House of Commons

Defence Committee

The Armed Forces Covenant in Action Part 5: Military Casualties, a review of progress: Government Response to the Committee's Fourth Report of Session 2014–15

Eleventh Special Report of Session 2014–15

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The Defence Committee

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Eleventh Special Report

The Defence Committee published its Fourth Report of Session 2014–15 on *The Armed Forces Covenant in Action Part 5: Military Casualties, a review of progress (*HC 527) on 30 October 2014. The Government's response was received on 14 January 2015 and is appended to this report.

Appendix: Government response

The Government's formal response to the HCDC's recommendations and conclusions is set out below and has been prepared by Defence in consultation with the Department of Health and NHS (England). Where appropriate, related recommendations have been grouped together and we have responded with a single narrative. The HCDC's findings are highlighted in bold, with the Government response in plain text. For ease of reference, paragraph numbering follows that in the "Conclusions and Recommendations" section of the HCDC's report.

The Government welcomes the HCDC's continued interest in military casualties and has considered its conclusions and recommendations carefully. The Armed Forces make a tremendous contribution and sacrifice through their service and the Government is clear that the needs of all of those who have served in the Armed Forces and their families will continue to be met. This is why we continue to place so much emphasis on the Armed Forces Covenant and its overriding intent to ensure that Service personnel and their families are not disadvantaged by their Service. However, we are not complacent about the future challenges and will ensure all Government departments continue to work together, with the NHS and the charitable sector in support of our Service personnel, veterans and their families.

Mental health of Armed Forces personnel

1. We welcome the introduction of the Trauma Risk Management system and the MoD's work in reducing the stigma attached to seeking help for mental health problems. We also welcome the fact that personnel are seeking help for mental health problems earlier than in the past. The Armed Forces have seen a significant increase in the number of personnel requiring treatment by the Defence Community Mental Healthcare Teams without a proportional increase in the number of staff. Given evidence that Service personnel are coming for mental health support sooner than in the past and while they are still serving, pressure on existing resources will only increase. In response to this Report, the MoD should inform us of its plans to deal with the increased volume of work and tell us how quickly it can ramp up its support for personnel in the event of any further acceleration in the number of personnel coming forward for help. (Paragraph 18)

There has been an increase in presentations at Defence Departments of Community Mental Healthcare (DCMH) since 2007 and we expect these to increase steadily because increased numbers of personnel have deployed and been exposed to combat. However,

Defence believes that the systems implemented in recent years will mitigate this increase and allow us to offer help and assistance to those that need it.

The Defence Mental Healthcare Review, initiated in 2013, aims to identify future mental healthcare requirements and how they can be configured to meet the future size, disposition and shape of the Armed Forces in 2020. As the number of Service personnel (including uniformed mental healthcare personnel) is being reduced across Defence, the precise configuration of the future delivery of Defence mental healthcare is still to be determined, subject to wider discussions on Defence resources. However, recruitment of additional permanent civilian Mental Health Support Worker posts has been agreed and is underway. The Strategic Defence and Security Review in 2015 will provide a further opportunity to review the overall requirement.

If there were to be any unexpected acceleration of presentations at any time then consideration would be given to additional measures to meet demand; for example by employing temporary locum staff to meet the extra clinical demand, the use of primary care facilities or to reduce non-clinical activities within DCMHs for the duration of any peak.

2. The higher incidence of mental health problems developing in reservists deployed to Iraq and Afghanistan has been known for some considerable time. Given our earlier recommendation in 2011 that it investigate the factors contributing to that higher incidence, we are disappointed that the MoD is still in the process of commissioning this research. This has meant that the MoD has yet authoritatively to identify or to address these issues and provide support specifically tailored for reservists. This is of great concern to the Committee given that the importance of identifying and addressing the particular problems facing reservists is increased by the growing dependence on Reserve Forces in Future Force 2020. (Paragraph 25)

The percentage difference between the likelihood of a reservist rather than a Regular Service person experiencing a mental health problem is very small[1], however, we do know that Reservists who have deployed have a different profile of mental health problems compared to similar Regulars; they are more likely to suffer from PTSD and are less likely to misuse alcohol. Research has now been commissioned both to identify factors that contribute to the development of mental health disorders in Reservists and to develop a Post Operational Stress Management (POSM) programme tailored to the needs of Reservists; both will report by March 2016.

The mental health study will explore factors which determine why Reservists may be more at risk than Regulars of developing some mental health problems on return from combat operations. It will also assess Reservists' awareness of mental healthcare and support services. These findings will be used to inform processes and interventions used for addressing mental health problems. The POSM research programme will look to provide recommendations on the most appropriate programme for improving Reservists reintegration and normalisation experiences and, consequently, to improve mental health outcomes.

1 Fear et al 2010 reported that 5.0% of deployed reservists reported symptoms for probable PTSD compared with 4.2% of regulars

Defence continues to develop and evaluate its training, interventions and treatments by investing in quality research to ensure evidence based, effective practice. The Kings Centre for Military Health Research (KCMHR) is currently undertaking a further phase of their longitudinal cohort study. This continues to include Regulars, Reserves and Veterans in order to monitor any changes in incidence of mental health over time. This phase will run until 2016 and report in 2017. Defence will be able to use this evidence to inform any required changes in policy.

Work is being conducted by the Future Reserves team to plan the healthcare needs of reservists under Future Reserves 2020; this will include deployment requirements and re-integration on return to the UK. If a Reservist develops a mental health problem during mobilisation they will receive support and treatment from the Defence Mental Health Services, although in such cases it may be in the patient's interest to transfer an individual's care to the NHS in the area where they normally live. Reservists are not demobilised until their initial medical care is complete, or they are medically boarded and a decision is made to retain or discharge them from the Reserves.

Once demobilised, the Reservists' support infrastructure is predominantly through their unit. Their medical care becomes the responsibility of their own local NHS Clinical Commissioning Group and the majority of Reservists' physical and mental health needs are met by these provisions. However, Defence recognises that it has expertise to offer in certain specific circumstances, and Reservists can attend the Veterans and Reserves Mental Health Programme (VRMHP) for a full mental health assessment by military specialists. If their condition is assessed as operationally attributable, they are entitled to out-patient treatment via one of the DCMHs or, in acute cases, Defence Medical Services (DMS) will assist with access to NHS in-patient treatment.

3. We welcome the MoD's acceptance of our previous conclusion that it needed to recognise the seriousness of the problem of alcohol consumption in the Armed Forces and that it has strengthened its response to the problem. However, we remain concerned that the MoD's response has not had any noticeable impact on the level of excessive and binge drinking in the Armed Forces. We are not convinced that sufficient focus has been given to dealing with the problem at every level of the chain of command. We also question whether the MoD has examined whether excess alcohol consumption may, in some Service personnel, be masking other mental health problems. (Paragraph 32)

4. We are disappointed that the MoD took well over a year to commission research into the drivers of excessive alcohol consumption. The conclusions of the study are very worrying. Clearly, urgent action is needed to tackle the harm caused by the abuse of alcohol to both Armed Forces personnel and their families. In its response to this Report, the MoD should tell us how it intends to implement the study's recommendations and in what time frame. (Paragraph 33)

5. The MoD should determine a comprehensive strategy and plan to tackle alcohol misuse, identifying how it intends to change the culture within the Armed Forces and identifying practical measures to reduce consumption including, if necessary, reviewing pricing policies and availability of alcohol on bases. The plan should incorporate the recommendations of the study on excessive alcohol consumption. It

should also include performance measures which will indicate whether the plan is working in reducing excessive alcohol consumption. (Paragraph 34)

Defence absolutely recognises it has a duty of care, and operational requirement, greater than other Government Departments or private companies, in ensuring their personnel are fit and healthy. As per societal norms, Defence believes that social drinking plays a part in social activities within the Armed Forces, a view which is supported by the Government[2]. The culture in Defence has changed dramatically over the last twenty years. For example, the number of unit bars has reduced and opening hours are restricted. Attitudes to alcohol misuse have also changed with a far harder line taken on those who misuse alcohol.

The Armed Forces largely recruit from societies where a drink during a social occasion is the norm. Many of those entering the Service will have seen alcohol misuse or have even misused alcohol themselves. The Army, in particular, recruits many of its personnel from areas where incidences of alcohol misuse tend to be higher. Defence has also lost some ability to influence our personnel as alcohol is available cheaply in supermarkets and pubs, and personnel choose to drink at weekends and away from the military environment.

Therefore the focus remains on providing Service personnel with the information they need to make informed decisions. The Committee will be aware from evidence supplied during the course of this inquiry that each Service has a clear substance misuse education and training policy. We believe personnel have the necessary information to allow them to make informed decisions. The frequency of training and education campaigns differ according to Service, but the focus of all activities is to encourage a sensible social approach to alcohol consumption.

Last year, Defence introduced a new offence[3] for those who exceed the alcohol limit for prescribed safety-critical duties. This also provided new powers to test for the presence of alcohol for those engaged in such tasks. Personnel who do not abide by the rules can be disciplined either administratively or by summary hearing. This can impact on their finances, their liberty and potentially their careers.

For those who genuinely have difficulty in controlling their drinking habits, DMS provide a comprehensive alcohol misuse assessment and treatment programme at one of the 16 DCMHs. Treatments are tailored to individual need following assessment. Specialist substance-misuse nurse input is available in a number of mental health teams and supports specialist training for other DCMHs. There is an ongoing review and development of alcohol misuse assessment and treatment pathways in line with evidence-based practice and NICE guidance. Personnel can also be referred to external services, such as AA, if this is deemed appropriate and beneficial. For those with severe alcohol problems, inpatient detoxification is available through Defence's contract for inpatient mental healthcare with the South Staffordshire and Shropshire NHS Foundation Trust in conjunction with seven other NHS Trusts across the UK.

2 Government Alcohol Strategy 2012."in moderation, alcohol consumption can have a positive impact on adults' wellbeing, especially where this encourages sociability"

3 Section 20A of the Armed Forces Act 2006

The need to continue to work to reduce alcohol misuse is set out in the Defence People and Training Strategy; this will be reflected in the Defence People Health Strategy 2015. The Plan for FY15/16 is currently being developed and reduction in alcohol misuse is a priority.

The 'Alcohol and the Armed Forces' research, commissioned in 2012, was not designed to provide new data but summarised existing evidence to both inform senior level understanding and decision making, as well as identify interventions to reduce the impact of harmful drinking. The main statistics used in the research were the results of a single paper (Fear *et al*, 2007) which studied 8,686 military personnel who were in service during Op TELIC 1. This makes the evidence somewhat dated, and, in order to provide Defence with a better understanding of the drinking context, the current phase of the KCMHR longitudinal study is reviewing: motivations for drinking; the drinking setting, and with whom Service personnel usually drink. This phase will report in 2016.

Defence has established a working group to look at the research outcomes and identify key policy or behavioural changes to support the reduction in alcohol misuse. The working group is considering: how best to prevent alcohol misuse through modifying the drinking context; targeting education campaigns more appropriately; collating statistics on alcohol misuse to inform policy; and early intervention methods.

By the end of 2015, Defence will introduce a screening tool which uses drinking habits (and not number of drinks) to identify if personnel are misusing alcohol, with the first tranche of results available in late 2016. The introduction of an alcohol brief intervention programme is also being considered and work is currently ongoing to understand whether such a programme is required, if it would have utility in a military context, how it would be designed and implemented and whether a civilian programme could be appropriately adapted.

It is understood that alcohol misuse can be linked to mental health problems and therefore Defence seeks to refer those identified with alcohol problems to the DCMH for assessment. Of the 5,351 new episodes of care for mental disorder during 2013/2014, 4.8% were for disorders due to alcohol.

Every Service person has a mental health assessment on leaving the Service; should a mental health issue attributable to Service life be identified, that individual can access the DCMH for up to 6 months post discharge, after which they will be supported into the NHS.

Significant advances have been made in altering the culture and reducing alcohol misuse among Service personnel; however there is still more that can be achieved. Through education, management and discipline Defence will continue to promote a healthy drinking culture where commanders are encouraged to reduce the link between alcohol and social activities, to make effective use of the discipline procedures and to enable their personnel to make informed decisions about the long-term impact of alcohol misuse.

6. Increases in violent offending behaviour are linked to deployment in combat roles and subsequent misuse of alcohol and other risk taking behaviour. The MoD should identify those most at risk of such offending and put in place measures to assist these personnel to manage the aftermath of deployment in combat roles better. (Paragraph 37)

Defence is working closely with KCMHR on a three-year study, funded by the US Department of Defense, of a possible screening tool for mental health issues for UK Armed Forces personnel. The trial will evaluate computer delivered psychological screening against the standard intervention of a POSM brief at the 12 week post-deployment point. This study will help understand the efficacy of screening and examine whether such a tool would benefit UK Armed Forces. The trial started in December 2011 and is due to report in 2015.

The 6 step operational stress management programme introduced in 2006 has facilitated improved mental health awareness and psychological resilience in personnel; it has also played a huge role in de-stigmatising mental health issues. In particular, Step 5 – POSM, has been widely tested and all three stages (Decompression, Normalisation and In Service Support) aim to minimise the likelihood of soldiers suffering from psychological problems and enable effective and timely management of those who have been exposed to traumatic or stressful events. It is this last stage of in-service support, which focuses on identifying potential adverse stress reactions in the individual which may present some time after returning from deployment rather than in the initial weeks. Those identified are kept under line management review through follow up interviews and management.

Should it be necessary, personnel can be referred to the DCMH for comprehensive out-patient treatment services for mental health problems or psychological injury. In-patient care, when necessary, is provided in specialised psychiatric units under contract with the NHS.

Following withdrawal from Afghanistan and the return to contingent operations Defence will continue to develop its strategy to reflect lessons learned from this conflict, as well as monitor new national and international developments in building psychological resilience and stress management.

7. The MoD needs to understand better the links between deployment on combat operations, alcohol misuse and domestic violence. The MoD must be more proactive at all levels and should re-examine its policies on domestic violence and develop plans to intervene to prevent domestic violence or, at least, reduce the incidence of domestic violence by Armed Forces personnel. These plans should deal with both regulars and reservists. (Paragraph 41)

Defence reviews its policy on domestic violence periodically and work is in hand to update Joint Service Publication 913, which sets out the tri-Service policy on domestic violence, to ensure that it is up to date and that there is a consistent approach to dealing with domestic violence across the three Services.

It is recognised that the levels of stress felt by individuals following deployment can vary greatly and no two people will deal with their experiences in the same way. Many will have no residual effects on return from operations. Others will take longer to adjust to routine military and family life and may require additional help to address issues such as aggression, alcohol misuse and repressed feelings which may manifest as incidents of domestic violence.

Service personnel returning from certain operational theatres are provided with a period of decompression to re-adjust in a graduated and controlled manner. This is one element of

the complete POSM package which improves the quality of homecoming by giving personnel the opportunity to discuss their experiences, as well as receive welfare briefings and have time to unwind.

Personnel who have alcohol abuse issues are referred to DCMH for alcohol management, and will also have their mental health assessed to establish if this is the cause of their drinking. The DCMH initial mental health assessment is comprehensive, covering presenting problems and behaviours in different areas, triggering factors, and wider social consequences. Consideration of an individual's mental health difficulties and the formulation of a diagnosis leading to treatment includes the consideration of alcohol misuse and domestic abuse issues.

Welfare information and help is also available to families, drawing attention to what can be expected when serving family members return. This includes information about signs of stress and behaviours to look for and how to get help if needed. Welfare officers, padres, and other associated organisations also provide information to families by email, through HIVEs and support groups.

Not all domestic violence can be attributed to issues associated with deployment and alcohol misuse. For this reason the Armed Forces' approach is to raise awareness about the comprehensive range of sources of help and information available to those experiencing violence. These include single-Service specialist welfare providers, welfare and personnel staff, Families' Federations and help-lines.

Support for Families

8. We are disappointed that the MoD has taken so long to act on the recommendation in our December 2011 Report to review the support it offers families. Families need improved support, in particular, the families of reservists who find it harder to identify sources of support than regulars. The MoD should provide us with its study of the support to the families of wounded, injured and sick personnel as soon as it is available. It should also tell us how it intends to implement the recommendations of the SSAFA report on support to bereaved families and the above report. We call on the MoD to use the reports it has commissioned as the basis for a revision to its policy for the support of families. (Paragraph 49)

A very high level of care and support is provided to the families of those injured or killed. Whilst Defence is confident that it has robust support structures and mechanisms in place, there is a continuing need to review these and independent research was commissioned into the support experiences and needs of families of the wounded, injured and sick (WIS). The Families Federations were consulted as part of the research proposal and worked with us to commission a consortium led by Dr Nicola Fear of Kings College in August 2013 to examine, and make recommendations, on the support, experiences and needs of families of the WIS. They will report their findings by February 2015.

The SSAFA review of support for bereaved Armed Forces families made 42 recommendations that fall within three key areas; procedures and training, support offered and recognition of parents and siblings. The review highlights that there is a need to further refine the support offered to bereaved families. Encouragingly, the report found that there has been much improvement since the 2008 study. The recommendations will

be taken forward by Defence's Casualty and Compassionate and Welfare Working Groups who will develop and action a plan to address the issues raised. Defence has already undertaken significant work on the return of personal effects and revised policy has addressed the report's findings on this subject.

Defence is not complacent, and the task of examining and improving the support offered, solely and in partnership with other government departments and charities, will never be complete. Defence will always strive to learn from those experiencing injury and bereavement, to further improve the support provided, revising policy if required, so as to meet the challenges faced by those who endure loss through service.

Support for the recovery of wounded, injured or sick personnel

9. The shortfall in the capacity of the Defence Recovery Centres has meant that some wounded, injured or sick serving personnel have not been able to benefit from them and reservists, in particular, have found it difficult to access them. We welcome the opening up of the Centres to veterans but recognise that this will also increase demand. Whilst we welcome the Army's decision to increase the number of Personnel Recovery Officers, we doubt that this increase will be sufficient. In response to this Report, the MoD should outline both its estimates of expected demand on the Defence Recovery Capability from serving personnel, reservists and veterans and its estimates of the additional resources, in particular, numbers of staff, needed to meet those demands and also clarify whether staff will be provided by the MoD or the charitable sector. (Paragraph 57)

10. The MoD should inform us of the latest progress in implementing the recommendations of its review of the Defence Recovery Centres. In particular, it should tell us how many additional Personnel Recovery Officers have been appointed, and when and how the new evaluation and assurance scheme for the Defence Recovery Centres will be implemented. (Paragraph 58)

In order to better understand future expected demand a mathematical model is being developed to assess the long term steady state requirement for, primarily, the Army Recovery Capability (ARC), which will facilitate the assessment of the required capacity at the Personnel Recovery Centres[4] (PRCs).

Defence Statistics (Health) has produced a high level simulation model[5] which mathematically models the long term steady state movement of Injured and Sick[6] personnel through the ARC process. Due to the data constraints and assumptions made in the development of the ARC Data Model, Defence Statistics assess that this model is sufficiently developed to inform policy direction but not to provide a definitive answer; the model will be reviewed, and revised if required, in February 2015.

Reservists on Full Time Service[7] (FTRS) are, on wounding, injury or sickness, entitled to the same level of recovery care and support as their regular counterparts. Reservists taking

4 Catterick, Colchester, Tidworth, Edinburgh, Germany.

5 Discrete event simulation model.

6 Wounded personnel were not included in the model.

7 Reservists who have been mobilised (under a provision of the Reserve Forces Act 1980 or the Reserve Forces Act 1996) or engaged on FTRS (FC) (under Section 24, Reserve Forces Act 1996 (FTRS)).

part in obligatory training, voluntary training and other duties (VTOD), or on an Additional Duties Commitment (ADC) to serve for a specific period, are ineligible for assignment to a Personnel Recovery Unit (PRU)[8]. Although non-mobilised Reserves are generally ineligible for assignment to a PRU, cases have been approved in exceptional circumstances, including access to Core Recovery Events (CREs) delivered in the PRCs; Veterans are able to access PRCs when there is spare capacity not required by Service personnel.

All medium-to-long-term WIS cases in the Army who are expected to be discharged are assigned to a PRU through the Army Recovery Capability Assignment Board. Commander Land Forces directed in October 2014 that the ARC PRUs will be uplifted with an additional 29 x Personnel Recovery Officers (PROs) in a two-phase approach; phase 1 will be realised on 5 January 2015 with the assignment of 16 x PROs. Phase 2 will occur in March 2015, informed by the revised ARC Data Modelling results. NHS England has also changed its registration rules to enable WIS service personnel who are expected to be discharged to register with an NHS GP up to 2 years prior to discharge to facilitate care closer to home and enable greater continuity of care on discharge.

An additional 13 x Training and Welfare staff are being resourced for PRCs and the Battle Back Centre to ensure that: the command and care of WIS is improved; and to enable the delivery of more Core Recovery Events (CRE) to better meet regional demand. Phase 1 of the uplift will be realised in Q4 of FY15/16 and will provide 9 x FTRS (Home Commitment) personnel comprising 5 x Instructors, 3 x Welfare Officers and 1 x Logistical Support NCO role.

The Defence Recovery Board (DRB) recently endorsed the 3rd party assurance framework developed by Ofsted to evaluate the DRC; a pilot programme started in November 2014. Ofsted will report on the productivity of the pilot and its findings by 31 March 2015. The Pilot Report will be reviewed at the DRB in April 2015 with a view to making a decision on the full scale implementation of the assurance process in 2015/16. Subject to implementation being approved, the DRB members have agreed that the assurance process will be funded from FY15/16 for three years (at £100k pa), to be split evenly between each single Service Top Level Budget, Help for Heroes and The Royal British Legion.

11. The Defence Medical Rehabilitation Centre at Headley Court has been a valuable resource for those injured in the Armed Forces. We welcome the announcement of a new Defence and National Rehabilitation Centre and commend the generosity of those charities and individuals who have committed to fund the Centre. In response to this Report, the MoD should tell us what its financial and other commitments to the establishment will be over the next ten years. The MoD should also inform us of the results of its negotiations with the trustees about the future of Headley Court. (Paragraph 61)

The Defence and National Rehabilitation Centre (DNRC) at Stanford Hall will open in 2018. Defence funding to support both the Defence Medical Rehabilitation Centre (DMRC) at Headley Court, together with the transition and transfer to Stanford Hall,

8 Whether the Reservist undergoing training was 'on duty' or 'off duty' at the time of wounding, injury or sickness will determine the level of recovery support to which they are entitled.

includes funding for the Defence share of the initial set-up and ongoing running costs for the new facility.

It is anticipated that the running costs of the DNRC will be broadly equivalent to those for the DMRC at Headley Court i.e. £27m per annum. The Headley Court estate and premises is owned in its entirety by the trustees of the Headley Court Charity. The trustees will decide on the future of the Headley Court site in due course.

12. The Government should tell us how it intends to respond to the conclusions and recommendations on the treatment of musculoskeletal conditions raised in the Chavasse Report for serving personnel, reservists and veterans. (Paragraph 64)

Many of the recommendations made in the Chavasse report are already being delivered by the NHS. Routine medical care to members of the Armed Forces is delivered by the DMS in partnership with NHS England and the Devolved Administrations. We are working together to see how Professor Briggs' proposals can offer more timely access to specialist centres for the Armed Forces Community.

NHS England has established a working group consisting of senior NHS professionals and Professor Tim Briggs, the author of the Chavasse report. This Group is reviewing the key proposal within the Chavasse Report on the establishment of a network of NHS rehabilitation units focussed on the needs of veterans. Other proposals made in the report in relation to raising awareness of veterans' needs, the health commitments of the Armed Forces Covenant and priority treatment have been taken forward with Professor Briggs and NHS England. In addition, the Department of Health will be consulting on changes to the NHS Constitution to include a requirement to meet the health commitments of the Armed Forces Covenant.

Defence is content with current waiting times and access for serving personnel and mobilised reservists to NHS services. Non-mobilised reservists are regarded as veterans when accessing NHS services. Veterans are able to receive priority treatment for service related health issues, subject to the clinical needs of others. There are no plans to change this arrangement.

13. The Government should tell us how it intends to respond to the recommendations on the support of Service personnel and veterans with hearing loss and tinnitus and on the prevention of hearing damage in younger members of the Armed Forces as set out in the Royal British Legion Report on hearing problems in the Armed Forces. (Paragraph 66)

Anna Soubry MP, Minister for Defence Personnel, Welfare and Veterans responded on 15 September to Chris Simpkins, Director General of the Royal British Legion (RBL), setting out in detail the Defence response to each of the '*Lost Voices*' recommendations. There is much in '*Lost Voices*' that Defence and the RBL consider common ground and the Government is clear that both stakeholders are working to ensure that awareness amongst personnel is high and that the best possible hearing protection and surveillance is provided. For those affected by hearing loss and its associated challenges best practice care and support is available. That support has recently been further enhanced following the Chancellor's Autumn Statement announcement that £10m of LIBOR money will be

allocated to help veterans with hearing problems. Departments and the RBL will work together to decide how best to spend this money.

The Government position on each of the three main areas of concern (hearing damage, compensation and research) is summarised below.

Hearing Damage

Defence shares the RBL's concern about hearing damage to Service personnel. Following the Control of Noise at Work Regulations 2005 chronic noise damage from workshop environments should be very rare, although the recent conflicts have produced a risk of acute weapons related impulse noise damage. To manage this risk the chain of command and Headquarters Surgeon General use the principles: Prevent, Detect and Treat. Defence continues to work to ensure that all personnel and commanders are fully aware of the risks of permanent hearing damage and vigilant about the use of hearing protection.

Where it is clinically appropriate suitable digital aids are fitted in-Service. Throughout the UK arrangements are in place for priority access to secondary care for veterans with service related hearing problems, and digital aids are fitted as standard in the NHS where clinically appropriate.

Defence accepted the Independent Medical Expert Group's (IMEG) recommendation in their 2013 Report that, in younger veterans, where hearing loss was just below the compensable threshold and because of the stigmatising effects of traditional hearing aids, 'receiver-in-canal' (RIC) or 'in-the-ear' (ITE) aids should be supplied wherever clinically appropriate. Ministerial colleagues responsible for health in Wales, Scotland and Northern Ireland have agreed in principle with the proposal.

'Proper' Compensation

The issue of adequate and fair compensation for Service personnel and veterans with Service-related noise damage to hearing is an important one. The Armed Forces Compensation Scheme (AFCS) provides no-fault compensation for injuries, including hearing loss, where caused by service on or after 6 April 2005. The level of compensation will vary depending on the severity of the injury and its effects. Compensation for hearing loss ranges from a lump sum award of £6,000 up to £470,000, and more serious injuries will also include a tax-free index-linked Guaranteed Income Payment (GIP). Following Lord Boyce's review, the IMEG were tasked to investigate hearing loss. The recommendations of their first report (2011), included the inclusion of blast and acute acoustic trauma injuries in the compensation tariff and also changes so that tinnitus is assumed to be present and taken into account in all hearing loss awards. These changes were accepted and, exceptionally, apply from the start of the Scheme.

For their second report, published in May 2013, the IMEG considered in-depth evidence on hearing loss, including discussions with the Medical Advisory Committee of the RBL. It particularly focussed on the compensation threshold to attract an income stream for life and made clear that the current threshold represents a specific level of hearing deficit, rather than the onset of disabling hearing loss. Following careful consideration it was concluded that the evidence was insufficient for the IMEG to recommend changing the compensation threshold.

'*Lost Voices*' records that veterans under 75 are three and a half times more likely than the general population to report hearing difficulty. The IMEG report devotes a section to the relationship between hearing disability and measured audiometric threshold. It makes the point that self-report is, on the one hand, easy to administer and has face validity but, on the other, it is subjective and not easily replicated even within the same subject. There is also marked variability in the measured hearing threshold amongst individual people of the same age and sex. People with 'normal' hearing have widely differing concepts of hearing normality and vary in their susceptibility to noise injury and the effects of ageing.

The RBL recommends that Defence does not rely solely on pure tone audiometry when assessing compensation but instead introduces more sophisticated tests of communication. While agreeing that new methods of assessment are being developed, quality assured pure tone audiometry remains the mainstay of assessment for compensation purposes in public schemes and the civil courts throughout the world. Defence will continue to investigate new and emerging assessment methods.

It is also suggested that awards are made for tinnitus as a stand-alone disorder. Tinnitus is a symptom, is common in the adult population and is not always associated with hearing disorder; in-line with international practice, when present on its own without hearing disorder, it is not compensated in any UK public jurisdiction. This is because it is subjective and, as yet, there is no robust method of assessment as required for equitable and consistent decisions and awards. All AFCS hearing loss awards include an element which assumes severe tinnitus is present. In all cases questions about the presence of tinnitus are routinely asked at in-Service occupational medical boards with subsequent specialist referral as appropriate.

Research

The "Lost Voices" report also draws attention to plans for the Earshot Centre which Defence and Health ministers are considering. However, serious consideration needs to be given to whether there is, in fact, a need or demand for such a centralised facility, the spectrum of need to be met and sustainability. From a research perspective it is critical that commissioning of research is coherent and collaborative and represents good value for money. It should be led by the country's leading experts and include NHS and health departments. The Surgeon General's Royal College of Defence Medicine, along with other academic departments, already have an established and active programme of research into military hearing loss.

Treatment after Discharge

NHS England can and does offer a full range of hearing aids, including in-ear and in-canal, which are provided according to clinical need. The Department of Health and NHS England are working with Defence to improve coordination and to set common standards for local commissioners.

14. Despite the assurances provided by MoD that the processing times had improved and backlogs reduced, we understand that serving personnel and veterans are still experiencing long delays in having their claims processed. We recognise that the backlog of cases awaiting award by Veterans UK has fallen but we are concerned that the throughput is still too slow. In response to this Report, the MoD should set out how it intends to reduce the time taken to adjudicate on claims under the Armed Forces Compensation Scheme and the War Pension Scheme. (Paragraph 71)

It is vital that veterans entitled to compensation receive it as quickly as possible. More claims are now being processed and waiting times are reducing. Last year Veterans UK finalised over 6,000 more claims than in 2010/11. Veterans UK have reduced outstanding Armed Forces Compensation Scheme (AFCS) cases by more than 50% and War Pensions cases by 20%, while average waiting times under both schemes are now around 4 to 5 months. The ex-Service organisations are kept fully appraised of the work to tackle these issues and are positive about the progress made.

Veterans UK is committed to dealing with all claims as quickly as possible and apologises to anyone who has experienced a delay. However, it is important to put these figures into context; Veterans UK maintain regular compensation payments to 145,000 people and last year (FY13-14) dealt with around 36,000 claims and appeals. The Defence Committee highlighted evidence of claims taking an unusually long time, and as a consequence officials have re-examined the process used to collate data. The average clearance time for an AFCS claim in FY13/14 was 109 working days, with a War Pension claim taking 110 working days during the same period. As at 30 November 2014, the average waiting time for a claim to AFCS was 91 working days; with a current caseload of 3,200 claims. For War Pensions, a claim is taking an average of 104 working days; with a reducing case load of 7,900, waiting times are expected to reduce further.

Every claim needs to be dealt with on a case by case basis. Many can be complex, and this often requires evidence from third party groups, which means they can take longer to process. Veterans UK are actively pursuing opportunities to speed up evidence gathering

from third party organisations such as the NHS and DWP, and internally from DMS and single Services. Additionally, Veterans UK has completed a full review of their claims process which has identified opportunities to increase productivity. They have simplified their business processes which will see a reduction in the number of transactions during the lifetime of a claim, from a current average of 80 to around 50. This change is currently being introduced across both schemes. Veterans UK are also exploring if the level of decision making authority should be changed to allow decisions to award minor compensation payments to be made by an experienced caseworker rather that a medical adviser, thus speeding up the processing time for simple claims.

Forty temporary administrative staff are currently supplementing War Pensions staff and, more recently, Veterans UK have recruited three additional medical advisers who are being trained on the compensation schemes. Defence is very aware that the time taken to process claims matters to the Service personnel and veterans who make them. Reducing the time taken to process claims remains Veterans UK's focus.

Longer term sustainability of support

15. We welcome the establishment of a longitudinal study looking at the long-term impact of injuries sustained in operations in Afghanistan. We will continue to take an interest in the progress of this long term study, its conduct and its management. (Paragraph 75)

Noted.

16. We remain very concerned about the long term impact of deployment in Iraq and Afghanistan on those personnel who were injured physically or psychologically. Other aspects of Service life may also have a long term impact on the health of veterans. However, there are issues which need to be tackled now; these include provision for those requiring musculoskeletal treatment and wheelchairs and those suffering hearing loss. (Paragraph 80)

The Government is committed to the Armed Forces Covenant, part of which seeks to ensure support for those in the armed forces, both during and after their time in service. When individuals leave the armed forces, their healthcare needs become the responsibility of the NHS. For the great majority, that works well. However, for some veterans extra provision is needed because of their reluctance to seek help or because of difficulties navigating the NHS.

The Transition protocol, previously provided to the Defence Committee, is in place to ensure that those responsible for the care of WIS Service leavers are fully aware of their individual needs. The NHS is able to provide excellent services for the population as a whole and offers additional services to ensure that the physical and mental health needs of veterans are met.

Defence, the Department of Health and NHS England have been tasked by the MOD/UK Departments of Health Partnership Board to develop a strategy for the long term post-service maintenance of wheelchairs and other medical devices that are provided in-service. That work is on-going and will report back to the Defence/UK Departments of Health Partnership Board on progress at its next meeting in March 2015. Further

information on the MOD/UK Departments of Health Partnership Board is provided in response to recommendation 21.

17. We are not aware whether the MoD has made concerted and comprehensive efforts to keep in touch with people discharged from the Armed Forces due to life-changing injuries. The MoD should tell us how it intends to remain in contact with such discharged personnel to ensure that it can monitor whether individuals are receiving the support they deserve. (Paragraph 81)

Defence continues to improve the support that it offers to those with life-changing injuries and now operates a Seriously Injured Leavers Protocol (SIL) which aims to ensure the identification and ongoing support for those Service leavers deemed likely to be medically discharged due to a severe physical or mental disablement.

This identification is based upon defined major disabling medical criteria, whilst the support is achieved through the closer working of Defence in-Service and post-Service welfare groups. Defence's Veterans Welfare Service (VWS) proactively intervenes for 24 months and then maintains contact as required, but at least annually on the anniversary of discharge. Full details of the SIL protocol are available at: http://www.veterans-uk.info/welfare/protocol_new.html.

VWS are linked into the Defence Recovery Capability process, having representation within PRUs/ PRC's in order to facilitate early intervention with those likely to be discharged. This reflects Defence's level of commitment to supporting those leaving service, providing assistance through the transition phase and beyond. VWS are also notified of, and make contact with, every medical discharge case, offering the support and services of VWS should they wish it.

However, just because someone has served in the military does not mean that they will wish to be contacted post-discharge, whether they have life changing injuries or have simply reached the end of their contract. They cannot be made to agree to future contact or ongoing support. Therefore Defence remains committed to supporting the Veterans UK 24-hour helpline, as well as the Veterans' Information Service which now contacts all Service leavers by letter or email at the one year post discharge point.

18. It is too soon to judge the long-term effectiveness of the measures to address the mental health needs of veterans. The MoD with the Department of Health should monitor the provision of mental health support to veterans and remedy any shortcomings identified. It should include the results of this monitoring in the annual report on the Armed Forces Covenant. The MoD should also monitor the implementation of the improved services for amputees, act on any shortcomings and again report the results in the annual report on the Covenant. (Paragraph 82)

The NHS in England is responsible for delivering the recommendations made by Dr Murrison in his reports on Armed Forces mental health and veterans' prosthetics. As part of this work, NHS England constantly monitors the effectiveness of the services being provided and is working to identify future needs. Updates on the services provided by the NHS in England, Scotland, Northern Ireland and Wales are discussed by the Armed Forces Covenant Reference Group and reflected in the Annual Report on the Covenant.

NHS England is working with Forces in Mind Trust and has initiated work to review current knowledge of mental health needs for veterans and their provision. This will lead to a review of the three nationally funded services (Big White Wall (on-line support), Specialist In-patient PTSD treatment and the 10 regional veterans' psychological services). NHS England will seek, in the light of national changes to mental health services and the availability of veterans' mental health services (e.g. from NHS providers, Combat Stress, Help for Heroes, etc.) to review how best to adjust services to evolving needs.

19. Despite assurances from the MoD and the Department of Health, we are still worried that, as operations in Iraq and Afghanistan fade from the public eye, the necessary long term support for those injured will not be maintained. In response to this Report, the Government should make explicit its continued support for those damaged physically or psychologically in the service of the country. (Paragraph 83)

The Armed Forces Covenant provides the assurance that the needs of all of those who have served in the Armed Forces and their families will continue to be met. The requirement under the Armed Forces Act for an annual report to be made to Parliament and the involvement of service charities and others in this process provides open and transparent public scrutiny of the ongoing commitment to delivering the Covenant.

NHS England is mandated to ensure that the health commitments of the Armed Forces Covenant are delivered. In addition, the Department of Health will be consulting on changes to the NHS Constitution to include a requirement to meet the health needs of the Armed Forces Covenant, thus further reinforcing the ongoing commitment to meet the long term needs of those who have been physically or mentally wounded. The response to conclusion 21 (paragraph 89) provides information on the MOD/UK Departments of Health Partnership Board.

20. The system intended to improve the transfer of the medical records of Armed Forces personnel leaving the Services has been in operation for less than a year. The MoD told us it will be monitoring performance closely. The MoD should provide us with a progress report on the success or otherwise of the system and the timetable for making the improvements that it was planning. (Paragraph 87)

Improvements to the efficiency of the system for transferring medical records between DMS and the UK Health Services continue to be made. Since December 2013, when a Service leaver registers with a civilian GP, the individual's NHS record has a letter enclosed which informs the GP of their status as a veteran, and explains how to obtain their military medical records. This change has led to a 64 per cent increase in the number of medical records requested from the DMS for Army personnel in the last calendar year (1438 compared to 878 the year before). When this figure is adjusted to take account of the increase in discharges over this period the improvement is 54 per cent. Defence are working with the NHS to improve this system further in 2015. The Enhanced Veterans Healthcare Summary (eVHS) project has been established so that service leavers, who consent to the transfer of their medical information, will have a summary of their in-service care included with their NHS record when it is sent to their civilian GP on registration.

As long as consent is given no further action is required from the GP or Service leaver to ensure that the summary of care is received by the GP in England, Scotland and Wales. The summary of care will include vaccination history, allergies, current medication, active conditions and significant past conditions. The GP letter is also being improved to make it clearer who to approach to obtain the full medical records. Delivery of this project is an Armed Forces Covenant Commitment for 2015, the progress of which is regularly reported to the Covenant Reference Group. This reflects the importance Defence attaches to delivering these improvements. It remains our goal to achieve electronic transfer of Service leavers' medical records between DMS and the UK Health Services. The requirement for the electronic transfer of medical records on transition is included as a user requirement that will be considered under Programme CORTISONE. This Programme will deliver, amongst other improvements; the future integrated Electronic Healthcare Record (iEHR) from 2018**.**

21. We have heard a great deal about the multiplicity of governance arrangements for healthcare and the processes for liaison between the MoD, the Department of Health, NHS England and the Devolved Administrations. We do not believe that these arrangements ensure that veterans get appropriate treatment for their needs and that this treatment is consistent across the whole of the UK. The Government should explain how the MoD's recently created Partnership Board with the Department of Health, NHS England and the Devolved Administrations will ensure that serving personnel and veterans are receiving appropriate and consistent treatment wherever they live. (Paragraph 89)

The MOD/UK Departments of Health Partnership Board is responsible for ensuring that Defence and UK Health Departments work together to meet the requirements of the Armed Forces Covenant (an obligation which the NHS in England is mandated to deliver), and to improve the health and healthcare of the Armed Forces, their families, and veterans. This includes maintaining a strategic overview of issues such as commissioning arrangements for Service personnel, transition of care from Defence to the NHS, and post-service initiatives in relation to mental health and prosthetics. The Board is co-chaired by Defence and the Department of Health (DH) and convenes three times a year.

The Partnership Board set up a sub-group earlier this year (chaired by Defence with representatives from DH, NHS England and the Devolved Administrations) to examine access to healthcare services across the UK for 'MOD patients', (defined as serving Armed Forces personnel, mobilised Reservists and families registered with the DMS). The Group also looks at cross-border health delivery issues between Defence and the UK Health Departments. Veterans are not the focus of this sub-group because their healthcare is the responsibility of the NHS.

The aim of the sub-group is to ensure that, in line with the principles of the Armed Forces Covenant, MOD patients are not disadvantaged compared to other UK citizens in the area in which they live. The sub-group met three times last year and in addition to reviewing the existing healthcare provision arrangements (with regard to what healthcare Defence provides and what the UK Health Departments provide), the sub-group also examined more closely certain elements of that provision. The sub-group has reported back to the main Partnership Board on its achievements which include implementing agreements for

the commissioning of both out-of-hours cover and screening services. The sub-group meets on a six monthly basis or when directed to by the main Board.

NHS services across the UK provide appropriate services to all, including veterans. For those who are being discharged with serious medical conditions the Transition Protocol is in place to ensure continuity of care wherever the veteran resides in the UK. The way in which services are delivered, and in some instances the types of services that are provided, will inevitably vary by region and by country. The Armed Forces Covenant makes clear the need to ensure that there is no disadvantage to the Armed Forces Community in accessing public services in the area that they reside.