Ministry of Defence

Defence Annual Health And Wellbeing Report

2015

CONTENTS

FOREWORD BY CHIEF OF DEFENCE PEOPLE (CDP) AND SURGEON GENERAL (SG)

Progress Towards a Healthier, Happier Whole Force

The World Health Organisation defines Health as a "state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity". There are a number of things that enable a person to be healthy. One of these is work where the evidence suggests that being employed has a positive impact on life trajectory.

People are Defence's greatest asset; if our workforce is to be resilient, our people should be encouraged to adopt a lifestyle which optimises their health and wellbeing, including a sensible approach to alcohol, smoking, sexual health, diet, mental health and fitness. This approach needs to be adopted both when our people are at work and as part of their private lives. In the first instance, education of both individuals and line managers is a vital aspect of making progress toward having a healthier and more resilient workforce, not least because a significant component of being healthy is non-medical.

As we seek increasingly to deliver Defence outputs using a 'whole force' mix of people – full and part time military, MoD Fire and Police Services, Civil Servants and other civilians, the health and wellbeing of every individual becomes ever more important. That is why having a Defence-wide approach to Health and Wellbeing is essential, something that has now been established for the first time.

As part of this, we have put in place proper governance - the creation of the Defence People Health and Wellbeing Board (DPHWB) is a good first step, and produced a Defence Health and Wellbeing Strategy. But neither of these are of any use if, over time, the behaviours of our people remain unreformed; as a result, we now have a Plan against which progress can be monitored and against which we should be held to account. Therefore, we commend this first Annual Defence Health and Wellbeing Report, not least because it does demonstrate progress. But it should be seen as just the first step along a pathway that will require sustained effort and investment if we are to fully achieve the ideal of maximising the health of the Defence workforce.

Chief of Defence People

Surgeon General

EXECUTIVE SUMMARY

'Improving the health of our People'

This report, prepared on behalf of the Chief of Defence People (CDP) and the Surgeon General (SG) by the Defence People Health and Wellbeing Board (DPHWB), is the first annual report since the publication of the Defence People Health and Wellbeing Strategy. It aims to inform and advise on the key issues affecting the health and wellbeing of the Whole Force. It details recent developments in the governance structure and provides a framework which will allow Defence to measure progress against strategic objectives. It sets out achievements since the strategy was published in July 15 and identifies areas where there is much more to be done.

The Defence People Health and Wellbeing Strategy[1] and Plan[2] acknowledge the through life and multifaceted nature of health. The Strategy is split into four pillars: Lifestyles, Mental Health, Injury Prevention and Preventive Health. Each pillar addresses the five domains of wellness [3] acknowledging the contribution to health of training and education, housing, managing debt, sport and recreation, and work itself. By ensuring those leaving the Services and the MOD Civil Service "leave well", Defence is acknowledging its role in wider society. The aim is that people who leave Defence will successfully transition to civilian life and continue to contribute to the Nation.

The objectives of the Defence People Health and Wellbeing Plan are generic, supported by specific tasks and detailed enabling actions, defined roles and responsibilities for their development and delivery. These objectives will inform the single Service health directives and reports but will not bind the single Services to a template of delivery. Importantly, health is an enduring characteristic and a long term commitment. For organisational change quick wins are few and far between. The Health and Wellbeing Plan will be reviewed annually, but many of the generic objectives will stay the same; reducing smoking prevalence, tackling obesity, improving attitudes to alcohol and substance misuse.

The key achievements this first year are:

- The introduction of a screening tool to identify alcohol usage in Armed Forces, coupled with the development of systematic alcohol identification, intervention and treatment policy.
- The development of an alcohol brief intervention course which will train personnel to identify peers with potential alcohol problems and deliver timely advice.
- Development of and training of PTIs for an Occupational Fitness Programme which will be piloted by both the RN and Army in Summer 2016.
- Development of a new, tri-Service endorsed Joint Medical Employment Standard with an initial operating capability of July 16.
- Introduction of a tobacco control policy which aims to modify smoking behaviours, establishes smoking cessation pathways, and, identifies methods of discouraging recruits from starting smoking including preventing instructors from smoking in the presence of recruits and trainees.

Maintaining a healthy workforce is a continual process so many of the achievements above will need to be reinforced and refreshed on a regular basis to ensure we do not fall back into bad habits. However, in order to cover the wide range of health and wellbeing activities priorities will be reviewed annually and for 2016 the following topics will be addressed:

- Further investigation into the recording and management of sickness absence amongst civilian and military personnel.

1 20150408-DPHWStrategy dated July 2015.
2 20150408-DPHWPlan dated July 2015.
3 Join, Train, Work, Live and Leave Well

- Development of a mental health policy to bring coherence to the various ad-hoc activities currently being used in Defence.
- Refinement of Key Performance Indicators for each pillar in order to measure the effectiveness of our interventions.
- Establishing better data capture and exploitation methods.
- Introduction of a new approach to fitness training in order to reduce the incidence of musculo-skeletal injury.
- Investigation into how some of the health interventions available to the military might be made available to the civilian workforce

Whether a job holder, line manager, senior manager, military or civilian, we all have a responsibility to make the Ministry of Defence a healthier place to work. To achieve that, we need to be aware of and embrace the support available, both within the Department and from external organisations and charities.

This report is for everyone in Defence, the change to a magazine format allows easier access to those sections that affect individuals. It is meant to be informative and instructive, the layout reflects the four pillars: Lifestyles, Mental Health, Injury Prevention and Preventive Health. The Defence Recovery Capability remains outwith the Health and Wellbeing strategy, but is included in this report for completeness. The final section of this report, Live Well, highlights some of the activities and events that contribute to the health of the Whole Force and that complement the strategy.

CHAPTER 1 - HEALTH AND WELLBEING

Maximising individual and corporate health is a team effort. Helping people to take control of their own health and wellbeing requires a cultural shift from one of dealing with problems to preventing them from happening. It requires a change in how services are designed and delivered and a shared commitment by everyone in the organisation to commit to making the necessary changes to improve individual and corporate health.

The Defence People Health and Wellbeing Strategy sets out a vision for working together to transform and improve the health of everyone working in Defence, military and civilian, and ensure that we all take responsibility for our part of the solution. However, there is much to do and it is not possible to take action on everything at once. The early strategy is about setting a realistic number of key strategic priorities to make a real impact and provide a platform to support the overarching outcomes articulated in the strategy. Some of the changes we can make to our lifestyle can achieve quick results for individuals, for instance stopping smoking gives some immediate benefits. However, the overall impact will not be seen for several years and we must guard against a short-termist approach that might see commitment to the health and wellbeing agenda marginalised because of a perception that progress is too slow.

To that end, the Defence Health and Wellbeing Strategy states from the outset that this will require a long term approach and, having established the right governance and strategic targets in 2015, next year it will create the key performance indicators and meaningful metrics that will enable us to monitor progress out into the future. In developing our Key Performance Indicators and Metrics we must ensure that our approaches and interventions are evidence based, properly resourced and that effects are measureable. Measuring effect is always challenging and 2016 will be used to baseline many of the health and wellbeing factors such as alcohol use, smoking prevalence, mental health and such employability occupational health measures as sickness absence monitoring and overall employability of the deployable Defence population.

To enable day to day delivery of the Defence Health and Wellbeing Strategy, the Department has a health and wellbeing team which is fully engaged with NHS (England) and the Devolved Administrations. This ensures that Defence health and wellbeing needs are represented at all levels from the Departments of Health for policy matters through to healthcare delivery by the Trusts and Health Boards and social services at the Local Authority level.

An important element of achieving a healthier Whole Force is communication. The key message is that we want to tackle the factors that reduce healthy life expectancy, such as alcohol misuse and smoking, whilst promoting healthy lifestyles and choices, such as physical activity to maximise people's capacity to work.

Health and Wellbeing Strategy

1. In July 2015 CDP, as the Defence Authority for People, published the Defence People Health and Wellbeing Strategy (DPHWS). The Strategy aims to create the conditions for Defence people[4] to enjoy a level of health and wellbeing that maximises the capacity of people for work. Governance is derived from the Defence Plan. The intent of DPHWS 2015 is to establish and sustain a through life process that creates a healthy culture, fosters wellbeing and reduces risks to health.

2. The Strategy applies to all Defence people and not just Service personnel. Evidence shows that healthy behaviour and good physical health are associated with enhanced job performance and a reduction in sick absence. Although there are differences in the Terms and Conditions of Service and requirements placed on civilian and military workforces, all people working in Defence contribute to Defence outputs; maintaining health, safety and wellbeing is, therefore, a priority for Defence. The DPHWS mirrors the 2014 Civilian Health and Wellbeing Strategy and, as practicable, has incorporated its key objectives with the ultimate aim of merging the two strategies.

4 All of the categories of people who work in Defence: Regular and Reserve Military Personnel, MOD Civil Servants and other civilians including contractors: DPTS 2014.

3. The Strategy encourages all Defence people to take responsibility for their own health by making informed healthy lifestyle choices. Providing a healthy and safe working environment with focus on protection and injury and illness prevention is key to a healthy workforce. Where injury or illness does occur, Defence Medical Services and the NHS deliver high quality and timely healthcare for Service personnel, eligible reservists and entitled civilians in peacetime and on operations; a largely, seamless transition from NHS to DMS healthcare provision on recruitment, throughout service and at the end of a Service career, back to the NHS. Departmental Occupational Health Services support the broad range of roles carried out by the civilian workforce across the MOD.

4. **What determines health and wellbeing?** Many factors determine an individual's health and wellbeing, these are:

   a. **Individual lifestyle factors** such as diet, smoking, alcohol or substance misuse, physical or sexual activity.

   b. **Living and working conditions** which include training, education, health and welfare services, housing, food and nutrition, bullying, harassment, discrimination, physical safety at work including equipment ergonomics, job security and job satisfaction.

   c. **Social and community networks** whether this comes from family, friends or colleagues, or locally through community or religious groups.

   d. **Access to healthcare services** including medical or dental, primary, secondary or tertiary care.

   e. **General socioeconomic, demographic and environmental conditions** such as position in society, income, location, and social and community networks.

While all factors are important, certain elements fall outside the remit of this Strategy which primarily focuses on aspects of those health factors addressed from within Defence. Not all will be applicable or possible for the Whole Force and not one agency within Defence can address all determinants[5]. Therefore any approach requires a range of stakeholders[6] and will be considered under 4 themes, each of which fall in the remit of one star working groups within the governance structure: Lifestyles, Injury Prevention, Preventive Health and Mental Health. The work of these groups forms the bulk of the rest of this report along with a short chapter dedicated to the Defence Recovery Capability.

5. **Strategic Objectives.** The strategic objectives are based around each life-stage of Defence people, and are summarised as:

   a. **Objective 1 - Join Well.** Recruiting Defence people whose physical and mental health, with reasonable adjustment where appropriate, enables them to undertake their chosen career within Defence.

   b. **Objective 2 - Train Well.** Defence people have access to training and education opportunities in a safe, supportive environment in order to maximise positive personal health behaviours and to support professional and personal development.

   c. **Objective 3 - Live Well.** Defence people adopt a lifestyle which optimises their health and wellbeing, including a sensible approach to alcohol, smoking, sexual health, diet, mental health and fitness.

   d. **Objective 4 - Work Well.** Defence people are supported to maintain or improve their health through healthy workplaces based on appropriate levels of risk management.

   e. **Objective 5 - Leave Well.** Defence people transition back in to the wider community in optimum mental and physical health.

6. **Governance.** CDP has ownership and responsibility for the governance of health both through delivery of the annual health report to the Defence People and Training Board and oversight of the associated health plan; he is supported in this by SG and the Top Level Budget holders (TLBs). The governance structure

5 SG as the Defence Authority for Healthcare and Medical Operational Capability will address these factors separately.

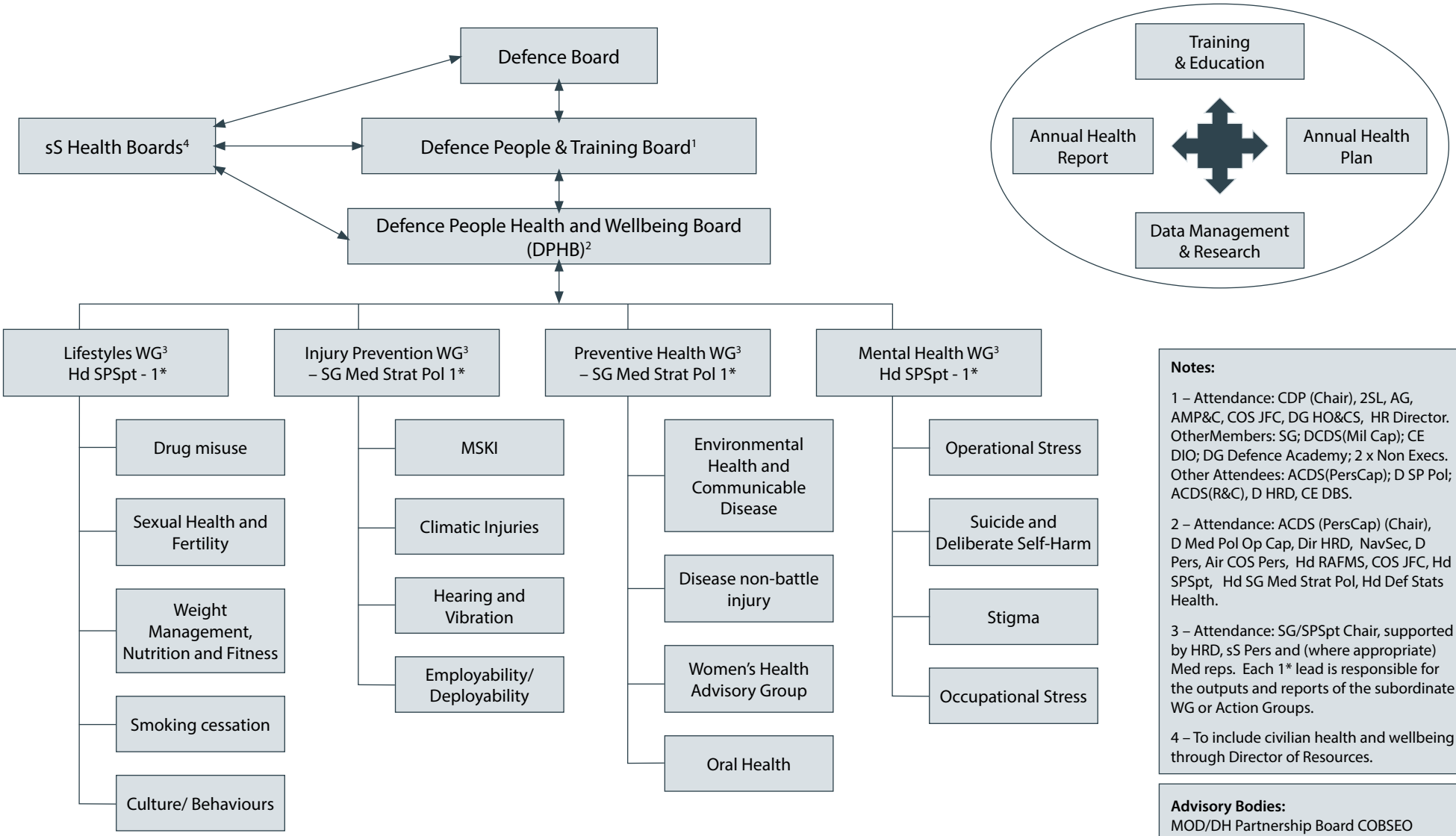
6 Stakeholders include the Individual, SG, CDP, Human Resource Directorate (HRD), Defence Safety Authority (DSA), Defence Equipment and Support (DE&S), single Services (sS), Defence Business Services (DBS), Joint Force Command (JFC), Other Government Departments (OGDs) and welfare departments.

at Figure 1 will enable CDP to provide a coherent structure for the management of Defence people's health, ensuring synergies where appropriate and targeted action where required. He will support and be supported by single Service Health Committees and Civilian HR in managing working groups to explore and develop key factors in health. This governance will provide advice and deliver evidence in support of the Annual Health and Wellbeing Plan and the Annual Health Report.

a. **Defence People Health and Wellbeing Plan (DPHWP).** This sets out Defence's health objectives for the forthcoming year, guides Defence on the activities required to meet the objectives, and documents the outcomes required, which are set as performance indicators. The Plan addresses damaging health issues in order to maximise the number of people fit to meet Defence outputs; the outcomes will be in the annual Health Report.

b. **Health Report.** The Annual Health Report is produced at the end of the financial year by the Defence People Health and Wellbeing Board, supported by the single Service Health Boards and informed by key stakeholders for the Defence People Training Board (DPTB). It reviews the Health Plan objectives and provides evidence in support of planned outcomes. This report is then presented to the DPTB, for discussion with the Defence Board.

DEFENCE PEOPLE HEALTH GOVERNANCE



Notes:

1 – Attendance: CDP (Chair), 2SL, AG, AMP&C, COS JFC, DG HO&CS, HR Director. OtherMembers: SG; DCDS(Mil Cap); CE DIO; DG Defence Academy; 2 x Non Execs. Other Attendees: ACDS(PersCap); D SP Pol; ACDS(R&C), D HRD, CE DBS.

2 – Attendance: ACDS (PersCap) (Chair), D Med Pol Op Cap, Dir HRD, NavSec, D Pers, Air COS Pers, Hd RAFMS, COS JFC, Hd SPSpt, Hd SG Med Strat Pol, Hd Def Stats Health.

3 – Attendance: SG/SPSpt Chair, supported by HRD, sS Pers and (where appropriate) Med reps. Each 1* lead is responsible for the outputs and reports of the subordinate WG or Action Groups.

4 – To include civilian health and wellbeing through Director of Resources.

Advisory Bodies:
MOD/DH Partnership Board COBSEO Health Cluster Combat Stress Strategic Partnership

Figure 1: Defence health and Wellbeing Governance Structure

CHAPTER 2 - LIFESTYLES

The Lifestyle Working Group oversees and supports the work of subordinate groups, to identify priority areas, initiate research, monitor health trends and facilitate access to resources including Defence Statistics and to develop health policies. In addition, the group engages with the Public Health England Sub-Partnership Board via a Memorandum of Understanding (MoU).

The approach of the 1* Lifestyles Working Group in overseeing the sub groups is:

- Establishment of accurate, representative baseline data with associated improvements in data collection methods and the application of evidence, experience and best practice across all decision making, reflecting in particular National Institute of Clinical Excellence (NICE) guidance.
- Promoting increased personal responsibility for health and wellbeing via positive lifestyle choices across Defence.
- Reduction in lifestyle-related inequalities between and within Services.
- Implementation of effective and cost effective approaches to prevention. This varies from health promotion community wide campaigns to individual digitised interventions reflecting advances in technology and remote service provision (online, telephone, text based etc).
- Application of the Make Every Contact Count model across lifestyle areas including access to Brief Advice and Brief Intervention where appropriate.
- Positive cultural change through improved education, training, targeted, evidence-based communications and positive role modelling throughout service.

The initial priority for all sub groups is to improve data collection and analysis systems to establish baselines for the population. In turn this allows detailed plans to be developed.

Smoking and Tobacco Control Working Group:

The Working Group is developing a strategy to maximise our efforts to reduce tobacco use. Smoking rates in the general population have fallen considerably since the 1960s, but over 8 million people in England still smoke. The smoking prevalence in the general UK population as at 1 May 2015 was 22 per cent for men and 17 percent for women[7] . The Armed Forces smoking rates are higher than the general population, unequal between single Services (greater than 10% difference- see figure 2) and in some Army sub groups are higher than some of the most deprived communities in England. We have some way to go in motivating the majority of smokers to quit following recruitment and we must address reports that suggest life in the military can encourage non-smokers to smoke and ex-smokers to restart; for some individuals joining the Armed Forces is the catalyst for them becoming a smoker.

7 ONS (2014): Adult Smoking Habits in Great Britain 2013. Statistical Bulletin

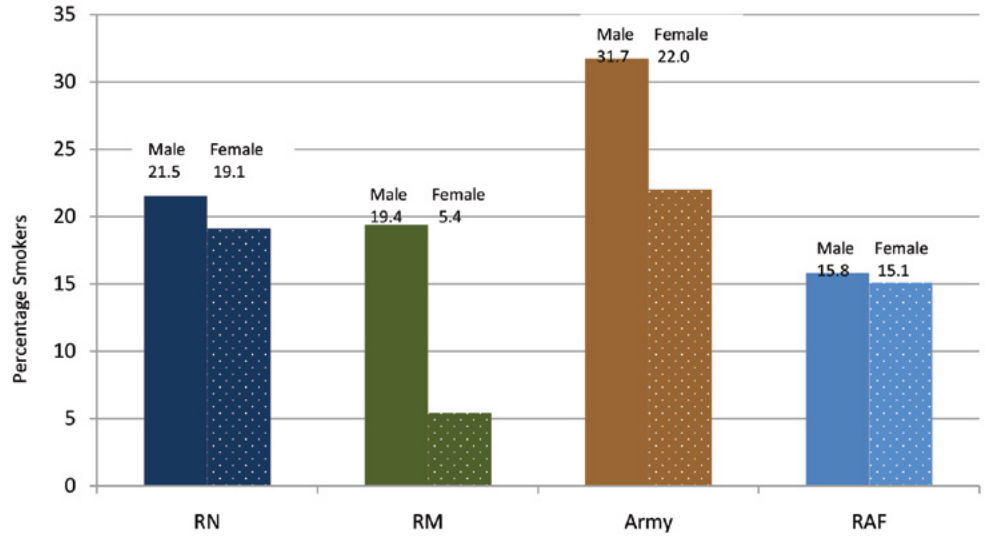


Figure 2: HM Forces (DMS), Percentage Current Smokers by Gender and Service, 1 April 2015,

As at 1 April 2015, 26% (n=40,653) of the regular UK Armed Forces were recorded as smokers (using the primary care record, DMICP). This was the same rate as seen in 2014. Between April 2014 and April 2015, 14% (n = 6,236) of Armed Forces personnel had given up smoking[8] but 5% (n=5,417) were recorded as having started smoking.

Rates of smoking were different across the Services, for those recorded as a smoker in the primary care record: 21% Royal Navy, 19% Royal Marines, 31% Army and 16% RAF.

The strategy builds on the achievements of the Government's community wide tobacco control policy and Public Health England is helping in many areas. The primary goals:

- Revision of current data collection systems to establish an accurate baseline and understanding of tobacco use in the various sub groups prevalence, monitoring trends and f patterns of smoking behaviour and the effectiveness of smoking cessation interventions.
- Improved access to Brief Advice, Brief Intervention and Smoking Cessation interventions.
- Application of evidence based models that recognise the often remote and mobile nature of the Defence population.
- Encouraging people to quit and make use of available support through the Make Every Contact Count model and 3 annual Quad-Service campaigns.
- Effect positive cultural change through the investigation of increased Tobacco Control restrictions, positive role modelling (trainers and instructors) and increased messaging relating smoking to military specific outcomes.

These actions should positively contribute to a reduction in smoking prevalence across military personnel and a reduction in smoking inequalities between and within single Services.

The justification for investing in smoking cessation is considerable. It contributes to Musculo-Skeletal Injury rates and the consequent absence from training due to injury, poor respiratory wellbeing and reduced sports and fitness performance[9] . The Armed Forces prevalence rates have seen some success in the past five years in terms of reductions, but unfortunately we are starting to stagnate. We have a mobile and, for some groups, remote population experiencing a range of different smoking patterns from young, easily influenced individuals with low

8 Gave up smoking describes the movement from "Current smoker" at 1 April 2014 to "Ex-smoker", "Never smoked" or "Non-smoker – history unknown" by 1 April 2015.

9 Siddall et al 2013: Influence of Smoking Status on Musculo skeletal Injury Risk in British Army Infantry Trainees. University of Bath Conference Paper.
Conway and Cronan (1992): Smoking, Exercise and Physical fitness. Prev Med; Nov 21(6) 723-34
NHS Choices – What are the health risks of smoking. http://www.nhs.uk/chq/Pages/2344.aspx?CategoryID=53 [28/11/15]

level dependence, but a powerfully negative social norm around smoking to older, higher dependency individuals who require high levels of ongoing support. We lack information in some areas but we know our high risk groups / career points including deployment and post deployment and some specialisations.

To address these issues a series of actions have been taken to ensure that a MOD wide, strategic approach is taken to reduce smoking prevalence;

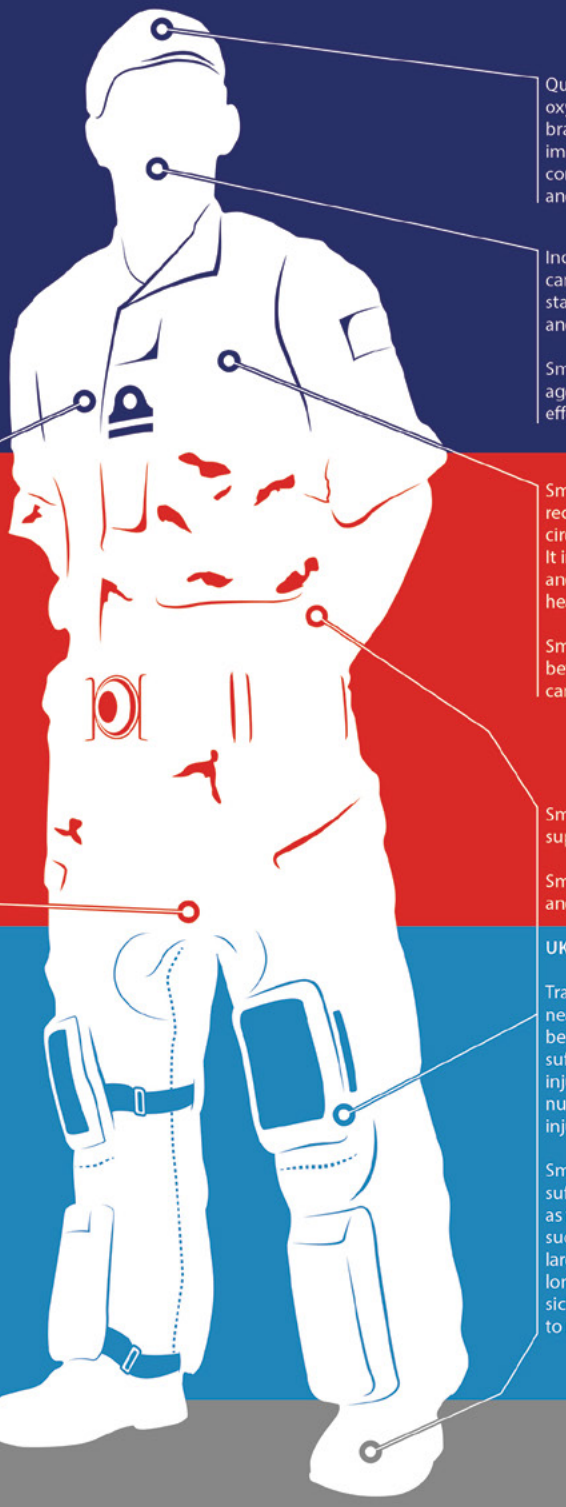
- Annually, three Defence wide, systematic, smoking cessation campaigns will take place; Stoptober, January New Year Resolution and National No Smoking Day. These will allow access to promotional materials offered by such organisations as Public Health England while also using military specific materials that respond to the experiences of our population. The first of these campaigns took place in October 2015.
- We will deliver an easily accessible, NICE compliant and military sensitive smoking cessation Service with an associated, comprehensive data collection system to determine cost effectiveness and evaluation in the next year. The first stage of this is complete with the publication of mandatory training and smoking guidance for staff. The next stage will commence in Spring 2016 with a full Service review and redesign.
- We intend to trial the use of Carbon Monoxide (CO) monitors in training locations. As an aid to smoking cessation, a breath CO monitor can be used as a motivational and educational tool. Self-reported smoking status has been shown to be unreliable and a CO monitor replaces this.
- Within the RAF, 22 Training Group has introduced a ban on trainers from smoking in front of trainees in its Phase 1 and 2 training locations. Military specific evidence[10] indicates that trainees who witness trainers smoking are 2.5 times more likely to smoke than those who do not. Role modelling is therefore a key aspect of generating a no smoking culture. In the next year we will look at opportunities to expand this positive messaging through staff behaviour across the whole of Defence.
- We need all health and health related professionals (medical, dental, pharmacy, physical training, welfare, CoC, line managers etc.) to maximise every opportunity to encourage smokers to quit. In the forthcoming year, pharmaceutical technicians will be the first health professionals to be offered training and support in delivering the 'Making Every Contact Count' smoking cessation model.

10 Green et al (2009): Peer and Role Model Influences for Cigarette Smoking in a Young Adult Military Population. Nicotine Tobacco Research; Oct 10(10); 1533-1541.

Stoptober

Time to quit smoking?

'If you stop smoking for 28 days you are 5 times more likely to stay quit'.



Quitting increases oxygen to the brain which improves concentration and memory.

Increased risk of oral cancer, bad breath, stained teeth and gum disease.

Smoking prematurely ages the skin by 10-20 years and effects can be seen from mid 20's.

Within months of quitting lung function increases by 10% allowing exercise to become easier.

Smokers suffer from shortness of breath almost three times as often as non-smokers.

Smoking weakens your immune system increasing chances of colds, flu, coughs and asthma.

120,000 UK men in their 20's and 30's are impotent as a direct result of smoking.

Smoking narrows arteries and reduces oxygen rich blood circulating to the organs. It increases blood pressure and heart rate so your heart has to work harder.

Smokers reach exhaustion before non-smokers do and can't run as far or as fast.

Smoking reduces blood supply to the bones.

Smoking delays fracture and tendon healing.

What to do next

If you would like to talk to someone about quitting smoking please visit your local Medical Facility where trained staff can offer advice and support.

Additional support can also be obtained from:

https://stoptober.smokefree.nhs.uk/

UK Armed Forces studies show:

Trainees who smoke are nearly twice as likely to be injured, more likely to suffer knee, foot and ankle injuries and lose a greater number of training days to injury than non-smokers.

Smokers are more likely to suffer traumatic injuries such as fractures, overuse injuries such as tendonitis, experience larger shoulder tears and take longer to heal affecting their sickness absence rate compared to non-smokers.

OCT

YOUR LIFE

After 20 Minutes

Blood pressure and pulse rate return to normal.

After 8 Hours

Nicotine and carbon monoxide levels in blood reduce by half and oxygen levels return to normal.

After 48 Hours

Lungs start to clear out mucus and other smoking debris. Ability to taste and smell is greatly improved.

After 72 Hours

Breathing becomes easier. Bronchial tubes begin to relax and energy levels increase.

After 2-12 Weeks

Your circulation improves.

After 3-9 Months

Coughs, wheezing and breathing problems improve as lung function increases by up to 10%.

Congratulations on wanting to quit.
Having a plan will make it easier! Don't rely on willpower alone to keep you smokefree. Prepare so that you can feel confident in your ability to stay quit.

S **Plan a quit date. Choose a date within the next two weeks, so you have enough time to prepare without losing your motivation to quit.**

T **Tell family, friends and work colleagues that you plan to quit. Help them to keep you busy and remind you of why you are quitting. If possible, find a quit buddy who wants to stop smoking as well.**

A **Access your local stop smoking service at your medical facility - you will be 4 times more likely to quit as they can offer you support, advice, Nicotine Replacement Therapy and help in how to manage cravings and withdrawal symptoms.**
Access www.smokefree.gov to support your quit with additional phone, text, online and app based help.

R **Remove cigarettes, tobacco, lighters and ashtrays from your home, car, remove yourself from cigarettes - avoid people and places where your are tempted to smoke. Avoid your big smoking triggers, at least during the first few weeks - caffeine, alcohol, pubs.**

T **Take small steps and short term goals - do it day by day or week by week. A stop smoking advisor is particularly good at helping with this. Reward yourself for each goal you achieve. Remember quitting smoking happens one minute, one hour, and one day at a time. Don't think of quitting as "forever". Pay attention to right now, and the days will add up!**

Avoid: Alcohol, Caffeine, Smokers
Increase: Exercise, Activities, Healthy Foods and Drinking Water

E-Cigarettes

Public Health England produced a comprehensive report on e-cigarettes in August 2015. Although there remain some uncertainties key findings were:

- Smoking cessation providers who complete mandated National Centre for Smoking Cessation and Training (NCSCT) training are trained in assisting individuals who choose to use e-cigarettes as part of their quit attempt in how to do this effectively within a behaviour change programme. E-cigs (EC) offer a higher level of nicotine than Nicotine Replacement Treatments (NRT). NRT and as such are particularly useful for those with a high nicotine dependency.
- Encouraging smokers who cannot or do not want to stop smoking to switch to EC could help reduce smoking related disease, death and health inequalities.
- There is no evidence that EC are undermining the long-term decline in cigarette smoking among adults and youth, and may in fact be contributing to it. Despite some experimentation with EC among never smokers, EC are attracting very few people who have never smoked into regular EC use.
- Recent studies support the Cochrane Review findings that EC can help people to quit smoking and reduce their cigarette consumption. There is also evidence that EC can encourage quitting or cigarette consumption reduction even among those not intending to quit or rejecting other support. More research is needed in this area.
- When used as intended, EC pose no risk of nicotine poisoning to users, but e-liquids should be in 'childproof' packaging. The accuracy of nicotine content labelling currently raises no major concerns.
- There has been an overall shift towards the inaccurate perception of EC being as harmful as cigarettes over the last year in contrast to the current expert estimate that using EC is around 95% safer than smoking.
- Whilst protecting non-smoking children and ensuring the products on the market are as safe and effective as possible are clearly important goals, new regulations currently planned should also maximise the public health opportunities of EC.

E-Cigarettes have only been available for general use for the last eight to ten years and existing MOD guidance on their use was based on the very small amount of research available. There is now more evidence to support their use in helping people give up smoking, indeed the first e-cigarette was licenced by the Medicines and Healthcare products Regulatory Agency (MHRA) in November 2015. MOD policy complies with national smoke-free legislation[11] which applies to virtually all wholly or substantially enclosed public places and workplaces. There is no suggestion that e-cigarettes will be allowed to be used in any of these places, but the Smoking and Tobacco Control Working Group will examine how these products may be best used in helping reduce the number of people using tobacco products.

Alcohol Working Group:

The Alcohol Working Group brings together representatives from the single Services, the Civil Service and those responsible for different pathways including primary health care, Chain of Command and discipline. The aim is to deliver a strategic approach towards changing Armed Forces and Civil Service attitudes and culture regarding alcohol consumption. The strategy is based on education, staff development, leadership as well as discipline, education and training.

The initial role of this group is to baseline prevalence of hazardous, harmful and dependent drinking within military personnel and develop methods to counter these behaviours. Data analysis will underpin the planning and delivery of evidence based interventions including Alcohol Brief Interventions provided by health services, Chain of Command and E-learning. In addition there will be evidenced and effective education and training, sensible, military and civilian specific messaging and policy change including an examination of access and pricing. These actions should progressively contribute to a culture change and a reduction in alcohol use.

Sensible, moderate consumption of alcohol can play a part in creating unit cohesion, but the benefits must be balanced against the hazards of misuse. The majority of Armed Forces personnel manage social drinking in moderation, but some misuse alcohol despite the advice provided. Recent research has highlighted the negative effects of heavy, hazardous and binge drinking within the UK Armed Forces[12] including post-deployment violence, negative relationship change, major problems at home during and following deployments, intentional self-harm and post-traumatic stress disorder (PTSD).[13,14]

Brief Interventions (BIs). BIs targeting alcohol consumption are effective in changing people's drinking levels[15,16] with one meta-analysis study finding that heavy drinkers were twice as likely to lower their consumption 6-12 months after a brief intervention than heavy drinkers who received no intervention[17]. BIs also reduce the number of alcohol-related problems and health-care utilisation and associated treatment costs.[18] Two different types of BI are being rolled out over the next twelve months; Alcohol Screening and Brief Interventions in Defence Dentistry; and the Military Alcohol Brief Intervention (ABI). Following their trial, we will look to see whether a similar buddy system should be rolled out across the MOD Civil Service.

11 Smoking, Health and Social Care (Scotland) Act, Smoking (Northern Ireland) Order and the principles of the Health Act for England and Wales
12 Jones, E., & Fear, N.T. (2011). Alcohol use and misuse within the military: A review. International Review of Psychiatry 23: 166-172.
13 Fear, N.T., Iversen, A., Meltzer, H., Workman, L., Hull L, Greenberg, N., Barker, C., Browne, T. (2007). Patterns of drinking in the UK Armed Forces. Addiction 102(11): 1749-1759.
14 Tamkin, P., Rickard, C., & Chapman, S. (2014). Alcohol and the UK Armed Forces. Internal report produced by the Institute of Employment Studies/Cranfield University on behalf of the Defence Human Capability Science & Technology Centre (DHCSTC), MoD, Final Report No. UC_DHCSTC_12_P_T2_025_A66 v4, 20 May 2014.
15 Watson, H. (1999). Minimal interventions for problem drinkers: a review of the literature. Journal of Advanced Nursing 30:513-19.
16 Bien, T., Miller W., Tonigan, J. (1993). Brief interventions for alcohol problems: a review. Addiction 88:315-36.
17 Wilk, A., Jense, N., Havighurst, C. (1997). Meta-analysis of randomised control trials addressing brief interventions in heavy alcohol drinkers. Journal of General International Medicine 12:274 – 83.
18 Fleming, M., Mundt, M., French, M., Manwell, L., Stauffacher, E., Barry, K. (2002). Brief physician advice for problem drinkers: long-term efficacy and benefit – cost analysis. Alcoholism: Clinical and Experimental Research 26:36-43.

Alcohol Screening and Brief Interventions in Defence Dentistry

The regular attendance of Armed Forces personnel for periodic dental inspections makes this an ideal opportunity to implement systematic alcohol interventions.[19] The dental profession now promotes alcohol screening and the provision of brief alcohol advice, as part of an holistic approach which considers the patient's overall health.[20,21] Not only will this promote a reduction in alcohol consumption but will also provide much clearer and valid data regarding alcohol use.

Several screening tools have been designed to help identify the risk of a patient's alcohol consumption patterns, some of which can be adapted into a dental setting. The AUDIT-C[22] screening tool offers a short, practical version of AUDIT which is the "Gold standard" developed by the World Health Organisation.[23] The three questions within the screening tool review alcohol consumption frequency, quantity and the occurrence of heavy episodic "binge" drinking. Everyone attending for a periodic dental inspection will be asked to complete AUDIT-C as part of the standard medical history questionnaire.

The introduction of alcohol screening using AUDIT-C will use a validated method to establish the extent of alcohol consumption risk across the Armed Forces population. This will allow a direct comparison with the UK adult population to support or deny the previous research and develop an evidence based strategy for the Armed Forces. The use of AUDIT-C and the brief intervention is a first step in creating a cultural change and increased awareness around alcohol in the Armed Forces.

Development of a Military Alcohol Brief Intervention (ABI)

An alcohol brief intervention (ABI) is a short, evidence based conversation about an individual's alcohol consumption. When delivered in a structured, non-confrontational way, it is proven to be one of the most effective ways to reduce total alcohol consumption and episodes of binge drinking for periods lasting up to a year.[24] Personnel scoring positive for hazardous (at risk of future problems related to alcohol),[25] harmful (has experienced health problems directly related to alcohol) will be given a brief intervention comprising verbal prompts. For those identified as at risk of possible dependence and unable to function without alcohol, referral to their relevant medical facility will be offered.

In 2014, a military pilot study[26] was conducted to assess the utility of alcohol screening and brief interventions, delivered in a dental setting. It was demonstrated that from a sample of 319 Service personnel, alcohol screening using the AUDIT-C tool identified 39% as drinking above hazardous levels, when compared to 7% from the previous self-reported alcohol data. Although in this study the sample was small, it applied a systematic, nationally recommended approach to the identification of alcohol consumption levels and the results compare closely with other national studies using the same methodology.[27]

19 McAuley A, Goodall CA, Ogden GR, Shepherd S, Cruikshank K. Delivering alcohol screening and alcohol brief interventions within general dental practice: rationale and overview of the evidence. British dental journal. 2011;210(9)
20 Standards for Dental Professionals: General Dental Council; 2013. http://www.gdc-uk.org/Dentalprofessionals/Standards/Documents/Standards for the Dental Team.pdf.
21 Delivering better oral health: an evidence-based toolkit for prevention .2014. http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/319471/DBOHv3JUNE2014.pdf.
22 AUDIT = Alcohol Use Disorders Identification Test
23 Babor T, Higgins-Biddle J, Saunders J, Moneriro M et al. The Alcohol Use Disorders Identification Test , Guidelines for use in primary care, 2nd Edition, WHO 2001
24 Kaner EF, Beyer F, Dickinson HO, Pienaar E, Campbell F, Schlesinger C, et al. Effectiveness of brief alcohol interventions in primary care populations. Cochrane Database Syst Rev. 2007;2.
25 NICE guidelines (PH24): Alcohol-use disorders: preventing harmful drinking. https://www.nice.org.uk/guidance/ph24/chapter/glossary
26 Field (2014) A Service Evaluation of Alcohol Screening (Audit C) and the Delivery of Alcohol Brief Interventions in Defence Dental Centres. MSC Dissertation.
27 Ibid

The next stage of development is to conduct a pilot study to determine if the alcohol screening delivery model and ABI training is effective in determining, differentiating and responding to the alcohol needs of the Armed Forces population as a whole. Over the past 9 months Army health experts have developed close links with Public Health Wales (PHW). The alcohol lead for PHW has provided full access to their learning materials and, as a result, a version of their successful ABI package has been produced for military use. The aspiration is to roll out training though a Train the Trainer package to create alcohol advisors within military units. These individuals will be able to deliver an ABI on an opportunistic basis to the needs of those picked up at trigger-points e.g. at disciplinary proceedings, by welfare services or those showing alcohol misuse indications. They will also be able to deliver a presentation as part of a wider unit alcohol educational activity. The full components of the ABI package are:

a. One day Train the Trainer Course.

b. One hour training package for the delivery of ABIs appropriate for privates and JNCOs.

c. One hour training package for the delivery of ABIs appropriate to officers and SNCOs.

d. Educational alcohol awareness presentation for delivery within Units.

To deliver ABI training, HQ DPHC (Dental) has collaborated with Public Health Wales and developed an ABI training package for Defence dental personnel.[28] Initially, 20 Defence dental personnel will undertake the ABI Train the Trainer course. These individuals will train dental personnel within their region prior to the proposed roll out date early in 2016.

The Defence Human Capability Science and Technology Centre is researching evaluation methods for ABI Work on this project is due to complete in early 2016.

Drug misuse

The MOD's policy is 'zero tolerance' to the misuse of drugs. Where an individual is found, through Compulsory Drug Testing (CDT) or other investigation, to have taken controlled drugs, the individual will normally be discharged from the Service, unless there are exceptional circumstances, which will be subject to single-Service direction.

The Armed Forces Act 2006, updated by the Armed Forces Act 2011, provides for the testing of drugs in specified circumstances on Service personnel. Acting under AFA06, the CDT programme conduct random drugs testing to ascertain whether a Service person has or has had drugs in their body. Here 'drugs' means a controlled drug, as defined by section 2 of the Misuse of Drugs Act 1971. At the time of writing, it is unclear what impact the Psychoactive Substances Bill[29] may have upon the CDT programme.

In 2013/14, around 0.5% of those tested opportunistically,returned a positive result. From 2010-2014 there have been between 600-700 positive tests per annum. These figures do not reflect the overall size of the issue as they do not include data in relation to courts martial, civil court appearances, administrative action, voluntary admissions, or medical referrals. We are exploring most efficient way of bringing this data together.

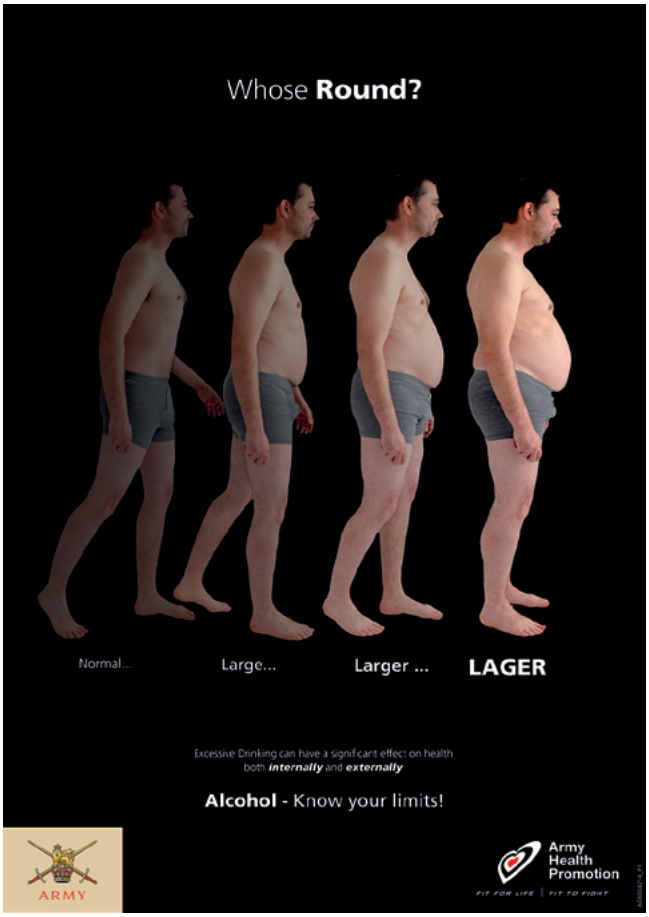
29

28 Public Health Wales." Have a Word" Campaign. http://www.haveaword.org.uk/Home.aspx

29 Having, completed the House of Lords and had it's First Reading in the House of Commons 21 Jul 15.

Weight Management and Obesity

Increasing rates of obesity are found in many Western populations, affecting all age groups and selected populations such as the military as well as the general community. Multiple risk factors include; unhealthy eating patterns, poor nutritional choices, increased sedentary behaviour, reduced physical activity requirements and hazardous alcohol consumption with associated calorific intake[30]. Growing numbers of individuals are identified as at increased health risk due to their weight. The implications of this trend relate not only to individual wellbeing, but to occupational outcomes, increased sickness absence rates, Musculo-skeletal injury (MSKI) rates in particular back pain and poorer mental health[31]. Within a military environment the existence of this trend has the potential to impact on both productivity and operational deployability. Multiple weaknesses in current data collection systems, resulting from a non-systematic approach to measurement and inadequate representation, make an accurate estimate of military prevalence difficult to achieve. Current weight management policy requires updating to reflect the current national evidence base on the delivery of an effective weight management and obesity pathway.[32]



Opportunities to promote a positive healthy eating and active culture in addition to moulding environmental factors to promote positive lifestyle choices exist, but are not yet being maximised. The following actions have therefore been taken:

- The 1* Lifestyles Working Group has endorsed the development of a Weight Management and Obesity Strategy informed by an expert stakeholder group. This will revise and update the current MOD weight management policy.
- The development and delivery in 2016 of a Defence Occupational Fitness Programme providing an expert based weight management programme, delivered by advanced health trainers.
- Investigation of a systematic, tri-service, evidence based approach to weight measurement to identify baseline prevalence and target groups.
- The design and delivery of an effective and cost effective weight management and obesity pathway applicable to those who are underweight through to those who are morbidly obese.
- Development of a multi-component plan through contracting, education, training, access and messaging to alter the cultural and environmental factors that underpin risk factors for obesity.
- Planned implementation of evidence based single Service, mandated fitness policies with 100% uptake minus exemption, reflecting tri core standards in both fitness testing and in fitness pathways for those downgraded.

Key strategic objectives will include the revision of the weight management policy to reflect evidence, best practice and NICE guidance including the establishment of a reliable, tri-service approach to weight measurement

30 Foresight Report (2007): Tackling Obesity: Future Choices. Project Report – 2nd Edition. Government Office for Science.
31 National Obesity Observatory (2010): The Economic Burden of obesity.
32 DH (2011): Healthy Lives, Healthy People: A Call to Action on Obesity in England.

and the implementation of cost effective and accessible interventions in weight management, reflecting current technology.

Additionally all single Service fitness/physical activity policies will be reviewed to establish tri-service standards in recruitment, testing and approaches to downgrading, reflecting changes in age and circumstance. Both areas of work will need to be based on Needs Assessment including evidence reviews around sedentary working and healthy workplaces.

Positive cultural/environmental change will take time and investment. A 5 year plan incorporating Defence wide application of INM/Nutrition WG learning, establishment of nutritional standards through application of evidence, contract monitoring and contract negotiation and assessment and revision of retail based access to unhealthy choices will be developed in 2016. In addition the strategy will ensure the incorporation of healthy eating and nutritional standards information across the Education and Training life course of both military personnel and relevant service providers.

The Defence Occupational Fitness Programme

The Army and Navy are conducting a trial for those with weight management problems to learn how to make long-lasting lifestyle changes with the goal of improved resilience to injury, mental and physical performance, and operational effectiveness. The two Services are sponsoring several iterations of the Defence Occupational Fitness Programme (DOFP) over 2016 which will then be evaluated ahead of potential Tri-Service adoption.

What is the problem with our occupational fitness?

Prevalence projections suggest that the UK population will be mainly obese by 2050.[33] As the Armed Forces recruit primarily from this population, the emergence of obesity as a distinct disease[34] could have far reaching consequences. Evidence indicates that obesity and poor physical performance capacity are incompatible with the demands of a military career and can degrade operational effectiveness.[35],[36] An MoD sponsored research study published in 2012 further added to our understanding of the scale of the obesity challenge in the British Army.[37]

In the short-term, being overweight or obese increases the risk of, and leads to slower recovery from, musculo skeletal injury (MSKI). Longer term, the risks are cardiovascular disease, type 2 diabetes, some cancers, disability, mental health instability and premature mortality[38].

So what are we doing about it?

This threat from poor occupational fitness was recognised in the Defence Health Strategy – Defence Health Agenda Framework 2007 which listed the reduction of obesity as one of the eight main focus areas. The Services Personnel Operating Board (SPOB) then directed the development of a weight management policy.

In turn an 'Army Obesity Conference' organised by the Health Branch, Army HQ in Aug 14, presented the findings of the Sanderson study, and explored shortfalls in our current strategy for managing individual soldiers with weight management issues. It was found that advice and guidance on weight management strategies and interventions for individual soldiers was lacking and must be provided.

33 Kopelman, P., Jebb, S.A., & Butland, B. (2007). Executive summary: Foresight 'Tackling Obesities: Future Choices' project. Obesity Reviews, 8 (suppl 1), 6-9.
34 Prentice, A.M., & Jebb, S.A. (2004). Energy intake/physical activity interactions in the homeostasis of body weight regulation. Nutrition Review, 62 (Suppl), s98-s104.
35 Kyrolainen, H., & Nindl, B. (2012). Preface – Body composition and military performance: Many things too many people. Journal of Strength and Conditioning Research, 26(7), /S1.
36 Dystad, S.M. (2007). Physical fitness, training volume, and self-determined motivation in soldiers during a peacekeeping mission. Military Medicine, 172(2), 121-127.
37 Sanderson P., (2012) Obesity in the Army: prevalence, correlates and predictors. The research was the result of a joint tasking by HQ RAPTC and Army Health Promotion and the output is linked to doctoral studies with Loughborough University.
38 Bennett A et al. (2011) Body Mass Index and Changes in Body Mass in Royal Navy Personnel 2007-2011. Institute of Naval Medicine Report 2011.044.

As a result DPS(A) tasked the Army Health Branch to scope and produce an intervention programme that is:

- evidence based;
- scientifically valid;
- multi-disciplinary (i.e. addresses all the contributory factors to weight problems) and
- will increase individual understanding and awareness of the benefits of adopting a through-career healthy lifestyle and of making positive health choices.

The Defence Occupational Fitness Programme (DOFP) is currently being trialled by the Royal Navy and Army in anticipation of it being adopted by all three services, if the 2016 trials prove successful. Currently the course is only available to military personnel.

Who is working on the DOFP?

The DOFP is collaborative. The staff lead is SO1 Army Health, who chairs a working group of SMEs drawn from, among others, the Institute of Naval Medicine, Public Health England, Defence Primary Healthcare, Defence Medical Rehabilitation Centre, HQ Royal Army Physical Training Corps and single Service Physical Education branches.

How will it work?

The WG recognised that obesity is a multi-factorial condition linked to a combination of physical inactivity, diet and metabolic factors, moderated by genetic factors. It also identified the importance of behavioural change strategies in effecting long term change towards healthy lifestyle choices.

The DOFP will provide an intervention programme called 'DO_Fit', which will support individuals to improve their physical activity habits, develop healthier eating behaviour, and hence promote occupational fitness, health and wellbeing. The DO_Fit will be a 5 day residential course for selected individuals and will include tailored physical development and eating programmes, lessons in cooking and food labels, goal setting and motivation sessions. After the course the participants will receive ongoing 'check in' sessions with their own PTI to receive support and monitor progress.

The DO_Fit courses will be delivered by Defence PTIs who have received additional training to become a 'Defence Health and Wellbeing Advisor' (DHWBA). This training will likely be residential and will provide experienced PTIs from across Defence with enhanced training in health and behavioural change coaching skills.

How will the DOFP benefit individuals?

The DOFP aims to provide individuals with long-term support and behaviour change strategies to address poor lifestyle choices and weight management issues. The DOFP will educate and raise awareness of the impact that poor lifestyle choices can have on fitness and health, and ultimately operational effectiveness. Behavioural self-awareness is at the core of the programme.

With a strong component in increasing individual resilience to injury, the DOPF also aims to reduce the incidence of MSKI in individuals with occupational fitness issues.[39]

How will the DOFP benefit wider Defence?

Whilst the DO_Fit courses are aimed at individuals, the programme will also have a wider impact on Defence through the development of evidence-based learning resources, enhanced training of PTIs and a 'cascade-effect' of healthy behaviour information and knowledge.

39 MoD Report -Army Med Discharges in the UK Regular Armed Forces 2009-2014 over this period 6,391. MSKI most common cause of discharge across 5 years - 3697 (60%) due to MSK disorders. DGAMS estimate that MSKI costs circa £100 M per year.

The DOFP aims to improve awareness of the:

- Importance of targeted physical conditioning to promote general health and reduce risk of MSKI.
- Influence of diet and nutrition on performance and operational effectiveness.
- Impact of healthier lifestyle choices on force readiness and robustness.

The DOFP aims to inculcate a Defence-wide, through career, positive culture towards fitness, health and wellbeing.

When will it start?

The pilot DH&WBA courses have already taken place and the plan is to deliver four pilot DO_Fit courses: two each for the Army the RN in summer 2016. Measures of success will be reported through the Lifestyles Working Group.

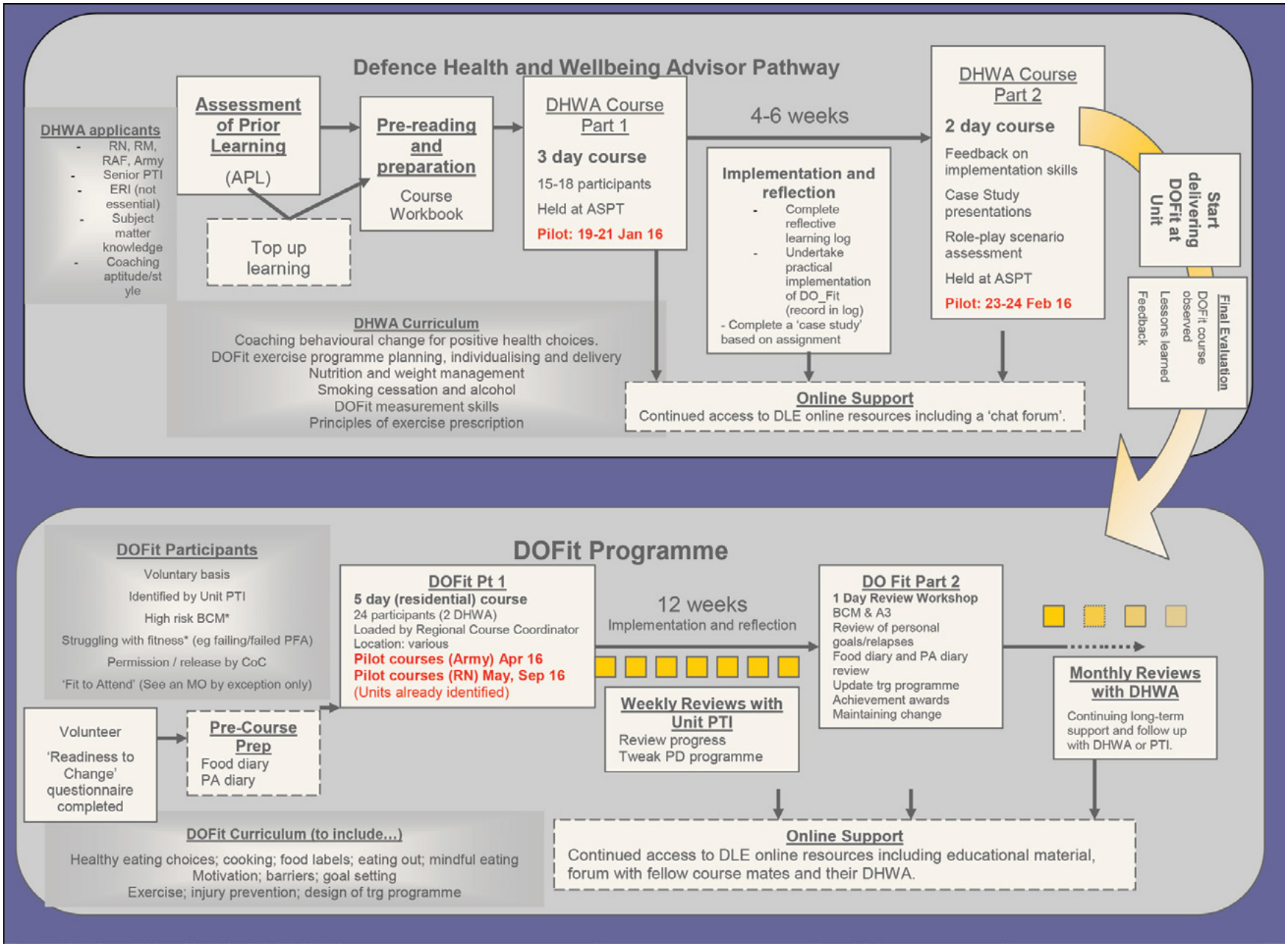


Figure 3: The DOFP delivery model

MOD Civilian Employee Wellbeing Service

The cost of sickness absence has increased from £48.2M in financial year 2013-14 to £50.2M in financial year 2014-15. Mental and behavioural disorders continue to be the largest cause of sickness absence for Non-Industrial personnel accounting for 23 per cent of the total. The largest cause for Industrial personnel is diseases of the musculo skeletal system accounting for 28 per cent of the total.

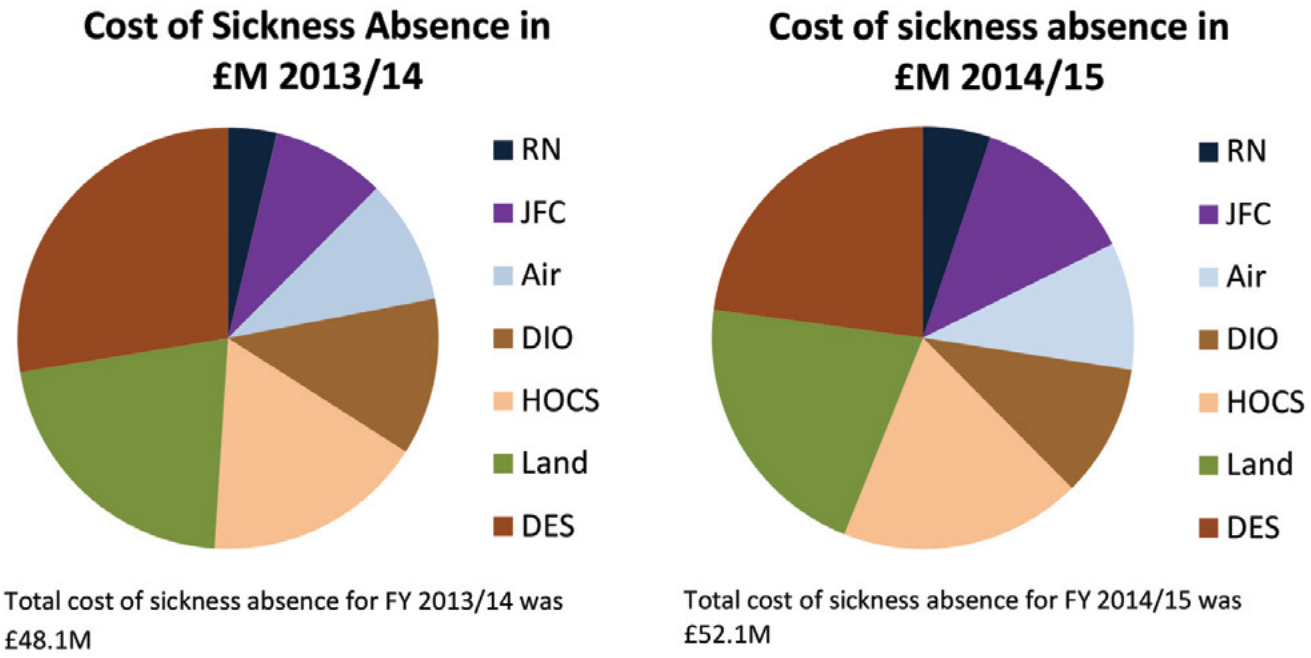


Figure 4: Cost of civilian sickness absence 2014-15

The Employee Wellbeing Service (EWS) is a comprehensive and holistic integrated service providing confidential and emotional support to either individuals or line managers. The service is provided by Defence Business Services and signposts people to sources of assistance for all issues that impact on an individual's performance or attendance. The service incorporates an EWS Helpline and experienced Wellbeing Consultants based in regional hubs.

The EWS telephone based service provides independent emotional support and assistance to individuals on a range of personal and work related issues including:

- long term sick rehabilitation;
- bullying and harassment;
- terminal illness, injury or medical retirement;
- signposting to other forms of assistance on relationship, addiction or financial problems;
- death in service and bereavement; and
- stress

Wellbeing consultants are trained to provide emotional support, post trauma support and information on a wide range of wellbeing issues. The wellbeing team is made up entirely of MoD employees and so have a working knowledge and understanding of its structures, working practices and HR policies.

Line Managers have primary responsibility for the wellbeing of their staff, but if additional support is required or the line manager is unable to help or if it is inappropriate to involve them then the EWS is available to assist. Line Managers are encouraged to seek assistance from the EWS when dealing with sensitive or challenging staff issues.

The DBS EWS Civilian Staff Counselling Service is a telephone based confidential service; its aim being to reduce sick absence attributable to work related stress. The service offers time set aside to explore the causes of work related stress and will involve sharing feelings, emotions, relationships, and ways of thinking and patterns of behaviour. Counsellors are professionally qualified, impartial and registered with the British Association for Counselling and Psychotherapy (BACP) and adhere to the Ethical Framework for good practice in Counselling and Psychotherapy. The counsellors will work with you collaboratively to decide on achievable goals or help you to develop alternative ways of coping. Talking through these issues may take time and will not necessarily all be concluded in one session. Eligibility to use the service requires the individual to be at high risk of incurring sick absence due to stress factors which are impacting on attendance or effectiveness in work and the individual is not receiving counselling from other sources including NHS, IAPT or Private Practitioner.

CHAPTER 3 - MENTAL HEALTH

Mental Health

Assessments for mental disorders at MOD Specialist Mental Health Services have risen steadily from 1.8% of UK Armed Forces personnel in 2007/08, to 2.9%in 2014/15[40]. It is unclear what proportion of this rise is due to the success of anti-stigma campaigns and what is a true rise in mental health problems and disorders. This rate is a bit higher than seen in the UK general population (2.4%)[41] and may be due to a lower referral threshold to specialist psychiatric care in the Armed Forces compared to the UK general population where patients may be treated wholly in primary care. Conversely, rates of in-patient admissions within the UK Armed Forces population for 2014/15 were lower than the rates in the UK general population (0.2% and 0.6% respectively). This reflects the much lower rates of severe and enduring mental health disorders in the selected military population.

Studies of a sample of the military population and their mental health have been carried out since 2004 by the King's Centre for Military Health Research (KCMHR) at King's College London. Two surveys, one published in 2006 and one in 2010 show rates of mental health problems have remained relatively stable: Rates of Post Traumatic Stress Disorder (PTSD) were about 4% in both studies and common mental health disorders were 20% and 19% respectively, with little difference between those who have deployed on operations and those who have not. Nevertheless there are higher rates in some groups: Combat unit personnel have a 7% rate of PTSD, and the rate in Reservists is 5%, and in those aereomedically evacuated that rate rises to 18%. Alcohol misuse is common in the Armed Forces at 13% overall (compared with 6-8% in the civilian population) and 16% in those deployed and 22% in those exposed to combat[42].

KCMHR is currently undertaking a further phase of its cohort study, which will collect data until 2016 and enable the publication of peer-reviewed research papers.

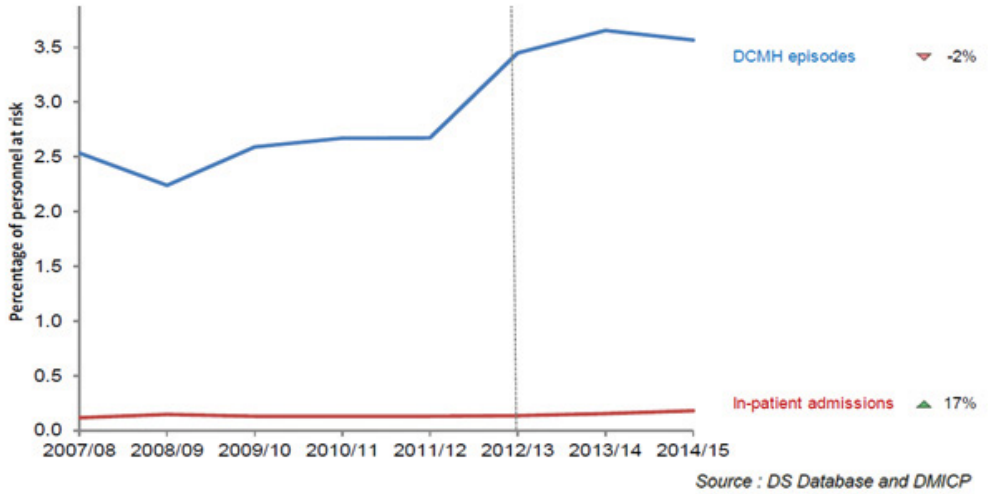


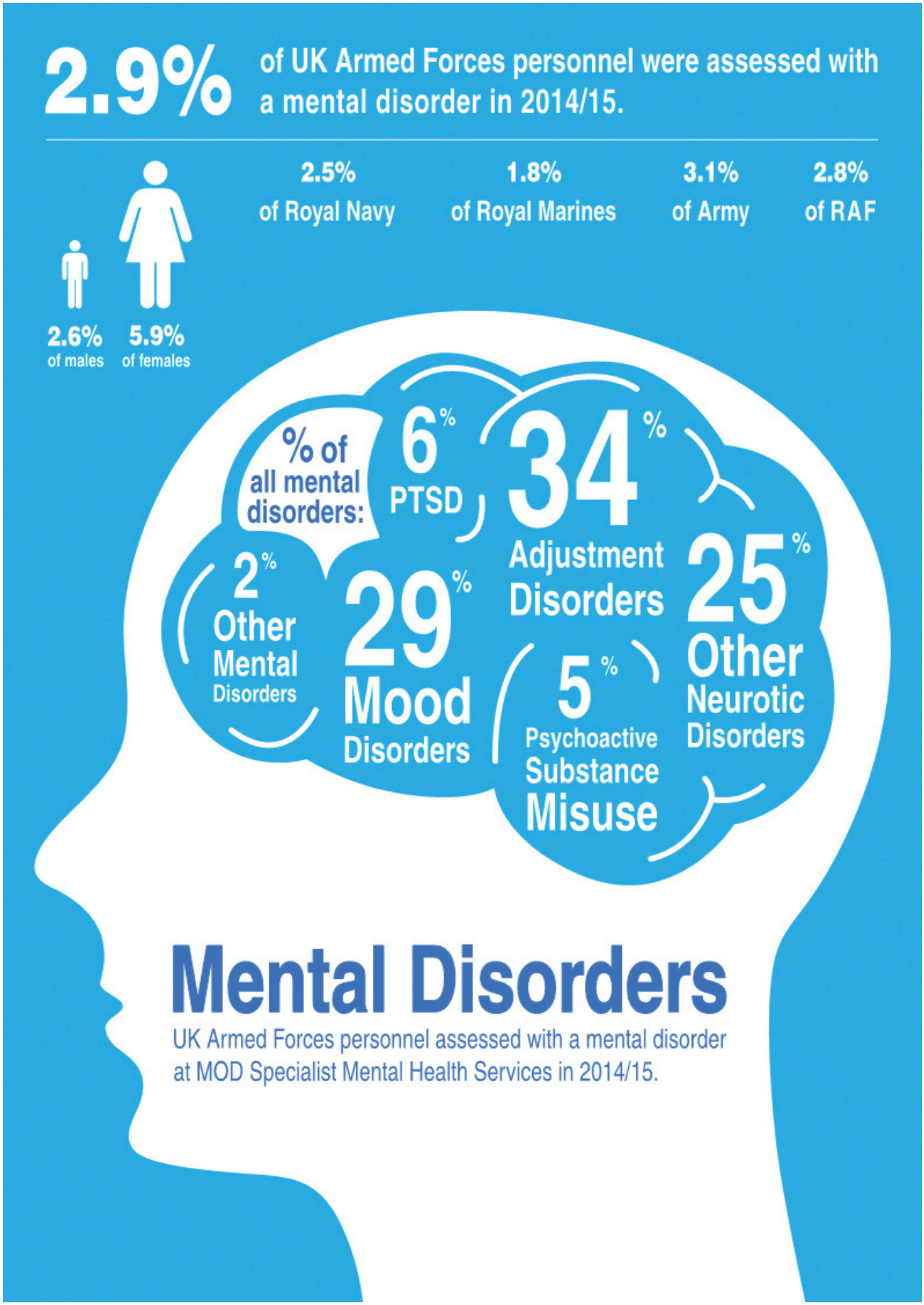
Figure 5: UK Armed Forces personnel assessed with a mental disorder by Departments of Community Mental Health and Inpatient Admission[43]

40 Source:https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/451062/20150803_Annual_Report_14-15_Revised_O.pdf

41 Ibid.

42 What are the consequences of deployment to Iraq and Afghanistan on the mental health of the UK armed forces? A cohort study. Nicola T Fear, Margaret Jones, Dominic Murphy, Lisa Hull, Amy C Iversen, Bolaji Coker, Louise Machell, Josefi n Sundin, Charlotte Woodhead,Norman Jones, Neil Greenberg, Sabine Landau, Christopher Dandeker, Roberto J Rona, Matthew Hotopf*, Simon Wessely

43 Source: https://www.gov.uk/government/statistics/uk-armed-forces-mental-health-annual-statistics-financial-year-201415


2.9%
of UK Armed Forces personnel were assessed with a mental disorder in 2014/15.
2.5%
of Royal Navy
1.8%
of Royal Marines
3.1%
of Army
2.8%
of RAF
2.6%
of males
5.9%
of females
% of all mental disorders:
6%
PTSD
34%
Adjustment Disorders
25%
Other Neurotic Disorders
2%
Other Mental Disorders
29%
Mood Disorders
5%
Psychoactive Substance Misuse
Mental Disorders
UK Armed Forces personnel assessed with a mental disorder at MOD Specialist Mental Health Services in 2014/15.

Defence Academy Launches First Ever Practical Stress and Psychological Resilience Course

Until August 2014, the MoD had no holistic psychological wellbeing programme solely dedicated to providing all Defence people with the knowledge and skills to deal with situations they might find difficult, thus reducing their stress and building their psychological resilience. Operational Stress Management training has been well-established in Defence for many years. Single-Service pre- and post-operational stress management programmes provide a robust channel for units to understand care access and to provide personnel with care-signposting at the right level through interventions including the Trauma Risk Management (TRiM) programme. In addition the single Services run other interventions such as suicide awareness training.

In recent years general awareness and concern in the UK about mental health symptoms and illness, including the effects of workplace stressors, their prevention, early detection and effective treatment has increased and Health and Safety regulations now apply to stress in the workplace. From 2013, the Defence Academy's Stress and Resilience Training Centre, part of the Beckett House Leadership Centre, dedicated itself to developing a programme to achieve the Chief of Defence People's vision for training Defence people with the right skills, stamina and mind-set to succeed on operations and in wider departmental workplace settings and business. The Centre focussed on giving Defence people, military and civilian, the skills and techniques to build psychological stamina and a resilient mindset, as part of a Primary Prevention Programme, in order to build resilience rather than look only to treat the symptoms of stress. The programme, called START Taking Control, was developed with a team of Defence people including Clinical and Occupational Psychologists and staff at the Stress and Resilience Training Centre in partnership with the Psychology Faculty at the University of East London and in consultation with the Oxfordshire NHS Health Trust.

START Taking Control Programme

Since August 2014, we have trained over 1,600 personnel from across Defence in 25 locations in the UK and at Defence locations overseas. The training is about whole life psychological wellbeing, recognising that working within Defence impacts on home life and home life can impact on work life. Delegates are taught practical tools to enable them to reflect on their actions and work out how their thinking can positively impact upon their behaviour. Resilience is a large component of the training with the key learning points focussed on building success and finding positive outcomes in one's life to enhance wellbeing. To complement this, delegates also get the opportunity to practise various 'in the moment' stress-reduction techniques and work out how they can drastically increase work productivity. The UK Government's Foresight programme estimated that presenteeism costs the UK economy £15.1 billion each year and the perceived stigma behind stress-related illness forces people to remain in or go back to work, even if they are sub-productive.

START Taking Control Foundation. The Foundation module provides individuals in Defence with the skills and knowledge to understand what stress is, what it does to the mind and body, when it is and is not appropriate and how to combat the ill-effects of chronic stress as well as tackle stress in the moment. It seeks to also build psychological resilience by giving methods for identifying and combatting negative thought patterns.

START Taking Control Practitioner. The Practitioner Course, aimed at leaders and managers, enables them to identify stress within their teams and provides methods and techniques for building team resilience through effective problem solving, developing positive psychology and strengths awareness and development, as well as providing information on where they can signpost, and seek, support.

START Taking Control Trainers' Course. The Trainers' course will be a 'Train the Trainer' programme which will qualify established-unit training personnel to deliver the Foundation- and Practitioner-level courses, enabling swift dissemination of stress management and psychological resilience training across Defence. This course is under development and is intended to commence in Spring 16.

START Taking Control Training for Senior Leaders. It is recognised that Senior Military and MOD personnel require a bespoke training intervention, in order to provide them with the knowledge to assimilate organisational

stress management issues across Defence and understand Defence direction on enhancing human and cognitive performance. The Stress and Resilience Centre is in the process of working with the University of East London and key stakeholders in Defence to develop a programme for senior leaders that can be incorporated into existing training and education.

Feedback from Delegates

'I attended the Foundation course 8 weeks after my diagnosis of "compound anxiety disorder, precipitated by Post Traumatic Stress Disorder and stress at work". The course design illuminates common symptoms of stress, explains them and then counters them by exposing the student to relevant and achievable exercises – instantly empowering them – and offering solutions for future reference. The Practitioner course, designed to enable Line Managers to recognise, understand and (where appropriate) tackle workplace and team stress and build team resilience, is a natural progression. As you would expect, it builds on the concepts introduced in the Foundation module, but then offers further insight into identifying stress, both within yourself and your team, and the methods to counteract it and enhance the workplace experience.

I firmly believe that were I exposed to this training earlier and its relevance to front line units, I might have approached whole aspects of my employment differently and perhaps evaded my diagnosis altogether'.

Army Major

'Of particular interest was the lesson on warning signs and symptoms. This lesson explored cognitive and behavioural systems of stress. 'When reflecting on this and transactional analysis awareness, it provoked my thoughts on past challenges the Squadron has been tasked with and further highlighted the need to manage stress far more astutely if a healthy work/lifestyle balance was to be achieved. The contents of both the foundation and practitioners course are very relevant when dealing with the pressures that our Service personnel are subjected to. Having the background knowledge to draw upon when managing myself, team and students has considerably contributed to maintaining team morale, whilst achieving output and ensuring students reach their potential'.

Royal Air Force SNCO

'I openly admit that at times I have been a 'stress-head', when experiencing 'Strain'. That said, I have, 'firmly boxed my chimp'. The lesson on 'What is Stress' hit it home for me in particular, reconfiguration resilience. This has allowed me to cope with adversity (where in the past this was not so easily the case) by growing and bouncing back stronger without emotion. In-turn this has seen my own health and wellbeing positively increase and has allowed me a free-thinking perspective of the issues we face as leaders, managers and that too of our instructors and students all of whom now seek my advice on the varying stressors they are continually subjected to.'

Royal Air Force, SNCO

Instructors and Management staff of CTS trained in the START Taking Control Course

Civilian Aspects of Mental Health and Wellbeing in the Workplace

The military environment is recognised as particularly challenging psychologically notably in combat situations. Mental health symptoms and illness can occur in Defence personnel, military and civilian, affecting function at work but not always due to combat, or work. Mental health problems are always multifactorial. They are common affecting one in four people[44] in the UK general community at some point in their life; and, nearly nine out of ten people who experience mental health problems say they have faced stigma and discrimination which can actually be worse than the symptoms themselves.

One of the key work strands in the Health and Wellbeing Strategy is to improve our understanding of mental health, how poor mental health can affect us and the colleagues around us and how we can support people who are experiencing problems including tackling stigma and discrimination.

Mental and Behavioural disorders account for 22% of civilian sickness absence across the Department[45]; the highest cause of Long Term Sickness, with data suggesting that this is harder to manage than more identifiable and physical illness.

All of us have mental health as we do physical health and both can fluctuate so what may be a minor issue one day could be a major problem the next. What is important is that mental health problems are supported in the same way that physical ailments are.

While mental health can seem like a difficult subject to tackle, you don't need to be an expert in mental health to support your staff or colleagues; in fact, Line Managers have a key role to play in improving and maintaining mental wellbeing in the workplace. Having open conversations with staff about their mental health, providing support and creating a culture of positive mental wellbeing within your team can make a big difference to how staff are able to manage stress and other mental health problems.

Line Managers are not expected to have all of the answers; however, they are well placed to notice when a problem begins to affect work performance or attendance. The available in-house services and training will enable, managers to support and guide staff to appropriate help for example the Employee Wellbeing Service, Reasonable Adjustments Team or Occupational Health.

The Employee Wellbeing Service and Reasonable Adjustment team have also recently enhanced their services to assist Line Managers and individuals who are coping with mental ill health.

Civil Service Mental Health Awareness Training

A Mental Health Awareness training course has been developed through Civil Service Learning to provide delegates with an understanding of mental health issues. The course explains the challenges that staff with mental health conditions can face, the common fears and misapprehensions some people may have about mental health and the impact these factors can have in the workplace. The workshop is aimed at Line Managers, but is open to anyone Civilian or military. The course teaches inclusive management principles which promote more open dialogue, better decision-making and a more diverse and inclusive workforce. Importantly, Line Managers will be able to identify when to seek professional help.

Training happens every month in various locations across the UK. Group bookings of up to 16 people can be catered for and the team will deliver at your location providing good value for money.

44 Source: http://www.mind.org.uk/
45 MOD Civilian Personnel Sickness absence Quarterly Report Aug 15.

Civil Service Reasonable Adjustments Service Team

The Reasonable Adjustments Service Team took on mental health issues from the beginning of July 2015. Staff who may require assistance from the team for mental health reasons, can contact them using HR Form 250. Whilst there is no one size fits all adjustment solution and each management area will have its own constraints in terms of options, there are often little changes that can be made to help which make a big difference. Many mental health conditions relapse and remit so adjustments are often temporary. The most important thing is for the Line Manager to have a discussion with the person to ask them what they think might help, to seek occupational health advice when appropriate and, when agreeing a way forward, do so with a structured plan with clear dates for review.

The Reasonable Adjustments Service Team is on hand to provide advice to MOD civilians and their Line Managers. Types of Reasonable Adjustment which might be relevant include:

- A phased return to work if the person has been on sickness absence starting with part-time working and building up to a full return. We recommend a maximum of eight weeks for a phased return. If the individual feels they need longer you could look at options for part time working.
- Offering the option to work from home for some of the time.
- Looking at aspects of the job that the person finds particularly stressful and rearranging responsibilities and/or timescales for tasks.
- Allocating some of an employee's duties to another colleague and adjusting the content of the job.
- Altering working hours e.g. reducing hours worked or offering a later or earlier start to avoid rush hour travel and review if any provisions are necessary or useful in terms of their physical health.
- Look at their physical environment and review what adjustments would be desirable. e.g. moving away from a busy corridor, allowing a person to use headphones to block out distracting noises.
- Offer a quiet place where they can go if feeling anxious or stressed
- Regular pattern of attendance during a phased return to work plan (it is beneficial for employees to have a routine rather than attempt to attend work when they feel well enough).
- Encourage the use of the Individual Assessment & Stress Reduction Tool to identify and deal with any triggers.

Having a structured plan in place can help the employee to see there is a commitment to helping them back to work and make them feel that they are making progress. A summary of the discussion should be recorded on the HR Form 2377: Fit for Work Planand the open and closed dates of the fit for work plan should be recorded on HRMS.

Longer term adjustment considerations could be:

- Allowing time off for attending therapeutic sessions; treatment, assessment and/or rehabilitation.
- Changing shift patterns or exploring different work options such as part-time, job-share, flexible working if the business can sustain.
- Identify training needs and provide support to develop the skills of the individual and their colleagues; e.g. specific job requirements and/or around skills enhancement such as communication skills or time management.
- Transferring the individual to another vacancy within your organisation. This clearly depends on a suitable job being available and will usually be a last resort once all reasonable adjustments have been fully explored in the individual's existing role.

CHAPTER 4 - INJURY PREVENTION

Prevention of traumatic physical injury supports good health, maximises deployability rates and contributes to operational effectiveness. Over the past 5 years more than 6,000 people had been medically discharged from the Army alone and almost 20 per cent of Service personnel have restrictions placed on their deployability. The Injury Prevention Working Group has been established to increase the number of personnel we have available to deploy and find ways of avoiding preventable injuries. As with the other one star working groups Injury Prevention is supported by a number of sub-working groups that specialise in particular subjects:

Joint Medical Employability Standards

Prior to November 2009, all three Services used variations on a common theme to describe medical employability. As such no common denominator existed, direct comparisons could not be made; to resolve this, a Joint system of classification was introduced - the Joint Medical Employment Standards (JMES) classification system - to be awarded by medical staff to inform commanders and career managers of the deployability and employability of Service personnel (SP). Specifically, the JMES describes the deployability (Medical Deployment Standard (MDS)), functional and geographical employability (Medical Employment Standard (MES)) and specific medical limitations (MedLims) of SP:

- **Medical Deployment Standard (MDS).** An overall 'deployability' summary coding with the sub-categories of Medically Fully Deployable (MFD), Medically Limited Deployability (MLD) and Medically Not Deployable (MND);
- **Medical Employment Standard.** An alphanumeric code combination reflecting an individual's fitness to be employed in the Air (A), Land (L) and Maritime (M) environments together with any additional specific Environment and Medical Support (E) considerations, eg A4 L1 M1 E1.
- **Medical Limitations.** Medical classification codes (MedLims) would be applied as necessary and visible on JPA, eg RAF Code 116 – unfit handling live arms.

The RN and RAF adopted the classification in its entirety but the Army only adopted the MDS element. Whilst this did not alter routine single Service internal practice, this meant that only MDS data was available for reporting to the Defence People and Training Board (DPTB) and the Defence Board (DB). Modifying JMES functionality to promote consistency of use and harmonisation should provide better information for the Executive decision-making processes and the ability to offer more accurate information to the DPTB and the DB.

The JMES Harmonisation Working Group (HWG) was created and recommended modifications to the JMES system to harmonise the way single Services currently use the JMES classification system for advice on employability to commanding officers and Service employment authorities. The aim was a system which was effective, consistent and equitable across the Services. Decision-making centred on an evolution of the current JMES classification (noting that the principles underpinning this are well established across the three Services and data management systems are already in place through the Defence Medical Information Capability Programme (DMICP) and Joint Personnel Administration (JPA)).

The JMES HWG presented its report to the Defence People Health Injury Prevention Working Group in Feb 15. The perceived benefits of the modified system are:

- **Strategic.** Evolution of the established JMES functionality will promote consistency of use and recognition of the importance of MES element thus providing better information for Executive decision-making. It will offer more accurate information for the DPTB and the DB and enhance the ability of commanders at all levels (strategic, operational and tactical) to practise safe systems of working.
- **Operational.** Provision of employment detail, with enhanced granularity and uniformity of application, will benefit PJHQ by enabling better definition of operational employability requirements. Force generation across the single Services will be clearer and more harmonised.

- **Tactical.** Implementation presents an opportunity to introduce effective quality assurance of employment medical advice placing greater emphasis on and allowing measurement of safer employment of Service personnel.

The DPHB considered the JMES HWG report and options for implementation. It is intended to have a 'go-live' date of Jul 16. Funding has been approved and preparations for implementation are advanced. Every effort will be made to ensure the transition is as straightforward as possible, including the development of a comprehensive roll-out information and training package. The implementation process presents an opportunity to improve medical officers' understanding and application of JMES thereby enhancing the ability of commanders at all levels (tactical, operational and strategic) to employ Service personnel safely.

Resilience

In other sections of this report the issue of obesity and physical unfitness is discussed and there is much concern, despite the legacy of hosting the Olympics and other events, that young people in the UK to-day are increasingly physically inactive and so for many young people joining the military and initial training can be a profound challenge. Musculo-skeletal injury is the most common cause of medical discharge including early medical discharge and MSK problems can also blight careers and impact on deployability and operational capability. Increasingly, account also needs to be taken of gender differences. The Army is leading on a new approach to fitness in order to:

- **PROMOTE.** Promote an environment which is favourable to good Musculo-Skeletal health and in which the risk of MSKI is minimised. To include: development of healthy culture, lifestyle choices, education and awareness.
- **PREVENT.** Prevent the occurrence of MSKI injury by increasing individual resilience to injury, reducing and mitigating injury-causing behaviours and activities. This will primarily be addressed through a comprehensive review and change to physical development regimens to increase physical conditioning for the rigours of modern Army life and reduce the likelihood of overuse injuries.
- **RAPID RETURN TO FITNESS.** Return SP back to operational fitness as rapidly as possible following injury through an optimised, fully resourced rehabilitation pathway.

Physical toughening and tempering are key components of resilience. Low aerobic fitness, flexibility, strength and muscular endurance are common risk factors for injury and medical discharge during initial training courses. To avoid injury it is essential that the body is adequately conditioned to meet the physical demands of the role. Part of the drive to reduce MSKI includes the Army's development of the 'Big 5' exercises designed to complement individual and unit physical training programmes. These are illustrated below:

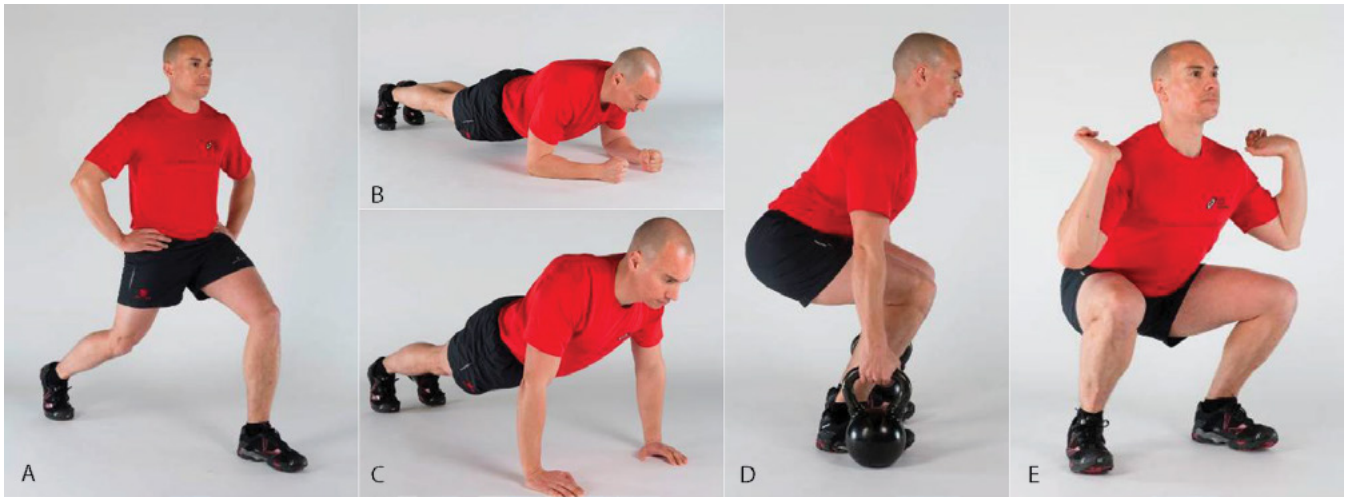


Figure 6: The Big Five – Army initiative to reduce MSKI prevalence

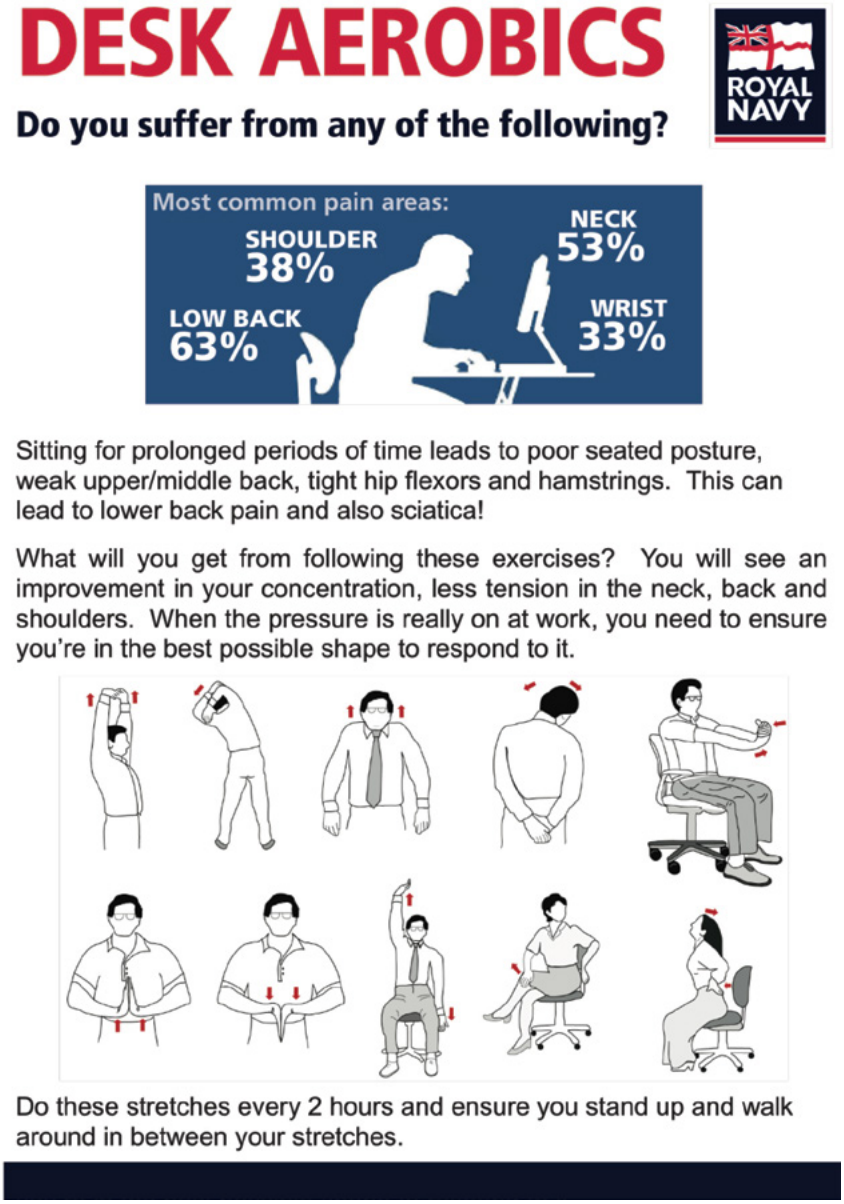


Figure 7: A Navy Command Headquarters initiative to avoid MSKI caused by working for prolonged periods behind a desk.

Cold Injury Working Group.

The main effort of the Cold Injury Working Group (CIWG) is on non-freezing cold injury (NFCI). NFCI is poorly understood as confirmed by a report by the Independent Medical Expert Group (IMEG) which was commissioned and reported in 2013. During 2014/2015 the CIWG has focussed on taking forward the recommendations. Changes have been made to primary care management with the establishment of a NFCI management network in DPHC with each region having a nominated NFCI lead. Guidelines for primary care are under development through a GP led WG. One of the key Report findings was the lack of suitable research on definition, diagnosis, assessment, treatment and longitudinal course of the disorder. Some epidemiological research has been commissioned, but more funding is needed to cover the full research requirement. Reporting of NFCI is a concern and Defence Statistics (Health) will be presenting the first Defence wide report in incidence to the WG in 2016. Further work will take place in 2016 to improve the content and mechanisms for recording in healthcare records and reporting through Health and Safety systems. Defence Statistics confirm that the number of UK personnel medically discharged due to NFCI as the principal or contributory cause from 6 April 2005 until 31 March 2014 was 518. Of these about 330 have AFCS awards for NFCI at some level of severity. In addition to no fault compensation, 707 claims for civil damages have been made between May 2007 and 31 December 2014 (470 have been settled with 197remaining active). The cost to April 2015 is £17.2 million damages and £ 11.3 million claimant legal costs.

Prevention is the mainstay and Army Health has updated Commanders' and Individual Guides and other material.

Everyone is vulnerable to cold injury but some SP react more adversely to the effects of cold and wet weather conditions according to their level of fitness, clothing and equipment and training. Afro-Caribbean personnel and Caucasians from Africa are also at increased risk. Commanders should note that NFCI occur mainly in the UK.

Cold injury in SP can be avoided by good planning, training, education and awareness of the effects of cold. There are a number of educational resources available to units and individuals that can bring this to life. Commanders at all levels have a role in preventing cold injuries. The approach must be based on force protection in line with a thorough assessment of the risk to ensure personnel are adequately prepared for the environment. This must include:

- The issue of appropriate, Service-issued cold weather protective clothing such as gloves, boots and gaiters during cold/wet weather; especially for high risk groups. Importantly SP must be directed to wear the clothing.
- Reviewing and if necessary adjusting the duration of activities where exposure to cold and wet is likely to increase the risk of cold injury.
- Ensuring that personnel have sufficient dry clothing to change into following exposure to wet conditions.

Cold injury is preventable.

Heat Illness Working Group (HIWG).

The sad deaths of three soldiers from heat illness in 2013 put into sharp focus the importance of the HIWG role in maintaining up to date evidence based policy in JSP 539 "A Guide to Climatic Injury in the Armed Forces"[46]. Wet Bulb Globe Temperature (WBGT) meter readings play an important part in assessing the risk of heat illness and the HIWG assessed training of non-medical and medical personnel in WBGT meter use. Training in non-medical personnel was assessed to be adequate and further work is being done on training medical personnel on the new Defence Medic training programme. Work has started at the Institute of Naval Medicine to update the work/rest tables in JSP539 to ensure that they accurately reflect the current evidence. Reporting of heat illness across medical and health and safety systems is uncertain and Defence Statistics(Health) will be presenting its first report, drawing upon multiple MOD data sets in 2016. Over-hydration offers no protection against heat illness and can have serious medical consequences. JSP539 will be updated to reflect the guidance that is already in Commander Guides. In 2016/17 the HIWG will be focusing on reporting heat illness and concluding the revision of work/rest guidance.

Defence Hearing and Vibration Working Group

Prevention and detection of hearing damage remains an important issue, and during 2015 the Working Group also took on responsibility for vibration health effects. Research to provide the evidence base for preventive and interventional strategies is vital and SG has provided the first £0.5M for the HearWELL research programme with further funding for this £10M research programme yet to be secured. Three PhD studies are underway and will start to report in summer 2016. An important enhancement in prevention is the roll out of the Tactical Hearing Protection System which commenced this year. Specialist assessment of personnel whose hearing tests indicate they may have hearing damage is an essential component of healthcare for Service personnel. The DHVWG will be developing options for audiology services in 2016. Vibration, both whole body and hand arm vibration, will be more closely examined by the WG in 2016, recognising the single Services work that is already underway.

The roll out of the Tactical Hearing Protection System (THPS) began over the summer 2015 with the first Units receiving the Basic User variety. Each individual is offered a choice from three different models appropriate to the size of their ear. This provides the opportunity for an optimum match in fit and comfort. THPS BU offers the wearer with equivalent levels of attenuation as previous hearing protection systems with the added advantage of switching between 'open' and 'closed' positions. In the open position the ability to hear is essentially unrestricted with protection afforded only with sudden, loud 'impulse' noise. This enables the wearer to maintain both their situational awareness and protect their hearing for example, whilst on patrol.

Specialist User sets are rolling out imminently and Dismounted Close Combat User is scheduled to roll out next summer. The introduction of THPS was accompanied by an update in policy with a revised version of AGAI 77 being published.

Despite improvements in the issued suite of hearing protection, compliance with wearing the personal protective equipment (PPE) remains an ongoing challenge. A culture of compliance is required and this is being addressed through a number of promotional activities. Throughout 2015, PS4 Health undertook a series of Clean, Fit and Healthy roadshows to brief formations on various health issues; which included the need for leadership in enforcing compliance with the mandatory wearing of PPE. Army Media and Communications are also working

46 JSP 539 contains guidance on both heat and cold injuries and their prevention.

hard to ensure that images of Army personnel clearly show the appropriate use of hearing PPE. Updates for 'Listen to Sense' DVDs and guides are scheduled for early 2016.

It is not just noisy weapons and vehicles demanding the attention of the Army: much work is also done to support our professional musicians. Noise levels for ceremonial bands can reach a staggering 143 decibels, The Corps of Army Musicians (CAMUS) is working with Leidos Customer Support Teams to procure an upgrade to the hearing PPE used by bands. There is also ongoing work to assess and wherever possible upgrade band practice room facilities.

Regardless of the hearing protection we provide, the Land environment remains a noisy place to work. Effort is ongoing across a number of areas to manage and wherever possible reduce the risk posed by our weapon systems and vehicle platforms. The Armoured Vehicle Programme (AVP) has been assessing noise and vibration levels produced by the Land fleet of armoured vehicle variants and has worked on producing a noise and vibration calculator. There has also been considerable work in managing the risk referrals and exemptions that apply to guns and mortars, in particular as this relates to protecting our personnel identified as most vulnerable to NIHL through routine and subsequently 'specialist audiometry.

CHAPTER 5 - PREVENTIVE HEALTH

Introduction

The Preventive Health Pillar sees the greatest degree of collaborative working with the Department of Health than any other pillar. This ensures that Defence is able to take advantage of National health promotion opportunities; can influence future initiatives, can track emerging health protection threats and feedback successes that Defence has achieved in the preventive health arena.

Over the past year the priority for the Preventive Health Working Group has been to take a disparate group of existing, clinically focussed groups and integrate them into the new themed, 1* led, pillars that deliver the research, advisory, policy and audit functions of the Defence Health and Wellbeing Strategy. The next priorities are to establish baseline data in the areas that are being actioned currently; to identify what information sources and data are available and to decide how to monitor progress against the strategy.

In terms of the day to day delivery of the preventive health function within the Health and Wellbeing Strategy and Plan, the delivery groups are:

Defence Public Health Unit

The Defence Public Health Unit (DPHU) brings together public health specialists from the three Services and HQ Surgeon General, to provide coordinated support across Defence while still providing an advisor on Health Protection for each of the Service Commands (SC). The unit is completely aligned to the Public Health Function in the home base provided by Public Health England (PHE) and Local Authority Public Health Teams working within the three core disciplines of Health Protection, Health Improvement and Service Improvement. In addition, the DPHU actively undertakes disease surveillance and also fulfils the Dental Public Health function. The DPHU is also fully engaged in providing advice and training in Public Health practice to personnel who might have to provide health advice to deployed Commanders. DPHU specialist advice is available 24 hours a day from a Public Health Consultant. The wider organisational structure is shown in the figure below.

Defence Public Health Unit - Responsibilities

- The function of the Defence Public Health Unit is to provide a single source of public health advice and information across Defence.

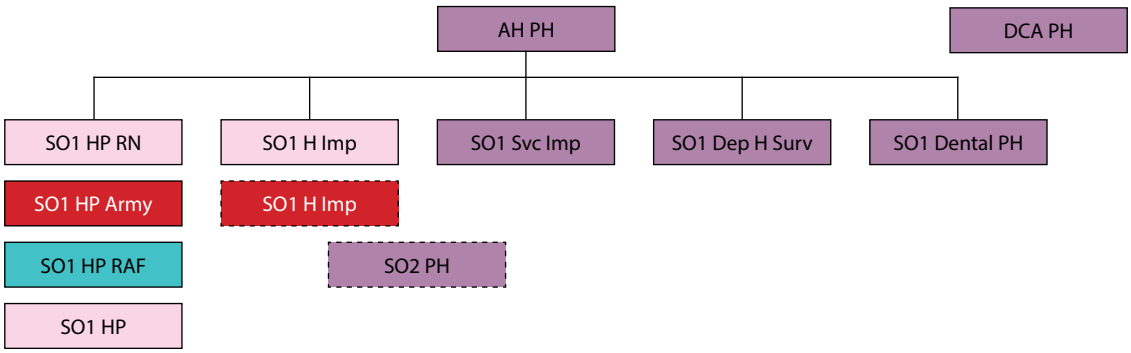
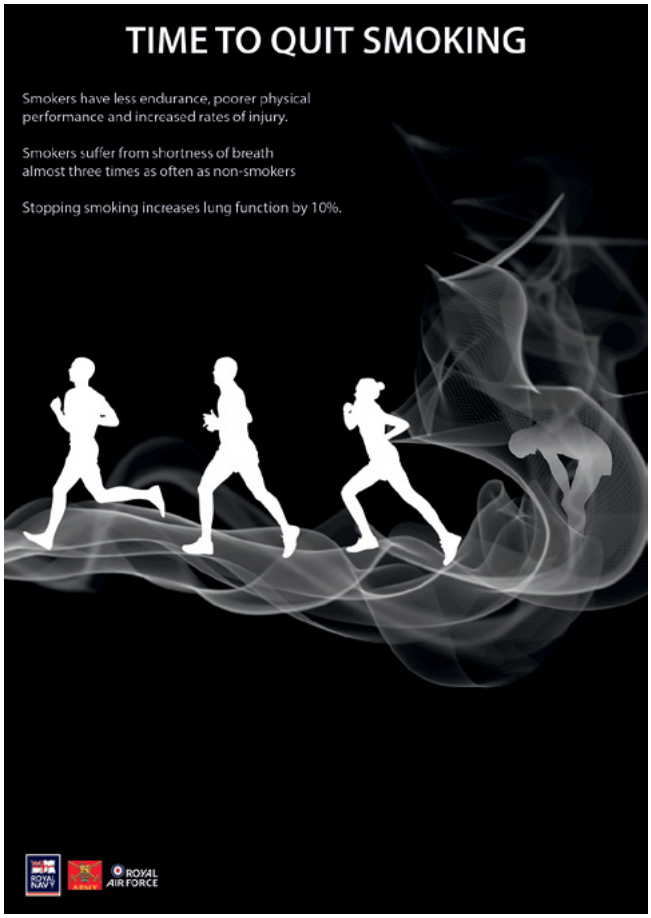


Figure 8: DPHU Responsibilities

The most important output of the DPHU is Health Protection; protecting the health of members of the UK Armed Forces and, where appropriate, their families. This mainly involves support to operations and exercises, working with PJHQ to ensure that Medical Risk Assessments are undertaken and that Force Health Protection Instructions detail those measures required to protect our people whilst they are deployed. In addition to having a consultant on call 24 hours a day to respond to health protection incidents affecting UK Armed Forces personnel around the world, the DPHU also co-ordinates the short notice deployment of a Preventive Medicine Operational Support Team (PMOST) to assist deployed medical staffs in controlling and investigating complex health protection issues such as large scale outbreaks of communicable diseases that might affect operational capability. This team would consist of a public health consultant plus environmental health support, reinforced by other Defence and civilian specialists as the situation dictates.

The DPHU also works with national public health authorities, supporting their investigation of public health incidents involving Defence locations in the UK and the UK response to international public health emergencies (such as the Ebola outbreak in Sierra Leone). The model of the PMOST is being exported to the Department of Health as it works to develop the UK Public Health Rapid Support Team (RST) which will provide an immediate response to public health incidents of national importance.

The DPHU also provides policy advice concerning vaccine preventable diseases and works closely with the UK Joint Committee on Vaccinations and Immunisations. Within this area, The DPHU has been leading on the drafting of new guidelines for immunisation against Anthrax. DPHU has also been closely involved in the malaria protection debate and continues to monitor the safety and efficacy of malaria chemoprophylaxis treatments to ensure that those deployed to malaria risk areas are appropriately protected from this potentially fatal disease.



Health Improvement is concerned with working with partners to inform, educate and empower Defence people to take more control of their health and the things that affect their health. This year, the DPHU supported CDP's staff in developing the Defence People Health and Wellbeing Strategy and the subsequent plan has focussed on three priorities; smoking, alcohol and fitness. The aim is to better deliver health improvement initiatives across Defence by making best use of national resources. This includes alignment of Defence initiatives with National

campaigns in order to take advantage of the PHE health improvement efforts. The team have worked with Defence Primary Healthcare (DPHC) to standardise and improve smoking cessation support to smokers across Defence, and to introduce a better way to identify those regular Armed Forces personnel who might benefit from additional support to reduce their drinking.

Service Improvement is concerned with assessing the evidence of effectiveness of health and healthcare interventions, programmes and services. The DPHU has worked with other agencies to improve the quality of primary healthcare provided by the Defence Medical Services (DMS) and, where necessary, improve access by regular Armed Forces personnel and DMS-registered dependants to NHS and Local Authority commissioned health services. Adult screening services are provided by NHS England and the devolved administrations.

The initial focus for the DPHU lay with supporting the transfer of cervical screening from a DMS contract to the NHS. Recent work has focussed on identifying the need for other adult screening services within the DMS registered population and ensuring they have access to the one that they require. The number of people that are affected are summarised in Figure x. Before this work a large proportion of these individuals did not have access to NHS screening services. Another on-going workstrand lies with supporting DPHC in developing their relationships with Local Authorities in order to improve access by the DMS registered population to health services for which they are responsible.

	DMS registered population eligible for screening programme (n)[47]					
Programme	**England**	**Scotland**	**Wales**	**NI**	**BFG**	**OSB**
Bowel cancer (60 -74 years) [48]	60	230*	0	0	170	120
Breast cancer (50-70 years)	480	20	10	10	530	430
Abdominal Aortic Aneurysm (65th year)	0	~	0	0	20	10
Diabetic Retinopathy (12 Years and older)	390	30	10	10	110	60

Figure 9: DMS registered population eligible for UK adult National screening programmes – Nov 15 [47,48]

Public Health Surveillance is the continuous, systematic collection, analysis and interpretation of health-related data needed for the planning, implementation, and evaluation of public health intervention. In Defence this is primarily the surveillance of Role 1 healthcare activity on operations and of infectious disease occurrence on operations and in the firm base. EpiNATO2 health surveillance is the tool routinely used on operations and working with colleagues in the NATO Deployed Health Surveillance Capability based in Munich, Germany, weekly analysis and feedback is possible. In addition to NATO missions, this was used on Op GRITROCK to identify unexpected peaks in primary care activity which could indicate a public health incident. Whilst this cannot yet identify public health incidents as they happen, work is ongoing to develop complimentary near-real-time surveillance tools and the introduction of the future Medical Information System (CORTISONE) should enhance this capability. Work is also in hand to improve the infectious disease notification system, which is currently based on the manual completion of FsMed85.

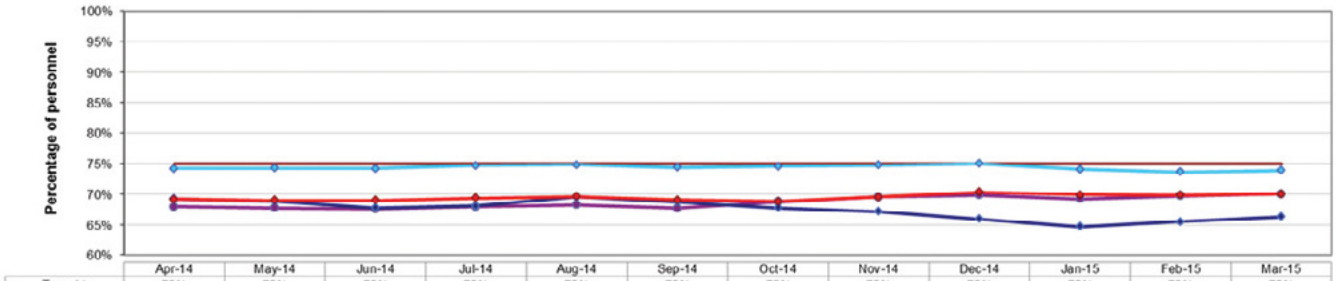
Dental Public Health is concerned with the oral health of UK Armed Forces personnel and entitled dependants. It encompasses oral health promotion, health improvement, service improvement and health protection. The latter is usually focused on the issues presented by infected health care workers in the dental setting, but this year involved collaborating with PHE to develop guidance for the provision of dental care in theatre and in the Firm Base during the Ebola outbreak. In addition, Dental Public Health has been responsible for the piloting, evaluation and leverage of a better deal for the oral health of Reservists as well as the expansion of Project MOLAR to both

47 Population numbers have been rounded to the nearest 10 in keeping with Defence Statistics rounding policy (May 2009). All populations fewer than 5 have been suppressed and represented as ~.

48 Bowel Screening conducted in Scotland from 50 -74 years of age.

the RN and the RAF. This is routinely delivering over 90% of trainees into the Regular Force with all their treatment needs met.

A recent development has seen the roll out of dental dashboards which make it possible to monitor changes in the oral health of the PAR. Figure 10 illustrates the percentage of service personnel in NATO Category 1 (dentally fit) by Service in FY 14/15.



	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15
Target >	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%	75%
All	67.9%	67.8%	67.6%	67.9%	68.3%	67.7%	68.7%	69.6%	69.9%	69.2%	69.7%	70.0%
Naval Service	69.2%	68.8%	67.7%	68.1%	69.5%	68.7%	67.8%	67.1%	65.9%	64.7%	65.5%	66.3%
Army	69.1%	69.0%	69.0%	69.3%	69.6%	69.0%	68.8%	69.5%	70.4%	69.9%	69.9%	70.0%
RAF	74.2%	74.3%	74.2%	74.7%	74.8%	74.4%	74.5%	74.8%	75.0%	74.1%	73.7%	73.9%

Figure 10: % Personnel NATO Category 1 (Dentally Fit) by Service FY 14/15

Dental public health has also been responsible for the delivery of an industry day to develop a model for a contracted dental hygienist service to meet the military requirement. Other important work has included the development of a dental Quality Outcome Framework aligned to that being piloted in the NHS; development with SG Inspector General of the dental element of the Patient Experience Tool; the introduction of a screening tool to identify those drinking more than they should and; working with Phase 1 training units to improve oral health education.

The effects of dental disease continue to be a major cause of disease and non-battle injuries (DNBIs). During Operation Herrick, the rate varied between 221 and 323 cases per 1000 per year at risk. Figure 1 shows the trend in Dental DNBI from Herrick 8 to 18

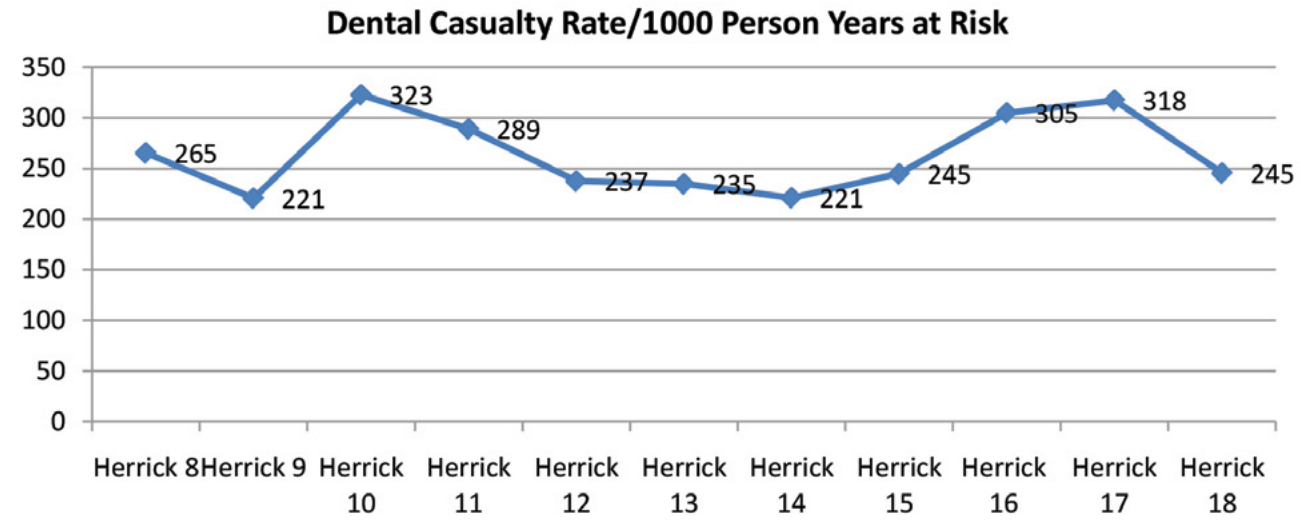


Figure 11. Dental Disease Non Battle Injuries Op Herrick 8-18

Additional research showed that the risk of dental morbidity was greater in those with outstanding treatment compared to those who had had all their treatment needs met. However, two thirds of all dental morbidity cases arose in those personnel who were "dentally fit" with the risk of experiencing dental DNBI increasing by 5% for every additional filling placed. On Op Herrick, those with the lowest disease experience had the lowest risk of experiencing a dental DNBI.

It can be concluded that dental disease, even when treated, leaves an irreducible residual risk which cannot be eliminated and is directly related to an individual's disease experience. The UK experience is internationally mirrored and there is compelling evidence that even in the best dentally prepared Force there will still be dental casualties.

To combat this and reduce dental DNBI, DPHC (Dental) continue to advocate an evidence based preventive approach with the aim of reducing both individual and population dental disease experience. Defence cannot legislate for a person's dental disease experience before they join the Armed Forces. However, DPHC (Dental) can treat existing disease in those joining and do everything possible to try and ensure personnel do not develop new disease during their service. A preventive approach is the bedrock of dental DNBI reduction strategy, but there must also be dental service provision in the Firm Base and operational space to treat the inevitable dental DNBI that will arise. Project MOLAR[49] has been central to this approach and by targeting dental care of recruits has maintained high levels of dental fitness for those entering the trained strength. On average, approximately 49% of recruits enter phase 1 training with no treatment required. This improves to over 80% by the end of phase 1 training and over 90% of recruits in all three services exit the training environment with all their treatment needs met[50].

The Defence Health and Wellbeing Plan acknowledges the importance of early oral health education in developing positive oral self-care skills. The training of JNCOs at Phase 1 training establishments to deliver evidence-based oral health education to recruits as part of health and hygiene aims to support this. After an initial pilot study, this initiative has been firmly established at the Royal Marine Commando Training Centre (CTCRM) with an intention to further deliver this across all phase 1 training establishments. This combined approach adds real value to the oral health of the Armed Forces.

Across the whole of Defence, the overall Dental Fitness (NATO Cat 1)[51] of Service personnel remained relatively stable through 14/15 at approximately 70%. However, at Apr 15, some 45% of all firm base Dental Centres were below the NATO Cat 1 Key Performance Indicator (KPI) of 75% identifying discrete areas of need and the requirement to investigate adequate provision. An oral health needs assessment for Defence is expected to report in April 2016 which will inform this. However, the size of the cohort of "Treatment Need Index 2" (TN2)[52] (Table 12 below) has shown a steady increase throughout 14/15 (Figure 2) and gives an indication of the additional treatment burden placed on dentists. To mitigate this, the case for a Market Skills Supplement for dental hygienists has been staffed with the intent of improving recruitment and retention.

49 Project MOLAR –Originally a JVA between the Army and RADC which guaranteed a minimum of 2 hours treatment time allocated to every recruit in return for the recruit being released from training for 2 hours. Scheme now active in both RN and RAF.

50 As reported by DPHC (Dental)

51 Service personnel in date for a periodic dental inspection and with all dental treatment needs met.

52 The "Treatment Need Index 2" (TN2) identifies the number of 30 minute treatment appointments required per 1,000 personnel for dentists to complete all outstanding dental hygiene care. This is only recorded where dental hygienist support is unavailable.

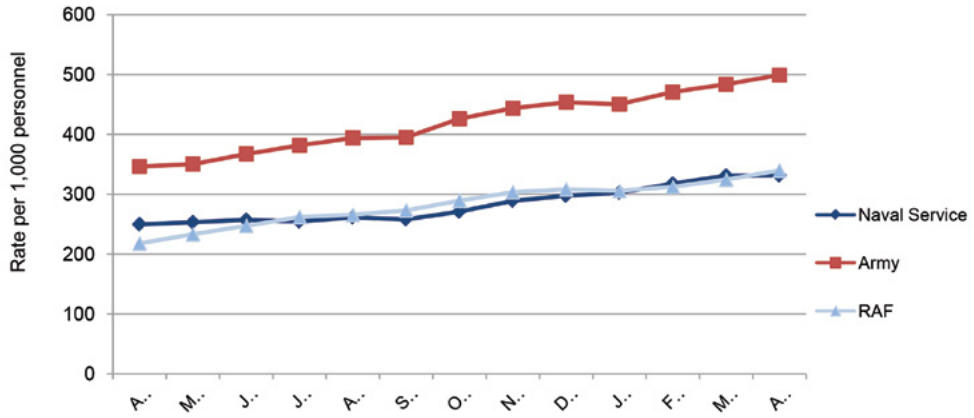


Figure 12. Treatment Need Index 2 - FY 14/15

Working more widely, collaboration between DPHC (Dental) and the Defence Food and Nutrition Working Group has seen the implementation of a study to explore the utility and uptake of the introduction of fluoride toothpaste in operational ration packs at CTCRM. During the study, only 14% of toothpaste tubes issued were discarded and user feedback demonstrated a clear understanding of the benefits both in terms of oral hygiene and the reduced burden on the supply chain during longer deployments where the opportunity for personal resupply may be limited or non-existent. Overall, all users from the study recommended the inclusion of a small tube of toothpaste in the 24 hr Operational Ration Pack (ORP).

Oral cancer is linked to alcohol consumption with the highest consumers being at the greatest risk.[53] Following a pilot[54] study Defence Dentistry has been identified as a suitable platform to introduce the AUDIT-C[55] alcohol screening tool and brief interventions to identify and reduce alcohol misuse across the Armed Forces; further information can be found in the alcohol section in the Lifestyles chapter. This initiative will benefit DPHC by establishing a better understanding of the patterns of alcohol consumption and associated health needs of Service personnel.

Communicable Disease Steering Group (CDSG)

The CDSG is a clinical advisory body; considering the impact of communicable diseases on the health of Defence people and providing guidance on how to prevent them. During 2015 key topics have included; development of clinical care of ebola victims on Op GRITROCK, revision of Defence policy on the prevention of malaria and anthrax amongst Defence personnel and, together with members of the Sexual Health Expert Advisory Group, review of the current policy for screening of healthcare workers.

A cluster of Escherichia colibacteria magnified 10,000 times

The group has also provided oversight of outbreak investigations affecting Defence people; including multiple examples of Gastro Intestinal infection across all three Services, West Nile Virus and Pertussis. Throughout the year discussions have continued to further integrate DMS disease notification systems with those of Public Health England.

53 Committee on Carcinogenicity of Chemicals in Food, Consumer Products and the Environment (COC) Statement on consumption of alcoholic beverages and risk available from : https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/490584/COC_2015_S2__Alcohol_and_Cancer_statement_Final_version.pdf

54 MPH Dissertation. Service Evaluation of the use of the alcohol screening tool and delivery of alcohol brief interventions , FIELD PR ,2013

55 Alcohol Use Disorders Identification Test - Consumption

Environmental Health Working Group (EH WG)

The EH WG is a new group formed to provide oversight and direction to EH teams across all three Services. In particular, the group contributes to the strategic target of "provide a healthy working environment to maintain and improve the health of the workforce". This may be divided into three areas of activity:

a. **Apply safe working practices:** In all three Services EH teams have undertaken Routine Environment Health Advisory Visits, providing advice to Commanders on the protection and improvement of health within the workforce. In addition, the teams have responded to specific requests for support and to specific incidents by undertaking reactive assessments, many of which included specific Occupational Hygiene Surveys.

b. **Ensure risk assessments are conducted where appropriate:** EH teams have delivered the annual programme of inspecting unit Catering, Retail and Leisure facilities, catering facilities (messes and feeders) and retail and leisure outlets (bars, shops, encroachments). In addition, the teams have conducted Force Protection Threat Assessments providing country specific, medical force protection information in support of current, and potential, operations.

c. **Educate Defence people on the prevention of occupational related injuries and communicable diseases:** EH teams have delivered structured pre-deployment health briefs to units and individual augementees from all three Services, contributed to the development of the Medical Force Protection input to single Service Medical Instructions for operations and exercises and overseen the development and delivery of generic travel health briefs during phase 3 training.

CHAPTER 6 - RECOVERY

Transitioning from Campaigning to Contingency – "What has Changed?"

Col D Wheeler, Chair Defence Recovery Working Group

The Defence Recovery Capability (DRC) is an MOD led initiative in partnership with Help for Heroes and The Royal British Legion alongside other Service charities and agencies. Its mission is to support Wounded, Injured and Sick (WIS) personnel in their recovery, to enable them to either return to duty or make a supported transition into civilian life.

The single Services have their own tailored approach to delivering a recovery pathway, to meet the needs of our WIS personnel and Service within the wider Defence capability. Collectively, they command 17 specialist recovery units and cells which are run by military personnel within 21 Defence locations. These specialist recovery units provide the day to day recovery support for wounded, injured and sick personnel and also are a focal point for advice and expertise on all recovery matters. In partnership with Help for Heroes and The Royal British Legion, the MOD has also established 5 Personnel Recovery Centres (PRCs), a Naval Service Recovery Centre, and the Battle Back Centre in Lilleshall. These provide a full range of recovery activities including courses, mentoring, adaptive sports and adventurous training within a military environment. They are not hospitals, rehabilitation or physiotherapy centres but take advantage of the full range of existing welfare, clinical, rehabilitation, education and resettlement facilities located in the garrisons close by. Those personnel who are not able to return to duty and will require to transition to civilian life earlier than anticipated will be able to access the 'Career Transition Partnership – Assist' programme. This is a specialist career service for those WIS who face the greatest barriers to employment.

This year has been a busy period within the DRC as it continues to evolve policy and delivery mechanisms with our charitable partners to meeting new challenges and opportunities. Importantly, this year the DRC has had an opportunity to identify what has changed since entering the era of contingency. HQ Regional Command, under the newly arrived Maj Gen Richard Stanford, took the lead for a Defence Conference jointly organised with Defence, Help for Heroes and The Royal British Legion but also supported by other key charities and organisations such as SSAFA, AFF, ABF The Soldiers' Charity, Vets UK and the NHS. It proved to be a most valuable day, focussing primarily on how the needs of our WIS have changed and how these changes impact on the services the capability delivers. The key messages from the day were: the wider capability and partnership can provide all the services our service personnel need, but acknowledge that we can always do better. The clinical input to the event underpinned the whole conference and brought substance to the perception of 'changing needs' and bridging the gap between the clinical and recovery pathways is an area in which we must do better.

This year has also seen the commissioning of an external 3rd Party assurance mechanism. Ofsted conducted a pilot assurance programme covering the period Nov 14 – Mar 15, visiting DRC units and locations, consulting widely with key stakeholders and produced an initial pilot report. The supportive and helpful recommendations

and observations focused on training, communication and management processes. These have now been incorporated into a Continuous Improvement Plan, which will be formally reviewed to enhance the holistic support available to the WIS cohort. This external oversight has already proven to be a valuable tool in identifying areas of improvement but also highlighting areas of 'best practise' to be shared across Defence.

The Grass Roots View

Lt Col S Bostock, Commanding Officer 4 Infantry Brigade Personnel Recovery Unit (PRU)

As the saying goes 'perception is reality' but our perceptions are influenced by many factors, including our general state of mind and wellbeing. It has not surprised me that WIS personnel assigned to the PRU arrive with differing expectations and attitudes. Some are convinced that assignment to the PRU equates to medical discharge and at the other end of the scale some arrive with the impression that we can and will fix everything. The reality is, of course, somewhere in the middle and those that have been well managed by their units or have done their own research know this.

Once the Army Recovery Capability Assignment Board has assigned a soldier to us, the soldier receives a letter from me to welcome them and to establish a few ground rules. Clearly it is the most complex cases that are assigned to a PRU and we are established to provide dedicated and comprehensive support beyond that of a Field Army unit, such as: an experienced caseworker to visit and coordinate everything from housing applications and adaptations, course bids, AFCS applications and charity applications; a clinical facilitator (registered nurse) to ensure appointments are booked, Boards and Reviews scheduled and that the soldier is getting appropriate treatment; face to face Veterans UK advice on pensions and other MoD financial entitlements; an in-house social worker to assess and assist with any welfare needs; and Career Consultants for those who are being discharged and face particular challenges due to their medical condition. But the soldier (on full pay and conditions, unlike civilian counterparts) has a duty to do their best to recover. The Army's Values and Standards still apply, even though the soldier may be at home for extended periods, appointments must be kept and the soldier must take responsibility for their recovery. There is now a clear distinction between being sick on leave at home (e.g. post operative rest) and being fit for Recovery Duty (when the soldier is assessed fit enough to engage in rehabilitation and recovery activities).

The clinical appointments and waypoints clearly have priority but there is generally always scope for the WIS soldier to keep active, if only intellectually. In fact this is imperative given the potential for spending long periods at home waiting for the next operation or appointment. There is a plethora of activity that the soldier could take part in (our soldiers have learned to fly, surfed in California and been attached to Middlesborough FC, thanks to the Battle Back programme and the generosity of the 3rd sector). It is important, however, to give structure to this and so there are 5 mandatory courses that soldiers have to attend which begin fairly gently with health education and self-awareness sessions and low impact activity, before building to include vocational assessments, visits to industry, CV writing and financial education. Should the soldier return to service then clearly this is good general knowledge and they will take away some useful life skills. These courses and the wider activity programme is, of course, as much about getting out of the house and alongside other WIS soldiers as it is about the specific skills learned. For some, particularly those with Mental Health conditions, it is no small undertaking to attend one of these courses, but we are fortunate in Catterick to have an excellent Personnel Recovery Centre where many of these courses take place. A partnership effort between the MoD, Help for Heroes and the Royal British Legion, it is light and friendly with a mix of uniformed military instructors and H4H staff running the facility.

For those who regain fitness we organise a Graduated Return to Work (GRoW) programme for the soldier in coordination with the Regional Occupational Health Team. These are generally successful and the soldier is soon back up to full speed and re-assigned from the PRU. For those whom the Medical Board directs medical discharge the focus then switches and the soldier has to make some decisions about a future career or at least what retraining they would like to do. This is a busy time particularly for those who are trying to undergo resettlement training whilst still attending medical appointments, operations or rehab. A decision to discharge will also mean a need to secure accommodation in the private or state sector, which can prove worryingly difficult. But the soldier and family are not alone in confronting these many compounding issues and it is the Personnel Recovery Officers' constant presence and experience that helps to calm the anxious and steer the directionless.

Each soldier's recovery journey, whether they return to work or leave the Army on medical grounds, is inevitably unique. The challenge is to ensure the solder is realistic and remains positive. Key to this is establishing trust, fostering self-belief through activity and building an increasing sense of control. From the outset a WIS soldier should be given an Individual Recovery Plan – a combination of some simple goals and aspirations and a schedule. Early on this is very much drawn up by the Unit Recovery Officer but, as the medical picture becomes clearer and the soldier understands the opportunities available, it becomes the soldier's own plan for their future. At final interview, with very few exceptions, there is genuine and heartfelt appreciation from the soldier for what the PRU and PRC have done to help them through their recovery. The most common regret? That they wish they had engaged earlier and accessed the additional support, entitlements and opportunities that are available to support them at every step throughout their recovery pathway.

CHAPTER 7 - COMPENSATION

The report focuses on health promotion, protection and where illness or injury occur, restoration through health care and other support including rehabilitation. The aim is to maximise operational capability for the organisation and maintain good health and wellbeing for the individual at all stages of career. Recognising the hazards of the military workplace, MOD as a good employer also provides reparation and restitution for injury and disorders caused by service and there are long established occupational pension and no fault personal injury compensation schemes both for military and civilian personnel. Where lapse of duty of care is an issue, civil damages may be pursued by both military and civilian personnel although for military personnel only for service causes from May 1987 and the repeal of section 10 of the Crown Proceedings Act. Civilian industrial Defence employees are eligible for DWP industrial injuries schemes. The Industrial Injuries Scheme covers accidental injury and prescribed diseases, many of which relate to exposure to chemical, biological or physical hazards seen in heavy industry, mining and manufacturing and of limited relevance to MOD personnel. Civilian employment is governed by the Equality Act 2010 which does not apply to military personnel although Defence policy and practice in the single services and workplaces is to thoroughly embrace its principles. This update primarily discusses military no fault compensation.

War pensions have been paid in some form in the UK since Elizabethan times with the present War Pensions Scheme broadly unchanged since 1917. Originally, as the name suggests, only war related injury was compensable but from 1947, any disablement causally linked to service up to 6 April 2005 or aggravated by it, can be the subject of an award. Awards are also made for deaths. The war pensions scheme applies to anyone who has served even for one day and claims may be made at or beyond service termination without time limits. The scheme is medically certified by doctors appointed for the purpose and the method of assessment is set out in the legislation. To support consistent and equitable decisions across the broad range of disablement, the legislation includes a list of Statutory Scheduled Assessments. These are important for themselves and act as signposts for all other disablements. Assessment is expressed as a percentage age in 10% bands and is used to determine the award level. For assessments of less than 20%, a gratuity is payable while for 20% or more regular payments are made.

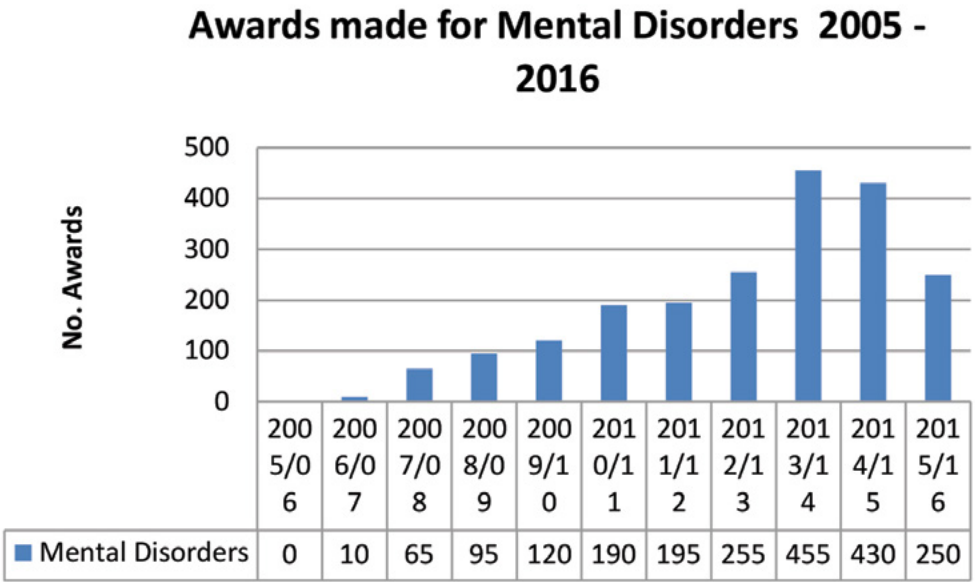


Figure 13: Compensation awards for mental disorders 05-16.

The scheme has a generous standard of proof such that any disablement having clinical onset in service must be accepted unless it can be shown beyond reasonable doubt that service has played no part in its cause i.e. we have to prove a negative. Where claims are made more than seven years after service, the claimant has to raise a reasonable doubt by reliable evidence of a service causal link. There are wide gateways to review and

while assessments and hence award can be reduced if the person's condition improves, over time assessments usually rise. Another reason for increase in assessments and award over time is that further conditions may be claimed even many years after service. These features mean that entitlement may be given for sporadic medical conditions of unknown aetiology having clinical onset in service or within seven years of service termination. One such disorder is multiple sclerosis. Because of the standard of proof awards are made even though there is no published peer reviewed scientific/medical evidence supporting a service causal link. Similarly over time a high assessment and award may result from a series of minor disorders so that the Scheme cannot be said to focus on those most disabled due to service.

Having origin before the Welfare state and disability benefits, the scheme has its own dedicated allowances. These address the disabling effects of accepted disorders and are generally paid at slightly higher rates than the civilian equivalents and in the case of mobility supplement, in contrast to civilian DLA /PIP the benefit can be claimed after retirement age. War pensions are tax free. They might also be said to be disablement enhancing in the sense that to keep your pension you need to remain sick and they do not necessarily reflect contemporary medical understanding of causation of disorders. The war pensions statistics then are of limited value in monitoring accurately, even at a high level, the impact of service on veterans' health and well-being.

From the Second World War, no fault military compensation determinations were the responsibility of the DSS, but in 2003 they moved back to MOD. In the mid-1990s a team from DSS and MOD including senior policy officials and a doctor developed a new scheme to better reflect the 21st century volunteer regular and reserve service, its terms and conditions, high standards of personnel management, occupational health and emphasis on health promotion, protection and timely access to best practice evidenced treatments. As before, awards would be made only where the injury or disorder or death was due to or worsened by service. Both scheme policy and individual decision making were evidence based and the onus was on the claimant to make their case using balance of probabilities standard of proof. The aim was that decisions should be consistent and equitable. On 6 April 2005 the AFCS was introduced covering injury, disorder or deaths caused by incidents events or behaviours occurring on or after that date. Underlying general principles were fairness: simplicity: modernity: security: employability: human rights and fairness at work and affordability. Discussion with a range of stakeholders also upheld the principle of no differentiation of injuries sustained on operations as this would undermine the ethos of "all of one company". The new scheme aimed to give particular recognition to the needs of those most seriously disabled, set compensation at realistic levels and for the most seriously injured provide lifetime financial support while not acting as a disincentive for those able to work.

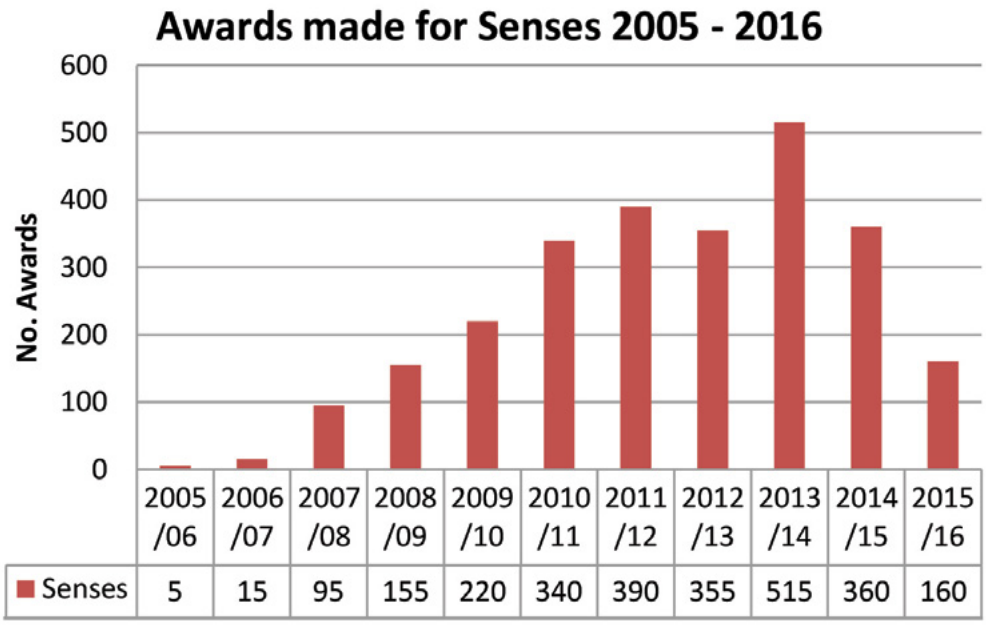


Figure 14: Compensation awards for senses 05-16.

The scheme is tariff based arranged in nine tables of injury categories relevant to a military population. Descriptors setting out criteria for the injury/disorder are listed with equivalent award level. In many cases the descriptor reflects the duration and severity of the disabling effects of the injury. Tariff levels range from £1,250 to £570,000 and compensate for pain and suffering. For the most seriously injured there is in addition an income stream or Guaranteed Income Payment, GIP. This reflects the effects the likely impact and duration of the functional compromise on the person's post service civilian employability. The aim is to make a full and final award as early as possible taking into account the optimum treated state and prognosis over the person's lifetime. As a no fault public scheme it does not include all the heads of damages associated with personal injury tort eg. awards do not include elements of health care or other support or loss of amenity.

Recognising the nature of some of the most complex traumatic injuries and that many of those injured or made ill by service will have a long post-service civilian life the scheme intentionally relies for other support on other public provision eg. Priority Treatment under the NHS and DWP employability and disability benefits. The AFCS is an element in the Military Covenant and the nation's commitment to those injured or made ill by their service. While all support and security should be provided for the most seriously injured, where possible the injured veteran should be able to take full advantage of developments in thinking and best practice in health care and other support eg. increasing DWP support to those with disabilities may increase financial benefits, but may replace or complement them by more active vocational rehabilitation, mentoring, mindfulness, talking therapies. Above all the scheme aims to empower people to enhance their wellbeing, and selfesteem, and to maximise their capacity and capability.

The 2009 AFCS review by Admiral the Lord Boyce and an Independent Scrutiny Group of academics, senior lawyers and doctors, service and ex-service organisations, representatives of injured personnel, families of the bereaved, confirmed that AFCS was fundamentally sound. Lord Boyce went on to make some recommendations which were accepted and implemented by government. One of these was the setting up of an Independent Medical Expert Group (IMEG). Members are appointed to this non departmental public body in line with Cabinet Office principles. Its function is to provide assurance to Minister (Defence Personnel and Veterans), (Min (DPV)), that the scientific and medical basis of the scheme is sound and reflects contemporary understanding. This independent assurance is also welcomed by stakeholders including claimants and the service and ex-service charities. To date IMEG has published three reports[56]. The Group is tasked by the minister and reports findings and recommendations to him. Topics may be raised by various routes including from individual claimants, charities, health and social care professionals and officials. To date findings and recommendations have been accepted and incorporated into the AFCS legislation as required. Individual decisions in both the War Pension Scheme and AFCS have medical input from medical advisers appointed for the purpose. They will have a track record in a medical speciality or general practice and some have a military background. They are trained in medico-legal determination as well as the two MOD schemes. Decisions under both schemes can be appealed to the independent First Tier Tribunal and, where there is an error in law, onward to the higher courts.

56 https://www.gov.uk/government/publications?departments%5B%5D=independent-medical-expert-group

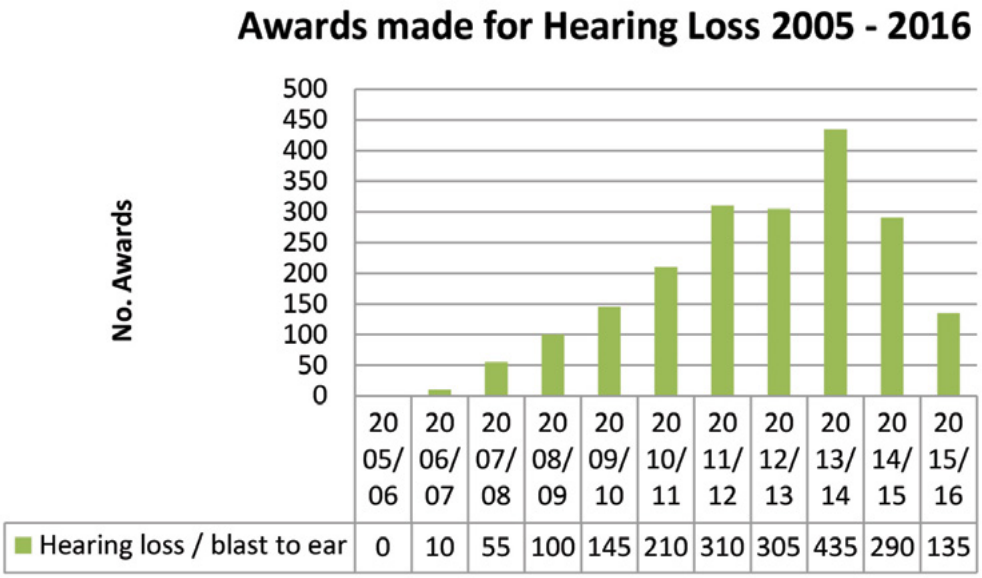


Figure 15: Compensation awards for hearing loss 05-16.

The AFCS scheme is now ten years old. It continues to build up to steady state with over 60,000 claims now made. To 30 September 2015 over £433 million had been paid in lump sum awards and £53 million in GIP. While AFCS claims can be made in service and lump sums paid, GIP is only payable from service termination; as the military rehabilitation pathway may last several years, some people will have underlying entitlement to GIP, but it will not be paid until/unless the individual leaves the service. As we take forward the Health and Wellbeing Strategy, an enduring issue is identification of simple, easy to collect and effective indicators of progress against the themes of health promotion, hazard protection and prompt evidenced treatment as appropriate. One possible measure may be AFCS claims and award statistics. Over the next twelve months we intend to explore the limitations and interpretation of AFCS claims and awards data.

CHAPTER 8 - LIVE WELL

A key strategic objective of the Defence People Health and Wellbeing Strategy is to Live Well. A lifestyle which optimises health and wellbeing, includes a sensible approach to alcohol, smoking, sexual health, diet, mental health and fitness with each of the four pillars of the Strategy, Lifestyles, Mental Health, Injury Prevention and Preventive Health underpinned by physical fitness. Whatever our age, there is good scientific evidence that being physically active can help us lead healthier and happier lives.

Physical inactivity is the fourth leading risk factor for global mortality (accounting for 6% of deaths globally). This follows high blood pressure (13%), tobacco use (9%) and high blood glucose (6%). Overweight and obesity are responsible for 5% of global mortality[57].

Physical activity has an important role to play in promoting mental health and wellbeing by preventing mental health problems and improving the quality of life of those experiencing mental health problems and illnesses. Evidence shows that physical activity can reduce the risk of depression, dementia and Alzheimers disease[58]. It also shows that physical activity can enhance psychological wellbeing, by improving self-perception and self-esteem, mood and sleep quality, and by reducing levels of anxiety and fatigue.

The MOD has a duty to inform personnel about lifestyle and health. People need to be aware of the levels of physical activity that deliver health benefits and the health consequences of an inactive lifestyle. There are wider Government initiatives and guidelines that assist policy makers, healthcare professionals and others who support health improvement and making this information available to all helps individuals to take responsibility for their own lifestyle choices. Public Health professionals in the Surgeon General's area are engaging with the Department for Health and Public Health England so that Defence people can benefit from the latest research and national campaigns; the latest being 'One You'.

57 World Health Organization (2010) Global Recommendations on Physical Activity for Health.
58 www.nhs.uk/stress,anxietyanddepression

The Value of a Healthy Attitude to Fitness

It is never too late or the wrong time to improve your lifestyle – the opportunity never ends. This has been recognised nationally and is now being recognised within the Armed Forces. As such, a focus on adult wellbeing, in particular those aged 40 and above is expanding. Examples of this are the NHS Cardiovascular Health Checks Programme (40-74 years) and the Public Health England national 'One You' campaign to be launched in Spring 2016, both of which are being adopted across Defence. Approximately 30,000 military personnel regular and reservist are aged 40+ years. These individuals generally hold senior positions, possess high levels of knowledge and expertise and act as a role model to other military personnel on a daily basis. Their health and wellbeing is an integral part of the success of their role and their productivity including minimising risk of sickness absence.

The National Health Checks Programme aims to help prevent heart disease, stroke, diabetes, kidney disease and certain types of dementia. Everyone between the ages of 40 and 74, who has not already been diagnosed with one of these conditions or has certain risk factors, will be invited (once every five years) to have a check to assess their risk and will be given support and advice to help them reduce or manage that risk.

ONE YOU – A Campaign in partnership with Public Health England

'One You' is a national campaign designed to target the entire population. Modern life has allowed diseases like type 2 diabetes, stroke, heart disease and cancer to creep into the lives of millions of adults across the nation, including those within Defence. Over 70% of these diseases are preventable. The 'One You' campaign is a National behaviour change programme encouraging, empowering and enabling people to protect and improve their health. It is about prevention not treatment, it is holistic and is supported through significant financial investment. It will launch in Spring 2016 nationally and within the MOD and will motivate and enable change with simple ideas, tools and products tailored to support a more healthy life. Individuals will move more, manage stress, check themselves effectively, sleep better, eat well, drink less and be smoke free.

Proactive prevention in mid-life is key

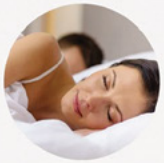
Modern life has allowed diseases like diabetes type 2, stroke, heart disease and cancer to creep into the lives of millions of adults across the nation.

Over 70% of these diseases are preventable. Our poor diets, sedentary lives and unhealthy habits like smoking and drinking too much are putting us at greater risk as we age.

One You will be there to help you tackle one or all of the things that could help you live a little bit more healthily, every day


Moving more


Checking yourself


Sleeping better


Eating well


Drinking less

Being smokefree


Managing stress

ONE YOU

DEFENCE SPORTS & RECREATIONAL ASSOCIATION

Ministry of Defence Sports Day 2015

Once again, the last Friday in June and the world-class facilities at the University of Bath's Sports Training Village hosted the annual Ministry of Defence Sports Day. Organised by the Defence Sports & Recreational Association (DSRA) and with Badminton, Squash and Table Tennis on offer for the first time, around 1500 Defence staff (past and present) from as many as 50 different Defence establishments embraced the opportunity to get involved in friendly competition across 1 of the 13 different sports available.

"It's not very often you get the chance to play competitive sport with work colleagues in a well organised event" – Nick (DE&S – Abbey Wood South)

Once again, the Football & Rounders competitions were extremely popular with over 1000 participants involved. With an average of 70 teams taking part over the last 5 years, the MOD Sports Day (6-a-side) Football Tournament is consistently one of the biggest sporting competitions available for public sector employees.

Sports Day encourages and welcomes people of all abilities to come together for a day of organised sport. The day shares the same ambition as most DSRA events, schemes or opportunities and simply aims to encourage good health and fitness amongst MOD staff and provide them with a valuable opportunity to meet up and engage with colleagues away from the office environment. The chance for some team-building in the fresh air is too good to miss

"Sports Day is a great opportunity to promote wellbeing and team cohesiveness as well as a chance to meet other people from across the MOD" - Mel (DBS, Abbey Wood North)

DSRA Celebrate 25 Years with Race Across America

In June 2015, 12 MOD civilian staff completed the world renowned, coast-to-coast ultra-endurance cycling challenge, Race Across America (RAAM).

Many of whom having never met before, the 12 members of 'Team DSRA' which included 8 cyclists and 4 support crew arrived in Oceanside, California aiming to become the first group of civilian defence staff to negotiate an arduous 3000 mile route across the USA and arrive in Annapolis, Maryland in under 216 hours (9 days) and complete one of the world's toughest team events and endurance races.

"Despite not being at all sure about what was to come or how I would do, I was hugely inspired by the challenge and didn't hesitate to apply for a place on the team" – Lee (DE&S)

RAAM is not only a non-stop race against the clock but a real adventure as teams must be almost entirely self-sufficient, managing everything from when and what to eat to how and where to rest. Inevitably for most teams, there is almost no room in the plans for proper sleep, cooked food or even a shower and the first few days spent in the USA preparing themselves and their equipment for the days ahead would be vital. This was not going to be an easy or luxurious trip.

"We went into the race believing that three things would be crucial - preparation, ongoing management and mental strength" – Tim (DI)

Each team member was picked on account of their skill and experience as well as the personal and professional qualities they would bring to the group. Whilst each of them would also manage at least one project area on behalf of the rest, they would all need fitness, resilience and be able to work together to reach the finish.

At 1241hrs (PDT) on Saturday 20th June, 'Team DSRA' rolled off the beach-front start line in Oceanside and after a short 'parade', began their race.

At 0441hrs on Saturday 27th June and 6 days, 13hrs and 1 min after they started, Team DSRA reached the Atlantic Ocean and was under escort into the dockside finish-line in Annapolis, Maryland. They had completed the 3004 mile route at an average speed of 19.1mph and successfully finished the race with 2.5 days to spare.

For the 12 members of Team DSRA, it wasn't just athletic performance or great endurance that was important, nor had they the benefit of unlimited funds or a huge support crew, it was an efficient and collaborative team effort that got them home.

Starting out as strangers and separated by 30 years of age and working in as many as 8 different buildings across 10 different areas of the MOD, they were led into a dangerous and unpredictable race with only a good level of fitness, an adventurous attitude and the willingness to work hard and to work together.

'Improving the health, morale and fitness of MOD civilian staff through sport & recreation'

Tough Mudder Obstacle Course 2015

On Saturday 22nd August, 120 MOD civilian staff completed the renowned Obstacle Course Race, Tough Mudder (South West).

Held this year at Cotswold Country Park in Gloucestershire, Tough Mudder is not a race but a challenge in which participants experience an arduous, long-distance military-style assault course, complete with hazards and obstacles that always include mud, water, and heights - sometimes even electricity or fire.

Organised for the first time by the Defence Sports & Recreational Association, the soon-to-be DSRA 'mudders' were the largest centrally-organised team ever to assemble at a single Tough Mudder event and shortly before their 1100hrs start, they left the safety of their own tent for the warm-up zone and to recite the Tough Mudder code:

"I understand that Tough Mudder is not a race but a challenge • I put teamwork and camaraderie before my course time • I do not whine – kids whine • I help my fellow 'mudders' complete the course • I overcome all fears"

As the fundamental principle of Tough Mudder is of teamwork and overcoming fear, the course and the many obstacles are specifically designed to encourage exactly that and although the group were never likely to remain as one large pack for the entire day, small pockets of friends and colleagues were inevitably formed as the runners moved through the 11.1 mile route.

By organising events and representative teams such as this and others in this section, supporting initiatives and providing financial support, DSRA have been using sport and recreation to promote good health, morale and fitness amongst MOD civilian staff for 25 years. DSRA are closely affiliated to CSSC Sports and Leisure, another non-profit organisation which aims to promote health and wellbeing across the entire public sector.