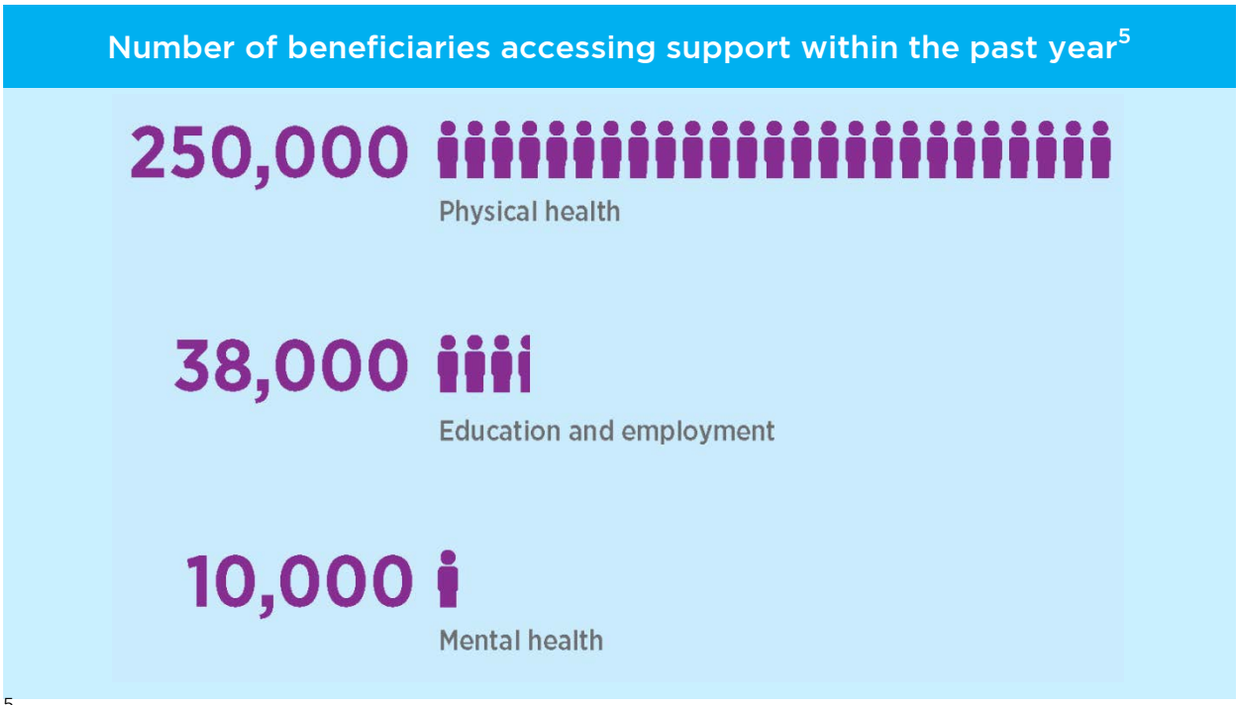
The minimum number of beneficiaries accessing physical health support is approximately 250,000 per year according to all charities which provided data on beneficiary numbers (N=52). This figure should be taken as a conservative estimate only, given that 57.0% of all charities featured within this report did not provide an approximate number of beneficiaries.

It should also be noted that members of the armed forces community may access more than one charity for support. Therefore, it is not possible with current figures, or through current service providers' record-keeping, to control for such overlap. As a result, these figures are a best estimate based on available data. Further research on the beneficiary community may be needed to provide a better approximate figure of multi-service usage.

Nevertheless, the minimum figures given by charities highlight that there is indeed huge demand for physical health support. A large number of beneficiaries (at least 250,000) accessed support from a relatively small pool of charities (121 in total).

Previous research by DSC found that at least 35,000 people accessed education and employment services and between 7,000 and 10,000 beneficiaries accessed mental health services during 2016 (Cole et al., 2017; Doherty et al., 2017). By comparison, a much greater proportion of the armed forces community appear to access support for physical injury and/or illness. The minimum number of beneficiaries accessing physical health provision is roughly seven times greater than those accessing education and employment services, and twenty-five times greater than those accessing mental health services.

Figure 2



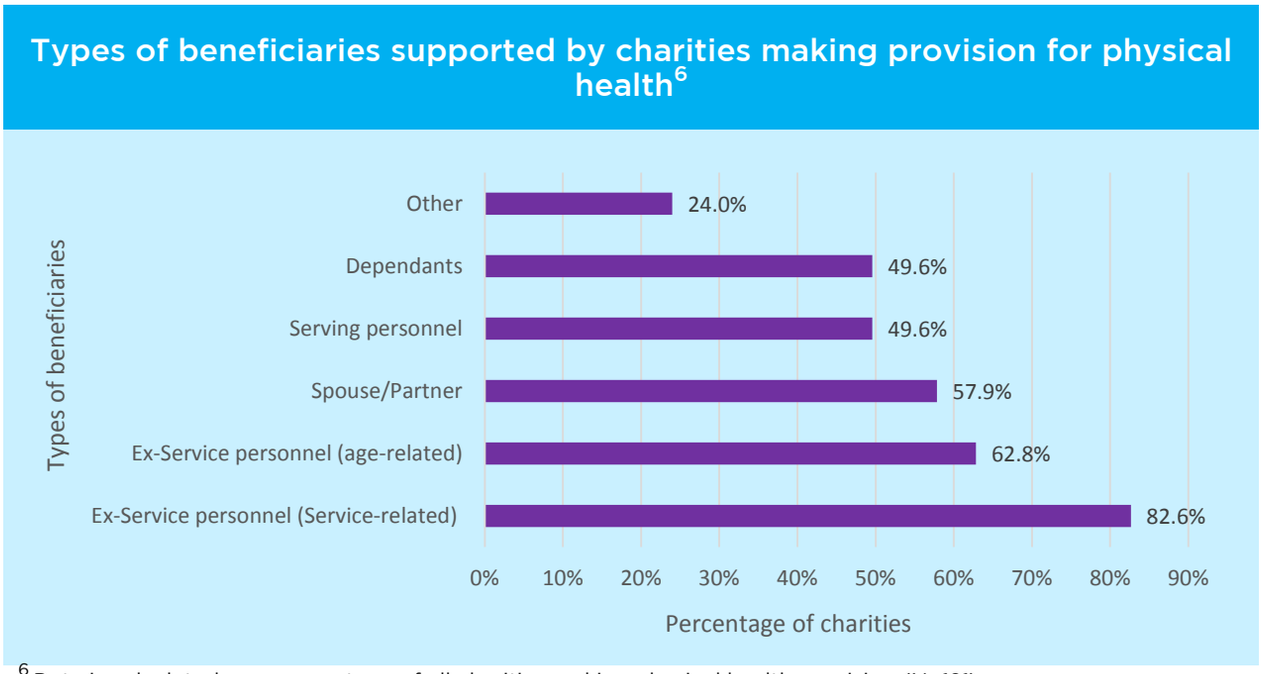
[5] Data is taken from the 2017 DSC reports: *Focus On: Armed Forces Charities' Mental Health Provision* and *Focus On: Armed Forces Charities' Education & Employment Provision.*

1.2.2 Types of beneficiaries supported

Figure 3 shows the types of beneficiaries which forces charities make physical health provision available to. The most common beneficiary category was ex-Service personnel, and this covered two sub-categories: over four-fifths (82.6%) of charities supported ex-Service personnel with Service-related health issues; and over three-fifths (62.8%) supported ex-Service personnel with age-related health issues.

A significant proportion of charities provide physical health support for the wider armed forces community. Almost three-fifths (57.9%) make provision for spouses/partners, while just under half (49.6%) support dependants and Serving personnel.

Figure 3



[6] Data is calculated as a percentage of all charities making physical health provision (N=121).

Initial analysis suggests physical health provision is generally accessible for the wider armed forces community. However, many charities enforce restricted eligibility criteria for beneficiaries.

Eligibility criteria varied significantly between charities. However, the most common requirements included:

- having a specific illness, injury or disability (mentioned by 12 charities);
- belonging to a particular tri-Service category (N=10);
- being wounded during Service or medically discharged (N=6);
- having an affiliation to a particular regiment/unit (N=5);
- or a combination of the above.

Other less commonly cited criteria for provision included:

- residing in a specific geographical region, hospital or home;
- being a veteran of a particular conflict/war;
- falling within a specific age range or financial position.

DSC's findings indicate that provision for physical health frequently extends to groups within the wider armed forces community, such as spouses and dependants. However, a significant number of the charities in question (38.8%) enforce strict eligibility criteria, some of which restricts beneficiaries to small or niche groups.

1.2.3 Beneficiary type: illnesses and injuries

While it is beyond the scope of this report to examine the physical health needs of the armed forces community, DSC gathered data on which types of illness/injury charities stated that they made provision for. In total, 85.1% of charities featured in this report specified this information (N=103).[7]

[7] For any references to provision for specific illness or injury types within charities' survey responses, regulatory information and websites were counted.

Table 1 shows the most common illness/injury types in descending order. Over three-fifths of charities made provision for limited mobility and for wounds (63.6% and 60.3% respectively) and over half (54.4%) supported limb loss.

Table 1

Beneficiaries presenting with illness/injury by type[8]		
Illness/injury type	Number of charities	Percentage of charities
Limited mobility Limitation of movement which may cause muscle weakness, balance problems, fatigue and impact motor coordination.	77	63.6%
Wounds Injury to tissue caused by a cut, blow or impact where the skin is typically broken.	73	60.3%
Limb loss Amputation (surgical removal) of a limb or part of a limb due to injury, trauma, infection or disease.	66	54.5%
Sight loss Visual impairment which causes blindness or partial sight loss.	48	39.7%
Neurological disorders Neurological disorders are diseases of the central and peripheral nervous system.	44	36.4%
Musculoskeletal Pain affecting the muscles, ligaments, tendons and bones.	44	36.4%
Hearing loss Deafness or partial hearing loss in one or both ears.	42	34.7%
Cardiovascular Conditions affecting the heart or blood vessels.	31	25.6%
Respiratory problems Problems associated with breathing, typically affecting the lungs.	28	23.1%
Neurodegenerative Umbrella term for diseases affecting the function of neurons.	27	22.3%
Chemical exposure Exposure to hazardous chemicals or substances via touching or breathing.	25	20.7%

[8] Note: data is taken from charities where specified and calculated as a percentage of all charities delivering physical health provision (N=121).

The majority of charities catered to a wide range of illness/injury types, whereas some catered exclusively to one or a small selection of types. For example, Blind Veterans UK caters exclusively for Service personnel who are suffering from sight loss, whereas Blesma's services are available to Service personnel with limb loss and sight loss.

In total, 18 charities (or 14.9% of those mentioned in this report) did not specify the types of illness/injury that beneficiaries commonly presented with. The majority of these charities tended to provide 'general' physical health provision, regardless of the type of physical health problem. Such charities typically responded to illness and injury on a case-by-case basis, and therefore did not distinguish between or collect data relating to illness/injury types. For example, the Royal Centre for Defence Medicine Patient Welfare Fund provides luxury items to all military patients in Queen Elizabeth Hospital Birmingham.

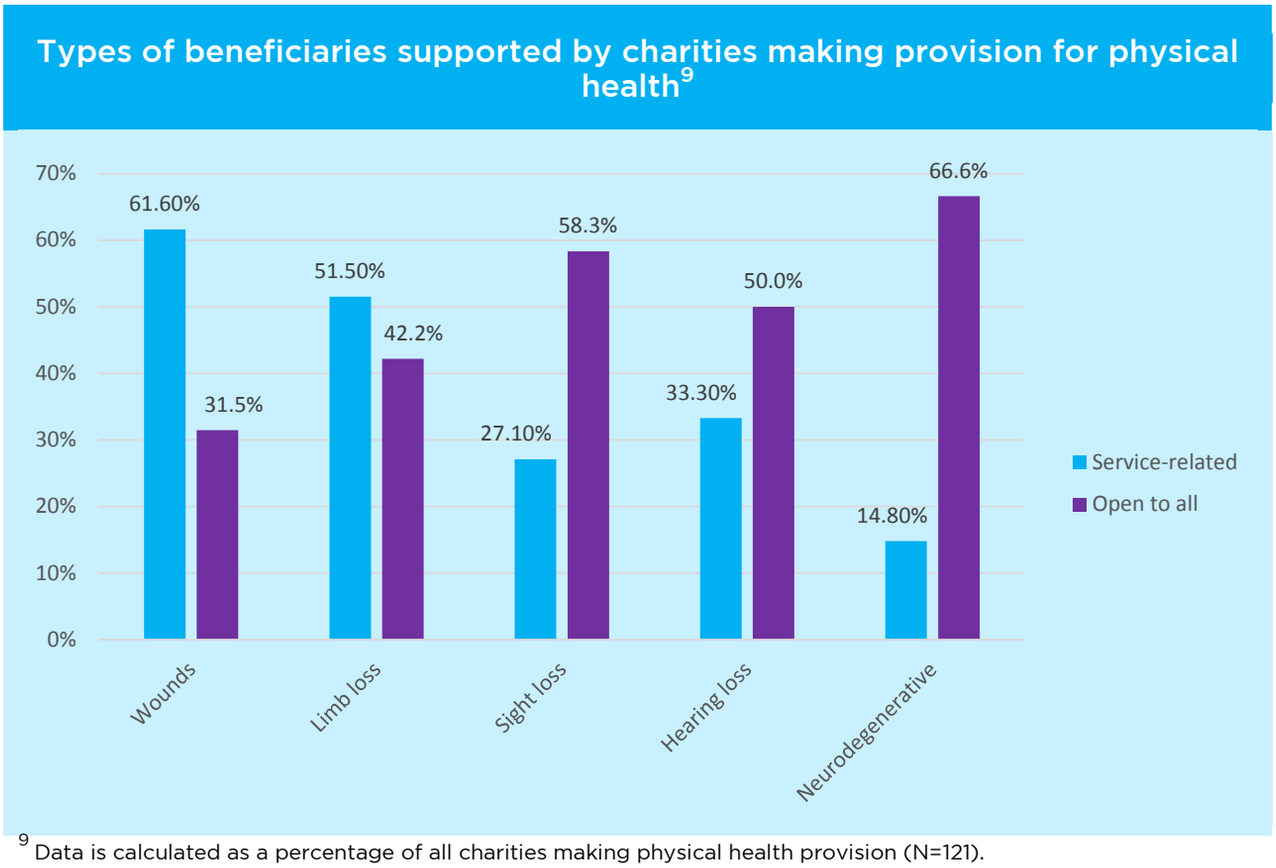
1.2.4 Beneficiary type: cause of illness/injury

DSC also examined whether the causes of illnesses and injuries impacted beneficiaries' ability to access charitable provision, specifically whether or not they were attributable to Service.

As evident in figure 4, over three-fifths (61.6%) of charities made provision for beneficiaries with Service-related wounds, whereas less than one-third (31.5%) provided support for wounds to all beneficiaries, regardless of cause. Similarly, charities were slightly more likely to provide support for limb loss if related to Service experience (51.5% v. 42.2%).

In contrast, charities which offered support for neurodegenerative diseases, sight loss and hearing loss, generally did not distinguish between whether physical health issues were attributable to Service experience or not. Typically, they specified that provision was open to all beneficiaries.

Figure 4



[9] Data is calculated as a percentage of all charities making physical health provision (N=121).

Occupational hazards vary considerably depending on individual Service experience; however, Service personnel may be vulnerable to combat-related injuries such as musculoskeletal problems, wounds and limb loss (MOD, 2017). In contrast, ex-Service personnel may be more likely to experience sight loss, hearing loss and neurodegenerative diseases later in life as these illnesses are typically associated with old age. Generally, forces charities responded to the diverse health needs of the armed forces population by making provision for both Service and non-Service related health issues. In many cases, access to

services was non-contingent upon injury/illness being attribute to Service, with the majority of forces charities providing long-term 'support for life'.

1.3 CHARITABLE EXPENDITURE

In terms of understanding charitable expenditure, it can be helpful to categorise charities into two distinct categories, based upon their charitable objects. Charities were classified as being 'Primary' or 'Secondary' providers of physical health provision.

Primary provider charities make provision for one specific area of support, in this case physical health, and regularly commit all of their charitable expenditure to a specific need.

Secondary provider charities make provision across a wide range of need and support. None of these charities focus on one topic of support, but provide a wide range of support to their many beneficiaries. Examples include well-known charities such as the RAF Benevolent Fund, SSAFA and The Royal British Legion.

In previous research, DSC often found Secondary provider charities to be financially larger than their Primary counterparts. Secondary providers more commonly had finances available to commit significant amounts of resource across many areas of need (Cole et al., 2017; Doherty et al., 2017).

Such financially large charities may devote a small percentage of their expenditure to a specific topic of need. However, due to their financial assets, just 20% of their annual expenditure could be greater than a more financially modest Primary provider committing 95% of its expenditure to the same topic.

It is however noted that there are financially large charities which are Primary providers (for example, Blind Veterans UK). In any case, this has generally been seen as the exception rather than the rule.

Figure 5

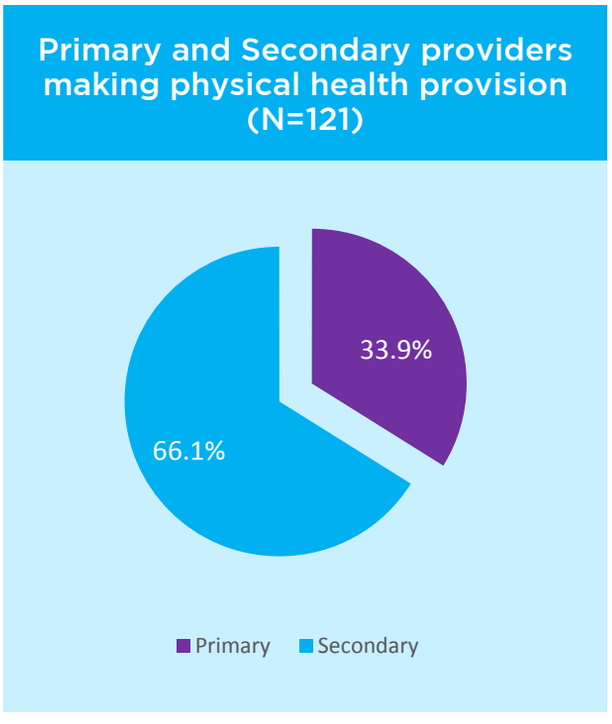


Figure 5 shows the split of Primary and Secondary providers for all charities identified as making provision for physical health (N=121). Approximately two-thirds (66.1%) of charities (N=80) were identified as being Secondary providers and one-third (33.9%) were identified as Primary providers (N=41).

Importantly, this is not in any way a value judgement on charities and their provision. There is no implied quality of provision, or of charities' commitment to making such support available. It is solely a means of identifying broad trends in expenditure.

All charities in this report were individually categorised as being Primary or Secondary in nature, so it is acknowledged that there is an element of subjectivity in this assessment. However, this method is useful as a means of distinguishing between those charities for which the physical health of the armed forces community is the primary focus, or for which physical health support is one strand of a wider provision for the armed forces community.

Annual expenditure on physical health from all forces charities is at least £103 million. Primary providers accounted for approximately £40 million of this total, while Secondary providers accounted for approximately £63 million. It should be noted however, that this figure is taken from data where available (N=49 charities) and is an approximation based on their reported percentage of expenditure on physical health provision only.

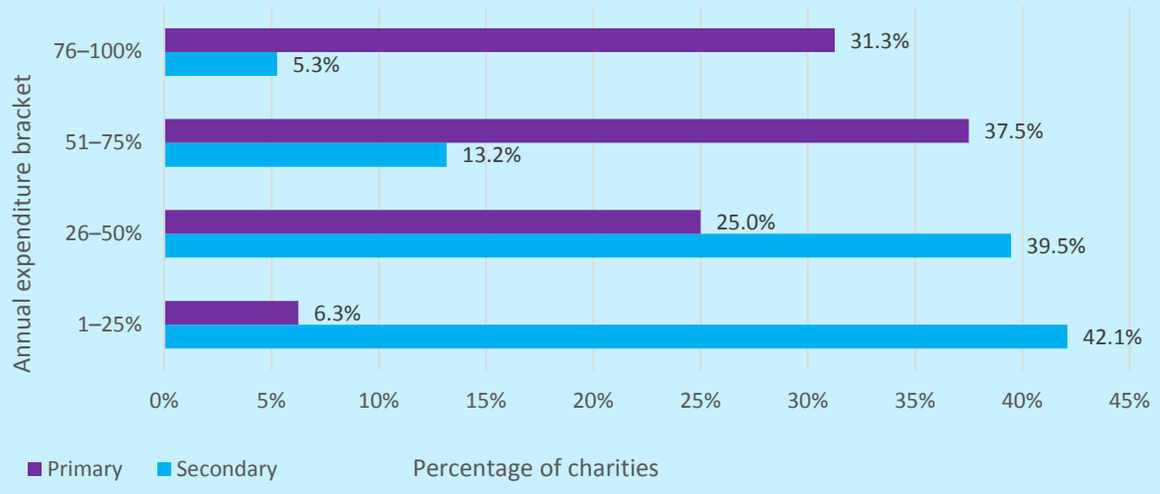
The minimum amount of expenditure dedicated to physical health provision by forces charities was significantly greater than the amount charities dedicated to both education and employment (£26 million) and mental health (£28 million) within the same period. (Cole et al., 2017; Doherty et al., 2017)

Each charity's reported expenditure has been back-calculated from charity regulator records on each corresponding charity's annual charitable expenditure. Survey data used in this calculation is based on approximate percentages of expenditure attributed by respondents to physical health support. It is recognised that there may be an element of 'double counting' in the expenditure figures, as one charity's expenditure (as a grant) can become another charity's income and would therefore feature twice in the overall financial accounting. Grant-making may also affect the accuracy of expenditure calculations, as discussed in more detail in Chapter Two.

Figure 6 shows the total amount dedicated to physical health provision as a percentage of total annual expenditure, which effectively illustrates the differences in spending patterns between Primary and Secondary providers. Primary providers are more commonly (68.8%) committing over half of their annual expenditure to physical health provision. In contrast to this, Secondary providers are more commonly (81.6%) spending less than half of their annual expenditure on this.

Figure 6

Percentage of annual expenditure dedicated to physical health provision[10]



[10] Note: data is taken from charities' survey responses, where expenditure was specified (N=49); Primary providers who specified (N=14), Secondary providers who specified (N=35).

1.4 CHAPTER ONE SUMMARY

Provision for physical health

DSC identified 121 charities which supported injured and/or ill Service personnel and/or their families, which represents 10.1% of all armed forces charities (N≈1,200). This finding largely debunks the myth that there are too many forces charities, as only around one-tenth make provision for physical health.

Beneficiaries

At least 250,000 beneficiaries accessed physical health support during the previous year. This was substantially greater than the number of beneficairies accessing both education and employment (N≈35,000) and mental health (N≈10,000) support during 2016 (Cole et al., 2017; Doherty et al., 2017). Ex-Service personnel were the most commonly supported beneficiary type, with 82.6% of charities supporting those with Service-related illness/injury and 62.8% supporting those with age-related health problems.

Charitable expenditure

Expenditure data (where available) suggests that forces charities' annual expenditure on physical health is in the region of at least £103 million. Again, this was significantly greater than the amount that forces charities dedicated to both education and employment (£26 million) and mental health (£28 million) within the last year (Cole et al., 2017; Doherty et al., 2017).

CHAPTER TWO

Service delivery: physical health provision

2.1 INTRODUCTION

This chapter provides information and analysis on types of services forces charities currently deliver to WIS Service personnel and their families. The chapter is divided into the following sections:

- Common types of physical health support
- How services are delivered
- Partnership and collaboration
- Accreditation, evaluation and impact
- Chapter summary

2.2 COMMON TYPES OF PHYSICAL HEALTH SUPPORT

As highlighted in the Introduction (page XI), 'physical health support' encompasses a wide range of services, including both clinical and non-clinical approaches to health care for Service personnel and their families.

DSC's definition of 'physical health support' takes into account any provision which aims to improve the physical health of beneficiaries, from physiotherapy to sports and fitness programmes. It also includes charitable provision which provides support for WIS beneficiaries in other areas such as housing, employment or social inclusion.

Table 2 shows the most common physical health services delivered by forces charities, listed in descending order of the most frequently provided.

Table 2

Physical health services commonly provided by Service charities[11]		
Services	Number of charities	Percentage of charities
Recreation Leisure activities such as day trips for hospital patients or adapted surfing lessons.	50	41.3%
Adapted housing Purpose built accommodation or home adaptions to improve accessibility, for example stair lifts/ramps/handrails.	46	38.0%
Respite/break centre Breaks (such as family holidays) for Service personnel, carers and family members with physical health problems.	45	37.2%

Sports/fitness Programmes which focus on physical recovery through sport/fitness. The Invictus Games is an example of this.	39	32.2%
Signposting Directing beneficiaries to appropriate organisations for physical health provision, such as GPs, charities or welfare groups.	35	28.9%
Mentoring Beneficiaries are assigned a dedicated mentor or case handler who delivers expert advice and guidance.	34	28.1%
Medical equipment Clinical equipment used in armed forces health care. For example, mobility aids or hospital scanners.	34	28.1%
Nursing/care home Residential care homes which typically provide nursing care in addition to social activities, typically specialising in elderly care.	31	25.6%
Physical rehabilitation Physical recovery programmes following injury/illness, which may take a clinical or non-clinical approach. For example, physiotherapy or equine therapy.	29	24.0%
Helpline A dedicated telephone advice service to advise beneficiaries with physical health needs, as well as their families.	17	14.0%
Medical research Academic or medical research which focuses on physical health issues affecting the armed forces community or contributes to advances in military health care.	15	12.4%
Prosthetics Artificial limbs for Serving personnel and ex-Service personnel who have experienced limb loss. May include grants for specialist care, advice services or support networks.	14	11.6%
Assistance dogs Provide practical assistance to individuals with various disabilities, including beneficiaries with hearing or sight loss, or limited mobility.	9	7.4%

[11] Note: data is taken from charities where specified and calculated as a percentage of all charities delivering physical health provision (N=121).

Other less commonly delivered physical health services (not reported in the table) included:

- food parcels or breakfast clubs (N=3);
- luxury basic items for hospital patients (such as sundries, DVDs and toiletries) (N=3);
- employment training for WIS Service personnel (N=3).

Table 2 provides an overview of forces charities' physical health provision, by successfully highlighting the diversity of physical health services. This is particularly evident when taking

into account the top two categories of support – recreation and adapted housing – both of which are non-clinical responses to forces health care, but nonetheless form an integral part of recovery and well-being.

There is significant overlap between areas of provision, as physical health support frequently expands into the areas of housing, employment, recreation, leisure and so on. Physical health support cannot be explored in isolation, as physical injury/illness inevitably impacts upon various other aspects of daily life for Serving personnel and their families.

2.3 HOW SERVICES ARE DELIVERED

In addition to exploring which physical health services were most commonly provided, DSC gathered data on how physical health services were delivered to beneficiaries.

Charitable provision can be delivered in the form of direct service provision or it can be delivered through grants to beneficiaries. The latter may enable beneficiaries to access appropriate services elsewhere or fund much needed treatment and equipment.

Alternatively, charitable provision can be delivered through grants to organisations, which effectively outsources service provision to external providers. Levels of organisational grant-making trends provide insight into the extent of collaboration and partnership undertaken by forces charities.

Grant-making trends also have implications for expenditure estimates, because of the possibility that expenditure is recycled within the same cohort of forces charities, thus artificially inflating sector expenditure.[12]

Overall, less than half (45.5%) of the charities featured in this report specified making grants. There was no significant difference in the number of charities delivering grants to individuals compared to delivering grants to organisations (34.7% v. 32.2% respectively). Previous research by DSC found that approximately only 10% of charities who state that they offer grants actually do so.[13]

This section explores how physical health services are delivered to beneficiaries. For ease of reading, services have been grouped together based on shared traits and have been divided into the following categories:

- Physical rehabilitation and prosthetics
- Nursing homes and respite care
- Adapted housing and assistance dogs
- Medical equipment and research
- Sports/fitness programmes and recreation
- Helplines, mentoring and signposting

The following graphs illustrate which delivery methods (services provided themselves, grants to individuals or grants to organisations) were employed to provide each type of physical health service.

[12] See Chapter One, page 6 for financial expenditure calculations.

[13] This situation is not specific to the armed forces charity sector. Earlier research by DSC published in *UK Grant-Making Trusts and Foundations* revealed that in general, many more charities state in their objects that they make grants than they do in practice.

2.3.1 Physical rehabilitation and prosthetics

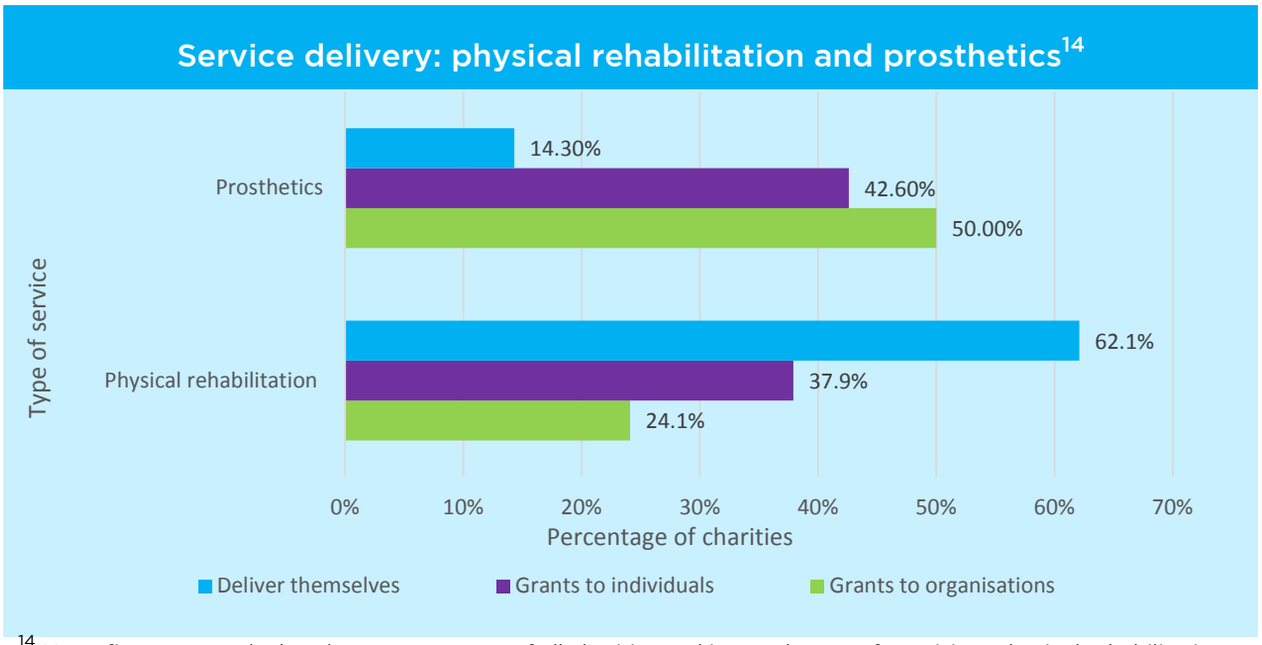
As shown in figure 7, prosthetics services were most commonly delivered through grants to organisations (50.0%) and grants to individuals (42.6%). Only 14.3% of charities delivered prosthetics themselves, which may be because this is a relatively specialist area of provision.

Prosthetics services include advice on prosthetics care, grants for prosthetics and research into prosthetics technology. The majority of charities operating in the field of prosthetics delivered non-clinical forms of support, as opposed to manufacturing, producing or fitting prosthetic limbs. This is highlighted in the following case study on Blesma.

Figure 7 shows that physical rehabilitation was most commonly (62.1%) delivered via charities themselves. Grants to individuals for physical rehabilitation were slightly rarer, offered by almost two-fifths (37.9%) of forces charities.

Physical rehabilitation can take place in a clinical or non-clinical setting, for example via a physiotherapist or via equine therapy. In total, 16.5% of charities delivered physical rehabilitation which was administered by a qualified health-care professional, such as a physiotherapist or occupational therapist.

Figure 7



[14] Note: figures are calculated as a percentage of all charities making each type of provision; physical rehabilitation (N=29), prosthetics (N=14).

CASE STUDY: BLEMSA – LOSS OF LIMB SUPPORT

Blesma is 'an armed forces charity dedicated to assisting Serving and ex-Service men and women who have suffered life-changing limb loss or the use of a limb, an eye or sight.'[15] Since the First World War, Blesma has supported over 62,000 limbless veterans.

Since its foundation, Blesma has lobbied successive governments in order to achieve improvements in pensions, standards of artificial limbs and the provision of suitable motor transport and employment opportunities. Blesma has opened residential homes, initiated wide-ranging health and well-being services, undertaken sporting activities and commissioned innovative research.

At present, Blesma looks after 3,093 members and widows. The charity has however observed a shift in the beneficiaries: 'Elder membership is increasingly frail, but younger membership has increased as a result of recent conflicts'.[16]

In the past year, Blesma provided:

- 1,609 home visits and 158 other visits;
- 1,176 individual grants to 757 recipients;
- and 42 rehabilitative activities to 312 participants.

The charity offers a wide range of services to support limbless veterans throughout life, helping them to regain mobility and independence. Methods of support include the following:

- Support officers: to provide direct support, advice and emotional support to veterans and their families.
- Recreation and leisure activities: to promote health and well-being (for example, cycling, fishing, horse riding, parachuting and scuba diving).
- Advice: to provide expert advice on a wide range of areas including prosthetics, the War Pension and Armed Forces Compensation Scheme and the national benefits system. Blesma answered 4,920 calls in the past year.
- Grants: to cover the additional costs and hardships of disability. Last year 1,176 individual grants were awarded to 757 recipients. All grant applications are considered on an individual basis but regularly include the provision of wheelchairs, mobility aids, and home and garden adaptions.

Blesma regularly engages in cross-sector collaboration in order to effectively serve its beneficiaries. It has established close links with NHS centre teams, Defence Medical Services (particularly the DMRC at Headley Court), as well as creating industry links.

The charity works closely with the NHS to ensure the latest advances in the relevant medical fields are converted into practical prosthetics solutions. It also helps prosthetists develop their skills at undergraduate and PhD level.

Blesma frequently partners with academics to undertake research on the impact of limb loss on veterans and their families. Examples of this are Anglia Ruskin's Veterans and Families Institute and Lancaster University.

In addition to being one of the few Service charities making direct referrals to the NHS, Blesma is the umbrella charity for the Veterans Trauma Network. The network provides specialist care to veterans with Service-specific traumatic injuries across ten regional centres in England.

[15] 'Our Mission' [web page], Blesma, 2017, http://blesma.org/, accessed 8 November 2017.
[16] 'How we spend your money' [web page], Blesma, 2017, http://blesma.org/about-us/how-we-spend-your-money/, accessed 8 November 2017.

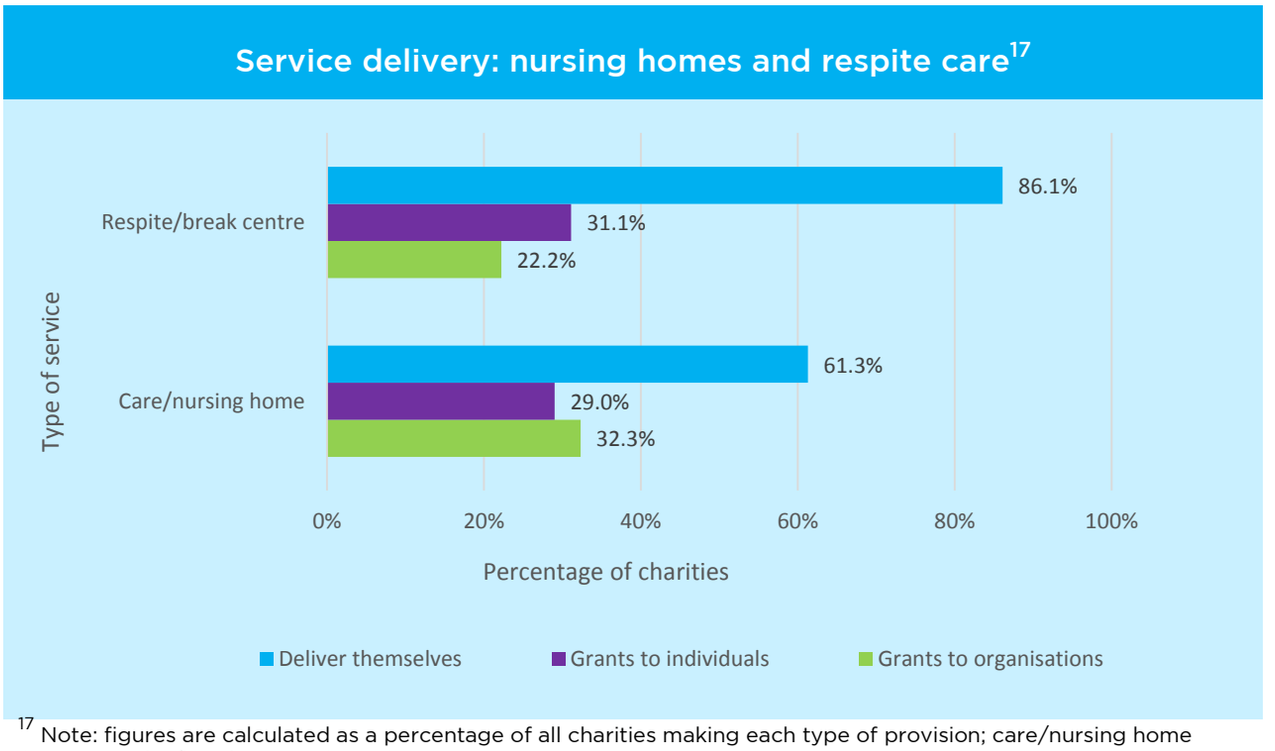
2.3.2 Nursing homes and respite care

As shown in figure 8, the vast majority (86.1%) of charities providing respite care delivered the services themselves. Approximately one-third (31.1%) of charities offered grants to individuals for respite and break centres. Respite care is yet another example of a service which can be delivered in either a clinical or non-clinical setting and is a service which takes many forms. It can be anything ranging from holidays for the families of WIS Service personnel, to short-term stays for elderly veterans in nursing homes in order to temporarily relieve carers.

In total, over three-fifths (61.3%) of charities making provision for nursing/care homes delivered the service themselves. A significant number of charities also made grants to fund nursing care, approximately one-third (32.3%) delivered grants to organisations and slightly fewer (29.0%) delivered grants to individual beneficiaries.

Nursing homes provide countless services which incorporate multiple areas of service provision. They offer residential facilities and social activities, in addition to 24-hour nursing care delivered by health-care professionals. Survey respondents (N=5), also stressed that nursing homes frequently provided onsite specialist clinical care such as orthopaedics, chiropody, speech and language therapy, occupational therapy and palliative care.

Figure 8



[17] Note: figures are calculated as a percentage of all charities making each type of provision; care/nursing home (N=31), respite/break centre (N=45).

CASE STUDY: THE ROYAL HOSPITAL CHELSEA – CARE HOME

The Royal Hospital Chelsea has been home to the iconic Chelsea Pensioners for 325 years. It was originally founded by King Charles II to care for those 'broken by age or war'.[18] Today over 300 army veterans call the Royal Hospital Chelsea home, including those who have served in Korea, the Falkland Islands, Cyprus, Northern Ireland and most recently, the Gulf War.

The Royal Hospital Chelsea provides single room, en-suite accommodation for veterans over the age of 65 years. There is an onsite GP and medical centre, as well as two nursing wards including a specialist dementia ward and domiciliary care service. Chelsea Pensioners can also access onsite therapy services (occupational therapy and physiotherapy) as well as taking part in a comprehensive activities programme which involves both onsite and external events and activities. In its most recent Care Quality Commission inspection (2016), the hospital's Margaret Thatcher Infirmary was rated overall as 'outstanding' for its care.[19]

Many of the Chelsea Pensioners work to support the routine and services at the Royal Hospital, as well as contributing to their community. This is done by undertaking a variety of roles and tasks including delivering the post, working in the gift shop, acting as a library or museum attendant and editing the in-house magazine. Residents also attend various meetings throughout the year to provide feedback on the Royal Hospital and its services. These roles and tasks, among many others, play a key part in ensuring that Chelsea Pensioners are able to keep active and maintain a sense of purpose.

The Royal Hospital believes in active aging and encourages the community of Chelsea Pensioners to support each other where possible. This includes accompanying each other to external appointments, spending time together socially and visiting each other in hospital.

The hospital's outreach programme ensures that the hospital works to support the wider veteran community. The Chelsea Pensioners regularly visit other veterans in supported housing (Veterans Aid), Personnel Recovery Centres (Help for Heroes) and veterans currently in custody in HMP Wandsworth. In the local area, the charity supports a homeless shelter and the Chelsea Pensioners volunteer weekly to help serve a hot meal to homeless people in the area.

In addition to the range of staff employed at the Royal Hospital to both care for and support the Chelsea Pensioners, working with other veteran charities means that they are able to access support for those with more specific needs. The Royal Hospital Chelsea have built an ongoing relationship with Blind Veterans UK (both at their centre in Ovingdean and with the London Outreach Team) which has assisted individuals in accessing equipment to improve their ability to read, as well as training and advice on how to manage daily tasks and activities with a sight impairment. Blind Veterans UK have also been able to support the hospital staff with training so that they can better support those with sight impairments. Being able to access specialist support has improved well-being, and has enhanced the ability to participate more in all aspects of life for Chelsea Pensioners at the Royal Hospital.

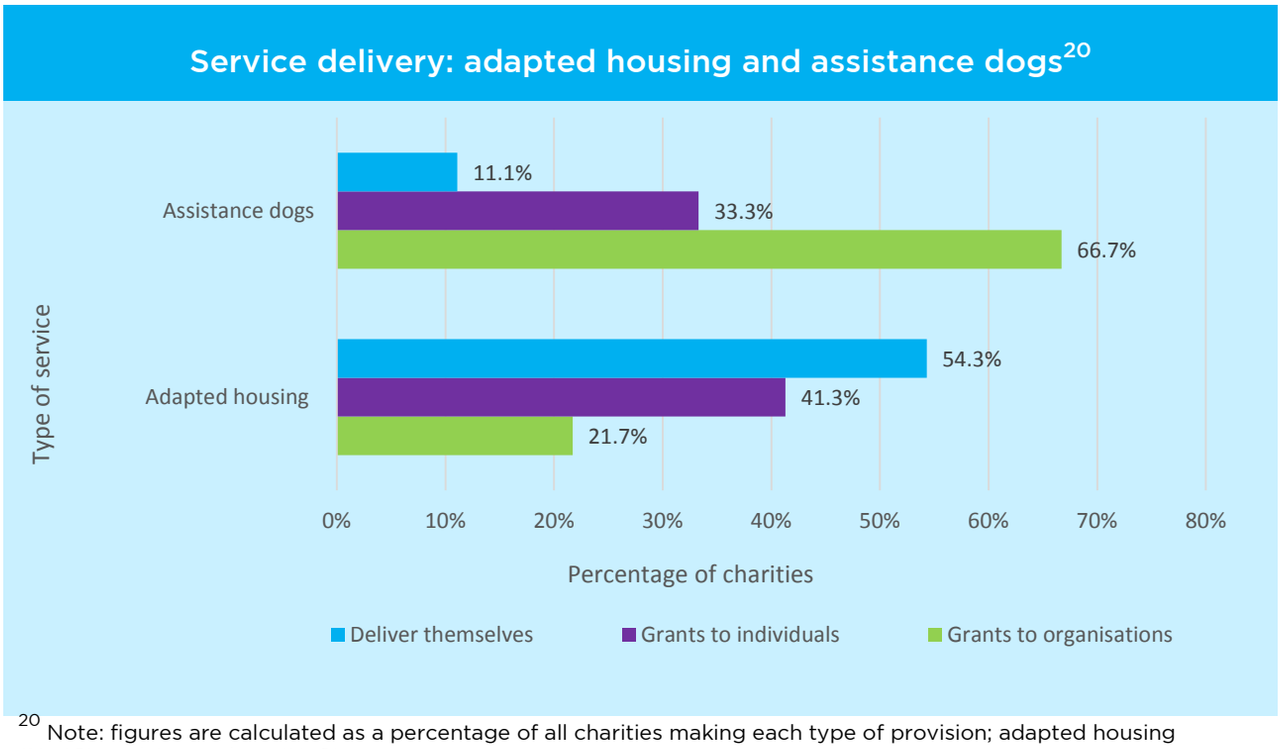
[18] 'History' [web page], Royal Hospital Chelsea, 2017, www.chelsea-pensioners.co.uk/history, accessed 8 November 2017.
[19] 'Royal Hospital Chelsea Margaret Thatcher Infirmary: Inspection Report' [web page], Care Quality Commission, 2016, www.cqc.org.uk/sites/default/files/new_reports/INS2-2519847696.pdf, accessed 8 November 2017.

2.3.3 Adapted housing and assistance dogs

Assistance dogs were most commonly provided through grants to organisations, according to over two-thirds (66.7%) of charities. Just over 11.1% of charities delivered this service themselves. Only one charity was found to provide assistance dogs for physical injury and illness themselves, although assistance dogs are more frequently being used in the treatment of PTSD. This may explain why grant-making is a more prevalent method of service delivery, as Service charities may outsource provision to other non-Service charities and organisations.

Over half (54.3%) of Service charities providing adapted housing delivered these services themselves. Grants to individuals were also common, delivered by over two-fifths of charities who provided adapted housing (41.3%). Adapted housing is a broad category which includes home adaptions and repairs such as installing stair-lifts, handrails or ramps and purpose-built accessible accommodation for WIS Service personnel. Temporary accommodation for families of injured or ill Service personnel is also included within this category. One example of this, Fisher House, is the focus of the following case study.

Figure 9



[20] Note: figures are calculated as a percentage of all charities making each type of provision; adapted housing (N=46), assistance dogs (N=9).

CASE STUDY: ACCOMMODATION FOR MILITARY PATENTS AND FAMILIES

Fisher House provides a 'home away from home' for military patients and their families at the Queen Elizabeth Hospital Birmingham (QEHB). It was established in order to provide a safe space for families to live, adjust and recover while their loved ones are treated at the QEHB, which is within walking distance of Fisher House.

Fisher House is owned and funded by QEHB Charity, whose mission is to support patients at the Trust by providing 'added extras' which are over and above what is provided by the NHS. QEHB is the home of the Royal Centre for Defence Medicine (RCDM) which provides emergency medical support to military operational deployments, and secondary and specialist care for members of the armed forces. It is a dedicated training centre for defence personnel with a focus on medical research.

Having opened its doors in April 2013, Fisher House has seen over 3,300 people stay at the accommodation – including patients, their parents, their partners and children. In total, over 18,000 nights of accommodation have been provided for people ranging in age from one month to 94 years.

In addition to comfortable communal accommodation, Fisher House facilities include a family room, children's play area, cinema room, access to a private garden, as well having access to the Trust's sports and leisure centre which is equipped with swimming pool, squash courts and gym. The property is fully wheelchair accessible.

A number of military charities support Fisher House, including Help for Heroes, Royal Marines Association, SSAFA, Troop Aid, Dougie Dalzell MC Memorial Trust, Royal Navy and Royal Marines Charity to name a few.

Another key charity partner is The Defence Medical Welfare Services (DMWS), whose welfare officers provide 24-hour support to Fisher House residents throughout their stay. DMWS welfare officers provide a range of services – from emotional support (such as a listening ear or bereavement counselling), to practical help (such as transport advice and providing toiletries and clothes). They also provide signposting to relevant professional agencies, manage welfare referrals from overseas evacuees and liaise with religious organisations.

Fisher House is an example of a physical health provider which caters primarily to spouses/partners and dependants of WIS Service personnel. It provides non-clinical services which directly support military families during the medical treatment and recovery process.

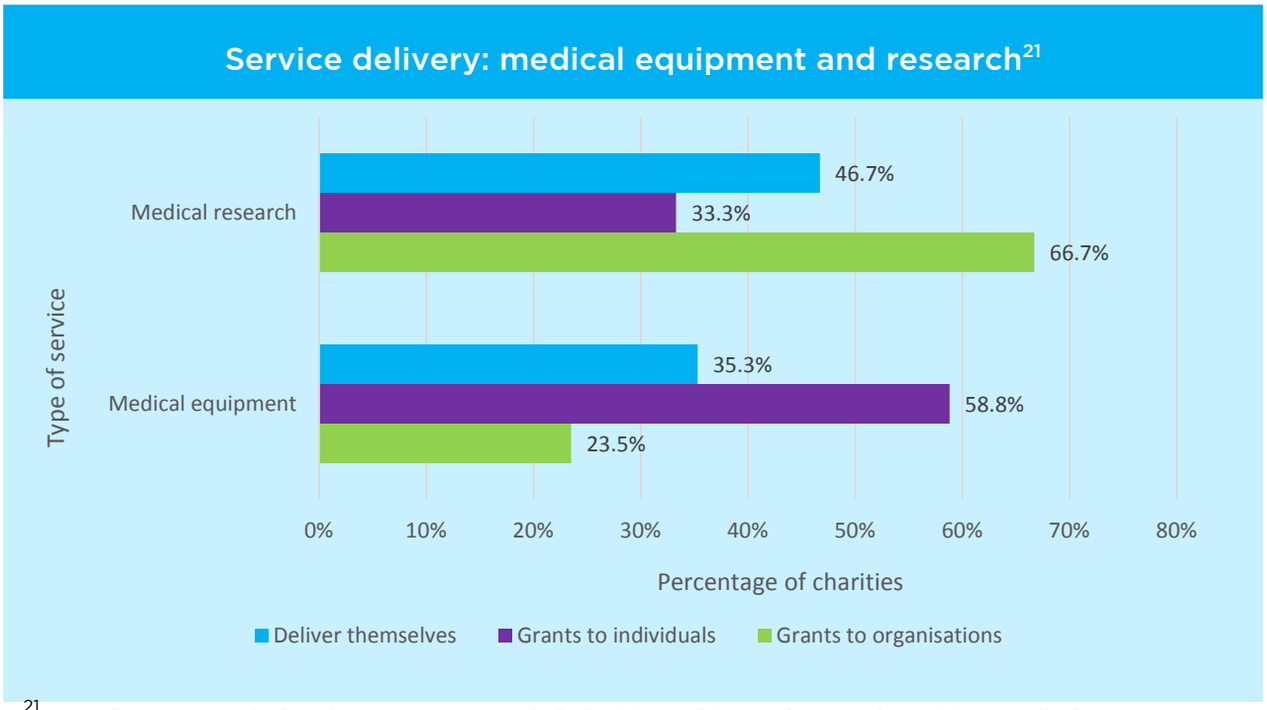
2.3.4 Medical equipment and research

Figure 10 shows how medical equipment and medical research were delivered. Medical research was most commonly provided via grants to organisations according to over two-thirds (66.7%) of charities. This figure indicates a certain degree of collaboration between forces charities, health authorities, research institutes and universities.

The case studies featured in this report on charities such as Blesma, Help for Heroes and SSAFA highlight charities' commitment to military health research via collaboration with universities. However, a significant proportion (46.7%) of forces charities carried out their own medical or health research and several charities' sole charitable object was to undertake research. For example, The British Nuclear Test Association conducts research on the effects of veterans' exposure to radioactive material.

Almost three-fifths (58.8%) of charities which delivered medical equipment did so via grants to individuals. Medical equipment is a deliberately broad term which includes mobility aids (such as wheelchairs), mobility scooters and hearing aids.

Figure 10



[21] Note: figures are calculated as a percentage of all charities making each type of provision; medical equipment (N=34), medical research (N=15).

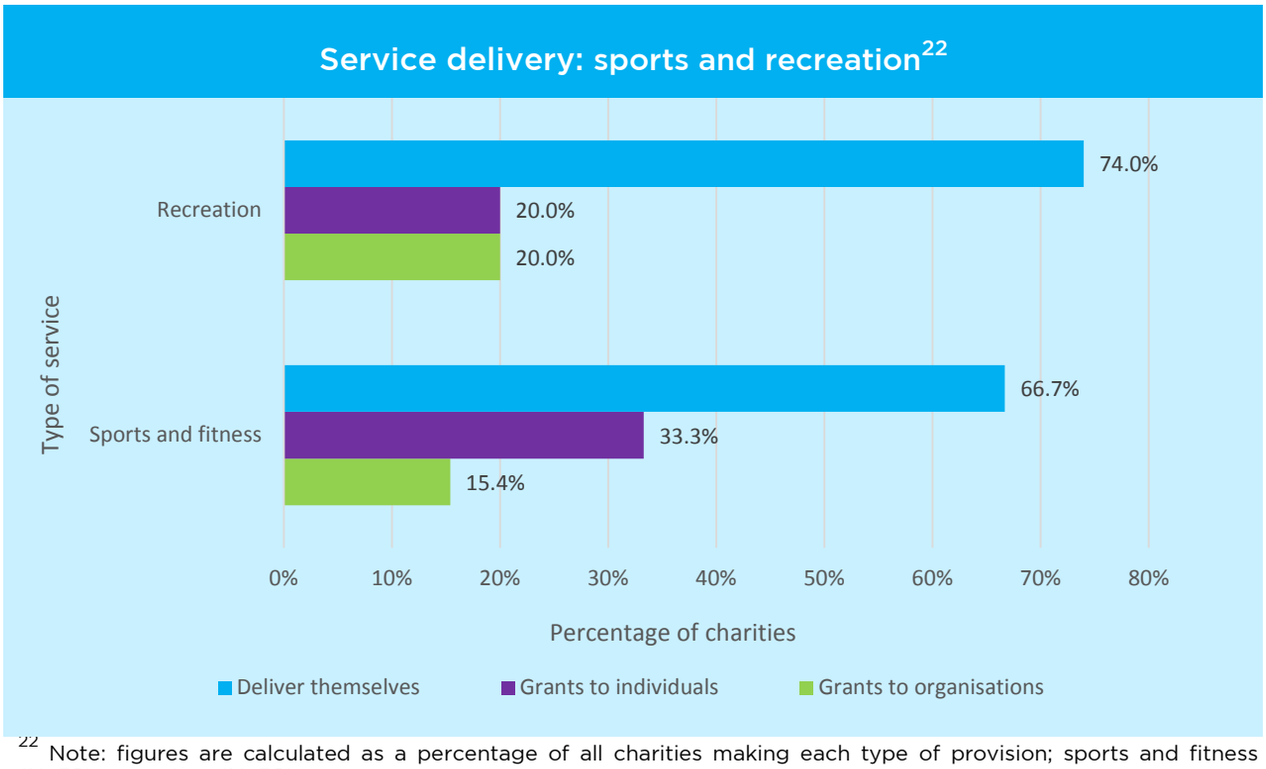
2.3.5 Sports/fitness programmes and recreation

As illustrated in figure 11, both sports and recreation services were most commonly delivered by charities themselves (70.4% and 66.7% respectively).

Forces charities delivered a huge range of recreational programmes which ranged from casual leisure activities (such as day trips for nursing home patients), to non-clinical activities grounded in evidence-based methods of physical recovery (such as equine therapy and surfing). In total, 16.5% of charities also specified delivering or funding sports equipment.

There is an element of overlap between recreational activities and sports/fitness programmes, as activities such as skiing, rowing, scuba diving and motorsports could arguably by classified in either category. However, the primary distinction lay in sports programmes' focus on competitive participation. International programmes such as The Invictus Games enable injured veterans to represent their country at a professional level.

Figure 11



[22] Note: figures are calculated as a percentage of all charities making each type of provision; sports and fitness (N=39), recreation (N=50).

CASE STUDY: THE INVICTUS GAMES – COMPETITIVE SPORTS

The Invictus Games is the only international multi-sport event for WIS Service men and women, both Serving and veteran. The word 'Invictus' means 'unconquered' – it embodies the fighting spirit of the wounded warriors. The Games harness the power of sport to inspire recovery, support rehabilitation and generate a wider understanding and respect for those that serve their country.

The inaugural Invictus Games were held in London in 2014, with subsequent Games hosted in Orlando, Florida in May 2016 and then Toronto in September 2017. The Invictus Games has grown consistently since 2014 with the most recent Games in Canada featuring 540 competitors from 17 nations, competing in 12 sports.

The Invictus Games Foundation (IGF) was established after the success of the inaugural Games. It exists to perpetuate the Invictus Games and to ensure that they adhere to the high standards that have been set. It owns the Invictus Games brand, selects future host cities and oversees the delivery of each Games.

In addition to hosting the most recent Invictus Games, the Toronto 2017 Organising Committee commissioned an evaluation of the Games, undertaken by the Canadian Institute for Military and Veteran Health Research. The overall conclusion indicated that the Games were 'a gift for competitors in their recovery', with one of the primary long-term benefits being the competitors' 'return to self'.[23] The research is intended to encourage further development of adaptive sport programmes.

Notably, the number of Canadians who wanted to support veterans with mental health issues and physical injuries doubled immediately after the Games were held.[24] Public opinion research (carried out by Maru/Matchbox) revealed that Canadians had a greater understanding of the challenges facing veterans returning from Service, following the week-long event in 2017.

Since the London Games in 2014, the UK Team have witnessed a significant increase in the number of Serving personnel and veterans registering their interest in the Games. Numbers have increased by one-third (33%) within the last year alone, and by over 400% since 2014. In total, 1,190 individuals have registered their interest with the UK Team to participate in the Sydney 2018 Games.

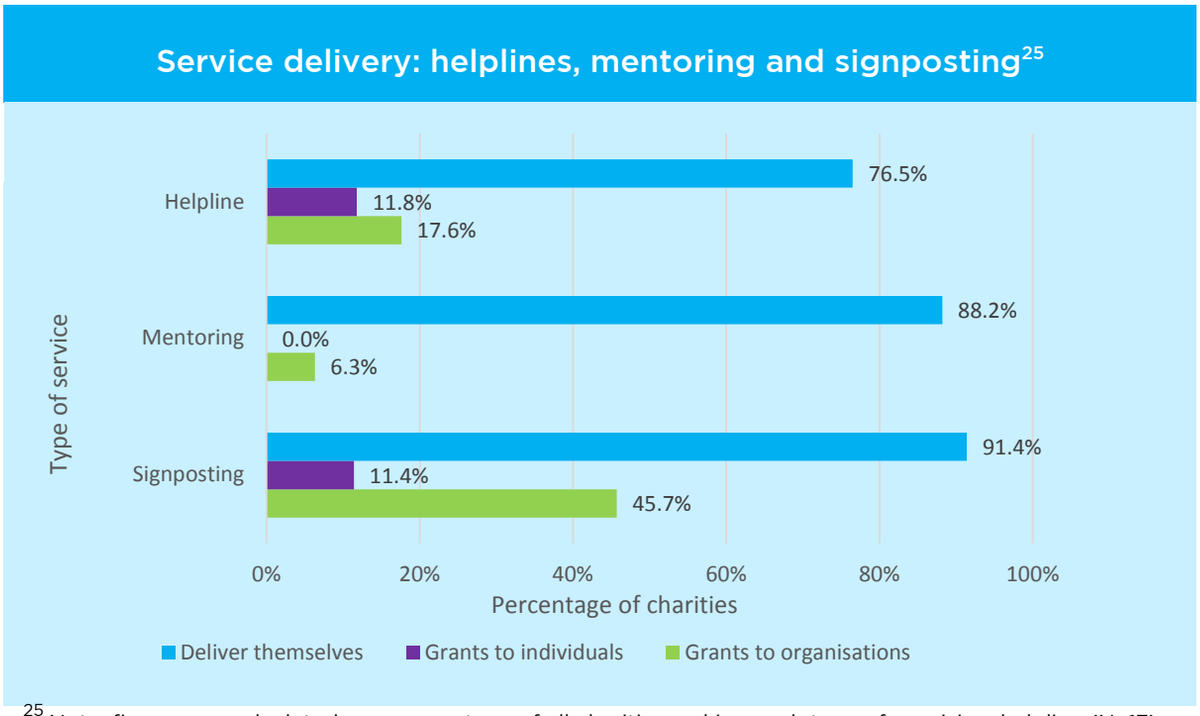
[23] 'Ground-breaking research examines impact of Invictus Games' [web page], Invictus Games, 2017, https://invictusgamesfoundation.org/groundbreaking-research-examines-impact-of-invictus-games, accessed 21 November 2017.

[24] 'Canadians' perceptions of ill, wounded and injured veterans have shifted dramatically following Invictus Games; poll' [web page], Invictus Games, 2017, www.invictusgames2017.com/canadians-perceptions-of-ill-wounded-and-injured-veterans-have-shifted-dramatically-following-23 invictus-games-poll/, accessed 21 November 2017.

2.3.6 Helplines, mentoring and signposting

Advice and advocacy services were most commonly delivered by charities directly. As figure 12 shows, over 90% of charities deliver signposting services themselves. Over four-fifths (88.2%) of charities deliver mentoring services directly and over three-quarters (76.5%) operate helplines directly. This trend is fairly predictable given that advice services may require less resources to deliver than other forms of provision, particularly signposting.

Figure 12



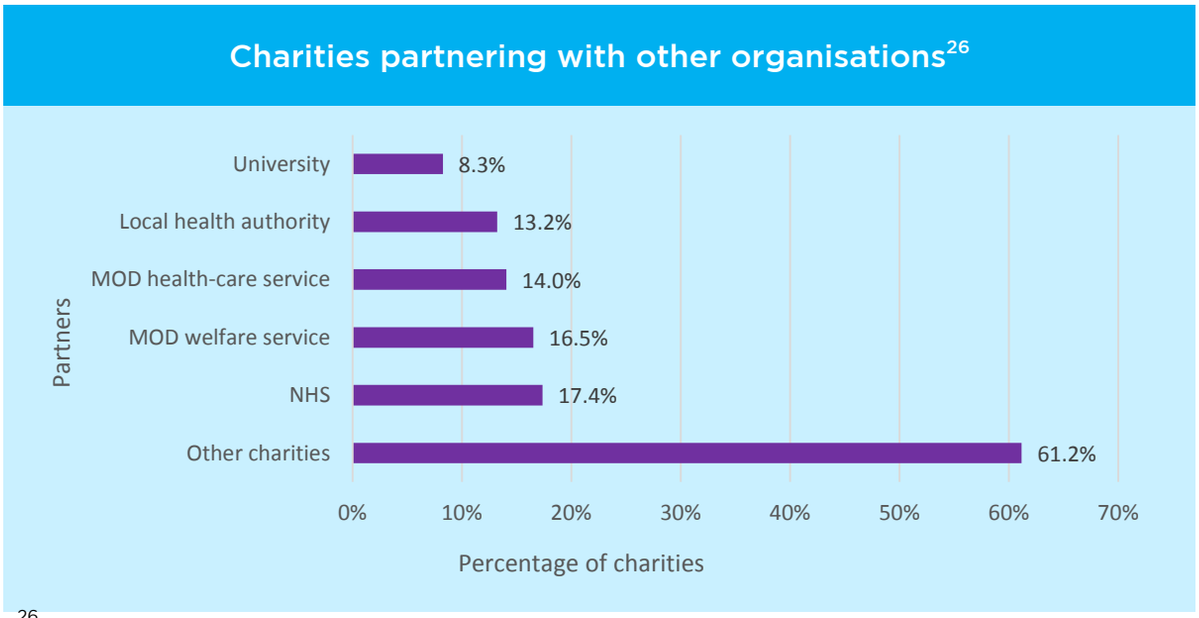
[25] Note: figures are calculated as a percentage of all charities making each type of provision; helpline (N=17); mentoring (N=34), signposting (N=35).

2.4 PARTNERSHIP AND COLLABORATION

Figure 13 shows the extent of partnership and collaboration between charities and other organisations. The most common form of partnership was between charities themselves – over three-fifths (61.2%) of charities partnered with other voluntary sector organisations.

Less than one-fifth (17.4%) of charities partner with the NHS and even fewer collaborate with MOD welfare or health services (16.5% and 14.0% respectively).

Figure 13



[26] Note: categories are not mutually exclusive, and percentages therefore do not sum to 100. Measured as a percentage of charities which make provision for physical health (N=121).

'Other' types of partnership organisations were also reported by nine survey respondents and included partnerships with research institutes, academics, local councils, private hospitals, Defence Recovery Centres and the Veterans Trauma Network.

Clinical services refer to any services delivered via a health-care professional, such as a qualified nurse or physiotherapist. Charities which delivered clinical services themselves were more than three times as likely to partner with the NHS, compared to those who did not (45.0% v. 11.9% respectively). Interestingly, charities who delivered clinical services directly were also much less likely to partner with other charities (30.0% v. 56.4% respectively).

Charities were also asked by survey if they provided any services that the NHS does not. In total 31 charities, or just over a quarter (25.6%), of those featured in this report specified providing treatments or services which fall outside of the NHS remit. Responses ranged from specialist services not freely available on the NHS (such as Acquired Brain Injury Care), to private health care aiming to speed up NHS waiting times, to alternative pain-relief therapies and non-pharmaceutical clinical trials. Examples of which are provided below:

'We fund private medical care to speed up provision which would otherwise be available on the NHS.'

'We are able to reach out to injured people on our database to see if they are OK and invite them to reunions to talk to their fellow injured, which is very therapeutic.'

'The Trust specifically offers support that could not be provided by statutory provision within a reasonable time on a case-by-case basis, including specialist equipment to improve quality of life, mobility and so on.'

'We provide gym programmes which build on the large research base which show they are very cost efficient in boosting physical and psychological well-being, indeed as good as taking anti-depressants.'

Survey respondents[27]

The quotes are taken directly from survey responses and highlight the wide range of approaches aimed at supporting the physical health of beneficiaries, which lie outside of the NHS remit.

[27] Quotes are for illustrative purposes only and the views expressed by respondents are not endorsed by DSC.

CASE STUDY: SSAFA – COLLABORATION AND PARTNERSHIP

SSAFA, the Armed Forces charity, is the UK's oldest tri-Service charity, helping Service families and veterans since its inception in 1885. SSAFA's health-care provision can be traced back to 1892 with the establishment of its nursing branch, later known as the Alexandra nurses.

The charity's object is to relieve need, suffering and distress among armed forces veterans and their families, in order to maintain their independence and dignity. SSAFA's health-care provision is now varied and extensive – throughout the previous year SSAFA has helped:

- 223 people through SSAFA's Support Group for Families of WIS Service Personnel;
- 119 people through the Forces Additional Needs and Disability Forum;
- and 25,000 people who accessed SSAFA's health-care and social work services in the UK and overseas (including 9,000 Serving personnel).

Through its collaborations with the MOD, NHS Foundation Trusts and worldwide local health authorities, SSAFA provides high-quality, patient-focused health care in response to the needs of the military community.

SSAFA provides a diverse range of physical health services for the UK armed forces community, from mobility scooters and care homes for veterans, to temporary home-from-home style accommodation for the families of WIS personnel undergoing acute care or rehabilitation.

Its health-care provision for the armed forces community extends beyond the UK to those stationed around the world. It currently supports military personnel and their families throughout Europe as well as Brunei, Canada, Cyprus, Gibraltar and Nepal.

The charity continues to be at the forefront of delivering health care to the UK Ministry of Defence overseas. It aims to ensure that Service families living away from home can access the same high quality treatment they could expect to receive in the UK.

SSAFA's teams are professionally led, its services are delivered via senior clinicians and social workers and adhere to UK care quality standards. Its standards meet both General Medical Council and Nursing and Midwifery Council requirements.

In terms of partnership and collaboration, SSAFA is also a member of several consortiums of Service charities including Cobseo, Veterans Scotland and the Veteran's Gateway.

CASE STUDY: HELP FOR HEROES – COLLABORATION AND PARTNERSHIP

Help for Heroes has been supporting WIS Service personnel and veterans since its formation in 2007, with its vision being to engage the nation to inspire, enable and support everyone affected by military service to lead active, independent and fulfilling lives.

Help for Heroes is a partner, alongside The Royal British Legion, in the MOD's Defence Recovery Capability initiative. It invested £70 million in four Help for Heroes Recovery Centres located in Catterick, Colchester, Tidworth and in the naval base at Plymouth. The first three centres host Personnel Recovery Centre teams who support Serving personnel during their recovery pathway, aiming for the swiftest return to duty or the smoothest transition to civilian life. The latter works alongside Hasler Company for Royal Navy and Royal Marines personnel (part of the Naval Service Recovery Pathway). Through its centres, and new team in Wales, the charity offers: welfare services support; a bespoke careers and retraining service; health and well-being support; sports and leisure activities; medical support; psychological well-being services; and fellowship and grant funding to individuals and partner charities.

The charity also partners with the DMS, who act as the MOD's primary health-care provider for Service personnel. The Help for Heroes Rehabilitation Complex is situated at the Defence Medical Rehabilitation Centre at Headley Court. The complex includes state-of-the-art facilities to aid the recovery of injured Service personnel, including a sports hall, swimming pool, cardiovascular treatment rooms, regional rehabilitation unit and gait-analysis centre.

Help for Heroes was recently awarded £1.5 million of LIBOR (London interbank offered rate) funding to provide specialist quality of life support for very seriously injured veterans or veterans with brain injuries, as well as their families. The award comes into effect in April 2018, but 20 veterans who require 24-hour support not previously met by the NHS have been identified for treatments such as neuro-physiotherapy and neuro-rehabilitation assistance.

The charity also employs a team of full-time Veterans' Clinical Advisors (VCA) – health-care professionals who guide beneficiaries to the most appropriate care or support. VCAs act a point of contact for beneficiaries with serious complex injuries and long-term health issues. A VCA also supports a Veterans' Specific Injury Clinic at Salisbury District Hospital, and represents Help for Heroes at meetings of the Medical Advisory Committee (MAC). This committee's objective is to promote the long-term health of the armed forces community through independent and impartial advice.

As part of its vision to help its beneficiaries lead active, independent and fulfilling lives, Help for Heroes champions sport as a means of recovery which brings physical, psychological and social benefits. Notably, Help for Heroes works in partnership with the British Paralympic Association, the UK Invictus Games and various UK sporting and national governing bodies.

Help for Heroes collaborates with academics and universities to conduct research aiming to better understand health issues facing the armed forces community. King's College London's *Counting The Costs* study, a comprehensive overview of health issues affecting veterans (Diehle and Greenberg, 2016), was commissioned by Help for Heroes. More recently, Help for Heroes' Plymouth Recovery Centre collaborated with Plymouth University to offer learning opportunities for Service personnel and veterans, as well as training opportunities for physiotherapy, social work and podiatry students.

Help for Heroes offers a hugely diverse range of services, some of which have been covered in this case study. From financial grants, to housing advice and career recovery programmes, Help for Heroes' provision often extends beyond the sphere of physical health recovery. The charity has established itself at the forefront of services for WIS individuals, Serving personnel and veterans. It provides a vast catalogue of physical health programmes and engages in extensive collaboration with defence health services, local health authorities and fellow Service charities.

2.5 ACCREDITATION, EVALUATION AND IMPACT

2.5.1 Best practice

In total, 16.5% of charities making physical health provision specified delivering clinical services themselves, such as programmes or treatments administered by a medical health professional. It is unsurprising that few charities deliver clinical services directly, given that clinical care tends to be highly specialist and resource-intensive. In order to deliver clinical services, charities would be required to employ health-care professionals and invest in medical facilities or equipment.

This may be difficult for smaller, low-income charities or those who have numerous charitable objects and do not frequently deliver physical health support. The majority of charities featured in this report (83.5%) were found to provide non-clinical forms of physical support only, with clinical treatment largely delivered via grant-making rather than direct service provision. However, the small number of charities which do directly provide clinical treatment (N=20) are expected to adhere to certain professional, legal and ethical standards of care.

DSC collected data on whether charities making provision for physical health adhered to clinical guidelines set forth by national regulatory health-care bodies, with a specific focus on the following organisations:

- Care Quality Commission (CQC): an independent regulator of health and adult social care in England, ensures health and social care services provide safe, effective, compassionate and high quality care.
- Scottish Commission for Care (SCC): regulates and inspects care services in Scotland to make sure they meet standards.
- National Institute for Health and Care Excellence (NICE): improves outcomes for people using the NHS and other public health and social care services via evidence-based advice, quality standards, performance metrics and information services.
- The Regulation and Quality Improvement Authority (RQIA): registers and inspects health and social care providers in Northern Ireland based upon minimum care standards.
- The Health and Care Professions Council (HCPC): an independent register of health and care professionals who meet standards of training, professional skills, behaviour and health.
- The General Medical Council (GMC): an independent organisation that aims to protect patients and improve medical education and practice in the UK, by setting standards for students and doctors.
- The Nursing and Midwifery Council (NMC): a regulatory body for nurses and midwives across the UK, exists to protect the public while setting the standards of education, training and conduct.

Figure 14 shows the percentage of charities delivering clinical services themselves (N=20) who also adopt clinical guidelines. In England, it is a legal requirement for all health and social care services to register with the CQC. In total, three-quarters (75.0%) of clinical providers were found to be registered with the CQC which have recently undergone or are currently awaiting inspection.

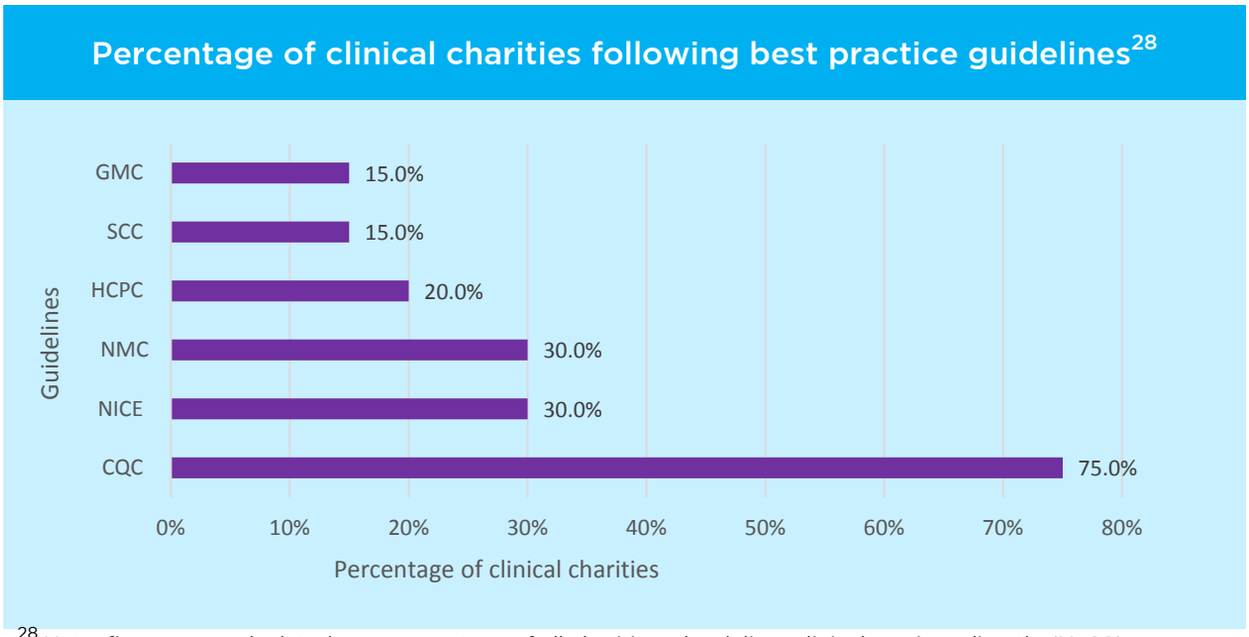
A further four charities operating outside of England were registered with national CQC equivalents, of which three charities were registered with the SCC and one with the RQIA.

DSC also examined the outcomes of recent CQC, SCC and RQIA inspections. It should be noted that some charities underwent multiple inspections, as they operated a number of care homes or medical facilities. In total, 12 charities received at least one 'good', rating, two were rated as 'outstanding', two 'required improvement' and two were still awaiting inspection.

Notably, two charities which provided clinical services were not registered with the CQC or any national equivalents. In both cases, the charities had partnered with established medical institutions to deliver physical health-care services. Although the charities themselves were unregistered, their partners administering the clinical services were CQC registered. Other

commonly adopted clinical guidelines included NICE and NMC regulations, which three-tenths (30.0%) of charities specified following.

Figure 14



[28] Note: figures are calculated as a percentage of all charities who deliver clinical services directly (N=20).

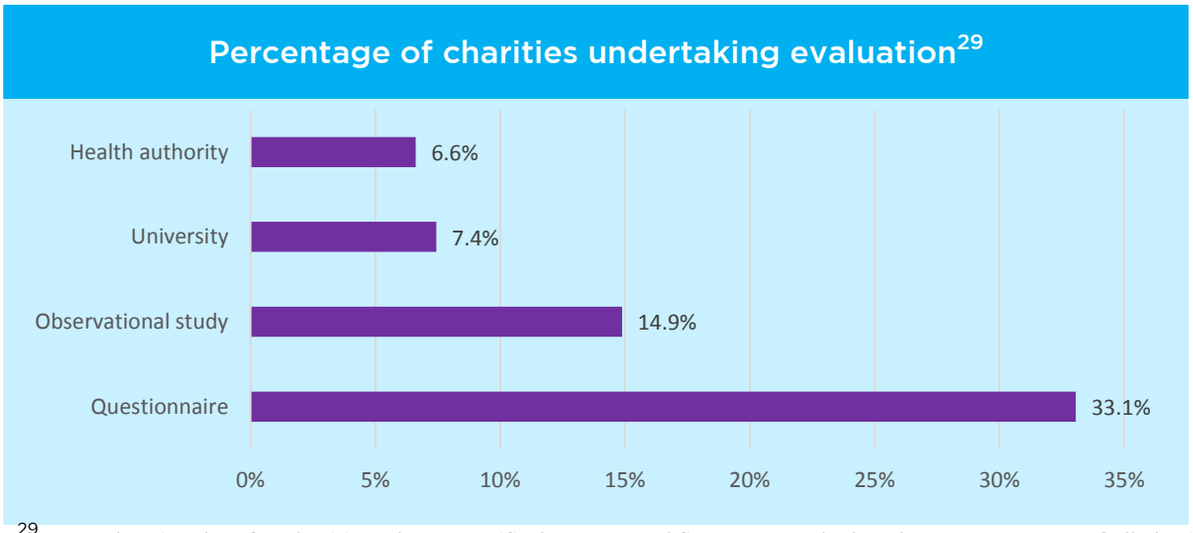
A small number of non-clinical charities (N=9) specified adhering to, or working towards, clinical guidelines despite not providing any clinical services themselves. This may indicate plans to expand into clinical service provision in the future, or this may indicate that they employ health-care professionals in an advisory or consultancy role, despite not currently delivering clinical services.

2.5.2 Methods of evaluation

Regular evaluation and monitoring of services is essential in order for charities to measure their social impact and judge whether their current range of provision is effective. In total, over two-fifths (44.6%) of charities specified undertaking at least one form of evaluation and monitoring.

Follow-up questionnaires were the most popular method of evaluation by a significant margin, carried out by one-third of charities (33.1%). This was followed by observational studies, undertaken by 14.9% of charities. Evaluation by a health authority was the least popular form of monitoring, undertaken by only 6.6% of charities. However, this method may only be suitable for clinical providers (N=24).

Figure 15



[29] Note: data is taken for charities where specified (N=54) and figures are calculated as a percentage of all charities making physical health provision (N=121).

2.6 CHAPTER TWO SUMMARY

Types of services

Forces charities delivered a hugely diverse range of services to support beneficiaries with physical health problems, the majority of which adopted non-clinical approaches. The three most commonly delivered physical health services were: recreation; adapted housing; and respite care (delivered by 41.3%, 38.0% and 37.2% of charities respectively).

Service delivery

How services were delivered varied significantly depending on the type of service. For example, general advice services (such as signposting, mentoring and helplines) were most commonly delivered by the charities themselves. On the other hand, specialist services such as assistance dogs, medical research and prosthetics tend to be delivered through grant-making.

Partnership and collaboration

The most common type of partnership was between charities themselves – almost two-thirds (61.2%) of charities collaborated with other voluntary sector organisations to deliver physical health provision. In total, less than one-fifth (17.4%) of charities partnered with the NHS. Notably, charities which offered clinical services directly were more than three times likelier to partner with the NHS.

Best practice

Clinical guidelines are especially relevant to the small proportion of charities delivering clinical services themselves (N=20), of which three-quarters (75.0%) followed CQC guidelines and over one-quarter (26.1%) adhered to NMC regulations and NICE guidelines.

Evaluation and monitoring

In total, over two-fifths (44.6%) of charities were found to undertake evaluation and monitoring procedures. The most commonly employed evaluation method (by a significant margin) was feedback questionnaires, with one-third (33.1%) of charities using this method. Observational studies were also carried out by 14.9% of charities.

CHAPTER THREE

The last word: conclusions and recommendations

3.1 INTRODUCTION

This chapter provides conclusions and recommendations based upon the research findings presented in this report. DSC's objective in undertaking this research was to provide an account of the provision being made by armed forces charities to improve quality of life for injured or ill Service personnel, and for their families. To address this remit, DSC devised the following research questions:

- How many forces charities support beneficiaries with physical health problems?
- How are physical health services delivered to beneficiaries?
- What standards of practice, collaboration and evaluation exist?

3.2 HOW MANY FORCES CHARITIES SUPPORT BENEFICIARIES WITH PHYSICAL HEALTH PROBLEMS?

DSC identified 121 charities which offer physical health support, which represent 10.1% of all UK forces charities (N≈1,200).

Forces charities provided physical health support to at least 250,000 beneficiaries during 2016. By comparison, previous research by DSC found that approximately 35,000 beneficiaries accessed education and employment support, and 10,000 accessed mental health support in 2016 (Doherty et al., 2017; Cole et al., 2017). The number of beneficiaries accessing physical health support annually was therefore more than seven times greater than those accessing education and employment, and twenty-five times greater than mental health.

The number of charities providing physical health support is relatively small, in comparison to the considerable demand for services. The ratio of armed forces charities making physical health provision is approximately one charity to every 2,070 beneficiaries accessing support. In the same way, there was one charity to every 450 beneficiaries accessing education and employment support, and one for every 130 accessing mental health support.

According to data, where specified, armed forces charities spent at least £103 million on provision for physical health throughout the previous year. Again, forces charities were found to dedicate significantly greater resources to physical health compared to both education and employment (£26 million), and mental health (£28 million) during 2016.[30]

Physical health provision commands greater resources and attention from the armed forces charity sector. This trend may indicate that physical illness and injury is more prevalent (or at least, perceived as being more prevalent) than mental health or education and employment needs within the armed forces community.

[30] See previous reports by DSC, Cole S., et al. (2017) *Armed Forces Charities' Mental Health Provision*; Doherty R., et al. (2017) *Armed Forces Charities' Education & Employment Provision*.

However, it still remains unclear whether forces charities respond to or predict need when delivering physical health provision. Due to the lack of comparable demographic research on educational attainment, employment statistics, mental health issues and physical injury/illness rates (for both the armed forces community and general public), this question cannot currently be answered.

It should be noted that all beneficiary and expenditure figures are conservative estimates for charities (where specified). Nevertheless, these figures illustrate high levels of demand for physical health support within the armed forces community and a strong response from forces charities.

3.3 HOW ARE PHYSICAL HEALTH SERVICES DELIVERED TO BENEFICIARIES?

Armed forces charities offered a huge range of services which broadly aimed to improve quality of life for Service personnel with physical health problems and their families, from nursing care to adapted scuba diving. Physical health provision often delved into other areas of support such as housing, social inclusion and mental well-being, in recognition that injury and illness often has a direct impact on all aspects of life.

The most common physical health services were recreation, provided by over two-fifths of charities (41.3%), adapted housing (38.0%) and respite/break centres (37.2%).

DSC also explored how services were delivered to beneficiaries, which varied considerably based upon the type of service. For example, advice and advocacy services were most commonly delivered via the charities themselves. Conversely, specialist services such as prosthetics, medical research and assistance dogs were typically delivered via grant-making.

This is unsurprising when considering that advice services (such as signposting and distributing information) can typically be provided with minimal resources and financial expense. On the other hand, more niche or clinical services may require a charity to employ leading experts and invest in training materials or medical equipment.

One-quarter (25.6%) of charities said that they delivered services which fall outside of the NHS remit, which included funding private health care to reduce NHS waiting times and providing specialist care not freely available on the NHS. It is interesting that a significant number of forces charities view their service provision as a direct response to gaps in statutory health-care provision.

3.4 WHAT STANDARDS OF PRACTICE, COLLABORATION AND EVALUATION EXIST?

DSC found evidence of extensive collaboration within the voluntary sector, with over three-fifths (61.2%) of charities partnering with other voluntary organisations. However, partnerships with external health authorities were not as common, only 17.4% of charities partnered with the NHS, 16.5% with MOD welfare services and 14.0% with MOD health-care services.

As expected, charities which delivered clinical services themselves (meaning the services were delivered by a health-care professional) were three times likelier to partner with the NHS than those which did not (45.0% v. 11.9% respectively).

Adherence to best practice is particularly relevant for the small number of charities which provide clinical services themselves (N=20). Overall, 90% of charities which delivered clinical services adopted clinical care guidelines.

CQC guidelines were the most commonly adopted form of guidelines, undertaken by three-quarters (75.0%) of charities delivering clinical services directly. Just over one-quarter (26.1%) of charities followed NMC or NICE recommendations.

However, commitment to carrying out evaluation was less evident. Less than half (44.6%) of charities featured in this report specified having carried out at least one method of evaluation. When undertaken, the most popular forms of evaluation were follow-up questionnaires, carried out by one-third of charities (33.1%) and observational studies (14.9%).

During the peer review process, a number of forces charities pointed to research fatigue as a barrier to charities conducting evaluative feedback with beneficiaries. Poor response rates may discourage charities from carrying out further evaluation. Questionnaires could be perhaps be more widely used as a relatively accessible and low-cost method of gathering feedback, as they can be easily distributed to a large sample group of current beneficiaries.

The number of charities which underwent evaluation by health authorities was low (6.6%). However, this form of evaluation may only be relevant to the small pool of charities directly delivering clinical services themselves (N=20).

Evaluation by universities was also a rare occurrence. Although there is a growing body of academic research which focuses on military health (King's College London and Anglia Ruskin University are notable examples of universities with dedicated military health-care departments), Service charities' involvement is often as a funder or data contributor. Few studies have set out to directly evaluate charities' physical health services.

3.5 RECOMMENDATIONS

3.5.1 Communicate adherence to clinical guidelines more effectively

This is especially relevant for the 20 charities featured in this report who specified delivering clinical services themselves (meaning the services were delivered by a health-care professional). As such, charities delivering clinical services themselves would generally be expected to hire fully-qualified staff and adhere to professional and ethical standards of care, which was indeed largely found to be the case.

In total, over 90% of charities delivering clinical services themselves adhered to clinical care guidelines. Three-quarters (75.0%) were registered with and recently inspected (or awaiting inspection) by the CQC. One-fifth (20.0%) of those delivering clinical services were registered with corresponding national equivalents such as the SCC and the RQIA.

It is important for charities to adopt clinical guidelines to ensure that staff are meeting ethical and professional responsibilities, protecting their beneficiaries' well-being and reducing liability. In this way, it is reassuring that the majority of charities follow some form of clinical best practice.

In some cases however, details of registration and outcomes were difficult to obtain. This information was rarely specified in survey responses and was absent from annual reports and websites, despite charities actively enforcing these guidelines. In the majority of cases, DSC obtained this data by conducting searches of regulatory body databases. DSC recommends that charities providing clinical services ensure that they are transparent about adherence to clinical guidelines, in order to promote public trust and better inform their beneficiaries.

3.5.2 Greater collaboration with health-care providers

While collaboration between charities was extensive, collaboration with external stakeholders, particularly the NHS and the MOD, could be increased. Only 17.4% and 16.5% of charities partnered with these two organisations respectively.

Recent initiatives have sought to encourage cross-sector collaboration. For example, the Veterans Trauma Network is a newly established network of specialist care providers for veterans with Service-specific traumatic injuries, extending across England. Another example is the Hospital Alliance, a network of over 20 UK hospitals seeking to become more veteran-

friendly. Both schemes have actively sought to collaborate with forces charities to boost referrals and awareness of their services.

The featured case studies on charities, such as Blesma and Help for Heroes, have exhibited examples of extensive collaborative projects between charities, health authorities, statutory organisations, welfare organisations and academic institutions.

However, DSC's findings suggest that more could be done to foster cross-sector collaboration across the board. It would be interesting to conduct further qualitative data analysis to examine whether charities experience any particular barriers to forming effective collaborations with health-care providers.

3.5.3 Greater commitment to measuring impact

Less than half (44.6%) of charities featured in this report specified undertaking at least one method of evaluation. It should be recognised that smaller charities providing physical health support on an irregular or ad hoc basis may find it difficult to carry out routine monitoring of service provision. Nevertheless, DSC recommends a greater commitment to measuring and reporting on impact.

Questionnaires were used by approximately one-third (33.1%) of charities and could be more widely adopted as a relatively accessible method of evaluation across the sector. Independent evaluation of charities' services should also be encouraged through increased collaboration with universities and research institutes.

Evidence-based evaluation of service provision enables charities to identify whether their services are effective, identify any gaps in provision, and most importantly, to identify whether services are meeting the needs of their beneficiaries.

3.5.4 Further research

As highlighted at the outset of this report, it is not currently possible to assess whether charitable provision is meeting need. This is mainly owing to the fact that research on health issues affecting Service personnel (such as MOD records and academic studies) are generally limited to small test groups, such as veterans of a specific conflict or the beneficiaries of a particular charity.

This gap in knowledge makes it difficult to draw wider conclusions on whether charitable provision is adequately responding to the specific health-care requirements of the armed forces community. This report found that the most commonly catered to illness/injury was limited mobility. This parallels a wide body of research which finds that musculoskeletal injuries and associated mobility issues are one of the key physical health problems affecting Service personnel (Legion, 2014; Briggs, 2014; Sharma et al., 2015). However, as these studies are limited to relatively small sample groups, only tentative trends can be outlined.

DSC recommends introducing a question in the UK census regarding military Service, which would provide an accurate estimate of the overall size of the armed forces community and how many in this community experience long-term physical health issues or disabilities. This action is backed by forces charities and policymakers, with a notable example including The British Legion's *Count them in* campaign (Royal British Legion, 2017). On a promising note, the Office of National Statistics have publically announced their intention to recommend it as a top inclusion for the 2021 census (ONS, 2017). This would help to facilitate further discussion of whether or not physical health services are meeting need.

This report also found that almost half of forces charities delivering physical health support delivered grants. It also highlighted the fact that charities collaborate extensively with one another, as over three-fifths of charities (61.2%) partnered with other voluntary organisations.

It would be interesting to examine the proportion of grants to organisations for physical health which was issued to fellow forces charities. This would enable a more accurate calculation of sector expenditure and confirm whether funds were recycled between a small

cohort of Service charities, or distributed to a wider network of organisations. It could also potentially yield further insight into how forces charities work collaboratively with one another, for instance whether or not they show preference to other military charities when grant-making.

Overall, the small subsection of the armed forces charity sector which delivers physical health support has been found to provide a hugely diverse range of services supporting injured/ill Service personnel and their families. Clinical providers in particular were found to undertake evidence-based treatments and adhere to best practice, while non-clinical providers responded to perceived gaps in provision, by delivering services outside of the NHS remit. DSC found evidence of a co-ordinated effort to improve cross-sector collaboration and partnership, although engagement with statutory and defence health services could be improved.

DSC hopes that this report will help illuminate this important subsector of charitable support for the armed forces community. The report will serve to provide insight to policymakers, the media, the forces charities themselves and, in turn, their many beneficiaries.

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FOCUS ON

Armed Forces Charities' Physical Health Provision 2018

This report follows on from the Directory of Social Change's (DSC) *Sector Insight* reports on UK armed forces charities, a series which DSC has been publishing since 2014. Building on these broader studies, the *Focus On* series exists to provide a more specific analysis of the work of armed forces charities across the UK – in this case, charities which are making provision for the physical health needs of Service personnel, veterans and their families. This study contributes to DSC's growing body of research on the armed forces charity sector, which also includes the *www.armedforcescharities.org.uk* website.

This report provides an overview of the physical health provision made by armed forces charities registered across the UK, focusing on:

- Exploration of physical health support offered by charities
- Insights into the beneficiary population
- Assessment of expenditure on physical health provision
- Collaboration, evaluation and standards of practice
- Conclusions and recommendations

This is a unique resource for charities, government, policymakers and researchers to understand what armed forces charities deliver in terms of their physical health provision. This subject area has been thoroughly explored to provide a body of evidence and insightful analysis which informs of policy, practice and research.

'The purpose of FiMT is to enable all ex-Service personnel and their families to make a successful and sustainable transition back into civilian life. This detailed report provides an important insight into the physical health support a relatively small number of charities provide to the armed forces community across the UK.'

Ray Lock, Chief Executive, Forces in Mind Trust

'The aim of the *Focus On* series is not only to highlight the vital work our armed forces charities do for their respective beneficiaries, but also to create a better knowledge base for policymakers and these charities to continue to act in the best interests of our armed forces community.'

Tom Traynor, Head of Research, Directory of Social Change

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to help others

This report is part of a wider project for and about armed forces charities, which includes the website **www.armedforcescharities.org.uk**