



Ministry  
of Defence

# The Armed Forces Compensation Scheme Quinquennial Review



## Armed Forces Compensation Scheme (AFCS) Quinquennial Review (QQR)

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## **FOREWORD**

### **By Chief of Defence People**

The Government is committed to providing no-fault compensation for members of the Armed Forces who are injured, become ill or die as a result of their service, and, where appropriate, for their dependants. In April 2005 the Armed Forces Compensation Scheme (AFCS) was introduced, replacing the War Pension Scheme (WPS), in force since 1917, to reflect more appropriately the changing conditions of military operations and the moral obligation to ensure that our Service people were appropriately compensated.

Six years after the first review of the AFCS in 2010 chaired by Admiral the Lord Boyce, the time has come for a further Review of the Scheme, to ensure that it still remains fit for purpose and has displayed the flexibility to adapt to changing conditions and environments.

The Review Team has worked for a year, seeking the views and opinions of many major stakeholders, both in Government and external (including claimants and the Charities who act as their advocates). Due weight has been given to all the opinions expressed, even though not all of these have found their way into the Report as recommendations. The distillation of all their work forms this Report; the Central Advisory Committee on Compensation (CAC), chaired by the Minister for Defence Veterans and Reserve Personnel, has been involved from the outset and was made aware of the findings.

I look forward to hearing views of the Report.

**Lieutenant General Richard Nugee**

**Chief of Defence People**

## **EXECUTIVE SUMMARY**

1. Following the announcement of the Ministry of Defence's intention to commence the Quinquennial Review (QQR) of the Armed Forces Compensation Scheme (AFCS), a Lead Reviewer was appointed at the beginning of 2016 to undertake the task of reviewing the AFCS along with an Assistant Reviewer and a subject matter expert from AFCS policy. The Scheme was last examined by Admiral the Lord Boyce in 2010. As the Lord Boyce Review was thorough and wide-ranging in scope, it was decided that this Review would not be a structural overhaul but would determine whether the AFCS **remained** fit for purpose. "Fit for purpose" is defined as providing "no-fault" compensation at realistic levels to Service personnel injured or made ill by their service on or after 6 April 2005, or their dependants. The QQR team categorised the themes it encountered in 17 chapters, as summarised below.

2. In the Executive Summary, the QQR of the AFCS sets out its conclusions on a number of themes central to the Review's purpose, as in the paragraph above. The QQR team categorised a number of key themes that centred around the key question it was tasked to address. The key themes included "Emerging Challenges" which assessed the changes in the environment the Scheme was operating in, "Status of the Scheme" to answer whether the Scheme remained fit for purpose to deliver the outcomes to Service personnel, "Level of Awards" to assess whether the values of the Awards were still appropriate, "Categories of Awards", discussing some specific frequently-raised conditions, and "Communications" to assess whether the Scheme was communicated effectively – all providing the building blocks that led to the QQR team's conclusions.

### **Chapters 1 and 2 – Introduction and Background**

3. This confirms the commitment by the Government to provide appropriate no-fault financial compensation for members of the Armed Forces who are injured, become ill or die as a result of their service, for the remainder of their lives, and, where appropriate, for their dependants. The section describes the underlying general principles of the AFCS. It describes the Tariff-based nature of the lump sum awards and the Guaranteed Income Payment (GIP) for the more seriously injured and the appeal options available.

### **Chapter 3 – Status of the Scheme**

4. The general view among internal (Ministry of Defence) and external stakeholders (Service charities, individual claimants) was that the Scheme remained on track and fit for purpose, with some areas needing improvement. The QQR team agreed, and concluded that the Scheme has evolved over the years, with the flexibility to adapt to changing circumstances. The QQR team also shared the view that there was still room for improvement, which meant a mixture of building on existing measures and creating new ones. The main recommendation in this particular chapter was to ensure that the Scheme was "equality-proofed", that is to say ensuring that no particular group found itself disadvantaged by the Scheme's provisions, providing the opportunity to ensure the fairness, relevance and transparency of the Scheme's provisions.

### **Chapter 4 – Scope of the Scheme**

5. Understanding the scope of the AFCS is fundamental to answering whether the AFCS remains fit for purpose. The Scheme aims to pay no-fault compensation to Service personnel for any injury or illness caused by service on or after 6 April 2005. Lump sum awards are made as a result of their injury or illness. For more serious injuries or illness likely to adversely affect civilian employability, an additional Guaranteed Income Payment (GIP) is payable from service termination or date of claim, for life. The QQR team found that

there were varying degrees of understanding on the scope/remit of the AFCS. The QQR team recommended that the AFCS would benefit from clarification as to what the AFCS does and does not compensate for, as well as providing context and definitions of the Scheme – for example, the QQR team came across AFCS narratives that reflected that the “lump sum” compensated for “pain and suffering”; however, the QQR was of the view that this concept needed to be explained owing to the frequent use of the term and interpretation in the other documents. In addition it recommended that the MOD should consider making use of the services of the Reservists’ Champion to support more effective communication with Reservists.

## **Chapter 5 – Emerging Challenges**

6. The QQR team identified a number of Emerging Challenges, that is to say matters which had been raised for the first time since the last review of the Scheme. The AFCS has reacted with flexibility to the many new challenges since the last Review, and it is essential that this flexibility is maintained to deal with future developments, known and unknown. Among these emerging challenges are new illnesses such as Ebola and Zika, although it must be remembered that the AFCS is designed to accept any injury or illness attributable to service. Similarly, there are conditions which seem more common than in earlier years, such as Non-Freezing Cold Injury (NFCI). The Armed Forces demographics have changed, with an increase in women Service personnel with more serving in front-line combat; a higher proportion of Reservists are now employed. The Scheme is reactive in nature, having the mechanism for temporary awards to be made for new injuries or illnesses. There is a requirement to study these new injuries and illnesses to make sure the descriptors and tariffs remain appropriate.

## **Chapter 6 – Data Collection**

7. Data collection concerns statistical and quantitative data available on the AFCS, verified by Defence Statistics. Having robust data on the AFCS provides insight into some of the experiences of AFCS claimants. It also answers stated research questions, for instance whether the AFCS remains properly fit for purpose, and to test hypotheses and evaluate outcomes. Statistics was just one of the resources the QQR team used to evaluate evidence and statements from stakeholders. This chapter focuses on the QQR team’s evaluation of the statistical data available and recommendations to enable robust data collection, for example knowing the data on claimed conditions and assessing that with awards made.

## **Chapter 7 – Categories of Awards**

8. This chapter examines four very specific medical issues which formed the subject of comment by a number of stakeholders. There has been a greater emphasis on mental health, musculoskeletal injuries, NFCI and brain injuries, all of which, though not new, have assumed a higher level of importance in the minds of stakeholders since the Lord Boyce review, as their incidence has increased sharply since that review.

### Mental health

9. Mental health claims have increased year on year since the Lord Boyce 2010 review. The QQR team engaged with leading specialists on military mental health, and one of the key findings was that attempts to diagnose and treat mental health disorders were much harder than in the case of physical injury or illness, where the nature of the problem was usually clearly apparent. The problem is compounded by the variable nature of the disorder, where sufferers can feel fine one day and terrible the next. Nevertheless, the correct courses of best-practice treatment, administered by trained personnel, are usually able to improve function to the extent that the patient can return to productive employment.

10. An important aspect is to reduce stigma. Many Service personnel are unwilling to admit to any mental condition other than Post-Traumatic Stress Disorder (PTSD), and even with that condition, they tend to present reluctantly and late, out of fear that admitting to the condition will adversely affect their military careers and chances of promotion.

11. The Lord Boyce 2010 review established the Independent Medical Expert Group (IMEG) as having a major role regarding advice on AFCS approaches to mental health, and increased the maximum Tariff for these disorders from Tariff 8 to Tariff 6 (£140,000). The QQR team recommended further consideration is taken regarding this, since it became clear during their investigations that the more severe mental health disorders may be just as disabling as serious physical injury, and an even higher maximum Tariff for these disorders is recommended.

#### Musculoskeletal disorders

12. Musculoskeletal disorders are the most common cause of medical downgrading, leading in some cases to medical discharge from the Armed Forces, and as such comprise the majority of AFCS claims, most commonly for knee injuries followed by back pain. The main cause of these is generally sporting and adventure activities (sport, to maintain fitness, is a recognised part of the military curriculum) rather than combat or operations. In such cases, best-practice treatment involves maintained activity, education about the nature of the injury and support in returning to the patient's own job.

13. The QQR team found that there was a range of Tariff awards, particularly for back problems where a substantial recovery did not occur; the lower awards cover cases where a substantial recovery is expected, and the higher levels for permanent incapacity. An improvement in the clarity of the descriptors for these conditions is required, particularly as prevention and protection are key to reducing the incidence of such claims. The QQR team strongly recommended adopting best-practice elements for reducing the incidence of such cases, such as those employed by the Royal Marines.

#### Non-Freezing Cold Injury (NFCI)

14. NFCI has been recorded in UK soldiers since the Napoleonic wars. Following the introduction of the AFCS, there has been a rise in the number of NFCI claims. An independent Task Force was set up in 2011 in collaboration with University College London, and research into this condition continues. New guidance on the condition has been formulated, and it is hoped that these measures will help to reduce cases and claims. The QQR team recommended that further study into the long-term impact of NFCI, particularly taking into account the seasonal nature of the condition, would be welcomed.

#### Brain injury

15. Brain injuries occur in combat or operational situations as well as in Road Traffic Accidents, assaults, adventure training and other similar circumstances. As for musculoskeletal injuries, the variation in Tariff awards for apparently similar cases reflects the short-term or long-term prognosis of the injury. One of the main criteria for assessing an award for brain injury is the functionally disabling effects of the injury. As in musculoskeletal injuries, the QQR team suggested clarification of the descriptors and associated Tariff levels for brain injury.

## **Chapter 8 – Level of Awards**

### Tariff 1 Uplift

16. A recurring theme from all external stakeholders, and a few internal stakeholders, was that lump sum awards, like military pensions, should be automatically uprated for inflation in line with the Consumer Price Index (CPI), to ensure that Service Personnel in the future would not experience a reduction in the value (in real terms) of their lump sum awards. The QQR team noted the value and depreciation over time of the lump sums, e.g. any award is worth 87% of what it was 6 years ago. The QQR team recommended that uplifting of the lump sum should be on a prospective (annual) basis only – not retrospective. The alternative would be the creation of an Internal Review Mechanism. It would comment on the value of awards, and recommend uplifting of awards, or not, in accordance with its perspective at the time. Another recurrent theme was uplifting the top Tariff level 1, currently £570,000, as it was last reviewed in 2010, and not increased since 2008. The QQR team formed the view, based on inflation statistics, that the appropriate level should be raised from £570,000 to £650,000 for new claimants only – not retrospective. This would also involve increasing the cap (for cumulative amounts resulting from multiple injuries) from £570,000 to £650,000.

### Additional Supplementary Exceptional Award

17. The QQR team formed the view that there should be an additional Supplementary Exceptional Award, in addition to respective claimants' lump sum awards and GIP. Its value would be £325,000 (uncapped). This would be an acknowledgment of those who experience the highest degree of dependency on others to remain alive, and consequently qualify for the highest need for support (essentially, 24-hour medical care, although this award is not intended to cover the costs of care).

## **Chapter 9 – Interim Awards**

18. The intention of a “full and final scheme” is that as early as possible after the claim, an award will be made which takes into account the likely progress and functional limitation associated with the accepted disorder over the person's lifetime. In contrast, interim awards are designed for claimants whose entitlement to compensation is established but where the diagnosis and/or prognosis of their injury or illness is unclear. Interim awards are made at the discretion of the MOD based on medical advice that the claimant is not yet in a steady state, and a full and final award based on the permanent effect of their injury cannot yet be made.

19. Interim Awards, therefore, are designed for cases where an injury or illness is clear, but its on-going effect is not. They provide claimants with some financial security pending their full and final award. Awards are reviewed after two years, and then if necessary again at four years, to see if a final award can be made.

## **Chapter 10 – Worsening**

20. Worsening is where a Service person has sustained an injury through some cause other than by service, but then that injury is made worse by service. The time limit for claims for worsening was extended from 7 to 10 years by the Lord Boyce 2010 review.

21. The conditions where worsening might apply are, firstly, where there is a pre-existing pre-service disorder, either acknowledged at service entry or not, or, secondly, where there is an injury or disorder due on balance of probabilities to an identifiable non service-related

accident or event. To accept worsening, service has to be the predominant cause of the worsening. The MOD cannot lawfully accept worsening which is just part of the natural history of the disorder.

22. Compared with civil personal injury claims and compensation schemes such as the Criminal Injuries Compensation Scheme, the AFCS has a relatively narrow selected client group. In line with its key aim of maximising operational capability, the military adopts high standards of people management, training, protection and prevention as well as occupational health including regular routine medical examinations and assessment of medical employability. Where injury or disorder arises, timely access to best-practice medical management and rehabilitation is called for. Some of the attributes of the AFCS including the “worsening” provision derive from these features. Awards are made under the AFCS where on balance of probabilities there is a causal link to service on or after 6 April 2005. This may be “due to service” or “worsened” by service. Awards are paid at the same level for both categories.

### **Chapter 11 – Spanning**

23. Spanning cases apply to Service personnel who served both before and after 6 April 2005, the date the AFCS first came into effect, where the origin or cause of their injury or illness (including late-onset illness) might be attributable to service either before or after that date. This might include periods of Regular and/ or Reservist service, either continuous or non-continuous. Increasingly, ex-Service personnel with spanning service are claiming compensation. A key aim is to avoid double compensation, i.e. making awards for the same disorder under both the War Pensions Scheme (WPS) and the AFCS.

24. The aim in spanning cases, where possible, is to make a single award under one Scheme, with appeal rights also under one Scheme only. While awards under both schemes are based on a causal link to service and both schemes are individual jurisdictions, with decisions based on evidence, there are innate differences between the two. The WPS is medically certified with much scope for subjective judgment, while the AFCS is medically advised.

### **Chapter 12 – Decision-making**

25. This chapter examines the quality and consistency of decision-making and its contributory factors. The outcome of a “decision” may not produce an award for the claimant; their claim may be rejected. It should be borne in mind that a negative decision is not necessarily a wrong decision. However, a claimant who is not content with the value of an award or the decision to reject a claim has a clear procedure to query that decision – see next Chapter.

### **Chapter 13 – Appeals**

26. This chapter outlines the stages to be followed if a claimant is not content with the value of an award, or the rejection of a claim. A claimant may ask DBS Veterans UK for a reconsideration, which is the first step towards an appeal. The appeals process is covered, starting with a request for a reconsideration, proceeding through the stage of an appeal, and ending with a Tribunal. The QQR team’s findings were arrived at after experiencing a Tribunal hearing.

27. Unnecessary appeals come at a financial expense to both the MOD and Charities, and cause unwanted stress for Service personnel dealing with an injury or illness. It is in all parties’ best interests to ensure that appeals are minimised and that Service personnel receive appropriate compensation on first application. Further review of communications

educating Service personnel on the AFCS and the training for decision-makers would go some way to addressing issues that may occur at the appeal stage and reduce the number of appeals. It should be emphasised that the MOD does not rely on appeals as a routine part of decision-making.

## **Chapter 14 – Communications: Education and Effectiveness**

28. This chapter covers the communication of the AFCS to its target audiences including Service personnel, veterans, families of the Armed Forces, medical staff and to a certain degree the general population including the media. The aim of the communication is to educate the target audiences, and effective communication can only be said to have taken place when the recipient clearly understands the message that the author intended to send.

29. Effective communication is the cornerstone to any Government scheme. There are many benefits such as bringing about harmonious relations between Government and public as well as cost-effectiveness to the taxpayer, just as there would be costs associated with waste through misinformation and misunderstanding. The QQR team found that, with respect to information, “Accuracy”, “Consistency”, “Reliability”, “Accountability” and “Timeliness” are the key principles of effective communication, but in many cases these remain an aspiration rather than actuality. Monitoring is required to ensure that effective communication is maintained. The current communication channels through which the MOD informs the target audience include JSP765, Infolaw (the lawyers’ information exchange website), briefs to Service Personnel and the web pages for DBS Veterans UK on Gov.uk at [www.gov.uk/veterans-uk](http://www.gov.uk/veterans-uk).

30. Some progress has been made since the Lord Boyce 2010 review, but feedback from stakeholders led the QQR team to conclude that although communications on the AFCS certainly exist, they are not sufficiently regular or comprehensive. The Plain English Campaign guidelines or the equivalent are recommended when undertaking communications. In addition, the QQR team recommended that the Communications Working Group, which was disbanded having achieved its purpose of publicising the Boyce Review, should be re-activated.

31. A number of stakeholders’ responses to the QQR questionnaire were rather indicative of their level of understanding or misunderstanding. It is fair to say that the AFCS is a comprehensive scheme, although, in parts, it could be said that the Scheme can be complex when related to an individual’s understanding of it.

32. The QQR team found that there appeared to be an issue of engaging with veterans on the AFCS, that is to say those that had not needed the AFCS up to the time of discharge from service, but who might need it in the future, if an injury manifested itself in later years. The QQR team therefore recommended that those leaving service should be made aware that Service leavers are issued with a guide containing full information on the AFCS.

33. The QQR team heard widely from different stakeholders that there needed to be a more comprehensive publicising of the GIP, i.e. the total financial amount of an award rather than just the lump sum. The background to this is the general reporting on compensation by the media. Although communications on this topic put out by the MOD always mention the GIP, it is almost invariably ignored when the finished articles appear.

## **Chapter 15 – Comparison with Other Schemes**

34. The AFCS was compared with other Government-funded compensation schemes and one scheme for the Armed Forces of a Commonwealth nation, Canada. The schemes studied included the Fire-fighters’ Compensation Scheme, the Police Injury Benefits

Scheme, the Criminal Injuries Compensation Scheme and the Canadian Armed Forces Scheme. Overseas comparisons were and are difficult to make owing to the widely varying social, welfare and healthcare arrangements in other countries; the QQR team felt that Canada provided a good basis for comparison, since Canada has a Public Health Service comparable to the NHS. The QQR team found (as did Lord Boyce) that one significant difference between the AFCS and all other Government-funded schemes is that only the AFCS makes payments in-service. All the other schemes require the claimant to have left service on medical grounds. The conclusions reached were that the AFCS is more generous in its provisions than other UK Government schemes, and that the QQR team did not identify any need to make any changes to the AFCS.

## **Chapter 16 – Additional Issues Raised**

35. Additional issues are those raised by Stakeholders which have not been covered in the analysis and recommendations of this Review. These issues included slips, trips and falls, hearing loss and the role of other State organisations supporting Service personnel. This chapter explains the specific circumstances in which slips, trips and falls may be eligible for an award. It likewise gives details of the circumstances in which hearing loss leads to eligibility, and considers the likelihood that Service personnel would tend to conceal hearing loss out of anxiety that it might affect their future careers. The QQR team also recommends that communication be enhanced between the Department of Health, NHS England and the Department for Work and Pensions (DWP) in order to reduce misunderstandings about the AFCS and how it interacts with other State benefits.

## **Chapter 17 – Issues Raised that were outside the Scheme**

36. Some issues outside the Scheme were raised unknowingly, as a result of misunderstanding what the Scheme covered, and one of the recommendations in the section on Communications is that every effort be made to inform stakeholders what is, and what is not, covered by the AFCS.

37. The predecessor of the AFCS, the WPS, was introduced at a time when the NHS and the Welfare State did not exist, and its provisions were designed to protect Service personnel in that environment. The AFCS was introduced in order to better reflect the situation obtaining in the 21<sup>st</sup> century, and so its terms and conditions are markedly different from its predecessor. Other stakeholders brought up the treatment in general of veterans in society, NHS Funding and general healthcare, compensation for “over-use” injuries “below Tariff”, access to “state of the art” prosthetics, re-training costs and other matters not considered relevant to the AFCS. Likewise, a number of issues raised did not concern policy but instead were operational delivery issues outside the remit of the QQR. Certainly, widespread engagement with stakeholders should be encouraged in order to identify any anomalies that may come to light, and, more importantly, to ensure increasingly wide knowledge of what the AFCS is meant to cover and what it is not.

## **Recommendations**

### **Chapter 3 – Status of the Scheme**

- Equality-proofing of AFCS policies (ensuring that no group is disadvantaged). It may be impracticable to analyse all policies in depth.

### **Chapter 4 – Scope of the scheme**

- MOD to indicate formally what the AFCS does not compensate for and what it does; this should be reflected concisely in the JSP.

- Because of the frequent use of the term “pain and suffering” in the AFCS literature, the term should be defined or, if not, avoided.
- Given the particular needs of Reservist personnel, the Reservists’ Champion should act as an advocate for Reservists if they encounter difficulties when making claims.

## Chapter 5 – Emerging Challenges

- In order to keep up with the digital age, MOD should investigate further how information technology could assist with improved customer service for prospective claimants. This includes speeding up processing and tracking individuals’ claims, being aware of how the AFCS is being communicated on social media and whether there is any merit in the AFCS administrators being part of that interaction on social media.
- The IMEG to consider gender differences in musculoskeletal injury, risk, type or treatment course. The MOD should consider how the IMEG’s findings could be shared with the respective training organisations.
- MOD to gain an understanding of why female claimants have a lower rate of award than male claimants.
- An annual one-page report to be produced by the MOD on the operational priorities and emerging challenges to Service personnel, to enable IMEG to have notice of what upcoming issues could be for Service personnel.
- MOD to consider the merit of the IMEG discussing the impact that Zika (and Ebola) could have on the AFCS.
- The AFCS Order to have clarified as a policy issue what infections are covered by the scheme and what are not.

## Chapter 6 – Data Collection

- That MOD should collect and record accurate data on the number of registered claims and their associated conditions, i.e. statistical data on claimed conditions.

## Chapter 7 – Categories of Awards

- Opportunities to be taken for further development of protective resilience amongst Service personnel.
- Given politicians’ commitment to good mental health amongst military personnel and veterans, the QQR team suggests that the various campaigns and support to individual claimants should continue, including by the Service and ex-Service charities.
- More guidance to be provided on the term “**permanent**”, with regard to Article 5 of the legislation, as having a permanent condition attracts a higher award and also a GIP, which is granted for permanent conditions.
- The MOD to look into the reasons why current Defence Medical Services (DMS) and NHS practice may make it difficult for diagnoses of discrete mental health disorders by a consultant-level clinical psychologist. MOD to consider if there is scope for IMEG to review the requirement.
- MOD to consider whether there is scope for increasing the highest level mental health awards, as the QQR team met specialists who confirmed that mental health disorders may be as disabling as severe physical injuries.
- MOD to review the clarity of descriptors and the award levels for back injury and pain syndromes.
- MOD to consider adopting the best elements from the Royal Marines on musculoskeletal disorders across all Services with the aim of reducing future injuries and therefore potential claims.

- Further study into the long-term impact of NFCI to be undertaken, particularly taking into account the seasonally fluctuating nature of the condition.
- MOD to consider clarification of the brain injury descriptors and award levels.

## Chapter 8 – Level of Awards

- Lump sum awards to be automatically updated for inflation in line with the CPI on an annual basis, thus ensuring that Service personnel suffering injuries in the future would not face a reduction in the value (in real terms) of their lump sum awards. The alternative would be the creation of an internal review mechanism. It would comment on the value of awards, and recommend whether uplifting of awards was needed without having to await a QQR. MOD should engage with the relevant parties and would report to the CAC.
- To uplift the top Tariff level 1, currently £570,000, as it was last reviewed in 2011 and does not sufficiently recognise the most seriously-injured and high-dependency cases. This should be from £570,000 to £650,000 (based on inflation statistics). In line with this, the cap for multiple injuries should also be increased to the same level. The QQR team does not recommend the complete removal of the overall cap (£650,000).
- To introduce an additional Supplementary Award, in addition to respective claimants' lump sum awards and GIP. The value would be £325,000 (uncapped). This would be for those who experience the highest degree of dependency on others to remain alive and consequently qualify for the highest need for support (essentially, 24-hour medical care). This would apply to claimants, provisionally named the “**Most severely injured and highly dependent Service personnel**”. The QQR team recognises that there would be work needed on refining the Supplementary Award in terms of its criteria, the timing of the decision and the responsibility for recommending Service personnel for this Supplementary Award.

## Chapter 9 – Interim Awards

- MOD to consider the proposal of an automatic right to review an interim award when approaching discharge date, if more than six months from the date of the award, with a review of Article 52 of the AFCS Order 2011 in order to determine the merit of a right to review an interim award at that time.
- MOD to liaise with the Financial Services Steering Group (FSSG) through the Armed Forces Covenant Team, with two objectives:
  - 1) To disseminate knowledge of the AFCS, given that there would be a number of their customers who would be recipients of large compensation pay-outs, and for some, a GIP.
  - 2) To inform claimants about interim awards and perceptions regarding financial insecurity.

The FSSG will be able to share this information with the Financial Services industry. Included in the FSSG are the following, which are all relevant to this issue:

- British Banking Association
- The Finance & Leasing Association
- Building Societies Association
- The Council of Mortgage Lenders

## Chapter 10 – Worsening

- MOD to consider whether the 7 year and 10 year time limits for claims are still appropriate and to highlight the time limit rules.
- MOD to support the IMEG review of the medically and scientifically sound approach to worsening. This will form part of the fourth IMEG Report in 2017.

## Chapter 11 – Spanning

- MOD to review legislation and policy on time limits for claiming.

## Chapter 12 – Decision-making

- MOD to refer points concerning musculoskeletal disorders and mental health problems to IMEG for their comment as part of their 2016/2017 review of musculoskeletal disorders and ten-year review of AFCS mental health claims.

## Chapter 13 – Appeals

- Further review of communications educating Service personnel – DBS Veterans UK to consider publicising guidance on its decision-making process, which is already available to anyone who wishes to see it (similar to that published by DWP) in relation to disability benefits, particularly when it comes to medical assessments.

## Chapter 14 – Communications

- DBS Veterans UK to use their **communication and marketing professionals** to convey information on the AFCS to its target audience of claimants, with information accredited by the **Plain English Campaign**. DBS Veterans UK to take forward.
- Reactivation of the **Communications Working Group** to meet at least quarterly on an on-going basis. Its functions should be monitoring and evaluating the communications employed, as well as providing centralised direction and guidance. It must be inclusive and collaborative in its approach, having the charity sector and the relevant MOD Departments and DBS Veterans UK around the table.
- The DBS Veterans UK communications professionals should assist with the production of a comprehensive narrative on the **GIP**, accredited by the Plain English Campaign.
- **Divisional courses/HR modules on the AFCS**. These must be brief and concise, specifically designed to provide essential information. They could be tagged on to an existing online course that all Service personnel do, or one could be specially created. To be taken forward by the Communications Working Group.
- Those leaving service should be informed about the AFCS. To be taken forward by the Communications Working Group.
- A finance course to be undertaken by awardees in receipt of substantial lump sums. The chain of command should direct individuals to their unit HR staff who can provide details of the Services Insurance and Investment Advisory Panel (SIIAP) or other organisations providing wealth management advice.
- An elevator pitch on the IMEG reports to be cascaded to Units and in addition the MOD, and DBS Veterans UK as a **verbal** briefing.
- A new approach to be taken for **letters communicated to claimants on their AFCS outcomes**. This should be facilitated by the communications professionals, with the

proposed letters tested on a focus group of Service personnel of varying ranks to review the content of the letters.

- MOD to compile a list of the most commonly-held misconceptions about the AFCS.

### **Chapter 15 – Comparison with other Schemes**

- No requirement was identified to make changes to the AFCS as a result of comparison with other Schemes.
- In any public statement where the AFCS is compared with other Schemes, MOD to continue to ensure that awards are publicised as a two-part settlement with due emphasis on the GIP.

### **Chapter 16 – Additional Issues Raised**

- MOD to take forward the stakeholders' feedback that other arms of the State apparently have insufficient knowledge of the AFCS and how it interacts with State benefits.

### **Chapter 17 – Issues outside the Scheme**

- AFCS guidance and legislation to be reviewed to ensure wide comprehension.

## **CONCLUSIONS**

During the course of the QQR team's research and investigations for this Report it was found that the AFCS remained on track, and had demonstrated that it had evolved over the years; however, the QQR team would like to emphasise the continuing need for periodic review of the AFCS in order to ensure that it continues to remain responsive to changes in the current environment, adapting accordingly.

The QQR team consulted with a wide cross-section of stakeholders during the evidence-gathering, and has made an effort to ensure that due weight has been given in the Report to all the views expressed, even if they could not all be adopted as Recommendations. The QQR team is content that the aims of the Scheme have been met and that the Scheme remains fundamentally sound, but recommends the changes set out, and presents this Report to the Ministry of Defence for its consideration.

# Chapter 1

## INTRODUCTION

### The Armed Forces Compensation Scheme

1.1 The unique nature of military service is reflected by the Government's continuing commitment to those who have been injured due to service, with an appropriate recognition for their sacrifice. The Armed Forces Compensation Scheme (AFCS) provides a no-fault compensation package for members of the Armed Forces, and their dependants. The Scheme covers all Regular and Reserve personnel. The AFCS is essentially a mechanism to deliver compensation payments to individuals. The Scheme is not intended to and does not 'look after' individuals.

1.2 It is important for Service personnel to know that they or their families will be compensated in the event that they are injured or become ill or die as a result of service. The Armed Forces Compensation Scheme is an important element of the moral component of the UK's operational capability. It also provides a suite of measures to empower claimants financially to enable them to lead as normal a life as possible in the circumstances.

1.3 It provides compensation for circumstances in which illness, injury or death may arise due to or to be worsened by service, on or after 6 April 2005. The AFCS provides a payment if the Service person can demonstrate that the balance of probabilities is such that their injury or illness is more likely than not to have been caused or made worse by service. Where the injury or illness is partly caused or made worse by service, compensation is payable if service is the predominant cause of the injury. As reflected in the AFCS legislation, "The standard of proof applicable in any decision which is required to be made under this Order is the balance of probabilities" (p. 38 para 61). The AFCS succeeded the previous arrangements under the War Pensions Scheme (WPS), which cover disablement caused by service before 6 April 2005, and the Armed Forces Attributable Benefits Scheme (AFAB).

1.4 In terms of what the AFCS is **specifically paying compensation** for, the **actual objective** of the Scheme is not laid down in [JSP 765](#) (the AFCS's intended statement of policy) nor in its legislation. However, the AFCS's narrative states that the full and final lump sum award is intended to reflect the nature and course of treated injury/illness over a lifetime. For the most serious injuries there is also a tax-free Guaranteed Income Payment (GIP) which, once awarded, is payable for life from service termination or date of claim. This reflects the impact of the accepted injury or disorder on suitable civilian employability. The narrative, in commonly-used AFCS literature, states that the lump sum is paid for "pain and suffering", with the GIP for more serious injuries. Where the individual's ability to earn income beyond their service career is detrimentally affected by their injury or illness, an income stream (GIP) is paid in addition to the lump sum. Details will be covered later on in the Review, in the section on "Level of Awards".

### The Lord Boyce Review 2010

1.5 Chaired by Admiral the Lord Boyce, the AFCS was subject to an independent review in 2010<sup>1</sup>. This was wide-ranging, with all recommendations accepted by Ministers, and implemented. This review concluded that whilst future reviews of particular aspects of the Scheme could not be ruled out, a more fundamental overhaul should not be required.

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<sup>1</sup> [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/228893/7798.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/228893/7798.pdf)

## The Quinquennial Review (QQR)

1.6 Five years or so from the last review of the AFCS, the MOD has undertaken the QQR. The QQR's Terms of Reference (TORs) (see Annex A) were proposed by the MOD and agreed by the Minister for Defence Veterans, Reserves and Personnel (DVRP). The Review's **intention and key aim** was to examine whether **"the AFCS remains fit for purpose providing appropriate recognition and financial support to those members of the Armed Forces who are injured, become ill or die as a result of service."** The Central Advisory Committee on Compensation (CAC) (a stakeholder advisory group for service compensation issues) also agreed with the Policy team's direction that the QQR team would not be a structural review, but would look at a number of specific issues in detail. This included scope of the Scheme, categories of awards, uprating (for inflation) of awards, Tariff levels, and appeals. Defence Business Services (DBS) Veterans UK undertakes the delivery of compensation claims processing. Their work is subject to separate consideration and therefore will not form part of this Review. The Review, however, has referred to the processing aspect of the AFCS when raised by Stakeholders as a recurrent theme.

## The Approach

1.7 The QQR team consulted with a wide cross-section of stakeholders using an open-ended questionnaire and follow-up meetings. Stakeholders consisted of claimants, charities including the Royal British Legion (RBL), Soldiers' Sailors' and Airmen's Families' Association (SSAFA), the Confederation of Service Charities (COBSEO), British Limbless Ex-Servicemen's Association (BLESMA), Help for Heroes, Veterans' Aid, advisory bodies such the Independent Medical Expert Group (IMEG), CAC, MOD Head Office policy staff, Principal Personnel Officers, single-Service Pay Colonels, DBS Veterans UK, DBS Resources, Defence Medical Rehabilitation Centre (DMRC) Headley Court and other Government departments. The QQR team also engaged with a number of additional stakeholders and experts who are acknowledged at the end of this Report.

1.8 The QQR team suggested that it would be particularly helpful if issues could be accompanied by illustrative examples or other evidence. Where appropriate, the QQR team grouped issues together as themes or chapter headings. More evidence was gathered and further discussions took place with internal stakeholders and experts. Findings, conclusions and recommendations were then developed. As work progressed, emerging topics were shared with the CAC, who confirmed that these reasonably represented concerns about the Scheme of which they were aware. It became clear that some of the issues were already being addressed, or that mainstream work was proposed. Some themes were primarily medical or complex, and in the time available the recommendations were inevitably a mixture of proposals and topics for further investigation. **It should be emphasised that the QQR team has identified only key recommendations to be taken forward; however, a number of observations have also been reflected in the report.**

1.9 The structure of the chapters is as follows: a topic is set out, followed by an explanation of why we have focused on it, the current Scheme provisions and the stakeholder perspective. There then follows a short summary of the QQR team's findings, observations, analysis, conclusions and recommendations.

## Chapter 2

### BACKGROUND TO THE ARMED FORCES COMPENSATION SCHEME

2.1 On 6 April 2005 the AFCS was introduced covering injury, illness or death caused by incidents, events, exposures or behaviours occurring on or after that date due to service. The underlying general principles of the Scheme were: fairness, simplicity, modernity, security, employability, human rights and fairness at work, sustainability and affordability arrangements should be realistic and fair to the tax-payer.

2.2 Discussions with a range of Stakeholders including serving and ex-Service personnel and the military charities in the consultation exercise, held prior to setting up the Scheme, had also upheld the principle of no differentiation in awards for combat or operation-related injuries or deaths, compared with injury in other service contexts. This feature is also seen in the WPS and it was felt that any change 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 by service, to set compensation at realistic levels, to provide security and certainty by making final awards as early as possible, and, for the most seriously injured, to provide lifetime financial support, while not acting as a disincentive for those able to work.

2.3 The AFCS is tariff-based, arranged in nine tables of injury categories relevant to a military population. In these tables, descriptors setting out criteria for the injury or disorder are listed, opposite the equivalent award level. In many cases, the descriptor reflects the duration and severity of the disabling effects of the injury. Tariff levels presently range from £1,200 to £570,000 and compensate for pain and suffering, i.e. as in civil non-pecuniary damages. Awards for pain and suffering are relatively objective and represent the claimant's likely immediate and future bodily, physical and mental hurt due to the accepted injury or disorder. This includes the hurt from the necessary medical, surgical and rehabilitative treatment. The aim is that awards for the same condition should be consistent between cases with similar accepted injuries and disorders and case-specific facts. As all physical disorders and injuries are accompanied by emotional effects, all awards include an element for psychological symptoms. Where a discrete psychological disorder is present, an additional award may be made.

2.4 Despite the high operational tempo since 2005, the evidence is that most claims in the Scheme have not been for combat-related traumatic physical or mental injuries but for musculoskeletal injuries to knees and back due to sport or adventure training. In terms of response to treatment and ultimate disabling effects, these disorders are in the main at minor or moderate level with good prognosis and expectation of return to previous or at least useful functional capacity. Associated awards are mainly at the lower Tariff levels 12 -15 (See Annex C) with only a lump sum payable.

2.5 Unlike the situation with civil damages where fault must be proven, as a no fault scheme the AFCS does not make awards for loss of amenity, i.e. the loss of ability to enjoy life and pursue enjoyable activities nor any of the other heads of civil damages. Assessments of these heads are inevitably individual considerations likely to be complex, lengthy and costly and to result in widely different award outcomes for similar injury type and severity, occurring in different people. For the most seriously injured, with AFCS awards at levels 1-11, there is in addition a Guaranteed Income Payment (GIP). This reflects 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. Claims under AFCS rarely make reference to possible lapse of duty of care or negligence. Where that is

an issue, recipients of AFCS awards separately may sue in tort<sup>2</sup> with adjustment of awards to avoid double payment.

2.6 Since the start of the AFCS, due to advances in medical treatment in theatre, servicemen and women in Iraq and Afghanistan have survived injuries which would previously have been fatal. As a result, a number of changes were made to the Scheme. These included additional descriptors, an increase to the highest lump sum award and a new multiple injury rule which recognised all injuries sustained. The intention is that the AFCS should be flexible and able to address changing circumstances and types of injuries and disorders claimed with full and appropriate compensation for any injury or disorder caused by service on or after 6 April 2005.

2.7 The AFCS has normal time limits for claiming, and has a **late-onset provision** for illness, physical or mental, capable of being caused by exposure or incident out with the normal seven-year claim time limit. It also covers late presentation for mental health disorders, acknowledging the situation where the disorder, although present within seven years of the trigger incident, means that the person suffering from it is unable to seek timely medical help. The Scheme can also make **temporary awards**. These are used where a service-related injury is not on the Tariff but is considered sufficiently serious to warrant an award. The Scheme can make a temporary award at a particular level and within a year of the date a new descriptor at that award level is incorporated into the Tariff. Finally, **interim awards** apply where injury benefit is appropriate but the prognosis of the injury or disorder claimed is uncertain. This may occur where a claim is made very soon after an injury is sustained or illness presents, or frequently where an adequate course of best-practice treatment for the claimed condition is not complete. This may mean that likely progress and prognosis cannot be determined. Where this happens, the most appropriate descriptor and Tariff award is selected and paid, with a review within two years maximum from the date of the first award. Exceptionally, a further extension of two years is possible, when a final decision will be made. If the final award is at the same Tariff level or higher than the interim award, any extra benefit due is paid. If a lower award is now appropriate, no further award is made but no amount already paid is recoverable. For both interim and temporary awards, appeal rights are notified when awards are made final.

2.8 As a no-fault public scheme, in addition to the lump sum and, for the most seriously injured, a GIP, AFCS awards do not include elements for health or other care. Recognising the nature of some of the most complex injuries with progress and prognosis presently unknown, and that many of those injured or made ill by service will have a long post-service civilian life, the Scheme intentionally relies for healthcare on support from other public provision, e.g. early access to world-class advances in treatment led by international and UK universities such as Imperial College's sponsored Centre for Blast Studies, delivered by the NHS, NHS Priority Treatment and Department for Work and Pensions (DWP) employability and disability benefits. The AFCS is part of the nation's commitment to those injured or made ill by their service. While the clear aim is to provide all support and security for the most seriously injured, wherever possible the injured veteran should be able to take full advantage of developments in thinking and contemporary best practice in health and social care and disability support.

2.9 The decision was also made that AFCS recipients should claim civilian disability benefits. The aim was to ensure that ex-Service personnel were able to benefit fully from best-practice thinking in disability support. DWP support in the future may increase the

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<sup>2</sup> A tort is a legal wrong which one person or entity (the tortfeasor) commits against another person or entity and for which the usual remedy is an award of damages.

financial value of disability benefits, but also may replace or complement them by more active vocational rehabilitation, mentoring and talking therapies.

2.10 Above all, the AFCS tries to empower individual people, enhance well-being and self-esteem, and maximise capacity and capability. Decisions under AFCS can be appealed to the independent First Tier Tribunal.

2.11 Finally, international comparisons confirm that it is not possible to equate the adverse effects of injury or disease with a sum of money, and compensation must always be seen as a last resort. Much more important with regard to occupational personal injury are protection, prevention, high standards of people management and training and occupational health, as well as timely access to best-practice medical and vocational rehabilitation. The MOD and single Services led by the Chief of Defence People (CDP), Surgeon General and the chain of command are fully committed to these approaches, including the CDP Health and Wellbeing strategy which focuses on mental health, lifestyle, injury prevention and communicable diseases.

## Chapter 3

### STATUS OF THE SCHEME

#### Definition

3.1 The status of the AFCS concerns the current perception and standing of the Scheme. Internal and external Stakeholders (internal: within the Ministry of Defence, external: Service charities, experts and individual claimants) were asked early on whether the Scheme remained on track with reference to the underlying principles of the Scheme and what success looked like. These questions were derived from the Review's aim, which was to examine whether the Scheme remained "fit for purpose".

3.2 This chapter will explain the key performance criteria to assess whether the AFCS was on track and also what the stakeholders said in response to the questionnaire (and various supplementary questions). The subsequent chapters will build on these conclusions, based on the work done by the QQR team.

#### Lord Boyce Review 2010

3.3 Lord Boyce concluded in his 2010 review that the AFCS was fundamentally sound, but made a number of recommendations to improve the Scheme. His review established that the underlying principles were appropriate, although greater clarification of the meaning of some of the principles was needed. The Scheme needed to reflect more clearly the key principle that the most seriously injured should receive the highest awards. Lord Boyce reaffirmed the principles, which originally appeared at the time of the initial studies for the AFCS in 2001, and they were: *Be Fair; Be Understandable, Accessible and Transparent; Be Contemporary and Joined-Up, Provide Security, Encourage Employability, Be Compatible with Human Rights and Fairness at Work, and Be Sustainable*. The QQR team used these as one of the key performance criteria to assess the status of the Scheme and to evaluate the merits of any recommendations throughout the chapters, and reached the conclusion that the Scheme continued to meet those requirements.

#### QQR Findings

##### Criteria for assessing the status of the AFCS and what a successful AFCS looks like

3.4 Generally, the QQR team did not encounter any disagreement with the design or underlying principles of the Scheme. However, the QQR team found that along with the concept of fairness, it is pertinent to consider the following:

- What is equitable across the Scheme, looking beyond the present, viewing the bigger picture.
- How conclusions may have unintended consequences on how we view compensation, and
- how the general population views AFCS compensation, a publically funded Scheme.

3.5 The QQR team is of the view that the AFCS needs to be cognisant of the views of Service personnel who have not claimed and those outside the Scheme, such as the general population when assessing the Scheme, and arriving at conclusions.

3.6 In addition, some stakeholders expressed the view that a successful AFCS had the following attributes:

- Transparency of awards, in terms of their determination
- Awards should keep track of the costs of everyday living
- The Scheme should be a straightforward and flexible scheme to ensure that no member is left without suitable compensation should they become injured as a result of service
- Equality proofed so that no particular group will find itself disadvantaged

#### Transparency of awards, in terms of their determination and awards that keep track of the costs of everyday living

3.7 With regard to transparency of awards, the list of descriptors, and corresponding Tariffs, included in the legislation is available for all to see on the gov.uk website. Notification letters and accompanying “Reasons for Decision” sheets sent by DBS Veterans UK to claimants are factual, helping to ensure transparency of awards. However, the QQR team noted a recurrent theme in stakeholders’ feedback that the decision letters sent to claimants can prove difficult to understand for claimants less used to coping with jargon and official forms.

3.8 A number of stakeholders said that “transparency” should include regular review of the amount the awards paid. Stakeholders questioned the current approach to the review of Tariff awards and expressed the view that the lump sums appeared to be evaluated only every five years. Although the AFCS is only 10 years old the awards have been reviewed twice, in 2008 and 2010. The QQR team believes having in place some type of routine review procedure for Tariff values would mitigate that assertion. Linked to this point, Stakeholders said there did not seem to be a mechanism for the lump sum awards to keep track of the costs of everyday living, apart from the GIP, which is linked to the CPI. This issue is picked up in the chapter “Level of Awards” (Chapter 8).

#### Claiming Compensation – Claims, Awards and Appeals

3.9 The intention of the AFCS is to compensate Service personnel if they become ill, injured or die as a result of service on or after 6 April 2005. As of 31 March 2016, there have been 63,098 registered claims and 35,601 awards made, and 1014 appeals resulting in new or increased awards for registered injuries or illness. The QQR team did not receive any evidence that Service personnel were unfairly left without an award, given the intention of the Scheme. However, there were views about the adequacy of Tariff values for some specific categories of injury, e.g. back pain.

#### Equality-proofing

3.10 Stakeholders expressed the view that an effective AFCS should equality-proof its policy and legislation. The Armed Forces and the AFCS came under the Equality Act in 2010. However, the Armed Forces are excluded from the Equality Act 2010 employment provisions on disability (EqA Sch 9 para 4(3)).

3.11 Although there have been amendments to the AFCS since 2005 and post-Lord Boyce review 2010, the QQR team did not see any evidence that any subsequent changes/amendments to policy or legislation were equality-proofed. It is important to note that equality-proofing forms part of broader mainstreaming strategies, which seek to integrate equality principles and practices into the everyday work of Government. **Proofing** is usually defined as a formal mechanism by which policies are assessed for their likely impact on a particular area or areas of concern, such as gender equality or diversity concerns. An **impact assessment** is carried out as part of the proofing process. Impact assessment is a tool used for assessing the impact of policy on agreed objectives, which, in the case of mainstreaming objectives, will relate to equality. The benefit of equality-proofing

is that it could prevent claims based on the propensity of certain protected groups to suffer disproportionately from some conditions.

**3.12 The QQR team is of the view that equality-proofing is central to the AFCS principles in terms of fairness, relevance and transparency. Equality-proofing of legislation provides the opportunity to examine the substance and consequent fairness of proposals.** Those drafting policy or legislation can ensure that they are in keeping with broad equality and social justice policy objectives, and can check that they comply with equality as well as human rights legislation.

Is the Scheme fit for purpose?

3.13 Overall, stakeholders expressed the view that the AFCS continued to be on the right path for the majority of claims, and that the AFCS was strong when dealing with acute and physical injury. Stakeholders used terminology such as “sound” and “very good”, which demonstrated the AFCS was doing well. However, they did emphasise that there was room for some improvement and change. The majority of AFCS awards (96%) are given at the lower Tariff levels where there are often more regular and “uncomplicated” claims.

3.14 Some said that the Scheme did not appear to be on track uniformly across all injury types or for the most seriously injured, and certain injury or disorder sub-categories, and long-term conditions. Admittedly, when comments are accumulated, it appears as though the AFCS is viewed by some stakeholders as a “glass half-empty” rather than “half-full”. The QQR team is of the view that given the sensitive and emotive nature of the subject, and also that the Scheme is publicly-funded and high-volume, it would always be a challenge to get complete satisfaction the response to every claim, especially for the most seriously injured or complicated illnesses/injuries.

3.15 The subsequent chapters in this report broadly set out what works well and where there is room for improvement. However, the chapter on Emerging Challenges considers views and evidence as to whether the AFCS is flexible, adaptable and responsive to new issues. This includes measures such as temporary or interim awards, reconsiderations or appeals. Therefore the AFCS has demonstrated that it has evolved over the years.

## **Conclusion**

3.16 In conclusion, the Status of the Scheme meets the design criteria, and the principles remain fit for purpose with some suggested enhancements for consideration. The AFCS remains on track, and has demonstrated that it has evolved over the years. Flexibility to adapt to changing circumstances needs to be maintained; hence, there is still room for improvement. Moreover, it is the QQR team’s view that room for improvement is to be expected, given that the AFCS is only 10 years old and still maturing.

3.17 A successful AFCS is one that adheres to the intentions of the Scheme, one that is relevant in terms of ensuring that policies are equality-proofed and where the awards evaluation process is transparent.

## **Recommendations**

3.18 The QQR team recommends the following:

- The MOD equality-proofs AFCS policies and carries out an impact assessment. Given resource constraints, it may be impracticable to analyse all policies in depth. There are screening tools to enable identification of those legislative/policy proposals, which require more detailed attention and analysis.

## Chapter 4

### SCOPE OF THE SCHEME

#### Definition

4.1 Understanding the scope of the AFCS is fundamental to answering whether the AFCS remains fit for purpose. The aim of the Scheme is to compensate Service personnel for injury, illness or death caused by incidents, events, exposures or behaviours due to service on or after 6 April 2005. Evaluating the intention of the Scheme, and comparing that intention with **what the stakeholders think the AFCS is compensating for and** with what they **think it ought to be compensating for** is integral to assessing the scope of the Scheme. This sheds light on the current perception and comprehension of the AFCS. Improvements in these areas could help demonstrate “what success looks like”.

4.2 This chapter will discuss what the Scheme provides and what the stakeholders had to say on the scope of the Scheme. The topic of Reservists will also be examined as part of the scope of the AFCS.

#### Lord Boyce Review 2010

4.3 Lord Boyce made the point in the 2010 review that the AFCS was a no-fault scheme, but that having an AFCS award does not preclude a negligence claim through the common law damages route, although an AFCS award would be taken into account in the damages payment and vice versa.

4.4 Lord Boyce carried out a comparative analysis of the AFCS with Damages in Personal Injury cases, referring to the concept of “pain and suffering”. He found that, “Lump sums paid under the AFCS compare well with those found in civil litigation for pain and suffering”.

4.5 The Lord Boyce review considered whether additional compensation or “heads of damages” as a civil negligence award might also provide should be paid, and, in particular, elements based on personal characteristics or individual circumstances, such as loss of amenity. In the final analysis, the Lord Boyce review rejected that approach, not least because in a publicly-funded no-fault scheme, identical injuries incurred in the same context might attract very different awards.

#### Scope of the AFCS

4.6 There are three levels of comprehension in this area, each wider in scope than the last. These are:

- What the Scheme does
- What stakeholders think it does, and
- What they think it ought to be doing

4.7 The QQR team asked both internal and external stakeholders what they thought the AFCS should be compensating for and, from that, gained an insight on what the Stakeholders also thought the AFCS was compensating for, which was in fact often wider than the Scheme’s intentions.

## What the Scheme provides

4.8 The AFCS provides compensation for injury, illness or death caused or made worse by service in the UK Armed Forces on or after 6 April 2005. A payment is made from the Scheme where the individual shows that, on balance of probabilities, an injury is more likely than not to have been caused or made worse by service. Where the injury is partly caused or made worse by service, compensation is payable if service is the predominant cause of the injury or the worsening. The Scheme applies equally to Regular and Reserve forces. It is also payable to dependants (spouse, civil partner, and surviving adult dependent and eligible children) in the event of death of the Service person. Compensation is paid for injuries which arise as a result of service, regardless of how or the context in which they are sustained. No distinction is made between injuries sustained on operations and those incurred during training, service-approved sport, or while undertaking specified activities to maintain fitness. Recognising that members of the Armed Forces do not generally choose where they deploy and what activities they undertake as part of their service, the compensation scheme covers the spectrum of activities the Armed Forces undertake.

4.9 While the responsibility for showing that the injury is caused by service rests with the individual, the process itself is designed not to be onerous. The process of determining a claim is inquisitorial and not adversarial, with Veterans UK undertaking the vast majority of evidence-gathering on the individual's behalf. Claimants are also free to provide any evidence they wish.

4.10 Lump sum awards can be made in service and any GIP is paid from service termination or, if later, from the date of claim. This is because Service personnel receive their military salary while still serving. The Scheme is designed so that awards are made full and final as early as possible, and take into account the expected effects of the injury or illness on function following best-practice treatment over the Service person's lifetime. This compares the injured or ill person with a normal person of the same age and gender over a lifetime. This means that once a final award is made, in the majority of cases, it does not need review or amendment and so individuals can have financial certainty, fully engage with treatment and rehabilitation and move forward in their lives. It also means that wherever possible the Service person can take up suitable civilian employment, and participate in life's activities without fear that doing so could reduce or remove their income or assets. Review provisions are however available, and a key policy intention is that in every case claimants should receive full and appropriate compensation for service-related disorders including where the course of treatment is unexpected or complex.

4.11 There may be cases where the injury or effect of the injury, while not necessarily having an impact on function for future civilian employability, can have a substantial effect on some aspect of the Service person's function or their self-image, confidence and self-worth. To recognise these circumstances, an additional payment, known as a Supplementary Award, is made if the primary injury meets certain specified conditions. Supplementary Awards are paid in addition to the lump sum and are paid at the same time. An example is an injury to genitalia that results in infertility.

4.12 Where an individual has an accepted injury with an on-going impact on their functional capacity for suitable civilian employment until retirement, a GIP which is a lifelong, tax-free, inflation-proof income stream is paid from service termination or date of claim if later. The Service person continues to receive military salary while still serving even if non-effective. The GIP is based on the Service person's age at last birthday and their basic pensionable pay (i.e. excluding 'additional' elements of remuneration such as allowances) at the time they leave service or updated to date of claim if later and the severity of the injury/illness. The calculation of GIP uses this data, along with a series of assumptions, to

determine the lifelong loss of earnings the individual is likely to face in terms of both salary and pension as a result of their service-occasioned injury or illness.

## QQR Findings

### What the Scheme compensates for

4.13 To understand what the Scheme compensates for, the QQR team consulted the Armed Forces and Reserve Forces Compensation Scheme Order 2011 in force from 31 May 2016:

- Benefit is payable to or in respect of a member or former member by reason of an injury which is caused (wholly or partly) by service, where the cause of the injury occurred on or after 6th April 2005. Where injury is partly caused by service, benefit is only payable if service is the predominant cause.

4.14 The QQR team found that one could be forgiven for assuming that the policy and legislation reflected the fact that the Scheme contextualised itself to cover “pain and suffering”. Narratives on the AFCS state that the AFCS compensates for pain and suffering, for instance in briefings, reviews and the DBS Veterans UK’s webpage ([www.gov.uk](http://www.gov.uk)) which states, under paragraph 2.4, “Types of awards: Lump Sum payments: For injury or illness, AFCS provides a tax-free lump sum payment for **pain and suffering...**”

4.15 Several stakeholders asked for a definition of the term “pain and suffering” which is frequently referenced in respect of the Scheme but not defined. Using the term “pain and suffering” can be confusing, considering that it is not explained in the context of the AFCS in legislation or the JSP. In addition, although the term “pain and suffering” appeared to have been coined by internal stakeholders to explain what the lump sum was for and to differentiate it from the compensation for loss of earnings like the GIP, the QQR team concluded that the term had been derived from Civil Damages cases, which can be compared with other schemes. The term is also to be found on the official forms sent by DBS Veterans UK to successful claimants.

4.16 The QQR team found that in discussions with external stakeholders on the AFCS, some used the term “pain and suffering” and noted that it provoked a wide variety of reactions. A particular issue was the view held by some external stakeholders that the AFCS compensated more widely than in fact is the case, because of the use of the term “pain and suffering” without explanation. For example, for some stakeholders, the lump sum was expected by some to cover healthcare costs and loss of amenity. One external stakeholder said, “I have never felt totally safe and secure. If I could only have that stability, it would help alleviate my constant mental pain and suffering, and I would at least feel part way compensated.” It should be noted that since the Beveridge Report in 1942, the NHS and local authorities have been the principal route to health and social care for those injured or made ill by their service to the country. In other words, the AFCS is but one of a suite of measures to support Service personnel.

4.17 The QQR team did explain to respective external stakeholders that the AFCS did not cover things such as healthcare, etc. some stakeholders expressed the view that the scope of the scheme should be widened. Statements were made such as, “The AFCS should form part of a package; assistance should be given to spouses/partners as part of the Scheme; assistance with housing modifications should be an integral part of the compensation; the Scheme should compensate for pain and suffering, ...” Others went on to say, “I experience pain and suffering every single day of my life.” From this one gains an insight into others’ perceptions of the AFCS, and shortfalls and lack of understanding from other arms of the State who provide services to Service personnel.

## Slips, Trips and Falls

4.18 Some expressed the view that it was hard to define slips, trips and falls (these are excluded under AFCS, Article 11 of the AFCS Order 2011). The individual nature of claims received citing slips, trips and falls sometimes causes difficulty in the consideration process. Some stakeholders said there was little guidance to assist in helping claimants to decide whether a claim was worthwhile. More detailed guidance as to the meaning of “a hazardous environment” would be welcome and could reduce nugatory work.

## **Reservists**

4.19 The AFCS covers Reservists. There is no distinction made between Reservists and Regular Service personnel, yet some expressed the view that Reservists were disadvantaged as they are not “in the loop” 100% of the time. This is an opportunity for improving the effectiveness of communication to this cohort. Stakeholders said that Reservists are normally expected to seek NHS treatment after reporting/recording incidents, given that they spend most of their time away from the Armed Forces. Indeed, although access to military medical facilities has been improved for Reservists, stakeholders have suggested, drawing from their experiences with Reservists that logistics dictate, that usually the local NHS facility will be their first port of call, given Reservists’ movements and the proportion of their time heavily weighted between home and work. There are no restrictions on Reservists’ access to military medical facilities when on duty, but given the relative number of NHS medical facilities compared with military facilities, the Reservist, unless actually on a base at the time of the incident, is much more likely to be nearer to an NHS facility than a military one. GPs in the normal run of events have no call to be aware of the AFCS.

4.20 However, given that the Government pledged in 2013 to increase 35,000 Reservists (30,000 for the Army, 5,000 for the Navy and RAF) for the Armed Forces by 2020, the QQR team believes that there is a greater need to ensure that Reservists and NHS medical personnel are at the very least aware of the AFCS and know where to go for further information. Currently, there are approximately 31,000 Reservists (26,000 trained), but we do not know the percentage of claims made by Reservists nor the awards Reservists have received, due to the limitation of statistics in this area, which is further explored in the chapter “Data collection”. Having this data will enable us to understand the experiences of the Reservists factually rather than anecdotally.

4.21 The growing use of Reservists, and their increasing integration into units of Regulars, does pose a challenge for the Scheme, given that Reservists’ exercise and training regimes are inevitably of a different pattern from those of Regulars.

## **Conclusion**

4.22 **In summary, the AFCS would benefit from clarification as to what the AFCS compensates for and provides context and definitions – the QQR team have seen in AFCS narratives that the lump sum compensates for “pain and suffering”, but this concept needs to be explained owing to the frequent use of the term in the other documents. When looking at what the AFCS does compensate for, it would also be advantageous to say what the AFCS does not compensate for.**

4.23 **In addition, it would help if there were support at Unit level responsible for assisting Service personnel’s dealings with the AFCS, particularly as Reservists, as mentioned earlier; have particular needs and a lifestyle which is different from the**

**regimented Service person.** To a certain extent, the DBS Veterans UK helpline fulfils this function, with, however, reported needs for improvement.

## **Recommendations**

4.24 The QQR team recommends the following:

- MOD to indicate formally what the AFCS does not compensate for and what it does; this should be reflected in the JSP and the language must not be vague.
- That there should be an explanation of what the AFCS Lump Sum award compensates for. Given the frequent use of the term “pain and suffering” in the AFCS literature, the term should be defined or, if not, avoided.
- Given the unique needs of Reservist personnel, the Reservists’ Champion should act as a mediator and advocate for Reservists if they have encountering difficulties when making claims.

## **Chapter 5**

### **EMERGING CHALLENGES**

#### **Definition**

5.1 We have defined Emerging Challenges to mean something new to be acknowledged, or more fully understood, or an increase in or widening of issues or threats for the AFCS or the Ministry of Defence.

5.2 This chapter will investigate whether the AFCS does have the flexibility to accommodate emerging challenges, and identify some present challenges for the AFCS.

#### **Lord Boyce Review 2010**

5.3 Lord Boyce identified what appeared to be the principal challenge for the AFCS at that time, that Service personnel who had suffered grave combat injuries should be properly compensated financially for the rest of their lives, and in particular to ensure that the most seriously injured received the highest compensation. In addition, Lord Boyce recognised that with regard to a growing category of claims, such as mental illness, an Independent Medical Expert Group (IMEG) should be created to provide medical and scientific advice to the AFCS, and also to look at any apparent anomalies in the Tariffs and make recommendations accordingly.

#### **QQR Findings**

5.4 As a result of conversations with, and testimonies from, Stakeholders and experts, the QQR team is of the view that since Lord Boyce's review, changes have occurred in the operational environment, economic climate, and types of illnesses and injuries claimed. It appears that since 2010, claimed injuries have moved from combat to non-combat disorders. In addition, there have been an increased number of non-combat deployments involving smaller units across the world. Furthermore, the composition of Service personnel has been changing, e.g. the increased use of women and Reservists, which we will explore further later on.

5.5 Identifying emerging challenges for the AFCS or MOD can provide opportunities for a better understanding of illnesses and injuries such as Non-Freezing Cold Injuries (NFCI) or Mental Health. As a result, there is the opportunity to enhance horizontal and vertical equity of awards. In addition, the acknowledgement of an increase in a particular injury and an understanding of its origins can assist in the advancement of preventive medicine. Taking advantage of these opportunities can result a reduction in loss of functionality to Service personnel as well as a cost-saving. It is fair to say that the AFCS is not static and can accommodate emerging issues and challenges for the Scheme. The AFCS has a degree of flexibility to absorb changes.

5.6 If an injury or illness considered to merit an award is not reflected in the Tariff descriptor, a temporary award can be given until a new descriptor can be added, if deemed appropriate. Since the Scheme began there have been a number of additional descriptors.

5.7 In addition, there is an active programme of policy maintenance and legislative amendment. The policy is set out in JSP 765 which is regularly updated and similarly legislative changes are made annually, for example, in the 2015 IMEG Report the additional

descriptors for Non-Freezing Cold Injuries<sup>3</sup> were recommended and subsequently following ministerial approval the legislation was updated in May 2016. Moreover, anyone can raise issues with the AFCS policy team at any time; there is no need to wait for a QQR. Hence, the AFCS can, when deemed appropriate, make changes; it is not a static Scheme. Stakeholders identified a number of issues that were emerging challenges for the Scheme, ranging from infectious diseases to the digital age.

#### Infectious Diseases - Zika and Ebola

5.8 A few stakeholders thought that infectious diseases were outside the scope of the Scheme, e.g. Zika and Ebola. The approach to infectious diseases is set out in Article 12 of the 2011 AFCS Order. The AFCS covers cases where the infection is acquired in a non-temperate region and the person infected has been exposed to the infection in the course of service or where, in a temperate region, there has been an outbreak of the infection in service accommodation or a workplace; but does not cover (i) an endogenous infection, where the origin of the infecting agent is the person's own body or skin, e.g. appendicitis or urinary infection, or (ii) an exogenous infection, notably the ordinary everyday infections common in our community, e.g. bronchitis. An exception is when there is an outbreak and infection by close contact such as living in barracks or training schools.

5.9 Most infections develop quickly and, treated or untreated, also have quick resolution. In many cases, an illness which is due to service will not attract an award as it does not meet the Scheme's threshold for award of benefit. The Scheme also excludes endogenous infections. In this way both Zika and Ebola in the Service person are in principle covered by the Scheme. However, the QQR team suggests two points. **One, the QQR team is of the view that there is some ambiguity in the current wording in legislation with respect to infectious diseases, and there is an opportunity to clarify the legislation on them. Two, that it recommends that the IMEG should look in particular at the Zika virus and discuss the circumstances in which the Scheme would accommodate those affected and how.**

#### Long-term survivors of serious injuries

5.10 Some expressed the view that the MOD needs a better understanding of how long-term survivors of the most serious survivable injuries, which would have been fatal in the recent past, should be compensated. A few posed the question, "What happens when 20 years after the original injury, further complications develop as a result?" The issue of responsibility comes into play because one needs to investigate whether the further complication has arisen due to the Service personnel's own activity. Given the intention of the Scheme, to provide a full and final award reflecting the likely progress of the injury over the Service person's lifetime, compensating Service personnel for such a late presentation of illness could throw into question one of the intentions of the Scheme. It must be noted that late presentation of diseases is currently accommodated by the Scheme, up to 10 years, and the Scheme is only 10 years old. There is flexibility if the late presentation of disease takes longer.

5.11 The QQR team noted that operating from the Defence Medical Rehabilitation Centre at Headley Court, there is "The Advance Study", which is an innovative study involving 1200 Service personnel (600 having undergone casualty evacuation and 600 in the control group, the latter having suffered non-battlefield injuries and not having required casualty evacuation) over a 20-year period; it is the first of its kind focused on the British military

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<sup>3</sup> The Independent Medical Expert Group (IMEG) Report and recommendations on medical and scientific aspects of the Armed Forces Compensation Scheme March 2015

casualty population. It aims to ensure that these serving individuals are not forgotten during and after their transition into civilian life, and that vital lessons are learned and evidence is gathered from their treatment and outcomes that will influence and change care and rehabilitation for all future battlefield casualties. Albeit this is a longitudinal study, the QQR team suggests that the MOD should take account of the outcomes and lessons learnt that would be pertinent to the AFCS.

### Operational Environment

5.12 The general trend (particularly post-Iraq and Afghanistan) is that the proportion of kinetic (impact) injuries was being overtaken by non-battle injuries and illness including infectious diseases. Overseas deployments for training or humanitarian purposes continue to provide risk of exposure to distressing and harrowing events and environments, and this can result in subsequent Mental Health conditions on return to stable circumstances. These points would be beneficial testimonies to the challenges faced in the operational environment, which the MOD could consider requesting IMEG to add to its work programme should these be expected to result in new injuries or illness requiring descriptors under AFCS.

### Musculoskeletal injury

5.13 Another emerging challenge was the high number of in claims for musculoskeletal injuries; they account for the largest category of claims, particularly due to sport. It has been suggested that a majority of these injuries are minor and preventable.

### Changing demographics

5.14 Some stakeholders acknowledged the changing composition of the SP in terms of gender, ethnicity, and nationality. The consequence of not taking account of these changes in composition could result in failing to recognise the impact of, for example, NFCI on the increasing number of ethnic minority Service personnel – NFCI has stabilised at around 4% of the total of awarded claims. Some stakeholders have suggested that further work was needed to understand the impact of NFCI, and although a few stakeholders appreciated that compensation for NFCI has been previously commented on by the IMEG, they would welcome further review into whether the Tariff levels sufficiently recognised the seasonal fluctuations of the impact of this injury. It was substantiated at a tribunal hearing where the QQR team heard a claimant express in detail the impact of NFCI had on his everyday activity.

5.15 The QQR team pointed out that following the IMEG review, amended NFCI descriptors had been added to the legislation. The new descriptors were welcomed however some stakeholder(s) still had significant concerns about the long-term impact of the condition. The QQR team is of the view that IMEG should maintain oversight of NFCI research, as there remain many gaps in understanding, and should make recommendations on descriptors and awards based on any further findings. If further study into the long-term impact of NFCI is undertaken, the MOD will have a systematic analysis based on longitudinal data. This should inform NFCI prevention with ultimately a reduction in AFCS claims.

### Statistics on demographics

5.16 The QQR team used Defence Statistics in its analysis; however, it must be noted that from the start of the Scheme (2005) to the present, 31 March 2016, the period is not very long to reach definitive conclusions, but rather shows the direction of travel.

## Age Profile

5.17 Of the 63,098<sup>P</sup> claims registered between 6 April 2005 and 31 March 2016, approximately half of claims (53%<sup>P</sup>) were registered by claimants aged under 30. The percentage of claims registered by claimants in each age group reduced as the age group increased. Over time, the percentage of claims registered by claimants aged under 25 reduced (from 53%<sup>P</sup> of registered claims in 2005/06 to 20%<sup>P</sup> of registered claims in 2015/16), whilst the percentage of claims registered by claimants aged 25 – 34 increased (from 31%<sup>P</sup> of registered claims in 2005/06 to 54%<sup>P</sup> of registered claims in 2015/16). The percentage of all claims registered by claimants aged 35 and over has remained stable over time.

5.18 This may be partly explained by the fact that the percentage of Regular Armed Forces personnel who were under 25 has reduced over the past 10 years and the percentage aged 25-34 has increased. Also, we should bear in mind that in 2005, older Service personnel had a right to claim under the earlier WPS, and with the passage of time a greater proportion of claimants are now claiming under the AFCS.

## Ethnicity & Nationality

5.19 Claimants' ethnicity and nationality have been recorded on the Joint Personnel Administration (JPA) database since 2007. Therefore, this section presents findings on claims registered between 1 April 2007 and 31 March 2016.

5.20 Given the ethnicity profile of the Regular Armed Forces over the past ten years, the percentage of BAME claimants account for a considerably higher proportion of claims than expected. It has not been possible to further investigate why. This could be considered further as part of the equality-proofing process.

## Gender

5.21 As at 31 March 2016, 35,601<sup>P</sup> of registered claims had been awarded. Of these, 57%<sup>P</sup> of male claimants and 50%<sup>P</sup> of female claimants were awarded. Since 2007/08, the percentage of awarded female claimants each year has remained lower than the percentage of awarded male claimants, though the trends for both genders have followed the same pattern as that of all awarded claims.

**5.22 It is pertinent as part of the equality-proofing process to gain an understanding of why female claimants have a lower rate of award than male claimants.**

5.23 Linked with the changing composition of Service personnel, and what tasks they carry out, for instance having women in combat roles, it was suggested that this could impact on the AFCS as well as the MOD. The 2015/16 Women in Ground Close Combat (WGCC) Review has built upon previous work and explored, in further detail, the potential adverse health effects on women identified in the 2014 report. It also considered mitigation strategies.

## Loss of ability to participate in everyday activities

5.24 The QQR team is aware that under present AFCS legislation "Loss of Amenity" is not taken into account. The Lord Boyce review specifically stated, "The AFCS does not provide a payment for loss of amenity and does not take into account factors such as the impact of the injury on an individual's profession or hobby." However, when taking into account the total loss of amenity experienced by someone so grievously injured that they are dependent on a medical team of 24-hour carers to ensure they remain alive, the QQR team is of the view that there is a case for consideration of loss of amenity as part of the AFCS package for

the highly dependent category. This is particularly so taking account of the fact that the civilian courts<sup>4</sup> (through which Service personnel may seek redress **where negligence is alleged**) take account of this. This should be looked at by the MOD.

5.25 Following Min(DVRP)'s direction, Defence Medical Services (DMS) are currently developing an enduring care model which provides a single focus for the clinical, health and social support of a cohort of veterans who have complex physical, neurological, and mental health issues resulting from injury whilst in Service. Integrated Personal Commissioning for Veterans (IPC4V) will reflect the NHS England Integrated Personal Commissioning (IPC) emerging framework with additional input from DBS Veterans Welfare Services (VWS) providing a coordination and integration role.

### The Digital Age

5.26 The QQR team has found that digitalisation is an emerging challenge for the AFCS, albeit not alone. Digitalisation is rewriting the rules on "customer" expectations: customers are increasingly demanding simplicity, transparency and speed in their transactions with businesses. Digitalisation also means mobility and speed of service demanded by customers, no matter where they are globally; this translates into investments in mobile and interactive technologies. Digitalisation also includes social networks; the growth of social networking, it can be argued, is one of the fastest ever global adoptions, shifting the balance of power towards customers. For example, Facebook has attracted over 33 million users in the UK, and Twitter 14.3 million (eMarketer, 16 September 2016). We have witnessed consumers becoming more comfortable with social networks, which bring about several possible scenarios for Service personnel.

5.27 Service personnel appear to exchange information through their own Service-specific websites, building networks of trusted colleagues and friends, shifting the emphasis from AFCS compensation experts and advisers to online communities and online social networks. These wield substantial purchasing power and are becoming new group compensation channels, benefitting from information-driven online intermediaries. Speaking with stakeholders, especially claimants, the QQR team found that the term "customer" in the digital age could easily be interchanged with the Service personnel/claimant.

5.28 With regard to what this means for the AFCS in practical terms, **the QQR team is of the view that the MOD, along with Service charities, should investigate further how information technology could assist with processing claims to increase the speed and also, importantly, the tracking of claims.** Claimants often expressed the view that they felt their application forms went in to a "black hole". However, through discussions, the QQR team is aware that tracking has been looked into previously and cost considerations for individual tracking of claims is prohibitive. Nonetheless, given the overwhelming feedback from claimants, the QQR team maintains that this area should be looked into further.

5.29 In addition, **the QQR team suggests that it would be helpful if the MOD was aware of how the AFCS was communicated in social media, and consider whether there is any merit in the AFCS administrators being part of that interaction to counteract misinformation.** Being cognisant of any wrongly held misconceptions that are being perpetuated can benefit the relationship between claimants and administrators.

5.30 All of the above proposals could lead in the future to cost and time savings especially in the "age of misinformation".

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<sup>4</sup> The civil courts always have and do consider loss of amenity for serious injury but only where fault is proven.

## Conclusions

5.31 To sum up, the AFCS can and does adapt to emerging challenges, as it is a flexible and adaptable scheme. If an injury or illness considered to merit an award is not included as a Tariff descriptor, a temporary award can be given. The AFCS's policy as reflected in JSP 765 is updated annually and subsequent changes to the legislation are made accordingly. For example, the IMEG provided additional descriptors for Non-Freezing Cold Injuries as a result of its investigation and emerging findings, and in turn the legislation was updated in May 2016. However, **the QQR team found that there was scope for the term "infectious diseases" to be clarified and an opportunity for the Zika virus to be looked into in term of the compensation context.** There are indeed challenges for the Scheme, e.g. changed operational environments as well as changing demographics.

## Recommendations

5.32 The QQR team recommends the following:

- In order to keep up with the digital age, MOD should investigate further how information technology could assist with improved customer service for prospective claimants. This includes speeding up processing and tracking individuals' claims, being aware of how the AFCS is being communicated in social media and whether there is any merit in the AFCS administrators being part of that interaction on social media.
- IMEG is looking into awards for musculoskeletal injuries, and this Review recommends that IMEG considers gender differences in musculoskeletal injury, risk, type or treatment course.
- MOD to gain an understanding of why female claimants have a lower rate of award than male claimants.
- Given shared interests, and the benefits of joined-up working practices, the MOD could provide an annual one-page report on the operational priorities and emerging challenges to Service personnel, where MOD could consider recommending that IMEG notes the findings thereof. This would enable IMEG to have notice of what upcoming issues could be for Service personnel, in addition to learning from the types of claims presented.
- MOD considers the merit of IMEG discussing the impact the Zika virus could have on the AFCS, the "who what where and how".
- The legislation on infections should be clarified to make clearer what infections are covered by the Scheme and what are not.

## Chapter 6

### DATA COLLECTION

#### Definition

6.1 Data collection concerns statistical and quantitative data available on the AFCS, verified by Defence Statistics. Having robust data on the AFCS provides insight into some of the experiences of AFCS claimants. It also answers stated research questions, for instance whether the AFCS remains properly fit for purpose, and to test hypotheses and evaluate outcomes. Statistics was just one of the resources the QQR team used to evaluate evidence and statements from stakeholders. This chapter will focus on the QQR team's evaluation of the statistical data available, and will provide recommendations to enable robust data collection.

#### QQR Findings

6.2 Defence Statistics provides a wealth of statistical data on the AFCS and also bi-annual reports<sup>5</sup> as well as an accompanying narrative.

6.3 Although the QQR team has access to 10 years' worth of data since the creation of the Scheme in 2005/6, it must be noted that SP and veterans have up to seven years to make a claim (10 years in exceptional circumstances and even more if agreed by the Secretary of State). Therefore, 10 years' worth of data in the wider scheme of things is a relatively short period to reach conclusions on statistical trends.

#### Limitations of the Compensation and Pension System (CAPS)

6.4 CAPS is the database on which all AFCS claim information is captured. There are a number of limitations to what Defence Statistics can present on the AFCS using the information held on CAPS, beyond basic numbers and percentages. There were several key topics of interest within the QQR team that could not be supported from the data available. In particular, it was not possible to:

- Present rejections broken down by condition
- Determine whether individuals had been awarded for the conditions for which they claimed
- Determine whether there are different award/rejections rates for specific conditions, and/ or by demographic groups

6.5 It would be helpful to report accurately on whether an initial claim outcome changed following a reconsideration or appeal.

6.6 All findings are based on registered claims captured on CAPS between 1 April 2005 and 31 March 2016.

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<sup>5</sup> <https://www.gov.uk/government/statistics/armed-forces-compensation-scheme-statistics-financial-year-201617>

## What is available?

6.7 The main statistics available to the QQR team were the numbers of AFCS claims by gender, age group, ethnicity and nationality registered each financial year between 2005/06 and 2015/16. Moreover, the statistics included the initial outcomes of these claims (numbers and percentages), i.e. those that were:

- a) Initially awarded (split into two – those awarded a lump sum payment and those accepted as Service-related but not serious enough for compensation to be paid).
- b) Initially rejected.
- c) Initial Outcome Pending.

6.8 Also included are the numbers and percentages of claims by gender, age group, race and nationality registered each financial year between 2005/06 and 2015/16 with an outcome of a. or b. above that went on to:

- d) Have a reconsideration submitted.
- e) Have an appeal submitted.

6.9 The QQR team also noted that reporting was by year of initial claim registration. Therefore, if a claim was initially registered in 2010/11 but had a reconsideration submitted in 2011/12, then this would be counted as a 2010/11 claim that went on to be reconsidered. It is the initial lodging of the claim that governs all subsequent references including the legislation covering.

6.10 The percentages of initial claims awarded by gender, age group, ethnicity and nationality were shown each year between 2005/06 and 2009/2010 by Tariff of injury table and Tariff level. It was noted that due to potentially small numbers some Tariff levels were grouped together in order for the information to be meaningful.

6.11 Over the time period there was no difference between males and females in terms of the percentage of claimants awarded a higher tariff level (tariff level 1-11) for Mental Disorders, Senses, Fractures and Dislocations and Musculoskeletal Disorders.

6.12 Between 6 April 2005 and 31 March 2016 a higher percentage of males were awarded a higher tariff level (tariff level 1- 11):

- 7% of males awarded for Injury, Wounds and Scarring were awarded at tariff levels 1-11, compared with 2% of females.
- 9% of males awarded for Physical Disorders were awarded at tariff levels 1-11, compared with 3% of females.
- 26% of males were awarded for Neurological Disorders were awarded at tariff levels 1-11 compared with 12% of females.

6.13 Of the 63,098 claims registered between 6 April 2005 and 31 March 2016:

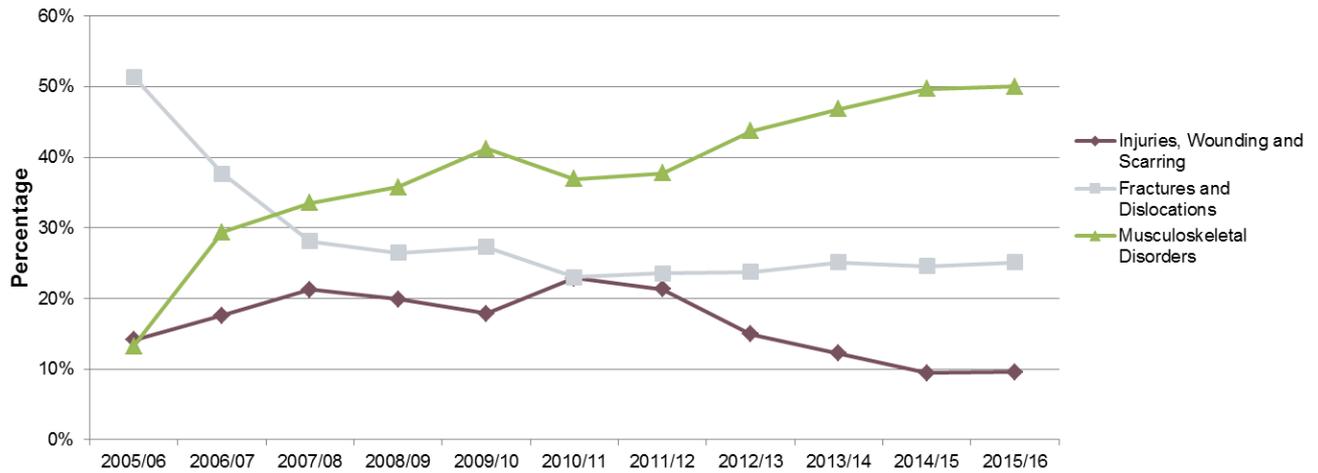
- Approximately half of claims (53%) were registered by claimants aged under 30.
- The percentage of claims which were registered by claimants in each age group reduced as the age group increased.
- Over time the percentage of claims which were registered by claimants aged under 25 reduced (from 53% of registered claims in 2005/06 to 20% of registered claims in 2015/16), whilst the percentage of all claims registered by claimants aged 25 - 34 increased (from 31% of registered claims in 2005/06 to 54% of registered claims in 2015/16).

- The percentage of all claims registered by claimants aged 35 and over has remained stable over time.

6.14 For types of awards for all AFCS claims (Tariff of injury), with specific reference to musculoskeletal disorders and mental health disorders, the numbers and percentages of all AFCS awards (where compensation was paid) each year between 2005/06 and 2015/16 by Tariff of injury table are as shown in graphs 1 and 2 below:

**Graph 1: Musculoskeletal disorders (green line) initial injury claims awarded under the top three tariffs, by financial year<sup>1</sup> and tariff percentages<sup>p</sup>**

6 April 2005 to 31 March 2016



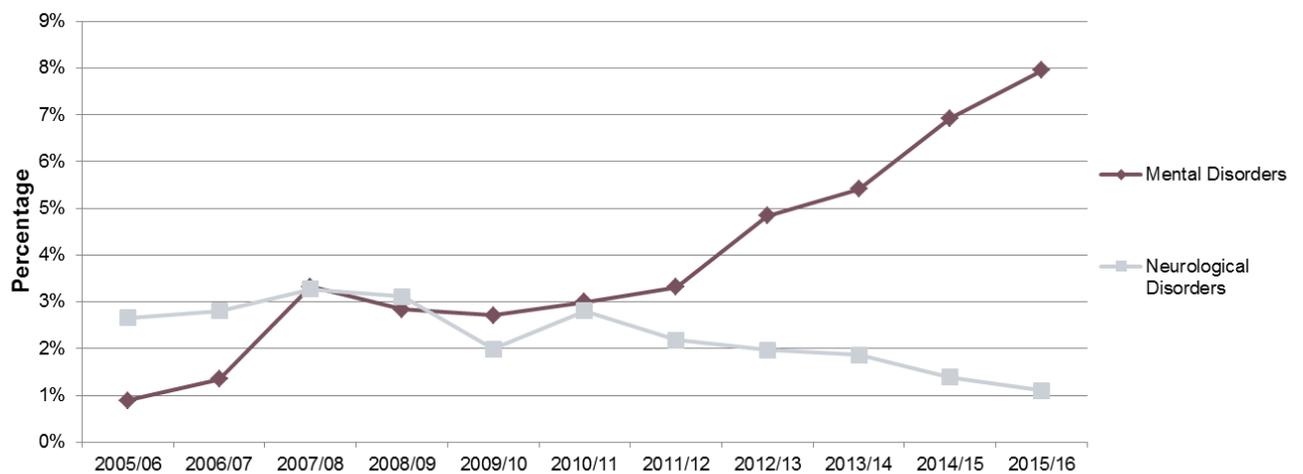
Source: Compensation and Pensions System (CAPS)

<sup>1</sup> Reported by financial year of awarded initial injury/illness claim on the CAPS

<sup>p</sup> Figures are marked provisional.

**Graph 2: Initial injury/illness claims awarded under the Mental Health and Neurological Disorders tariff, by financial year<sup>1</sup> and tariff percentages<sup>p</sup>**

6 April 2005 to 31 March 2016



Source: Compensation and Pensions System (CAPS)

<sup>1</sup> Reported by financial year of awarded initial injury/illness claim on the CAPS

<sup>p</sup> Figures are marked provisional.

## All registered appeals

6.15 The numbers of claims registered each financial year between 2005/06 and 2014/15 leading to reconsiderations and 2005/06 and 2015/16 leading to appeals are detailed in the paragraphs 6.16 and 6.17.

6.16 Between 1 April 2007 and 31 March 2015 there were over 9,000 registered claims that went on to have a reconsideration registered. Overall:

- 25% of BAME claimants went on to register a reconsideration compared with 18% of White claimants.
- Similarly 31% of African claimants, 25% of American claimants and 25% of Nepalese claimants went on to register a reconsideration compared with 18% of British<sup>6</sup> claimants.
- Due to small numbers it is difficult to determine trends over time within most groups.

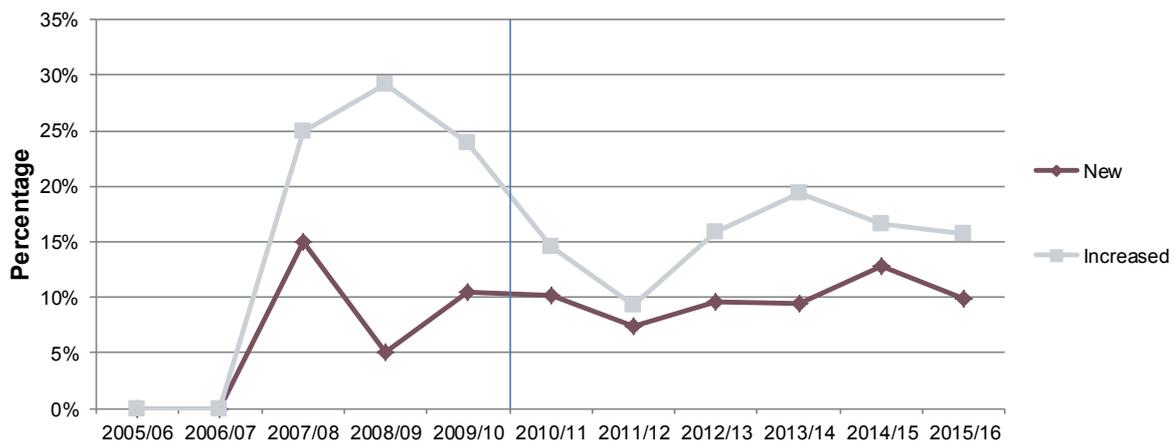
6.17 Between 1 April 2007 and 31 March 2016 there were over 5,000 registered claims that went on to have a registered appeal. Overall:

- 12% of BAME claimants went on to register an appeal compared with 8%<sup>p</sup> of White claimants.
- 15% of African claimants, and 12% of American and Nepalese claimants went on to register an appeal compared with 9% of British claimants.
- Due to small numbers it is difficult to determine trends over time.

6.18 The percentages of all appeals that were successful, resulting in either a new award (where none was made originally) or an increased award are shown in graph 3 below:

**Graph 3: Appeal outcomes, new and increased awards by financial year<sup>1</sup>, percentages<sup>p</sup>**

6 April 2005 to 31 March 2016



Source: Compensation and Pensions System (CAPS)

<sup>1</sup> Reported by financial year of appeal outcome date recorded on the CAPS

<sup>6</sup> Due to small numbers, nationality has been presented by continent. However, British claimants are presented separately, as are Nepalese claimants due to on-going interest in the Gurkha population and their accessibility to the scheme.

## Improving data processing

6.19 **The QQR team found that improving data processing meant, as already highlighted, that we needed to have data not just on awards made but on claims.** The QQR team found that the MOD receives a number of inquiries from the public on how many Service personnel made claims. In addition, it would be beneficial to know the precise cause of Service personnel injuries, i.e. caused by operations or in training, as this would assist in understanding the context of their claims, where work needs to be done on preventing injuries.

6.20 The QQR team noted that there was no readily available statistical data, like other demographic information, on Reservists' outcomes. The Regular/Reserve differential marker was not on the CAPS dataset. In order to find out whether a claimant was a Regular or Reservist would require the linking of the CAPS data with military administrative systems (Joint Personnel Administration). Furthermore, as has been pointed out, some Service personnel change from Regular to Reservist or vice versa during their careers, which would make it even more challenging to determine whether the Service person was a Regular or a Reservist at the time of injury. Having this information would indicate whether Reservists are more likely or less likely to claim than Regulars, and the outcome of their claims. It would highlight, and substantiate with quantitative evidence, whether there are any questions for the AFCS, DBS Veterans UK or the MOD. The QQR team found that there is the facility for Service personnel to provide their status at time of injury on their application form for compensation.

6.21 The QQR team noted throughout its investigation, particularly in reference to the specific aim of the QQR – to ascertain whether the AFCS remains fit for purpose – that it would have been beneficial to have knowledge of the claimants' experience of the AFCS process. To this end, an evaluation form could be sent with a claimant's award letter asking whether they were satisfied with the process – yes/no – or whether they understood how the decision was made – yes/no. Having that basic information would be insightful but not conclusive, given the limitations of the statistical data. Collecting limited information without the opportunity to expand would not be worthwhile, however customer satisfaction surveys are periodically undertaken so there may be an option to capture information there.

## **Conclusion**

6.22 The QQR team noted that Defence Statistics do not themselves collect data, but process data received from DBS Veterans UK. Improved data collection would enrich our understanding of the perceptions of the AFCS, and might identify priority issues and inform policy. However, statistical data only provides one perspective and sometimes raises more questions than conclusive answers. Statistics is only one research tool; it sits amongst research publications and personal testimonies.

## **Recommendation**

6.23 The QQR team recommends the following:

- That MOD should collect and record accurate data on the number of registered claims and their associated conditions, i.e. statistical data on claimed conditions.

## Chapter 7

### CATEGORIES OF AWARDS

#### Definition

7.1 Despite changes to awards following the Lord Boyce review, stakeholder comment regarding the adequacy of awards and equity across award types continued to be an issue for this Review. The major focus was mental health disorders, but questions also arose on some physical injuries including NFCI, musculoskeletal disorders and brain injury, which are reflected in this chapter on Categories of Awards.

7.2 The impact of any injury or disorder is unique to the individual. This is particularly challenging for tariff-based high-volume publicly-funded no-fault compensation schemes. These aim for consistent equitable decisions, and focus on comparison between the claimant and a healthy person of the same age and sex who is not injured or suffering from the disorder. These facts also pose the question of whether horizontal<sup>7</sup> and vertical<sup>8</sup> equity in terms of where the respective categories sit on a tariff system like the AFCS can ever be completely achieved.

#### Mental health disorders

7.3 The QQR team engaged with recognised specialists on mental health for context and background of mental health disorders. The QQR team agreed that determination of cause and level of compensation for mental health disorders was made difficult by their very nature. Severe and enduring mental health problems such as schizophrenia and bipolar disorder are rare in the Armed Forces and not generally caused by service. Conversely, psychological symptoms and the common mental health disorders like anxiety, low mood and adjustment disorder occur in serving personnel and the veteran community. Most up-to-date research suggests that overall levels are similar to that of UK civilian society.

7.4 Psychological symptoms are subjective, and vary, depending on personality, family, cultural, support and societal values. In the period between 1980 and the introduction of the diagnosis of Post-Traumatic Stress Disorder (PTSD), best-practice effective treatments, often including the so-called “talking therapies” for PTSD and other conditions, have become available. A major aim of these is to give people insight into the origin of the problem, and as with physical disorders such as high blood pressure and arthritis, to help them self-manage the problem and to know when to seek expert help. The evidence is that these treatments work for service-related disorders. Adequate courses of best-practice treatment delivered by trained personnel are able to improve function and often lead to resumption of activity, including paid work as before. AFCS awards are paid where disorders are predominantly caused by service.

7.5 This chapter will first look at Lord Boyce’s 2010 recommendations on mental health, and will then summarise what the Scheme provides, before considering in more detail stakeholder points and the QQR team’s response.

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<sup>7</sup> “Horizontal equity” is defined as injuries of similar severity receiving similar compensation.

<sup>8</sup> “Vertical equity” is defined as awards in the same category or AFCS Tariff Table increasing with injury severity.

## **Lord Boyce Review 2010**

### Mental health

7.6 Lord Boyce acknowledged that mental health was a priority for the Government and for the military. He highlighted the on-going work including within Defence and the single Services to raise awareness, reduce stigma and discrimination and address barriers to care. Types of mental health conditions that would be caused by military service are not disorders such as schizophrenia and bipolar disorder, but essentially the common mental health problems such as anxiety, adjustment, mood disorder and PTSD. Nonetheless, from a compensation perspective it was important that appropriate parity was achieved between comparable injuries.

7.7 Lord Boyce identified the IMEG as having a key role in advice on AFCS approaches to mental health, and proposed that they should carry out an early review of the Scheme's approach. He proposed that the highest award for mental health disorder should be at Tariff level 6 (£140,000 lump sum) with a 75% GIP, and that there should be a general review of mental health Tariff levels with these kept under review by the IMEG. He endorsed the use of interim awards for mental health disorders "because of the difficulty of determining prognosis soon after diagnosis".

7.8 The IMEG, which included an internationally-renowned Professor of mental health with a particular interest in trauma, carried out an in-depth review of compensation for mental health disorders, published in the Second IMEG Report in May 2013. The investigation included scrutiny of the literature, and discussion with civilian and military experts as well as representatives of charities. The IMEG also spoke with claimants and their supporters. All recommendations in the report were accepted by the Minister and, as required, incorporated into the legislation and exceptionally made retrospective to the start of the Scheme.

### **What the Scheme provides**

7.9 It became clear during this Review that there remained some misunderstanding as to what the AFCS presently provides. All descriptors and awards under the AFCS include an element for psychological symptoms, which means symptoms short of a discrete diagnosable disorder. Where a person has a discrete diagnosed mental health disorder, an award may be payable from Table 3 of the Tariff included in the AFCS Order.

7.10 The AFCS has a normal time limit for claiming of seven years, but taking account of the tendency to delay seeking help from the Scheme, there are special rules for mental disorders developing more than seven years after the causal incident, or where seeking help occurs seven or more years after onset of the illness.

7.11 The May 2013 AFCS Order, Table 3, headed "Mental Disorders", describes the conditions not as a list of diagnoses, e.g. PTSD, adjustment disorder etc., but in generic terms with focus on the descriptors, the associated functional limitations or restrictions and the likely duration. The Table 3 footnotes provide that in assessing functional limitation or restriction, account is to be taken of psychological, social and occupational function. Mental health disorders are to be diagnosed by a consultant psychiatrist or psychologist. The footnote also defines "severe" and "moderate" functional limitations or restrictions which are expressed in terms of civilian employability.

7.12 Article 12 of the AFCS Order precludes payment of benefit for personality disorder or injury due to the consumption of alcohol or non-therapeutic use of drugs. Awards range from level 14 (£3,000) for disorders impacting on function for less than 26 weeks to level 6

(£140,000 and 75% GIP) for permanent disorder, causing severe functional limitation or restriction.

7.13 The two highest mental health disorder awards automatically attract the DWP benefit, which is known as the Armed Forces Independence Payment (AFIP). This is paid at the same level as the enhanced rate for Personal Independence Payment (PIP) and includes both mobility and daily living elements. All AFCS recipients with a 50% or higher GIP are automatically entitled to AFIP, which is tax-free and paid for life with no review.

7.14 Article 5 of the AFCS Order 2011 is headed “Descriptor – further interpretative provisions”. This sets out the meaning of functional limitation or restriction, and defines duration of effects in relation to Table 3 disorders as from the date the claimant first sought medical advice for the mental disorder. Finally, it sets out how functional limitation or restriction is to be assessed and the meanings of “permanent” functional limitation or restriction and the word “significant”. The term “permanent” is defined as “where, following appropriate clinical management of adequate duration, an injury has reached a steady or stable state at maximum medical improvement and no further improvement is expected.” “Significant” means that the functional effect or restriction has an extensive effect.

7.15 Since the beginning of the Scheme and again since the Lord Boyce review, claims and awards for mental health disorders have increased year on year. Precise reasons for this are complex and may include the raised stress awareness and stigma reduction campaigns, which if successful result in more people seeking expert help, as well as the simple build-up of the Scheme to a steady state. Whatever the explanation, it is too simplistic just to conclude that the rise in awards reflects a rise in mental health disorders. This is especially the case in light of the several studies from the King’s College Mental Health Research Group since 2005, which by and large found similar levels of common mental health problems in the military and civilian communities.

7.16 The AFCS is a lay scheme but decision-makers have open access to dedicated medical advice from DBS medical advisers trained in medico-legal work and the AFCS jurisdiction. It is Defence policy that for mental health claims, reconsiderations and appeals, medical advice must always be sought. JSP 765 sets out the circumstances where Defence policy is that medical input to case determination is sought routinely.

## **QQR findings**

### Mental health disorders

7.17 The QQR team spoke with several senior military and civilian academics and mental health specialists and noted that since 2010, both in the wider UK community and in Defence, work has progressed to promote good mental health and to encourage early detection and access to best-practice treatment. The Defence Mental Health Strategy is an integral part of overall health and well-being, and the ultimate objective is to develop resilience. The approach is multifaceted and sponsored by the Chief of Defence People and Surgeon General. It involves the chain of command who lead on prevention and protection, working closely with Defence Medical Services (DMS). It is multi-professional with personnel, welfare and clinical staff (nursing, social work, occupational therapists, psychologists, psychiatrists, occupational physicians and general practitioners) from public, private and charitable sectors working together.

7.18 Many mental health challenges, e.g. delay in seeking help, are common to both civilian and military communities, particularly among young men. There is evidence that the most junior serving personnel with the shortest service, and especially those who leave prematurely, called “early service leavers”, are most at risk of mental health issues; this may

be not be because of service but because they enter service with a predisposition to these. By contrast with those with longer service, there is the opportunity for development of protective resilience, which the QQR team advocates, as this could be a significant step towards reducing potential claims.

7.19 During the course of the QQR team's investigations with leading specialists, it was drawn to the Team's attention that the terms "disease", "illness" and "sickness" were often used as if they were exactly synonymous, but in fact there were specific differences in meaning. This was particularly relevant when discussing symptomatic illnesses. Accurate definitions enable a more precise description of the situation and create better understanding between assessors, claimants, and stakeholders.

7.20 "Symptoms" and illness are what a patient declares himself to be experiencing, and "sickness" is what Society accepts to be the case. There may have been a decrease in mental health *disease*, but mental *illness* may have conversely increased – a typical manifestation is when the individual is no longer able to cope. The definitions for, and distinctions between "disease", "illness", "disability", etc., are well described in the monograph "Models of Disability" authored by leading experts in this field.

### Stakeholders' Issues

7.21 Stakeholders provided the Review Team with a number of concerns based on their own experiences. These included:

- There are difficulties in **claiming for mental health disorders**, in terms of the awards process. Some Stakeholders alleged that the questions on the claim form were more biased towards physical injuries. The QQR team examined the current Claim Form and noted that the relevant question reads: "What date did the injury occur or when did you first notice symptoms of illness?"
- There needs to be **parity in assessing claims for mental health disorders**, since the aim is to place mental health on the same **financial footing as physical injuries**.
- Some stakeholders' comments were also made about availability and access to **mental health treatment**, still sometimes considered the "poor relation" to physical injuries, and that parity of esteem is not yet a reality nationwide. As well as an adverse impact on the person's well-being, delay in diagnosis, assessment and treatment could obviously impact on the duration of disorders and hence the compensation paid.
- **More guidance is needed on the term "permanent", as having a permanent condition attracts a higher award and perhaps GIP and AFIP.**

The QQR team has looked into these points

### *Claiming*

7.22 Having reviewed the claim form, the QQR team is unable to agree the perceived difficulties with it, as expressed above, since the Review Team considers that the form reasonably accommodates both physical and mental injury and disorders. Difficulties in claiming on the AFCS include a perceived reluctance to claim due to stigma, low self-esteem and concern regarding possible negative impact on career or promotion. The QQR team is sympathetic to these problems, which are not unique to service. Having discussed the

Review with military stakeholders in community-wide initiatives on stigma reduction, etc., the QQR team maintains the view that the recent increases in AFCS claims and awards suggest some improvement in these factors and increased willingness to claim.

7.23. Table 1 presents the number of personnel who have been awarded compensation for a mental disorder since the AFCS began and those awarded for a mental disorder, the number who claimed PTSD by financial year as at 31 March 2016.

**Table 1: Claims<sup>1</sup> awarded to personnel for a Mental Disorder, by financial year, Numbers<sup>2</sup>**

6 April 2005 – 31 March 2016

	All Years <sup>3</sup>	2005/06	2006/07	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16
Mental Disorders Awarded	2,171	1	10	61	88	106	171	179	230	408	385	532
Of which claimed for PTSD <sup>4</sup>	1,781	0	6	45	63	85	119	126	196	340	336	465

1. Claims are based on the initial claim outcome

2. Personnel can be awarded for more than one claim for their time in Service

3. 6 April 2005 to 31 March 2016

4. May include claims for PTSD that were awarded for other mental disorders

7.24 However, as a deeply-ingrained cultural issue, changing society’s perception of mental health symptoms and illness is likely to take some time. The QQR team notes the continued interest of senior politicians, and their commitment to good mental health amongst military personnel and veterans. While respecting the rights of individuals to make claims or decline to do so, **the QQR team suggests that the various campaigns and support to individual claimants should continue, including by the Service and ex-Service charities.** This should not be limited to the dedicated mental health specialist organisations, not least because of the increased incidence of mental health problems where there is physical injury or other illness, but should be supported more generally, especially by the case-working organisations. The QQR team also notes that for serving personnel and civilians there is continued emphasis on achieving and maintaining good mental health and well-being throughout Service life and beyond, to which purpose the Defence Mental Health Strategy is presently being reviewed and revised.

7.25 Because of the reliance on self-reporting of symptoms and lack of objectively verifiable criteria for diagnoses of discrete mental health disorders, the Scheme requires diagnosis by a consultant-level clinical psychologist or psychiatrist. This followed a recommendation by the IMEG. The QQR team also notes that accurate diagnosis not only informs appropriate treatment, but also compensation. The QQR team found much evidence world-wide that there was a high risk of diagnosis of PTSD in military personnel or veterans whenever they present with mental health symptoms and illness. **The QQR team is aware that current DMS and NHS practice may make engaging with a consultant level clinical psychologist or psychiatrist difficult. The QQR team invites the IMEG to review the requirement for a consultant diagnosis**

7.26 Stakeholders have also commented on the fact that mental health claims seem to attract more interim awards than claims for physical disorders. Again, here the QQR team found some evidence of misunderstanding both of the reason for making interim awards and their financial implications. This topic is discussed separately and more fully in the chapter “Interim Awards”.

7.27 Some stakeholders suggested that attendance at Tribunals could be a daunting prospect for some claimants with mental health problems. The evidence the QQR team uncovered suggested that this was not a common problem. The Tribunal system was

introduced, and later maintained, because of its informality compared with the civil courts, e.g. the court layout, habitual dress, etc. and, most importantly, the hearing itself, which is inquisitorial, not adversarial. In addition, there is a member who has served in the Armed Forces on each Tribunal, one of whose functions is to help put the appellant at ease. It may be that some of these issues could be addressed in general communications material about the Scheme, perhaps with some material from the Tribunal service. **The QQR team is of the view that the MOD, DBS Veterans UK, the Veterans' Welfare Service and the charities all have a role here.**

#### Inequity between awards for physical and mental disorders

7.28 The work done by the IMEG ahead of its 2013 report included consideration of the approaches of other schemes and the civil courts, as well as the American Medical Association system of assessment of permanent impairment including mental health disorders. This took account of the need for horizontal and vertical equity. The QQR team is aware of recent media discussion regarding an apparent anomaly between awards for some mental illnesses where, at service termination, the person is unable to work, and those polytrauma<sup>9</sup> injuries where, at service termination, recent Defence Health Reports confirm that 90% of people are fully independent in the activities of daily living. It is important to bear in mind that the AFCS is a "full and final payment" Scheme, with the aim of making a final award as early as possible, reflecting the disabling functional effects of the illness over the person's lifetime. As discussed above, and as concluded by Lord Boyce and the IMEG report, mental illnesses such as PTSD can be very disabling. Effective best-practice treatments are available, and it should be exceptionally rare that a person is permanently incapable of any kind of suitable civilian employment. On the other hand, and although the Advance study will be key in informing understanding of the progress of Iraq and Afghanistan polytrauma injuries, published evidence from the Nordic countries, Israel and the USA confirms that in both military and civilian contexts the early good functional outcome of major traumatic physical injury may not always be sustained.

7.29 The QQR team noted that the IMEG is to revisit mental health claims and awards during the first ten years of the Scheme, following implementation of many of its 2013 report recommendations. It is hoped that this will cover claims and award rates and level of awards, including review of the higher level of awards. The QQR team heard from specialists regarding the award level for mental health disorders; it was explained that these can be as **disabling as physical injuries**. It is important to note that in determining award levels the aim is to assess functional effects over the person's lifetime. **The QQR team recommends that the MOD invites IMEG to revisit the award levels for mental health disorders especially the highest award.**

7.30 It would be helpful if IMEG could revisit best practice for assessment of claims, and in particular severity of associated functional compromise. During the Review Team's discussions, it became clear that there were a number of approaches and protocols for mental health assessment which might be considered. However, the fact that there is no single preferred approach is itself significant, and the QQR team is mindful that mental health assessments may be required for a variety of purposes and under different jurisdictions, e.g. compensation, social security, employability or disability allowance. The QQR team's own observations and specialist advice received confirm that being subject to multiple assessments may be distressing to claimants, and the QQR team ideally would recommend a single short multi-purpose process applicable to all these areas.

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<sup>9</sup> Polytrauma or multiple trauma is a medical term describing the condition of a person who has been subjected to multiple traumatic injuries.

7.31 The QQR team also suggests that more guidance is offered on the term “**permanent**”, regarding Article 5 of the legislation given feedback from stakeholders.

#### *Post-Traumatic Stress Disorder (PTSD) – Case History*

7.32 A stakeholder provided a case study to the QQR team demonstrating the difficulties a claimant comes across submitting a claim to the AFCS for a mental health disorder. Using a typical veteran as an example, they followed his journey through the compensation process. In many cases, a Service person has not made a claim prior to referral and assessment by Combat Stress, as no “label” has been applied to the problem; where a claim has been made, this can exacerbate the problem due to postponement of resettlement and a feeling of being under-valued. Many veterans are still ashamed to admit to a mental illness and see the only “honourable” claim as PTSD. It is hard to persuade them that anxiety, depression and other problems are just as life-changing and worthy of a claim. As already discussed, the accumulation of evidence can present significant difficulties is considerably more scope for diagnosis to vary from one psychiatrist to another, often because the claimant can present differently from one day to the next. Getting to see a consultant psychiatrist remains more time-consuming than reaching consultants in other areas of speciality. In addition, the prognosis may vary depending on where the individual lives, because of the geographical variations in NHS resources for mental health.

7.33 Claims that are turned down may be challenged at a Tribunal. Some Stakeholders were of the view that appearing at a Tribunal was a very daunting experience for claimants, especially for those already suffering from mental health problems. A Tribunal appearance is at best only a snapshot of the condition, and, unlike the case with physical injuries, sufferers can feel good one day and terrible the next.

#### *Making a claim – evidence*

7.34 Within the time span of the QQR, the QQR team were unable to go into detail as to possible types of evidence to inform AFCS decisions, and in particular to consider the role of reports from treating clinicians who have the clear advantage of knowing the patient/claimant, and with whom he or she is likely to be at ease. The QQR team believes such reports can be invaluable, especially where they provide a narrative of the contemporary course of the disorder based on clinical notes rather than a report compiled expressly for compensation purposes.

7.35 The QQR team is aware that some treating clinicians refuse to provide reports on their patients. Treating clinicians are unlikely to be aware of the specific regulations governing claims, and if they are unable to support their patient’s perspective, there may well be an adverse impact on the therapeutic relationship. The QQR team is of the view that a factual report from treating clinicians with reason for opinions, and citing evidence relied on, can be very helpful.

#### *Parity of esteem*

7.36 The point about parity of esteem relates mainly to availability of NHS mental health services and consequent delay in assessment and treatment. This is an on-going but variable problem. The QQR team notes that much work setting up the National Network of Veterans’ Mental Health Services in England and the equivalent in Wales and Scotland has been done. There continues to be good cooperation between DMS mental health staff and NHS clinicians. The joint assessment of needs at transition and arrangements for their delivery may be crucial in a few cases. This is particularly so where it would not be in the person’s interest to be treated/retained in a Service setting.

## Stakeholder comments on other specific categories of awards

7.37 Stakeholders provided the QQR team with a number of additional points below:

- *Traumatic physical injury: Concern was raised at apparent inequity between awards for retained but seriously damaged limbs which might require multiple major surgical interventions and prolonged rehabilitation compared with awards made for loss of limb*
- *Musculoskeletal awards: In general, awards for low back pain were considered inadequate especially because of their impact on employability. See also descriptors at Table 9, Items 2A and 6 (from 6 April 2015)*
- *NFCI: Again there was some suggestion that awards did not reflect seasonal variation in the disorder and disabling effects on employability*
- *Brain injury: there was concern re Table 6 items 17 and 22 (amendment to Tariff AFCS Order 2011 in May 2015)*

### QQR comment

7.38 The 2015 IMEG report includes sections on the cardiovascular and other effects of traumatic extremity amputation and a report on compensation aspects of combat-related complex lower limb injuries. The QQR team believes these fully answer the stakeholder comments regarding disparity between awards for amputation and retained complex lower limb injury. The QQR team recommends, in any case with perceived difficulties or inequity, that claimants or their supporters request a detailed explanation and reasons for the decision.

7.39 Musculoskeletal disorders (Table 9) are the most common cause of medical downgrading and discharge in the Armed Forces, and similarly comprise a majority of AFCS claims. In general, claims and awards for knee disorders are the most common, followed by back disorders including mechanical low back and neck pain. The context of these tends to be sport and adventure activities, and both Reservists and Regulars as well as women are at risk. In some cases of non-specific back pain, there may be on-going symptoms, pain and disability which are not reflected in objective physical findings. In such cases, best-practice management involves maintained activity, education about the nature and prognosis of back pain and, in most cases, support into paid work, if possible back to their own job. The QQR team also understands that there is little evidence that military activity or sport causes these disorders, and had an interesting and informative discussion with experts on bio-psychosocial disorders, including the distinction between disease, disorder and illness.

7.40 The QQR team also learned of perceived inequalities in Tariff levels for back problems with similar descriptors in the April 2015 edition of the 2011 AFCS Order Table 9, Items 2A and 6. These have almost identical descriptors but attract different monetary levels (the lower level is intended to cover cases where a substantial recovery is expected, and the higher level is for permanent incapacity). **The QQR team recommends that MOD reviews the clarity of descriptors and the award levels for back injury and pain syndromes in Table 9.** Through its research, the QQR team is aware that between 2005 and 30 Sept 2015 over 16,000 lump sum awards have been made for musculoskeletal injuries at a cost of about £100 million in compensation. Other costs include loss of operational capability, training investment for those affected, loss of personal fitness and self-esteem, and potentially longer-term health and well-being problems. The QQR team is aware of the importance of prevention and protection in this context and notes the principles of military

rehabilitation. These are: early assessment, use of multidisciplinary teams, active case management, functional exercise-based rehabilitation and rapid access to specialist opinion as required. The QQR team visited the Royal Marines (RM) at Poole, and attached at Annex B is the RM approach. **The QQR team suggests that the MOD considers the scope for shared the best elements across all Services, in order to reduce injury and potential claims.**

#### Non-Freezing Cold Injury (NFCI)

7.41 NFCI was also referenced as a challenge for the Scheme. NFCI is almost always a military injury and has been recorded in UK soldiers since the Napoleonic wars. There was risk of significant NFCI in the Falklands but subsequent war pension claims remain low. However, soon after the introduction of the AFCS, an increased number of claims for NFCI were seen, notably from soldiers recruited directly from sub-Saharan Africa. The majority of injuries were sustained in winter recruit training in the UK. An independent Task Force led by Prof Hugh Montgomery of University College London (UCL) was set up by the Surgeon General in 2012 and confirmed the many gaps in understanding of NFCI. These include its definitive diagnosis, use of and limits to specialist tests in assessment of severity, and long-term prognosis and effect on function. New guidance for the chain of command and medical personnel has been formulated and implemented, and a new recruiting policy introduced. A research programme has also begun which is believed to include longitudinal study and follow-up. It is hoped that that these measures will help to reduce cases and claims. The IMEG in 2015 (Third Report) also reviewed the topic in the context of the AFCS and made recommendations which the report was careful to describe as being within the limits of the evidence. New descriptors were introduced in legislation for claims from May 2016. Some stakeholders suggested that the previous Tariff did not adequately reflect seasonal variation in symptoms. The QQR team is not able to agree with this, having read the IMEG report and its reasons for conclusions. The QQR team concludes that present approaches are necessarily limited by the available evidence and that the IMEG should continue to monitor emerging research studies and literature and as required update their findings. The QQR team noted that stakeholders expressed the view that they still had significant concerns around the long-term impact of the condition. The stakeholders were not aware of any existing longitudinal studies completed or best practice clinical management on which to definitively base this judgment. **The QQR team acknowledged the stakeholders' view that further study into the long-term impact of NFCI would be welcomed, particularly taking into account the seasonally fluctuating nature of the condition.**

#### Brain injuries

7.42 The QQR team was presented with an example of diagnosis of a brain injury with two possible outcomes. It was explained that awards were based on descriptors of injuries, and that the compensation received was based on the descriptor that was the closest approximation to the injuries. For an individual with traumatic brain injury, there were two possible descriptors that applied:

- Tariff 8 descriptor

Brain injury from which the claimant has made a substantial recovery and is able to undertake some form of employment and social life, has no major physical or sensory deficits, but one or more of residual cognitive, behavioural change or change in personality. This Tariff pays £60,000.

- Tariff 4 descriptor

Brain injury where the claimant has moderate physical or sensory problems; one or more cognitive, personality or behavioural problems and requires regular help from others with

activities of everyday living, but not professional nursing care or regular help from other health professionals. This tariff pays £290,000.

7.43 Brain injuries in the Scheme are addressed in Table 6. They occur in both combat and non-deployed service, often in Road Traffic Accidents (RTAs), assault, adventure training and often in military personnel and veterans where the injury is not due to service. A specific question was raised regarding differentiating Table 6, Items 17 and 22; the descriptor wording is similar but there is a significant difference in award values. The QQR team understands the question, but considers the two descriptors are reasonably differentiated especially when the footnote applicable to item 22 is taken into account, i.e. the claimant is able to work regularly albeit in a less demanding job than appropriate to his experience, qualifications and skills at onset of the illness.

7.44 In relation to selecting descriptors in general, the QQR team would make reference to the advice in the 2009 Court of Appeal judgment re the need to take into account when selecting Tariff values the functionally disabling effects of other injuries attracting the same levels of award. **Finally, the QQR team suggests that the MOD considers the need for any clarification in the descriptors and award levels in question.**

## Conclusion

7.45 The task of achieving parity of assessment and subsequent treatment between physical injuries and diseases on the one hand, and mental health conditions on the other, is a difficult one. Physical conditions are usually obvious, while mental health conditions are difficult to diagnose, since they are based on symptoms, vary from one individual to another and even from day to day in the same individual. The incidence of mental health conditions and AFCS claims is rising, possibly reflecting a greater willingness to acknowledge and present with symptoms. This Review supports continued awareness-raising, further reducing stigma and barriers that still exist to best-practice mental health care.

## Recommendations

7.46 The QQR team recommends the following:

- There is further development of protective resilience amongst Service personnel.
- Given the continued interest of senior politicians, and their commitment to good mental health amongst military personnel and veterans, the QQR team suggests that the various campaigns and support to individual claimants should continue, including by the Service and ex-Service charities.
- More guidance is needed on the term “**permanent**”, re Article 5 of the legislation, as having a permanent condition attracts a higher award and also a GIP, which is granted for permanent conditions. Thus, further investigation into the terminology of these descriptors would be appropriate.
- The MOD looks into the reasons why current DMS and NHS practice may make it difficult for diagnoses of discrete mental health disorders by a consultant-level clinical psychologist or psychiatrist. The QQR team suggests that IMEG reviews the requirement.
- Consideration should be given to see whether there is scope for increasing the highest level mental health awards, because the QQR team met experts who confirmed that mental health disorders may be as disabling as physical injuries. Such conditions, attributable on balance of probabilities as being due to service, are usually amenable to best-practice treatment.
- The MOD reviews the clarity of descriptors and the award levels for back injury and pain syndromes in Table 9.

- The MOD considers whether there is any scope for sharing the best elements from the RM in Poole on musculoskeletal disorders across all Services.
- That further study into the long-term impact of NFCI would be welcomed, particularly taking into account the seasonally fluctuating nature of the condition
- That the MOD considers the need for any clarification in the brain injury descriptors and award levels in question.

## **Chapter 8**

### **LEVEL OF AWARDS**

#### **Definition**

8.1 This chapter examines the level of AFCS awards. This covers the amount of benefit awarded for each of the 15 Tariff levels, uprating and uplifting of lump sum awards and the GIP.

8.2 The value of awards and compensation is part of the Government's and the UK's moral obligation to the Armed Forces. The Armed Forces not only defend the UK in armed conflicts abroad but are also involved in humanitarian disaster relief, military aid to civil authorities and stabilisation – although the majority of AFCS claims relate to fitness training and sports. However, it must be borne in mind that the AFCS is a publicly-funded Scheme, and therefore the value of the awards paid has to be considered in that context.

8.3 Moreover, when looking at the level of awards relative to the relevant underlying principles of the Scheme, the QQR team asks, "Are they fair, transparent and sustainable?" The QQR team also considered whether horizontal and vertical equity were being maintained.

8.4 This chapter will look at the recommendations of the Lord Boyce review before continuing with what the Scheme provides and evaluating the views of the QQR stakeholders said.

#### **Lord Boyce Review 2010**

8.5 As Lord Boyce acknowledged in his 2010 review, the Government increased the top level tax-free lump sum award to £570,000 from £285,000 in 2008. The other Tariffs were increased in 2010. Lord Boyce said that the award at Tariff 1 of £570,000 was a level that the review found was commensurate with the life-changing nature of the injuries involved. He recommended, however, that the "other Tariffs should be increased, with the awards for the most seriously injured below the top two levels increasing by over 50%" (See Annex C).

8.6 Lord Boyce recommended that the monthly tax-free income stream paid to the most seriously injured known as the GIP and the Survivor's Guaranteed Income payment (SGIP) for their eligible partners should be increased to reflect the lasting effect of more serious injuries on future promotion prospects and on the ability to work to the age of 65. The GIP starts from Tariff level 11 (See Annex C).

8.7 Bereavement grants were also increased for both Regular and Reservist personnel.

#### **What the Scheme provides**

8.8 JSP 765 and the legislation sets out the level of awards and the basis of the calculations. In paragraph 3.3 in the JSP, "The Scheme is designed so awards take into account the expected effects of the injury and treatment over the person's lifetime. This means that once an award is made, in the majority of cases, it cannot be amended or removed except in limited circumstances (for example, interim awards). This is to enable individuals to move forward with their lives following injury with financial security and to encourage individuals to take up future employment and activities of life according to their ability, without fear that doing so could reduce or remove their income or assets." Therefore,

awards made at the four lowest Tariff levels (12 – 15) provide the Service person (with less serious injuries) with a one-off lump sum award.

8.9 The JSP also reads that the most seriously injured receive the highest awards: “The Scheme’s underlying principle is to pay the highest awards to those most seriously injured. There comes a point, in cases where the most profound injuries are sustained, where distinctions cannot be drawn between one individual’s injuries and another’s” (para 3.7).

8.10 In addition, it is pertinent to note that the AFCS does not solely base awards on the number of injuries but more on their seriousness and impact. The QQR team agreed this conclusion, given the testimonies it heard from claimants. The JSP reads that “It would also breach the Scheme’s principle of delivering equity if a number of lesser injuries provided a greater award than a smaller number of more serious injuries which had, overall, a greater impact on the individual. For these reasons, the maximum lump sum payable to those individuals with the most profound injuries, sustained in a single incident, will be equivalent to the single Tariff level 1 award, which is currently £570,000. Individuals with this level of award will also receive the maximum level of GIP, the value of which can be £1m or more over a lifetime, leading to an overall compensation package with a value of over £1.5m. There is no limit to the amount of compensation that can be paid from the Scheme to any individual in terms of lump sum plus income stream (para 3.7).

#### Supplementary Awards

8.11 Supplementary awards are a feature of the AFCS and are in the spirit of the underlying principles of the Scheme. The JSP 765 reads “There may be cases where the injury or effect of the injury, while not necessarily having an impact on future employability, can have a substantial effect on some aspect of the person’s function or their self-image, confidence and self-worth. To recognise these circumstances, an additional payment, known as a Supplementary Award, is made if the injury is accompanied by certain specified conditions”.

#### **What the MOD has been doing**

8.12 The MOD has looked at Royal British Legion’s (RBL) request to “Protect the lifetime income of injured veterans by uprating their military compensation by the highest of earnings, inflation or 2.5% (the ‘triple lock’)”. The MOD has not agreed to RBL’s demand due to the costs and the risk of similar claims from other public sector workforces. All public service pensions are uprated in line with the CPI and the Treasury does not support any move away from this.

#### Triple Lock Guarantee

8.13 The triple lock guarantee, which means uprating annually by the highest of the rate of earnings, Consumer Price Index (CPI) or 2.5%, only applies to the basic State pension. All the extra elements of the State pension (SERPS, State Second Pension, Graduated Retirement Benefit, extra pension from deferring, and additional pension derived from purchasing Class 3A contributions) are linked to the CPI. The CPI is produced to international standards in line with European regulations. It is the inflation measure used in the Government’s target for inflation.

8.14 This issue has been raised by the RBL which has argued that compensation payments and allowances that specifically relate to employment, that is, the GIPs, which are currently uprated annually in line with the CPI (as are WPS & DWP awards and allowances) rather than with average earnings, meaning that the value of the payments in real terms is decreasing year-on-year.

8.15 The AFCS GIP is uprated annually by applying the same principle that the DWP uses for uprating social security disability benefits. The approach taken, by increasing awards with reference to the CPI, is in line with other public service schemes. As such, it is consistent with the measure of inflation used by the Bank of England. The triple lock applies only to the State Pension.

## **QQR Findings**

8.16 The QQR team was given first-hand testimonies by some claimants who said the £570,000 was not enough for the most serious injuries and dependent injured Service personnel; for example, one quadriplegic patient whose life depended on a 24-hour team of 4 carers found that his lump sum payment of £570,000 was entirely taken up by his purchase of a house (he having no choice in location as he was obliged to live near his base) leaving nothing over (apart from the GIP, AFIP and other DWP benefits), although of course he continued to be able to access NHS and Local Authority support.

### Lump sums

8.17 The top Tariff award was increased to £570,000 in 2008 and all other lump sums were increased in 2011.

8.18 The QQR team has responded to the most repeated feedback from Stakeholders that “the lump sum awards have not maintained their value.” The QQR team shares the view that although the GIP is uprated in line with the CPI annually, the lump sum awards have not maintained their value throughout the years, and 96% of award recipients, based on initial claims, receive awards at Tariffs 12 – 15 and therefore do not receive GIP.

### Inflation Calculation

8.19 With regard to the lump sum values, for example, a Tariff level 15 lump sum award of £1,200 in 2010 would have a value of £1,381 in 2016/17 if uprated for inflation (CPI). A Tariff level 1 lump sum award of £570,000 in 2010 would have a value of £656,052 in 2016/17 if uprated for inflation (CPI). The cost of increasing all Tariff levels in line with inflation in the five financial years from April 2017 would be £13.93m. This figure derives from the current actual forecast of AFCS annual lump sum expenditure from 2017/18 to 2021/22 as submitted to the Office for Budget Responsibility, increased in line with the CPI.

8.20 The original intention of the Scheme, as expressed in the 2005 Guidance booklet, was that “The tariff and amounts to be awarded will be reviewed on a regular basis and any necessary amendments made. These reviews will take account of any civil law or medical developments and ensure that the levels of awards are equitable”. **The QQR team now suggests that lump sum awards should be considered for uprating for inflation on an annual basis.**

8.21 The current practice is that to maintain consistency the determining factor for all awards is the date the claim is submitted, because depending on circumstances there could be a significant gap between the date of the injury or illness and the date of the claim.

## How are AFCS Awards reviewed?

8.22 A recurring theme that was expressed to the QQR team was that AFCS awards have only been reviewed once since the Scheme commenced, and there should be a systematic review procedure in place. The QQR team agreed, given the principles of the Scheme, i.e. transparency and fairness. If the value of the lump sums is not to be updated automatically annually, without any exercise of discretion, in line with the CPI, the alternative would be to have an internal Review mechanism with the authority to recommend changes to the Tariff levels. Having a Review mechanism would maintain trust and confidence in the system.

### Top tier, Tariff 1

8.23 The QQR team looked at whether the top tier lump sum award of £570,000 should be uplifted, since it was a recurring theme from many stakeholders, and it was last reviewed in 2010. The numbers in receipt of Tariff 1 awards are low. There have been 10 Service personnel since the start of the Scheme, roughly working out as 1 a year. The QQR team investigated the awardees in receipt of Tariff 1 (not those with multiple injuries who cumulatively reached the same level, of whom there are 75 awardees) and the typical range of injuries was as follows:

- Bilateral trans femoral above knee amputations. Right hand injury. Head injury including skull and multiple facial fractures, Facial numbness with facial lacerations and loss of lips
- Traumatic brain injury, Scarring of scalp, Scarring of face
- Depressed open fracture to skull with severe traumatic brain injury. Fragmentation injury to right thigh

8.24 From the stakeholder comments submitted, and the QQR team's analysis, the QQR team has formed the view that Tariff 1 has sufficient grounds to have its award level uplifted due to:

- The severity of injury/illness
- To create a clearer distinction between Tariffs 1 and 2
- Level 1 Tariff was last uplifted in 2008, although it was seen as commensurate in 2010

### **Calculating proposed percentage uplift of Tariff 1**

**8.25 The QQR team suggests that the Tariff 1 lump sum award should be uplifted from £570,000 to £650,000 for future awards. This is the cost of increasing this Tariff level (£570,000) in line with inflation (CPI) starting from 2011 to 2017.**

8.26 However, there are a number of questions that this raises:

### What impact would having the Tariff 1 award uplifted have on the **other Tariff levels**, especially 2-6 which are considered high-level Tariffs?

8.27 Tariff 1 recognises the needs of the most seriously-injured SP, and the uplifting of this Tariff has the effect of automatically raising the cap for cumulative injuries not necessarily attracting a Tariff 1 award. The other Tariff levels were uplifted in 2011 (implementation of Lord Boyce review recommendations).

Is this in line with the principles of **fairness and sustainability**?

8.28 The Lord Boyce review stated: “The arrangements should guarantee a fair deal for all those who are entitled to compensation, and should in particular give due recognition to the needs of those most seriously disabled.”

What impact does the uplifting have on the **cap level** and what are the total financial implications?

8.29 At present AFCS Lump Sum compensation is capped at a maximum amount of £570,000. If the Tariff 1 award uplift were to be accepted, this would also automatically uplift the cap level from £570,000 to £650,000 (**not retrospective**). This means that those with multiple injuries could qualify to receive £650,000. Based on awards for those with multiple injuries, it could be assumed that each Service person in this situation would receive an award capped at £650,000 rather than £570,000, an increase of £80,000. Since Scheme inception there have been 85 Service personnel in receipt of this top award level of £570,000 due to multiple injuries, either as a cumulative sum (75 Service personnel) or as a Tariff 1 award (10 Service personnel). However, present deployment conditions suggest that there will be a significant reduction in such future cases.

Complete Removal of the cap.

8.30 A few stakeholders expressed the view that the cap should be completely removed. The QQR team examined the list of individuals’ total awards, i.e. without the cap, and formed the view that removing the cap would not solve the issue of reported “unfairness” as expressed by one stakeholder. This is mainly for three reasons:

- AFCS is a publicly-funded scheme, paid for by UK taxpayers; therefore, it is about reparations rather than restitution (trying to place the claimant in the position before the injury took place). “No amount of money can ever adequately compensate for the consequences of injury” (Lord Boyce).
- It is a no-fault scheme.
- No Government-funded scheme is limitless. (The cap level of the Criminal Injuries Compensation Scheme (CICS) is set at £500,000).

8.31 In addition to the above, the QQR team does not wish to create further unfairness by removing the cap, as one could have a scenario of a quadriplegic awarded £570,000 with high dependency and a triple amputee who may be able to lead a relatively independent life, awarded £1.1 million. The QQR team is of the view that the cap should remain to avoid anomalies such as the above.

**Supplementary award for the “Most severely injured and highly dependent Service personnel”**

8.32 Taking account of the principle expressed in the Lord Boyce review, that the most seriously injured should receive the highest amounts, which is also in line with the AFCS principle, the QQR team initially assessed the cases of those in receipt of a Tariff 1 award and spoke to claimant(s) and their advocates to understand their detailed circumstances.

8.33 The QQR team found that all individual claimants are unique and have their own individual needs, but the range of conditions coming under Tariff 1 appears to be very wide and varied. Some stakeholders, including claimants, expressed the view that there was a distinction to be made between different claimants in receipt of the highest Tariff awards. As a result, the QQR team also looked at other recipients in the high Tariff levels i.e. Tariffs 2 and 3, and concluded from the evidence presented that there were two separate categories

within the highest Tariff levels, those who appeared to require 24-hour care (a very small minority) and those who did not. It is worth bearing in mind that those who at service termination appear able to lead a reasonably independent life may in years to come suffer significant worsening, and as a result may move into the high-dependency category, although there are no current examples of this.

**8.34 The QQR team is of the view that there should be an additional Supplementary Award, in addition to respective claimants' lump sum awards and GIP.** This would be for those that experience the highest degree of dependency on others to remain alive and consequently qualify for the highest need for support (essentially, 24-hour medical care). Thus, this would be at the extreme end of the most seriously injured claimants, whom we have provisionally named the **“Most severely injured and highly dependent Service personnel”**. The QQR team feels that the criterion should be individuals requiring 24-hour medical care, who may have received their £570,000 not as a Tariff 1 award but as a cumulative sum on the strength of several, and sometimes many, separate injuries. It must be emphasised that individuals continue to have access to NHS and Local Authority care.

#### Criteria for determining the Most Severely injured and highly dependent Service Personnel

8.35 The QQR team looked at a number of markers that could define the “most severely injured and highly dependent Service personnel”, for example:

- the Tariff level
- the compensation level
- the inability to participate in even the most elementary everyday activities
- whether the SP requires 24-hour medical care

8.36 The QQR team came to the conclusion that the 24-hour medical care requirement was the most heavily-weighted criterion. The Supplementary Award is to compensate those Service personnel who have to depend on professional qualified carers, particularly those requiring medical care 24 hours a day in order to survive. This is a view that was widely echoed among stakeholders. This is not diverting the compensation awards towards “continuity of care”, it is instead compensating Service personnel for the loss of dignity and associated feelings of helplessness resulting in emotional suffering (the AFCS does not cover care costs). There are also issues about whether the supplementary award applies only to someone who at service termination requires 24 hour medical care. The QQR team is aware that a claimant may become eligible for 24 hour medical care at a date post service discharge as a result of deterioration. The QQR team is also aware that the MOD is looking at the continuity of care for Service personnel and Veterans<sup>10</sup>. More work will be required in defining the precise eligibility criteria for the supplement and ensuring coherence with the wider continuity of care arrangements.

8.37 In terms of the value of the Supplementary Award, the QQR team engaged with specific stakeholders during its investigations and was made aware of the work carried out by the Department of Health and the MOD on identified Service personnel who qualified as the “Most severely injured and highly dependent Service personnel.” The QQR team has concluded that the Supplementary Award should be set at 50 per cent of Tariff 1, which is itself proposed to be uprated. The QQR team recommends that the current £570,000 should be uprated to £650,000, so that the Supplementary Award would be £325,000 on top of a high Tariff level award. For example, on top of the revised Tariff 1 award, this would come to a total of £975,000. It is worth reiterating that this is not an AFCS award to supplement care

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<sup>10</sup> Integrated Personal Commissioning for Veterans (IPC4V) – see paragraph 5.24

costs, as the AFCS award compensates Service personnel for their injury or illness, **not care costs**. This will only apply to a very few individuals.

8.38 The QQR team recognises that the criteria for the supplementary award, including timing of decision, how and by whom the decision is made should be defined in parallel with the wider continuity of care arrangements.

8.39 The QQR team strongly recommends that the MOD considers this proposal **that there should be an additional Supplementary Award, in addition to respective claimants' lump sum awards and GIP**.

### Combat Compensation

8.40 On 1 December 2016, the MOD announced a consultation on proposals to provide better and faster compensation in future combat situations. It said compensation would be provided to members of the Armed Forces and their families consistent with what a court of law would award without the need to bring lengthy and costly legal cases. It is hoped that by doing so it would reduce the difficult and traumatic experience that often arises in such cases. This proposal is also in line with the MOD's commitment to the Armed Forces Covenant. At the same time, it intends to clarify in primary legislation the ambit of the long-standing common law principle of combat immunity that the Government is not liable in negligence as a result of injuries or deaths sustained in combat. It is the QQR team's view, that were a new scheme to be introduced there would remain a place for our recommendations, including the Supplementary Award, for any eligible claims that were not sustained in combat. This scheme is intended to be entirely separate to the AFCS (but clearly you cannot be compensated for the same injury twice).

### **Conclusion**

8.41 AFCS lump sum awards are not currently uprated in line with inflation. The Scheme is now over ten years old. Although lump sum Tariff levels have increased during these ten years, all Service personnel who have suffered injuries and/or illnesses of the same severity since 2011 (or since 2008 in the case of Tariff 1 injuries) have received the same lump sum award.

8.42 The real value of lump sum awards is decreasing year on year and will continue to do so unless the Scheme is reviewed periodically and lump sum awards are increased appropriately, or lump sum awards are uprated periodically for inflation.

8.43 GIPs are awarded to all Service personnel who receive a lump sum award at Tariff level 11 or above, and all Service personnel who are awarded a GIP at 50% or higher are eligible for the AFIP. A 50% GIP is usually awarded to those in receipt of a lump sum award at Tariff level 8 or above, but is also awarded to those in receipt of two or more lump sum awards at Tariff level 9.

### **Recommendations**

8.44 The QQR team recommends the following:

- That lump sum awards are automatically uprated for inflation in line with the CPI on an annual basis. This would ensure that Service personnel suffering injuries in the future would not face a reduction in the value (in real terms) of their lump sum awards. The alternative would be the creation of an internal review mechanism. It would comment on the value of awards, and recommend whether regular automatic

uplifting of awards was needed rather than awaiting a QQR. MOD should engage with the relevant parties and would report to the CAC.

- Uplifting the top Tariff level 1, currently £570,000, as it was last reviewed in 2011 and does not sufficiently recognise the most seriously-injured and high-dependency cases. This should be from £570,000 to £650,000. In line with this, the cap for multiple injuries should also be increased to the same level. The QQR team recommends maintenance of the overall cap (£650,000).
- There should be an additional Supplementary Award, in addition to respective claimants' lump sum awards and GIP. The value would be £325,000 (uncapped). This would be for those who experience the highest degree of dependency on others to remain alive and consequently qualify for the highest need for support (essentially, 24-hour medical care). Thus, this would be at the extreme end of the most seriously injured claimants, whom we have provisionally named the "**Most severely injured and highly dependent Service personnel**". The QQR team recognises that there would be work needed on refining the Supplementary Award in terms of its criteria, the timing of the decision and the responsibility for recommending Service personnel for this Supplementary Award.

## Chapter 9

### INTERIM AWARDS

#### Definition

9.1 Interim awards are a significant component of the AFCS. Interim awards are designed for cases where an injury or illness is clearly caused by AFCS service, but its on-going effects are not. They are intended to provide claimants with some financial certainty with an award until a final decision can be taken. Awards are reviewed within two years to see if a final award can be made. Lord Boyce was supportive of interim awards in that they provided an advance recognition of a service causal link before prognosis was established.

9.2 Article 52 of the 2011 AFCS Order concerns interim awards. The intention of a full and final scheme is that as early as possible after the claim, an award will be made of which the aim is to take into account the likely progress and functional limitation associated with the accepted disorder over the person's lifetime. Interim awards were designed as a goodwill gesture to claimants whose entitlement to compensation is established but the diagnosis and/or prognosis of their injury or illness is unclear. Interim awards are made at the discretion of MOD based on medical advice that the claimant is not yet in a stable condition and a full and final award based on the permanent effect of their injury cannot yet be made.

9.3 Interim awards do not carry appeal rights. Awards are reviewed within two years and if appropriate finalised. If that is still not possible, DBS Vets may extend the interim award for a further two years with a full and final award being made after a maximum of four years. An appeal right is then notified. If the final decision is to maintain the award at the same or a higher level, any difference between benefit paid and benefit now due is payable. Where the final award is less than the interim award, no further amount of benefit is payable but no overpayment is recoverable. In its Second Report (2013)<sup>11</sup> and following the Lord Boyce review, the IMEG considered mental health disorders. It recommended that full and final awards should be made only when the person has engaged and undertaken an adequate course of best-practice treatment for at least long enough for prognosis to be reliably determined.

9.4 Where interim awards are made for mental health disorders, the reason is often failure to undertake or complete adequate treatment at the time of claim. Disorders which, on balance of probabilities, can be accepted as due to service are the common mental health diagnoses such as anxiety state, depressive episode or PTSD, all of which have best-practice evidenced effective treatment guidelines. In most cases an adequate course of best practice treatment results in improved function.

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<sup>11</sup> The Independent Medical Expert Group – Report and recommendations on medical and scientific aspects of the Armed Forces Compensation Scheme – 17 May 2013

## What the Scheme provides

9.5 The policy for interim awards is detailed in [JSP 765](#) on pages 18-19 and the legislation is laid out in the [Armed Forces and Reserve Forces \(Compensation Scheme\) Order 2011](#) under Article 52.

## QQR Findings

9.6 Some stakeholders stated that the interim awards process was a welcome aspect of the AFCS, as it provided greater flexibility for claimants to ensure that they were able to claim for the full extent of a developing injury. There were some concerns, however. As stated at paragraph (1) (a) Article 52 of the AFCS Order provides for an interim award to be made where a prognosis is uncertain. It was stated that the reason for this was sound in the case of serious injury, but that it made for uncertainty for a period of possibly up to 4 years.

9.7 Stakeholders felt that this could cause hardship in cases where there was a requirement to find accommodation, obtain a mortgage or make alterations to an existing home (through the Local Authority) because of the unfinalised nature of the interim award. It was thought that there should be a continuous review of the interim claim and that Article 52 should provide adequately for the uncertain prognosis, but in practice interim awards were made routinely for two years regardless of how soon a final prognosis could be expected, rather than on the basis of consideration on an individual basis. It was stated that Service personnel who had been injured as a result of service needed to know as early as possible what their financial circumstances were going to be on discharge, because a lack of certainty added to stress, especially when determining future employment and resettlement options. **The QQR team considers that an automatic right to review of an interim award when approaching discharge date would go some way to addressing this concern.**

### What do the statistics say?

9.8 Of the 35,601 awarded claims under the AFCS from 2005-16, 5.8% were granted an interim award as at 31 March 2016.

## Conclusion

9.9 The AFCS is designed to make awards as soon as possible after the claim. These awards are full and final and not subject to continuing review, in order to provide individuals with a degree of certainty about their financial position. DBS Veterans UK makes interim awards at a 'safe' level that is almost certain to be maintained or increased as a final award. The first interim award will be made for a maximum period of two years. Coming up to the end of this period the claim is re-visited and, where possible, finalised. In some cases it may be appropriate to extend the interim award for a further two-year period. That said, the QQR team believes there would be merit in reviewing Article 52 of the AFCS Order in light of the findings.

9.10 There was a view that interim awards may lead to financial insecurity, especially, for example, if a Service person was medically discharged and their injury meant that they could not work and would have difficulty in securing a mortgage, as an interim award could be regarded as temporary. Because an interim award is by definition not final, banks may fail to understand that an interim award is never reduced and not see it as an appropriate basis for granting a mortgage. **The QQR team believes that there is an opportunity here for a communication piece in terms of educating banks about the AFCS and explaining what an interim award is through the Financial Services Support Group (FSSG).**

## Recommendations

9.11 It is recommended that the MOD:

- Considers whether there is any merit in the QQR team's belief in the proposal of an automatic right to review an interim award when approaching discharge date, if more than six months from the date of the award.
- Liaises with the Financial Services Steering Group (FSSG) through the Armed Forces Covenant Team on AFCS interim awards in order to:
  - 1) Educate the FSSG (and Charities) on the AFCS, given that there would be a number of their customers who would be recipients of large compensation pay-outs, anything from £10K to £570K, some of whom would receive a Guaranteed Income Payment (GIP).
  - 2) Inform them about interim awards and the situation regarding financial insecurity – initiating a discussion on what possible solutions there could be between parties involved.

The FSSG will be able to share this information with the Financial Services industry. Included in the FSSG are the following, which are all relevant to this issue:

- British Banking Association
- The Finance & Leasing Association
- Building Societies Association
- The Council of Mortgage Lenders

## Chapter 10

### WORSENING

#### Definition

10.1 This chapter looks at the subject of worsening. It will discuss what the Scheme provides and what the stakeholders had to say on worsening.

#### What is worsening?

10.2 As well as paying compensation for injuries which are caused (wholly or predominantly) by service, compensation may be payable where Service personnel sustain injury through some other means, but then that injury is made worse by service.

10.3 Compared with civil personal injury claims and compensation schemes such as the Criminal Injuries Scheme, the AFCS has a relatively narrow selected client group of generally fit people. In line with its key aim of maximising operational capability, the military adopts high standards of people management, training, protection and prevention as well as occupational health including regular routine medical examinations and assessment of medical employability grading. Where injury or disorder arises, timely access to best-practice medical management and rehabilitation is called for. Some of the attributes of the AFCS including the “worsening” provision derive from these features. Awards are made under the AFCS where on balance of probabilities there is a causal link to service on or after 6 April 2005. This may be “due to service” or “worsened” by service. Awards are paid at the same level for both categories.

#### *In what circumstances might worsening occur and be accepted under the AFCS?*

10.4 Firstly where there is a pre-existing pre-service disorder, either acknowledged at service entry or not, or where there is an injury or disorder due on balance of probabilities to an identifiable non service-related accident or event. To accept worsening, Armed Forces service has to be the predominant cause of the worsening. MOD cannot lawfully accept worsening which is just part of the natural history of the disorder.

#### **What the Scheme provides**

10.5 In line with Lord Boyce’s recommendations, the time limits in which personnel can make a claim, including late-onset illness claims, were increased from 7-10 years. An additional right to request a review of a decision 10 years after that decision was made was introduced. Where the illness (including mental illness) is medically considered a late-onset illness, the time limit is three years from the date of diagnosis, whenever that diagnosis takes place (i.e. it could be some decades after service has ended).

10.6 The policy for the above is laid out in [JSP 765](#) on pages 34-35 and the legislation is detailed in the [Armed Forces and Reserve Forces \(Compensation Scheme\) Order 2011](#) under the following Articles:

- Article 3 – Definition of ‘late-onset illness’
- Article 9 – Injury made worse by service
- Article 56 – Review – exceptional circumstances within 10 years
- Article 57 – Review – final

## QQR Findings

10.7 The time limit for making a claim under the AFCS is seven years with an additional right to request a review of a decision 10 years after that decision. The QQR team were informed that with the passage of time that there was now an increase in the numbers of cases where Service personnel fell foul of the 7-year rule through no fault of their own. This stakeholder thought that some individuals were supported through many years of surgery, rehabilitation etc. without making a claim until 7 years had elapsed, and it then became too late to make a claim. It was suggested that one option might be to relax the exceptional criteria for late claims, e.g. making the provisions of Article 47(3) apply to injuries as well as illnesses.

10.8 Some stakeholders also stated that there was a problem with regards to the position with claims for worsening after leaving service. They stated that an individual cannot claim for worsening until after leaving service; however, this could be well be more than 7 years from initial manifestation of the problem. The choice should not have to be between continuing in Service with the injury, or leaving Service (GIP of course is not in any case payable until after service termination).

## Conclusion

**10.9 Some stakeholders felt strongly that the legislation governing worsening was too tightly drawn, to the extent that Service personnel whose condition had clearly been worsened by their Service might not be compensated because of the AFCS Order, especially the time limits. The QQR team agrees that this matter should be explored.**

10.10 This issue was raised with Lord Boyce by stakeholders and he recommended that IMEG advise on the matter. As worsening can only be considered at service termination, in 2009/10 few cases had been seen and the IMEG is only now considering the matter. This work will form part of the fourth IMEG Report in 2017. **The QQR team recommends that IMEG should pay particular attention to AFCS worsening of musculoskeletal disorders and mental health symptoms and illness.**

## Recommendations

10.11 It is recommended that the MOD:

- Considers whether the 7-year and 10-year time limits are still appropriate. If it is considered that the current legislative framework for time limits under the AFCS strikes the right balance, then much more needs to be done by way of highlighting the time limit rules for claims through the Chain of Command so that Service personnel can make a claim in time.
- Supports the IMEG review of the medically and scientifically sound approach to worsening. This will form part of the forthcoming 'fourth' IMEG Report in 2017. The MOD can consider the need for any policy/legislative amendment once this has been received. The QQR team recommends that IMEG should pay particular attention to AFCS worsening of musculoskeletal disorders and mental health symptoms and illness.

# Chapter 11

## SPANNING

### Definition

11.1 This chapter looks at the subject of spanning. It will discuss what the Scheme provides and what the stakeholders had to say on spanning. The issue arose because when the AFCS was introduced it applied only to injury or disorder caused by service on or after 6 April 2005 while the WPS, with its open gateways to claim, remained in place for disablement or death claims attributable to service before 6 April 2005.

### What is spanning?

11.2 Spanning cases are identified at or beyond service termination, where the person has served both before and after 6 April 2005. This might include several periods of Regular and/ or Reservist service. Increasingly ex-Service personnel with spanning service are claiming compensation.

11.3 For these cases we need claims processes which are lawful, understandable to claimants and administratively practical. A key public policy aim is to avoid double compensation, i.e. making awards for the same disorder under both the WPS and the AFCS.

11.4 Some specific categories of claims are especially affected by spanning service and for consistent equitable outcomes, we need to agree approaches which meet the criteria and are medically sound. Claim types include hearing loss and musculoskeletal/orthopaedic disorders where both chronic attrition and acute trauma to joints/structures are involved, and mental health problems.

11.5 The aim in spanning cases, where possible, is to make a single award under one scheme, notifying one appeal right. While awards under both schemes are based on a causal link to service and both schemes are individual jurisdictions, with decisions based on evidence, there are innate differences between the two. The WPS is medically certified with much scope for judgement, while AFCS is medically advised. The lay decision maker, who will not be medically qualified, may request medical help. Lord Boyce identified certain types of case likely to be medically complex, e.g. polytrauma or mental health problems which were judged likely to benefit from medical input.

### **What the Scheme provides**

11.6 The policy for the above is laid out in [JSP 765](#) and the legislation is detailed in the [Armed Forces and Reserve Forces \(Compensation Scheme\) Order 2011](#).

11.7 The automatic consideration of “spanning cases” was removed from legislation as part of the changes that were made to the Scheme in August 2010, brought about by the Lord Boyce review 2010.

## **QQR Findings**

### Double Compensation

11.8 Some stakeholders felt that the cases which caused the most confusion and inconsistency were those where the claimant had suffered an injury which could be considered under either the WPS or the AFCS or, if it was a continuing developing disability, under both. It was also thought that the lack of clear statutory provisions which apply to injuries or disabilities which span both schemes gave rise to uncertainty for the claimant, those advising Service personnel and even the Tribunal panels.

11.9 When the AFCS legislation was originally laid in 2005, it was assumed that a person might first claim under the AFCS i.e. while still in service, but could only claim war pension at and beyond service termination, i.e. second. To address that situation, a provision was introduced into the WPS to prevent double compensation for the same injury or disorder, i.e. the amendment said that if there was an award under AFCS there could not be one for the same disorder under the WPS.

11.10 In addition, although the AFCS includes a “worsening” provision, claims can only be made for worsening after the end of all service. It was thought that if an injury was accepted under the WPS, all subsequent later disablement would also be accepted under the same Scheme, and so it was not necessary to introduce any similar exclusion into the AFCS, i.e. to exclude an additional AFCS award for the same disablement in the presence of war pension award.

11.11 There was a legislative amendment in Apr 14 which included an exclusion under Article 12 (AFCS Order 2011) that where a person is in receipt of an award under the WPS that disablement shall not be accepted as an injury caused by service for the purpose of the AFCS Order. This was to address the issue of awards being made under both schemes, i.e. causation under WPS and worsening under AFCS.

### **Conclusion**

11.12 There are three main case types where spanning is an issue; they are hearing loss, musculoskeletal disorders, mainly attrition-related, along with traumatic accidental orthopaedic injury and mental health problems. Lord Boyce made reference to spanning cases in his review but at that date examples of such were rare in the Scheme. Identifying a lawful practical approach in the time available to this review was simply not possible. The QQR team noted that as agreed by the Minister, the IMEG is now considering the scientific and medical aspects of spanning cases. Findings will be included in the Fourth Report due in the summer of 2017. The QQR team hopes that an understandable and administratively straightforward position can be reached.

### **Recommendation**

11.13 The QQR team finds that there would be merit in a further review of legislation and policy for the themes ‘time limits and spanning’ .

## Chapter 12

### DECISION-MAKING

#### Definition

12.1 This chapter will cover policy and legislative aspects of decision-making. It will examine the quality and consistency of decision-making and its contributory factors. The outcome of a “decision” may not produce an award for the claimant; their claim may be rejected. However, a claimant may request a reconsideration, which is a prerequisite to an appeal; they may request this because they may not be content with the value of the award or the decision to reject a claim.

12.2 The QQR team will look at what the Scheme provides, followed by an assessment of stakeholders’ views on decision-making.

#### What the Scheme provides

12.3 Lord Boyce reviewed the claims and adjudication process and reached the following conclusions relevant to this Review:

- He focussed first on the need for more effective communications and guidance on the Scheme to members of the Armed Forces families and supporters and for better support to claimants in navigating the claims process.
- He felt this was the responsibility both of the scheme administrators and the chain of command. He also felt that claimants should be kept better informed on the progress of their claim and once an award is made have access to independent financial advice.
- In terms of decision-making he rejected the request for a move to a fully medically adjudicated claims process and felt the available access to medical input was adequate. He recommended greater military oversight and the identification of particular circumstances where as a matter of Scheme policy, medical input would be routine. He gave a few examples of such cases, e.g. reconsiderations where awards are at levels 1-6 and at appeal.
- He favoured greater use of interim awards and the introduction of an optional early fast payment for significant injuries accepted as due to service but likely to require protracted treatment to recovery.
- He suggested the addition of some further decision review processes including where errors have been made by decision-makers or new evidence becomes available.
- He recommended a fully consolidated version of the legislation as soon as possible to incorporate the Scheme changes coming out of the Review.

12.4 In the time since the Lord Boyce review 2010 most of these recommendations have been implemented including the required legislative amendments. The policy for decision-making is detailed in [JSP 765](#) and the legislation is laid out in the [Armed Forces and Reserve Forces \(Compensation Scheme\) Order 2011](#).

#### QQR Findings

12.5 Many changes were made as a result of Lord Boyce’s review to improve the clarity and understanding of the Scheme. However, it was felt in light of issues raised by stakeholders that more work was needed on effective communication about the Scheme.

This is likely to be most successful if it involves coherent working including MOD, DBS, military colleagues, the Charities.

### Stakeholder issues

12.6 These are presented as a list in no particular order of priority:

1. One stakeholder said that it was difficult to identify a point cause or trigger of musculoskeletal injuries or sometimes a mental health issue. The Scheme was poor at compensating for injuries caused by prolonged strenuous training. By contrast some stakeholders held the view that there was a risk that AFCS awards might be made for injury or disorder which was not predominantly caused by service.
2. There was a tendency for disorders, especially mental health problems, to be rejected on the basis of a pre-existing condition or vulnerability.
3. Some stakeholders requested further clarification of “permanent” in the context of mental health disorders.
4. The causes of both mental health and musculoskeletal injuries are difficult to pinpoint as often both result from cumulative stress rather than one triggering incident, and the AFCS was weighted towards combat trauma injuries.
5. Comment was made on the continued high number of claims for hearing and difficulty in judging tinnitus objectively.
6. One stakeholder said that ‘Infectious Disease’ claims were doomed to failure as there had to be an “outbreak” before a claim could be considered.
7. A small number of diseases – e.g. meningitis – can be presumed to be due to Service without the usual burden of proof. This is not reflected in AFCS legislation and Article 60 – Burden of proof - should be reviewed. The QQR team found that this was covered by Lord Boyce in his 2010 review and that recognised diseases had been covered in the IMEG reports.

### What do the statistics say?

12.7 Decisions on claims from Scheme inception (6 Apr 05) to 31 Mar 16, there were 63,098 claims registered. Of these, 35,601 (56.4%) led to an initial AFCS award.

12.8 For further details please also see the Armed Forces Compensation Scheme statistics: financial year 2015/16 - tables 4, 5 & 9 - <https://www.gov.uk/government/statistics/armed-forces-compensation-scheme-statistics-financial-year-201516>

### **Conclusion**

12.9 Many changes were made as a result of Lord Boyce’s review to improve the clarity and understanding of the Scheme and improve DBS Veterans UK procedures. However it was felt by stakeholders that more needed to be done to improve the quality of information communicated to claimants.

**12.10 The QQR team notes that a number of points raised above specifically refer to musculoskeletal disorders and mental health problems and recommends that these are referred to IMEG for their comment as part of their 2016/2017 review of musculoskeletal disorders and ten year review of AFCS mental health claims.**

12.11 Stakeholder issue (5) above discusses hearing claims. All AFCS hearing descriptors in Table 7 include an element for tinnitus whether it is present or not and no separate award is made for tinnitus alone. Much work has been done and continues surrounding military hearing loss. Over the last 25 years there has been discussion on how best to compensate

occupation-related hearing loss and there have been several independent expert reviews of the condition. This includes the 1991/2 review led by the then Chief Medical Officer, Sir Kenneth Calman, the 2002 Command Paper by the Industrial Injuries Advisory Council (IIAC) on Occupational Deafness and, in the military context, a review including on acute acoustic trauma in the [May 2013 IMEG report](#).

12.12 The stakeholder issues: (6) and (7) concern infectious diseases. The QQR team suggests, as above under the chapter on Emerging Challenges, clarification in JSP 765 will help understanding. The concept of recognised diseases in the Scheme and their acceptance through a presumed service link is set out in the IMEG reports. This is a matter of AFCS policy and does not require amendment of Article 60 of the AFCS Order.

### **Recommendation**

12.13 The QQR team recommends the following:

- That points raised above that specifically refer to musculoskeletal disorders and mental health problems are referred to IMEG for their comment as part of their 2016/2017 review of musculoskeletal disorders and ten year review of AFCS mental health claims.

## Chapter 13

### APPEALS

#### Definition

13.1 This chapter will cover appeals. The topic of appeals will focus on the appeal process followed by what the statistics say and conclude with the QQR team findings during a Tribunal hearing. It should be emphasised that the MOD does not rely on appeals as an integral part of decision-making.

13.2 Firstly, we will look at Lord Boyce's conclusions in 2010 review and what the Scheme provides followed by an assessment of stakeholders' views on appeals.

#### Lord Boyce Review 2010

13.3 The subject of Appeals was not a key theme in the Lord Boyce review but the report included a section on a July 2009 Court of Appeal judgement brought by MOD to obtain clarity on a few key issues including how AFCS should deal with illnesses and disorders as opposed to injuries and how to take account of the development of an injury or disorder over time.

13.4 Related issues discussed in the Lord Boyce review included time limits for claiming, for reconsideration requests, appeals and the treatment of deterioration.

13.5 The Lord Boyce review recommended an increase in the time limits for claiming from 5 years to 7 years. The time limits were increased from three months to a year for reconsiderations and a further 12 months beyond reconsideration for appeals.

#### What the Scheme provides

13.6 The policy for the above is detailed in [JSP 765](#) and the legislation is laid out in the [Armed Forces and Reserve Forces \(Compensation Scheme\) Order 2011](#).

13.7 More information on the tribunal procedures can be found in the: **The Tribunal Procedure (First-tier Tribunal) (War Pensions and Armed Forces Compensation Chamber) Rules 2008 (S.I. 2008/2686 (L. 14))**<sup>12</sup>.

#### QQR Findings

13.8 Unnecessary appeals cause unwanted stress for Service personnel dealing with an injury or illness and come at both a financial expense to the MOD and Charities. It is in all parties' best interests to ensure that appeals are minimised and that Service personnel receive appropriate compensation on the first application. Further review of communications educating Service personnel on the AFCS and the training for decision-makers would go some way to addressing issues that may occur at the appeal stage and reduce the number of appeals. This applies to Service personnel and veterans as well as Scheme decision-makers.

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<sup>12</sup> <https://www.gov.uk/government/publications/war-pensions-and-armed-forces-compensation-chamber-tribunal-rules>

## Stakeholder issues

13.9 These are presented as a list in no particular order of priority:

1. There was a growing perception from stakeholders that to get the right decision, claimants must be prepared to pursue reconsiderations and appeals. This could lead to nugatory appeals at a Tribunal.
2. A number of contributors to the QQR team commented that other elements of internal appeals in relation to pay, allowances and pension, have military input or oversight of the process to bring a service perspective and to provide credibility to the process for Service personnel. The AFCS, by contrast, does not have such in-service military contribution. First Tier Tribunals do, however, have a Service member on the panel at each appeal. It should be noted, however, that a number of other contributors advocated no such involvement due to perceived risks of bias from the Chain of Command.
3. A suggestion to this Review, again as in 2010, was for increased medical input to cases including independent medical advice at appeal rather than reliance on service medical records. Post-Lord Boyce situations where medical input to decisions by DBS medical advisers is routine have been identified and are set out in JSP 765. They include all cases involving mental health problems: cases where a supplementary award is likely; temporary awards; reconsiderations or appeal cases; exceptional or final reviews; multiple injuries where zoning applies; service termination reviews and all other cases where the decision-maker judge's medical input would aid their decision, e.g. interim awards.
4. One contributor to the QQR team suggested that even first decisions and reconsiderations should be made by a body entirely independent of the MOD, and not just appeals.
5. One stakeholder suggested that **it would be helpful for DBS Veterans UK to publicise guidance on its decision-making and appeals process, similar to that published by the DWP in relation to disability benefits, particularly when it comes to medical assessments.** This would help claimants, as well as their advisers, by ensuring that claimants were fully prepared in advance of making a claim. The stakeholder also proposed that one simple improvement to the process would be for comprehensive evidence-referenced explanations to be provided for decisions in notifications to all applications.
6. Another stakeholder thought that time would be saved if appeals could be made directly to Tribunals – this is known as a 'Direct Lodgement Appeal'. Appeals against decisions made with regards to WPS and AFCS claims are lodged with the decision-maker (DBS Veterans UK) rather than direct to the Tribunal. On receipt of the notice of appeal, DBS Veterans UK undertakes the reconsideration process. If at the end of that process, a dispute remains, DBS Veterans UK lodges a response to the appeal with the Tribunal. Submission of appeals through DBS Veterans UK helps to reduce unnecessary appeals which cause financial expense to the MOD and also unwanted stress for Service personnel dealing with an injury or illness.
7. Stakeholders raised some issues with regards to the Tribunal hearing itself. They said that Service personnel require proper representation at the Tribunal hearing and often appellants do not understand the Scheme or appeal process (Service personnel are usually represented by one of the Charities, e.g. BLESMA or RBL).

## What do the statistics say?

13.10 From 2005/05 to 30 Sept 16, there were a total of 6,199 appeals registered as shown at Table 1 of the [UK Armed Forces Compensation Scheme Biannual Statistics](#).

## **Conclusion**

13.11 It seems that the appeal process is also not fully understood by some claimants and there may be an opportunity to make the process easier to understand in collaboration with the Service charities. In this QQR, appeals attracted a number of comments from stakeholders but there was no single dominant issue and it was notable that a significant number of issues were matters of misunderstanding. This in itself is an important observation for the QQR team confirming the on-going challenge of accurate effective communication about the Scheme.

13.12 The QQR team is not aware of any other system in which even the initial decision on entitlement and level of award is taken independently. It is the view of the QQR team that the independent element is applied at the Appeal stage as with other tribunal systems in the UK (such as the Pensions Ombudsman, Employment Tribunals, or the First Tier Tribunal Chamber dealing with social security benefits and tax credits).

## **Recommendation**

The QQR team recommends the following:

- Further review of communications educating Service personnel – DBS Veterans UK to consider publishing guidance to its decision-making process, similar to that published by the DWP in relation to disability benefits, particularly when it comes to medical assessments.

## Chapter 14

### COMMUNICATION: EDUCATION & EFFECTIVENESS

#### Definition

14.1 This chapter covers the communication of the AFCS to its target audiences including Service personnel, veterans, families of the Armed Forces, medical staff and to a certain degree the general population including the media.

14.2 Effective communication is the cornerstone to any Government scheme. There are many benefits such as bringing about increased understanding between Government and public as well as cost-effectiveness to the taxpayer, just as there are costs associated with misinformation and misunderstanding. The QQR team agreed that with respect to information “Accuracy”, “Consistency”, “Reliability”, “Accountability” and “Timeliness” are the key tenets of effective communication. These all need monitoring to ensure effective communication is maintained. The current communication channels through which the MOD informs the target audience include JSP765, Infolaw (the lawyers’ information exchange website), briefs to Service personnel and the web pages for DBS Veterans UK at [www.gov.uk/veterans-uk](http://www.gov.uk/veterans-uk).

14.3 This chapter will commence with the recommendations from the Lord Boyce review to assess whether progress has been made on them. It will also take into account the state of play with regard to the information flow on the AFCS and feedback from stakeholders. Internal stakeholders expressed the view that the Communications objectives from the Lord Boyce 2010 review were met at that time; however, the QQR team felt that there was room for improvement in order to maintain the effectiveness of the AFCS communication push.

#### Lord Boyce 2010 review

14.4 Lord Boyce’s review was greatly concerned at the low level of awareness and understanding of the Scheme among Service personnel and their families. Substantial improvements were required to the way in which the Scheme was communicated. His review noted that the following needed improvement: the level of support provided to individuals in making claims, understanding what a claim is for, and making informed decisions, with assistance and financial advice about how to manage the potentially substantial sums. His recommendations also included that all existing guidance and information material should be reviewed for content and accessibility, especially for comprehension purposes on what the awards are for.

#### What progress has been made?

14.5 An AFCS Communications and Training Working Group with representation from the three Services, the AFCS Policy Team, DBS Veterans UK, training experts and other stakeholders was established to improve awareness and understanding of the Scheme. The group delivered a detailed communications programme in 2011 to the Armed Forces and families. Products included a promotional tri-fold leaflet; an AFCS contact card issued in hard copy to all serving personnel at the time; new training presentation packages; a poster for display in Units; an awareness video; articles in magazines; three podcasts and website blog entries and email bulletin to ex-service charities.

14.6 The then SPVA also undertook a review of all communication products that referred to making AFCS claims and the claims procedure. However, the QQR team noted that the AFCS Communications Working Group ceased activity in 2012. The group had a limited

remit following the Boyce review; its main task was to communicate the changes to the AFCS and raise awareness.

14.7 Claim acknowledgement letters were amended to include more information on how the claim would be processed and assessed. Where cases might take longer than average to process, interim letters were issued to explain what progress had been made and what remained outstanding. In award letters, clear presentation of how the compensation had been calculated was provided, along with an explanation of appeal and reconsideration rights.

14.8 In addition to the work to develop communications, the changes to the AFCS led to development of a training and education package for all Armed Forces personnel. This package provided an overview of the AFCS and explained changes to the Scheme. It was delivered via presentations referenced above by the chain of command and included within initial military training, and also interactive media. This web-based 'toolkit' contained communications products that provided more information on the AFCS.

#### Current state of play

14.9 In order to understand the state of play, the QQR team asked DBS Veterans UK, the Army, Navy and RAF what they **presently** do. The QQR team wanted to learn what processes and procedures were currently in place to educate Service personnel and to assess whether there was any coherence and consistency in terms of delivery. The details are provided below; however, in summary, it can be concluded that although communications on the AFCS do indeed exist, they do not appear to be formalised, regular, or monitored or have anyone substantially accountable or responsible for information flow on the AFCS.

14.10 The DBS web pages on [www.gov.uk](http://www.gov.uk) are the main source of communication on the Scheme, and that the information therein contained was extensive and written to the accepted plain English standards. The narrative was also fully accessible to those with disabilities, optimised for different web browsers and also for Google and other search engines. There were clear links to the claim forms and the DBS Veterans UK free helpline service should more information or a verbal conversation be required. [www.gov.uk](http://www.gov.uk) is the main portal for accessing all Government services – all in one place. DBS Veterans UK has worked with the Government Digital service to improve the AFCS information, and have published summary level guidance on the Government's mainstream core service content in addition to the detailed information published by DBS. DBS suggested this counted as "regular communications" using the Government's mandated central website for information to individuals. However, the QQR team has noted pertinently that other than [www.gov.uk](http://www.gov.uk), there has been no further concerted communication campaign on the AFCS since the Boyce campaign.

14.11 However, although there has been a lot of activity during certain periods, the QQR team found the following across the Services:

- The three Services had varying levels of briefings (at various stages in their career) to their Service personnel on the AFCS.
- The subsequent follow-up to the initial presentations was somewhat inconsistent, e.g. some units provided a brief to personnel at the actual Medical Boards, so if they had missed earlier presentations they could receive advice on the spot, and some did not provide any follow-up at all.

14.12 In addition to training on the AFCS provided by the three services, DBS Veterans UK reported on delivering presentations on the AFCS to Infantry Warrant Officers at the Infantry

Battle School, Brecon and also to all ratings recruits at HMS Raleigh, Devon. They also deliver a presentation at every Unit Welfare Officer course at Easingwold, York.

## QQR Findings

14.13 The QQR team has seen that there has been a lot of effort put into communications since the Lord Boyce review. However, in terms of “How are communications doing presently?” the QQR team heard testimonies from stakeholders to the effect that although communications have improved generally, they were still patchy and there existed a lot of misunderstanding over what the AFCS does.

14.14 The QQR team came across evidence that suggested that many Service personnel did not appear to understand that AFCS did not pay out for injuries caused whilst travelling to and from work, or undertaking fitness training other than that authorised as part of military physical training activities. The communication messaging agreed with DBS Veterans UK regarding policy for the AFCS was that people should claim ‘if they felt they might have a claim’ and to ‘leave it to the experts in DBS Veterans UK to decide if a payment was due’. Again, DBS Veterans UK reported that this was not surprising, because the onus has always been to encourage all ‘possible’ claims and not to let people ‘fail to claim because they thought they weren’t entitled’. On that basis, personnel on the front line would most likely not know this level of detail, because they have always been told to ‘claim if they just think they might – for any reason.’ In addition, the QQR team found there were misunderstandings on slips, trips and falls. Also, there was a frequent (but mistaken) assumption by some stakeholders that a certain proportion of the lump sums/GIP provided by the AFCS was to pay for care.

14.15 The QQR team recognises that there would be merit in making use of the existing communication and marketing professionals in DBS Veterans UK and DDC, to further inform the target audiences about the AFCS. **The QQR team suggests that to ensure that the Scheme’s narrative can be improved, the MOD considers a range of other suppliers to accredit the AFCS’s narrative in Plain English, given the recurrent themes from stakeholders on the language employed, especially from Service families.**

The benefits would ensure that:

- The AFCS content adheres to the tenets of effective communications
- It would promote a better relationship between the claimants and the AFCS administrators as a result of reduction in misunderstandings
- The AFCS would operate more efficiently and smoothly as less time would be involved in “fire fighting” as a result of inaccurate information
- The AFCS’s narrative would be improved in terms of its clarity and professionalism

14.16 Communications is a recognised profession with tried and tested techniques; therefore, rather than employing a “common-sense approach” to communications, the QQR team is of the view that the use of experienced professional communications specialists, challenging commonly accepted beliefs, would go some way to ensure that the average person would be able to understand the message.

14.17 The QQR team believes that it is arguable that to deliver lectures or briefings on the AFCS during the induction process to new recruits who are already in an unfamiliar environment, and who are being deluged with all sorts of new information, is unlikely to make a lasting impression. In such circumstances, it would be sensible if the AFCS literature/narrative concentrates on what appears to be of immediate importance for their key target audience at the time of induction, i.e. that the AFCS exists. However, this work stream

should involve a focus group of claimants and prospective claimants of varying rank, Service families and Service charities. It seems logical to provide refresher training on the AFCS to all Service personnel at significant milestones in their career training, perhaps when promoted to Corporal (Army, Royal Marines, RAF) or Leading Hand (RN).

14.18 There appeared to be inconsistency of awareness and knowledge amongst stakeholders, especially Service personnel on deployment, families, and other Government Departments (OGDs). A repeated theme from stakeholders was that families were sometimes at a loss with the AFCS, especially for the recently bereaved where they experienced “information overload”. The QQR team is of the view that families are a key target audience, since anecdotal stories suggested that they would often be the ones assisting their loved ones with AFCS claims. Based on repeated themes by stakeholders via written submissions and discussions, this suggested that there was a lack of knowledge and awareness of the AFCS, albeit at various levels. The impact can be two-fold: that repeated inaccuracies are eventually (though erroneously) accepted as “facts”, and incomprehension leads to undermining some of the successes of the Scheme.

14.19 Stakeholders’ responses to the QQR questionnaire were rather indicative of their level of understanding or misunderstanding. It is fair to say that the AFCS is a comprehensive scheme, although, in parts, it could be said that the Scheme can be complex and difficult to understand but this can be overcome by the provision of adequate information. The QQR team asked DBS Veterans UK to consider misconceptions surrounding the AFCS.

#### **Misunderstandings and misconceptions regarding the AFCS Scheme.**

14.20 Internal stakeholders reported to the QQR team that there were many misconceptions regarding the Scheme. Potential results of these included wasted time and unfavourable media coverage. **The QQR team therefore recommends that it would be helpful if the MOD could draw up a list of the most commonly-held misconceptions and appropriate Q & As.**

#### **Engaging with Veterans**

14.21 The QQR team found that there appeared to be an issue of engaging with veterans on the AFCS, that is to say those that had not needed the AFCS up to the time of discharge from service, but who might need it in the future, if an injury manifested itself in later years. **The QQR team recommends that those leaving service should be made aware that Service leavers are issued with a guide containing full information on the AFCS.**

#### **GIP**

14.22 The QQR team saw many examples of GIP calculations. However, despite that, the QQR team heard widely that there needed to be more comprehensive information on or about the GIP, i.e. the total financial amount of an award rather than just the lump sum. The knock-on effect of this is the general reporting on compensation by the media which invariably excludes all mention of the GIP award. **The QQR team recommends that communications professionals assist with the production of a comprehensive narrative on the GIP, accredited by the Plain English Campaign, given that the existing narrative does not appear to be working.**

#### **Financial advice**

14.23 The issue on the need for financial advice for awardees was a repeated theme throughout the QQR. Stakeholders said, “Financial advice is needed to help Service

personnel spend the award sensibly on through-life disability issues.” It is noted that this was a theme found in the Lord Boyce review. The level and size of AFCS awards for the most seriously injured can be significant – with up to £570,000 being paid as a lump sum. Therefore, **the QQR team is of the view that it is essential that individuals seek independent financial advice to ensure that the award they receive is managed to provide the long-term support that may be required for life. To address this, the QQR team suggests that the chain of command should direct individuals to their unit HR staff who can provide details of organisations providing independent wealth management advice.** The HR staff will be able to provide details of the Services Insurance and Investment Advisory Panel (SIIAP) or other organisations. In addition, it should be advisable for such recipients to attend a Financial Awareness course, run by Training, Education, Skills, Recruiting and Resettlement (TESRR) in the MOD.

### **Lack of awareness of the IMEG reports**

14.24 Although there was a lot of praise for the IMEG and its work across all stakeholders, the QQR team found that there appeared to be a lack of awareness of the actual content on IMEG reports. A few stakeholders said that areas requiring focus were hearing loss, non-freezing cold injury (NFCI) and Mental Health issues. The IMEG has written extensively on hearing loss, NFCI and Mental Health in particular. **The QQR team recommends that there should be concise messages covering critical aspects of IMEG’s reports – what communications experts call an “elevator pitch”.** This is a brief, concise and persuasive 20 to 30-second verbal summary. Elevator pitches should accompany IMEG reports cascaded to Units, and, in addition, to the MOD, DBS Veterans UK and to cross-Government Departments during **verbal** briefings, rather than assuming that people have pulled information from the website. The benefits would be the highlighting of the valuable work performed by IMEG and the potential areas of shared interest with other stakeholders, not only within the MOD but also across Whitehall. This would be in line with joint Government working, ensuring that Departments are not working in isolation.

### **Other issues raised, and subsequent QQR responses**

14.25 *Communications on rejections and appeals should be much more personal and less standardised.*

- This could be addressed by the communications professionals, and tested with a focus group of Service personnel of varying ranks, covering the narrative used in the letters.

14.26 *The AFCS does not appear to accommodate emerging challenges (infectious disease, Ebola, the Zika virus, recurring diseases)*

- This was a common theme in the QQR team’s investigations, which has been expanded in the chapter “Emerging Challenges”, even though these diseases are actually covered.

14.27 *Skewed perception of the AFCS – it can be perceived to be adversarial.*

- Again, this can be addressed by the communications professionals when drafting narratives on the AFCS and addressed during training of Service personnel at pivotal points in their career.

14.28 *There also seems to be a lack of specific support for Service personnel and their families when completing these forms.*

- The QQR team recommends that this should be discussed between the Pay Colonels and DBS Veterans Welfare, to see what improvements could be made, but ensuring that they engage directly with the respective Service Families' Associations.

14.29 *Service personnel are not always told that having an AFCS award does not prohibit them from bringing a negligence claim through the courts. If they are not told this, then it is understandable when they think the Scheme, by its title, provides their only route to "compensation".*

- The QQR team recommends that this should be discussed between the MOD and DBS Veterans UK, and with an AFCS Communications Working Group.

## Conclusion

14.30 The focus of communications should relate to awareness and understanding regarding the AFCS, in terms of education and its effectiveness, is quite extensive. It could be argued that every chapter in the QQR stands or falls on communications. They are practically the building blocks of the AFCS. The QQR team has looked at how MOD should address any continuing misunderstandings about the AFCS, i) in service and ii) post-service. There is a need to publicise the GIP, and independent financial advice is needed, especially with the higher awards. Awareness of the IMEG reports is also a requirement.

14.31 The QQR team has concluded that the AFCS's successes have been eroded due to misunderstandings and inadequate communication of the Scheme. Although there have been general improvements in communications since the Lord Boyce review, there is still inconsistency and a lack of laid-down procedures and processes for channelling accurate information on the Scheme to the assigned personnel who are accountable and responsible. The QQR team strongly recommends that Communications should be recognised as a discipline that deserves professional accredited communications and marketing experts to foster engagement between the MOD, DBS Veterans UK and the charity sector. **There needs to be a reactivation of the Communications Working Group, which should meet at least quarterly on an on-going basis.** Its function should be monitoring and evaluating, as well as providing centralised direction and guidance across the board. It must be inclusive and collaborative in its approach; hence, the recommendation of having the charity sector as a member of the Working Group together with representatives of claimants.

14.32 In terms of educating Service personnel on the AFCS, rather than relying on their actively seeking out information, **the QQR team recommends that the educational process should be carried out through divisional courses and HR modules to raise awareness and understanding of the AFCS.** The content must focus on essentials, rather than risking information overload, and should be brief and concise. This could be tagged on to an existing online course that all Service personnel do, or a new one could be created.

14.33 There was strong emphasis on communications with an extensive communications campaign conducted as a result of the Lord Boyce review, including leaflet campaigns, DVDs, presentations at Units, etc. Linked to the point expressed in the previous paragraph, the QQR team suggests that it is inadvisable to rely on leaflets, etc., to inform Service personnel, but instead to have interactive courses and communications professionals to assist in the general dissemination of information on the AFCS. There are, therefore, opportunities to raise awareness of the AFCS through divisional courses and HR modules. Not seizing this opportunity could result in adverse financial implications for the MOD, arising from a rise in reconsiderations, appeals, and accusations of negligence as well as general

information overload. However greater use of the Scheme will have greater financial implications.

## Recommendation

14.34 The QQR team recommends the following:

- DBS Veterans UK to engage the services of their own **communication and marketing professionals** to assist in conveying information on the AFCS to its target audiences and ensuring that the Scheme's narrative is accredited by an approved **Plain English Campaign**. DBS Veterans UK to take forward.
- Reactivation of the DBS Veterans UK **Communications Working Group** to meet at least quarterly on an on-going basis. Its functions should be monitoring and evaluating the communications employed, as well as providing centralised direction and guidance across the board. It must be inclusive and collaborative in its approach, having the charity sector and the relevant MOD Departments and DBS Veterans UK around the table together with representatives of claimants.
- The DBS Veterans UK communications professionals should assist with the production of a comprehensive narrative on the **GIP**, accredited by the Plain English Campaign.
- **Divisional courses / HR modules on the AFCS**. These must be specifically designed on a need-to-know basis rather than just creating information overload, and should be brief and concise. They could be tagged on to an existing online course that all Service personnel do, or one could be specially created. This should be taken forward by the Communications Working Group.
- Those leaving service should be informed about the AFCS. To be taken forward by the Communications Working Group.
- The Chain of Command should direct claimants who are awarded substantial lump sum payments (the exact definition of "substantial" to be agreed) to their Unit HR staff who can provide details of the Services Insurance and Investment Advisory Panel (SIIAP) or other organisations providing wealth management and advice. In addition, it should be advisable for such recipients to attend a Financial Awareness course, run by Training, Education, Skills, Recruiting and Resettlement (TESRR) in the MOD.
- An elevator pitch on the IMEG reports to be cascaded to Units and in addition the MOD, and DBS Veterans UK as a **verbal** briefing. This is to be facilitated by DBS Veterans UK communications professionals.
- A new approach to be taken for **letters communicated to claimants on their AFCS outcomes**. This should be facilitated by the communications professionals, with the proposed letters tested on a focus group of Service personnel of varying ranks to review the narrative used in the letters.
- That it would be helpful if the MOD could draw up a list of the most commonly-held misconceptions and appropriate Q and As.

## Chapter 15

### COMPARISON WITH OTHER SCHEMES

#### Definition

15.1 When addressing the question posed to the QQR team whether the AFCS remains fit for purpose, it is helpful to consider how the AFCS compares with other Government-funded compensation schemes and ascertain whether there are any lessons learned, best practice for the AFCS as well as points to note. However, the QQR team is conscious that the context within which each scheme operates can be very different.

15.2 The QQR team conducted research on the Fire-fighters' Compensation Scheme, the Police Injury Benefits Scheme, the Criminal Injuries Compensation Scheme and, for international comparison purposes, the Canadian Armed Forces Scheme. Before looking at these, the QQR team reminded itself of what Lord Boyce concluded on comparisons with other schemes.

#### Lord Boyce Review 2010 and “One Year On”

15.3 Lord Boyce's review undertook comparisons with other schemes and compensation arrangements from both national and international perspective and concluded that they did not require any changes to the AFCS. However, the Review acknowledged that adverse comparisons had been made in the media on UK common law settlements and AFCS awards. These had concentrated on the AFCS lump sum awarded and often neglected the considerable additional value of the GIP. The Review therefore recommended that the MOD should continue to explain at every opportunity the full value of AFCS awards.

#### Other Public Sector Schemes – 1 – Fire-fighters' Compensation Scheme

15.4 The Scheme compensates injured and disabled fire-fighters who are unable to continue in that profession, and also compensates widows and dependants when a fire-fighter is killed in the course of duty. The Fire-fighters' Compensation Scheme provides an injury award made up of a gratuity and pension. The injury gratuity is a lump sum based on a percentage of the final pensionable pay. The percentage is decided according to the degree of disablement.

15.5 For example, for a full-time regular fire-fighter with 75% degree of disablement and final pensionable pay of £30,000: the injury gratuity would be assessed as  $37.5\% \times £30,000 = £11,250$

15.6 For those unable ever to work in any employment there also is a disablement lump sum ([Fire-fighter's Compensation Scheme \(England\) Order 2006/1811 Schedule 1](#) - The Fire-fighters' Compensation Scheme (England) and A Guide to the Fire-fighters' Compensation Scheme 2006.)

15.7 Disablement gratuity is payable only in the case of total and permanent disablement such that the individual will never work again in any employment, and is reduced by the amount of any gratuity already paid and also by any damages payments.

#### Disablement lump sum

15.8 To qualify for a disablement lump sum (known as “duty-related compensation” in the Scheme) a fire-fighter must at the date of retiring, be permanently incapacitated from

carrying on any occupation. Dependants may qualify for payment where the fire-fighter has died.

15.9 Compensation is an amount equal to 5 times the annual rate pay of a person employed by the fire authority for 4 years. If the negligence or misconduct contributed to the circumstances in which the injury was sustained, the fire authority can reduce the sum as appropriate. Also, the fire authority must deduct the amount of any damages paid to the fire-fighter or dependants, and any lump sum payable under the Compensation Scheme or occupational pension scheme.

15.10 Example: For a regular fire-fighter injured in the performance of his duties who will never be able to work in any occupation, the Disablement lump sum might be: 5 x £28,000 = £140,000.

### **Other Public Sector Schemes – 2 – Police Injury Benefits Scheme**

15.11 The Scheme compensates injured and disabled Police officers who are unable to continue in that profession, and also compensates widows and dependants when a Police officer is killed in the course of duty. The Police Injury Benefits Scheme provides an injury award made up of a gratuity and pension. For those unable ever to work in any employment there also is a disablement gratuity ([The Police \(Injury Benefit\) Regulations 2006](#)).

15.12 The lump sum payment is increased if the injury occurred while protecting a member of the public or other Police personnel (as opposed to routine patrol duties). Sporting injuries (even if carried out as part of fitness training) are not normally considered as claimable. Widows' pensions stop on the re-marriage of the widow.

15.13 Each claim is normally decided on "case law" (precedents) and on medical advice. The paying Authority can appeal if they think an award is unreasonable. Injury pensions are increased annually by the CPI percentage. Travel to and from work is considered as "on duty". Worsening – it is always open to the claimant to request a review to consider worsening appeals.

### **Other Public Sector Schemes – 3 – Criminal Injuries Compensation Scheme**

15.14 This Scheme compensates members of the public who sustain an injury or death caused by the criminal activity of another person. A person may be eligible for an award under this Scheme if they sustain an injury directly attributable to their being a direct victim of a crime of violence committed in a relevant place. ([The Criminal Injuries Scheme 2012](#))

Types of payment (see document at the link above)

15.15 There are a number of types of payment that may be made to victims under this Scheme:

- Injury payments
- Loss of earnings payments
- Special expenses payments
- Bereavement payments
- Child's payments
- Dependency payments
- Funeral payments
- Certain other payments in fatal cases

15.16 The maximum award which may be made under this Scheme to a person sustaining one or more criminal injuries directly attributable to an incident is £500,000. The lump sums are not updated in accordance with CPI.

15.17 Since April 1996, the level of compensation has been determined according to a Tariff set by Parliament. Following the enactment of the Criminal Injuries Compensation Act 1995, CICS was established to administer a Tariff-based compensation scheme in England, Wales, and Scotland. Since 1996 the Tariff Scheme has been revised three times, with the latest revisions having been approved by Parliament in November 2012.

15.18 Under the Tariff Scheme there are two main types of compensation—personal and fatal injury awards—with additional compensation for loss of earnings, dependency or special expenses where applicable.

#### **International Scheme – 4 – the Canadian Armed Forces Scheme**

15.19 There are 13 categories of benefit that may be claimed by wounded and injured veterans or their dependants in the event of death of the veteran. It is noteworthy that these benefits are restricted to veterans, that is to say those Service personnel who have left the Armed Forces.

#### **Conclusions**

15.20 It will be seen from the above that the AFCS is generous in its provisions when compared to other UK Government-funded schemes, and is comparable to the extensive provisions made by the Canadian Government for their Armed Forces Veterans.

15.21 It is also worth pointing out that the MOD provides other benefits alongside the AFCS i.e. Funeral Grants and other admissible expenses (laid out in JSP 751), Joint Casualty Compassionate Cell (JCCC) payments to the deceased Service person's estate and family / next of kin pension rights (this list is not exhaustive).

#### **Recommendations**

15.22 As with the 2010 review, it is clear that the QQR team's consideration of other schemes has not, in itself, identified a need to make changes to the AFCS. Such adverse comparisons as have been made with other schemes have always concentrated on the lump sum payments and taken no account of the tax-free GIP, which over a lifetime could amount to considerably over a million pounds, easily dwarfing the original lump sum settlement.

15.23 As expressed previously, the QQR team recommends that the AFCS awards are always publicised as a two-part settlement, emphasising the value of the GIP, and that the MOD should continue explaining the full value of AFCS awards at every opportunity.

## Chapter 16

### ADDITIONAL ISSUES RAISED

#### Definition

16.1 This chapter focuses on additional issues raised by stakeholders. These reflect other important issues the QQR team found during the course of its investigations, but which have not been touched on in the analysis and recommendations of this Review. However, the QQR team will suggest how these issues could be taken forward. The issues cover slips, trips, falls, hearing loss and the role of other arms of State in supporting Service personnel. In addition, Equality-Proofing was raised but that has been covered under the chapter on “Status of the Scheme”. These issues merit further attention to ensure that there are no anomalies or legislative pitfalls.

#### Lord Boyce Review 2010

16.2 Lord Boyce’s review expressed the view that stakeholders said that hearing loss was not properly catered for in the Scheme, as provisions at the time were insufficient and required review. His review also noted that recent operations have been associated with impulse noise related to weapon firing and associated hearing loss and tinnitus, and recommended that this should be looked into by the IMEG. In addition, the point was raised that the threshold levels of hearing impairment that warrant awards and other issues should be referred to the IMEG.

16.3 With regard to the role of other arms of State in supporting Service personnel, Lord Boyce reflected this in his review under “Issue 2 – What the compensation is for and its relationship with other State benefits.” He highlighted that the AFCS lump sum and associated GIP were not intended to pay for care provided by the public sector in the UK. He noted that Service personnel can access civilian social security benefits and related programmes and schemes, such as the Personal Independence Payment (PIP), daily living and mobility allowances and Employment and Support Allowance. Priority access to NHS secondary care is also provided to AFCS recipients for the accepted condition, as well as to all veterans where the clinician considers that the condition might be due to service.

#### What the Scheme Provides

##### Slips, trips and falls

16.4 JSP 765, para 2.26, states that awards are not automatically paid under the AFCS for a slip, trip or fall which occurs while undertaking an activity linked to service, or which takes place on Defence property. Each case is considered on its individual merits. An AFCS award is only payable if the slip, trip or fall occurs when the individual is undertaking at least one of the following:

- Activity of a hazardous nature
- Activity in a hazardous environment, or
- training to improve or maintain their effectiveness in the Armed Forces.

16.5 In para 2.28 it states that “if the injury is sustained in one of the above contexts the balance of probabilities test will be applied, i.e. an assessment will be made as to whether the individual’s service, on the balance of probabilities, caused the slip, trip or fall. If the slip, trip or fall did not occur in one of these contexts, then an award will not be made.” It should

be noted that the QQR team found that this area was a commonly misunderstood topic and provided an extensive narrative on this in the Communications chapter.

### Hearing loss

16.6 With regard to hearing loss, the IMEG investigated and wrote extensively on the topic. It is worth providing the detail. In its first Report 1 Jan 2011 it said that it considered the impact of the hearing descriptors on civilian employability, and recommended that awards for Items 6 (Total deafness in both ears), 9 (Bilateral permanent hearing loss of more than 75dB averaged over 1-3 kHz), 12 (Total deafness in one ear) and 16 (Bilateral permanent hearing loss of 50-75 dB averaged over 1 – kHz) should be increased beyond those decided by the Lord Boyce review. For “Acute Acoustic Trauma”, the IMEG recommended that the existing “blast damage to ears” descriptors should be expanded to include hearing loss due to acute weapons-related acoustic damage, and that new descriptors are added for asymmetrical losses. For tinnitus, the IMEG proposed that tinnitus is taken into account in all awards for hearing loss. Table 7 descriptors have been revised with removal of reference to tinnitus. For each descriptor, awards are now made on diagnosis and measured audiometric impairment and the awards previously applicable in cases with severe tinnitus now apply to all cases. The IMEG also said the following:

- No award should be made under the AFCS for tinnitus alone.
- As in other AFCS tables, where hearing loss is accompanied by psychological symptoms, in the absence of a discrete diagnosis, they are accounted for in the primary award. If service has caused a discrete psychological diagnosis, an additional award may be made.

16.7 IMEG’s second report, dated 17 May 2013, included detailed analysis on hearing loss, particularly acute acoustic trauma and blast damage. However, the evidence was not sufficient to make a recommendation for change to the compensation threshold which would be robust and based on clear scientific evidence.

### **QQR Findings**

16.8 The QQR team heard testimonies from stakeholders that Service personnel would tend to conceal hearing loss if possible, as it was perceived that it would adversely affect their future career. The QQR team suggests that MOD engages with the single Services and Charities on this for evidence of examples so that effective solutions can be identified, although this could be also a communications issue. A key remedy would seem to be prevention through enhanced vigilance on the provision and mandatory use of hearing protection.

16.9 The QQR team proposes that IMEG could suggest areas for study or data capture by MOD which would go some way towards closing the gaps where scientific evidence is not available to support its consideration of the descriptors and tariffs for compensation.

16.10 Some stakeholders’ feedback suggested that other arms of the State apparently fail to have sufficient knowledge of the AFCS and how it interacts with State benefits. **The QQR team proposes that the MOD should engage with the Department of Health (DH), NHS and the DWP to investigate the obstacles and report to the CAC.** The purpose of this is to ensure that Service personnel are better informed about the relationship between the AFCS and State providers.

16.11 The QQR team noted that for slips, trips and falls, claims were rejected under Article 11 of the legislation. However, when appealed, Tribunals made awards to some claimants.

The QQR team recommends that the MOD clarifies the concept as part of the annual review of JSP 765.

## **Conclusion**

16.12 The additional issues raised have been important to note.

## **Recommendations**

16.13 The QQR team recommends the following:

- The MOD takes forward the stakeholders' feedback that other arms of the State apparently fail to have sufficient knowledge of the AFCS and how it interacts with State benefits. The MOD should engage with the Department of Health (DH), NHS and the DWP to investigate the obstacles and report to the CAC. The purpose of this is to ensure that Service personnel are better informed about the relationship between the AFCS and the MODs existing ties with Other Government Departments.

## Chapter 17

### ISSUES RAISED THAT WERE OUTSIDE THE SCOPE OF THE QQR

#### Definition

17.1 There were several issues raised by some stakeholders that were outside the AFCS. While their interest in, and comments on, these points have been noted, the QQR team concluded that issues were raised outside the Scheme sometimes unknowingly, as a result of misunderstanding of what the AFCS covered.

17.2 The QQR team suggested in the Chapter on Communications that further and better communications were necessary to ensure that all stakeholders were fully aware of what is, and what is not, covered by the Scheme. It is recommended that issues outside the Scheme should be noted by respective Government departments, particularly since issues raised related to Departments such as the NHS.

17.3 This chapter will highlight the issues raised by stakeholders and suggest recommendations.

#### Background to the War Pension Scheme (WPS)

17.4 War pensions have been paid in some form in the UK since Elizabethan times with the present WPS broadly unchanged since 1917. Originally, as the name suggests, only combat-related injury and death was compensable, but from 1947, any disablement or death causally linked to any service up to 6 April 2005 or aggravated by it can be the subject of an award. The WPS applies to anyone who has served 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 WPS; the assessment then forms the basis of the award.

17.5 Many of the features of the WPS relate to conscript service, World War conditions and pre-welfare state provisions. The Scheme has a generous standard of proof such that any disablement having clinical onset in service and claimed within seven years of service termination must be accepted unless it can be shown, beyond reasonable doubt, that service has played no part in its cause or course. Where claims are made more than seven years after service, the onus passes to the claimant who has to raise a reasonable doubt by reliable evidence of a service-causal link. Cases can be reviewed at any time on any ground and so while assessments (and so awards) can be reduced if the person's condition improves, in reality over time, assessments usually rise. Assessments also increase as further conditions are claimed for the first time even many years after service. A high assessment and award may result lawfully many years after service from a series of fairly minor, often mainly age-related disorders.

17.6 From the Second World War, no-fault military compensation determinations were the responsibility of the Department of Social Security (DSS) but in 2003 they reverted to the MOD. In the mid-1990s a team from DSS and MOD, including senior policy officials and a doctor, developed a new scheme, the AFCS, to better reflect the 21<sup>st</sup>-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 well as modern thinking on disability. As before, awards would be made wherever the claimed injury, disorder or death was due to/worsened by service. Both AFCS policy and individual decision-making were evidence-based, reflecting contemporary medical understanding of the cause and course of injuries

and disorders, and the onus was on the Service person to make his case using the “balance of probabilities” standard of proof. An aim was that decisions should be consistent and equitable and in contrast to the WPS, claims could be made in service.

## QQR Findings

17.7 Some stakeholders frequently touched on the following topics such as the WPS, how Veterans are treated in society in general, NHS funding and general healthcare. These were repeated themes throughout the QQR team’s investigation. In addition, stakeholders mentioned the following issues:

- a. More Service personnel now with Mental Health issues in Personnel Recovery Units (PRUs).

Much has been done around the subject of Mental Health since the Lord Boyce review as detailed in Chapter 7, Categories of Awards. Due to campaigns to rightly reduce the stigma of Mental Health and raise awareness, MOD might well see more claims.

- b. There needs to be better access to state of the art prosthetics after leaving the Service.

This is not within the remit of the QQR. Some stakeholders stated that they had heard stories of the retrograde fitting of old fashioned prosthetics. This would form part of the aftercare package for the individual and would be dealt with through the NHS and regional trauma networks.

- c. Disparities between PAX/SLI conditions and injury standards.

This is not relevant to the QQR.

- d. Improving determination of claims, especially covered by the War Pensions Scheme (WPS).

This QQR is a review of the AFCS, not the WPS.

- e. Procedures following underpayment of pension or GIP.

There is a process laid out in JSP 765 detailing the process for adjusting the GP when an Armed Forces pension is paid.

- f. Overuse injuries not compensated as considered due to non-surgical treatment deemed below Tariff.

One stakeholder stated that “over-use” injuries, which doctors felt were best treated with non-surgical treatments, even though they had caused pain and suffering and potentially lifelong complications, did not qualify for any compensation as they were deemed “below Tariff”.

Each case is considered on its merits by DBS Veterans UK and in most cases they will seek medical advice when assessing a claim or appeal at the outset. The appropriate evidence must be provided to achieve the higher award. This could be covered in the IMEG review of MSK disorders.

- g. Discrepancies between awards made under WPS and the AFCS, e.g. infections occurring in a war zone.

A stakeholder stated that there was a discrepancy between what would be awarded under the WPS and the AFCS, e.g. diseases such as Ulcerative Colitis, and infections which occur in a war zone (such as the conditions found in a Forward Operating Base in Afghanistan) would be awarded under WPS, but since the disease is currently of idiopathic aetiology, it cannot succeed as the basis for a claim as it cannot be shown to be caused by service “on balance of probabilities”. This is not for the QQR team to consider, as for the WPS there are differing standards of proof.

h. The WPS is the Gold standard for timeframe for claiming and burden of proof; there are anomalies between the WPS and the AFCS.

Again the WPS is not covered in this review. The Lord Boyce review noted that the AFCS introduced a number of significant improvements over its predecessor, the WPS. The WPS arrangements had been criticised on the grounds that they did not provide sufficient funding as an advance payment to enable those most seriously injured to pay for the special arrangements that a disabled lifestyle may require. The AFCS changes reflected the contemporary best practice in relation to disability, by supporting and encouraging people to look forward in their lives following illness or injury. Under the AFCS, the individual must show that the injury is caused wholly or partly by service and if partly, predominantly by service.

i. The AFCS definitions do not explain the purpose of the Scheme.

A stakeholder stated that the guidance which explains the purpose of the Scheme was not to be found embedded within the Scheme’s own definitions. This made it harder to explain to Tribunals the policy concepts behind the Scheme. Thus, Tribunals then use their own decisions to fill in policy gaps, not necessarily in the correct way.

**Though this is not within the QQR teams remit there may be merit in reviewing the guidance and legislation ensure cohesion.**

j. Treatment of (uninjured) veterans by society in general.

This is not within the remit of the QQR team. The Government has made a commitment through the Armed Forces Covenant to ensure that Armed Forces personnel get the respect and support they deserve in recognition of the sacrifices they make.

k. Should AFCS pay for re-training costs on medical discharge?

The AFCS was not designed to cater for re-training costs and there would be a cost to do so. All those medically discharged from service are entitled to full MOD funded resettlement training regardless of length of service. For medical discharges this may be deferred dependent on their recovery stage or transferred to spouse of partner.

l. Should there be regular uplifts in the AFCS to match those of the WPS?

War Disablement Pensions and allowances are uprated annually in line with the DWP approach to social security disability benefits, i.e. increasing by the CPI. For the AFCS, the GIP is uprated annually in accordance with the CPI but the lump sum is not. As part of this review consideration is being given to see if the AFCS lump sum should be uprated annually in accordance with CPI (see Chapter 8).

17.8 A view was expressed that there needed to be better clarification of the definition of fairness, as statutory authorities cannot in general terms give advantage to ex-Service

personnel. This is order to avoid challenges under the Equality Act 2010, so in relation to health, for example, priority is based on clinical need rather than the status of the individual. It should be noted that the AFCS does not compensate for healthcare; it is just one of a suite of measures, and relies on other arms of the State to carry out those duties, i.e. the NHS.

## **Conclusion**

17.9 It has been apparent that widespread engagement with stakeholders should continue to ensure that anomalies are identified within the Scheme and that it is reviewed in a regular basis. It has been found that there remains some ignorance of what the AFCS does or does not cover and the opportunity should be taken to improve communications across the Armed Forces (see Chapter 14).

## **Recommendations**

17.10 The QQR team recommends that consideration should be given to reviewing the AFCS guidance and legislation to ensure cohesion.

## **ACKNOWLEDGEMENTS**

The research and investigations of the QQR team were supported by numerous stakeholders, both internal (Ministry of Defence) and external (claimants, and the Service Charities which frequently act as their advocates). The QQR team very much appreciated the expertise provided by the stakeholders who greatly assisted their research. All stakeholder opinions were carefully considered, though not all have appeared as recommendations in this Report.

### Contributory Stakeholders:

Admiral of the Fleet Lord Boyce

Central Advisory Committee on Compensation (CAC)

The Armed Forces Compensation and Insurance Team (AFC&I)

DBS Veterans UK

Dr Anne Braidwood, CDP Medical Advisor

Independent Medical Expert Group (IMEG)

Single-Services Pay Colonels

Chief of Defence People (CDP)

Defence Medical Rehabilitation Centre, Headley Court, and Focus Group

Aldershot Personnel Recovery Unit (PRU)

Royal Marines, Poole

The British Limbless Ex-Service Men's Association (BLESMA)

Confederation of British Service and Ex-Service Organisations (COBSEO)

Combat Stress

Help for Heroes

Royal British Legion (RBL)

Naval Families' Federation

Soldiers', Sailors' and Airmen's Families' Association (SSAFA)

Veterans' Advisory Pensions Committee (VAPC)

Meredith Solicitors

HM Treasury

Department of Health

NHS England

Home Office

Central Legal Services (CLS)

Chief of Joint Operations at Permanent Joint Headquarters (CJO)

Director of Defence Communications (DDC)

Defence Resources

Defence Statistics

Director, Judicial Engagement Policy (DJEP)

Mrs Diane Dernie

Cdre Jim Patrick RN

Capt Dave Henson MBE

Surgeon General

Tribunal Judges

Professor Sir Simon Wessely, King's College, London University

Professor Sir Mansel Aylward, Cardiff University

## GLOSSARY

**Accepted Injury / illness Claim:** This is a definition used by Defence Statistics to identify claims for injuries / illness that have been considered to be attributable to Service on or after 6 April 2005, but where the severity of the injury / illness does not meet the minimum tariff level descriptor. Therefore, the claimant is not awarded a lump sum payment.

**Appeal:** If a claimant is not satisfied with the outcome of their claim they may lodge an appeal to an appropriate Tribunal.

**Armed Forces Compensation Scheme (AFCS):** Compensation Scheme for all members of the Regular and Reserve Forces. It provides compensation for all injuries, ill-health and death attributable to service where the cause occurred on or after 6 April 2005.

**Armed Forces Independence Payment (AFIP):** On 8 April 2013 the MOD, in conjunction with the Department for Work and Pensions (DWP) introduced a new benefit called the Armed Forces Independence payment (AFIP). The AFIP is a simplification of the financial support available for members of the Armed Forces who have been seriously injured as a result of Service since 6 April 2005. The AFIP provides eligible recipients with on-going payments to help with the additional costs associated with their injuries.

**Armed Forces Pension Scheme (AFPS):** Pension available to members of the Regular Armed Forces who have served for a minimum of two years. AFPS 75 – Introduced in 1975 and closed to new members from 6 April 2005. Pension benefits are based on rank and time served. AFPS 05 – Introduced on 6 April 2005. Pension benefits are based on time served and final salary.

**Armed Forces Covenant:** The Armed Forces Covenant is a promise from the nation that those who serve or have served in the armed forces, and their families, are treated fairly.

**Awarded Injury/illness Claim:** A claim is classed as awarded when DBS Veterans UK agree, based on the evidence provided, that the claimant's injury and/or illness is attributable to Service on or after 6 April 2005. The claimant will then receive a lump sum award, and depending on the severity of their condition(s), they may also receive a GIP.

**CAC:** The Central Advisory Committee (on Compensation). A Stakeholder Advisory Group, chaired by the Minister for Defence Veterans, Reserves and Personnel, which meets bi-annually.

**Categories of Awards:** See “Tariff of Injury Tables” below.

**Claim:** The term ‘claim’ is used to refer to both injury claims raised by a claimant as well as medical discharge and death-in-service cases which are automatically referred to DBS Veterans UK for consideration.

**Cleared Claim:** A claim is classed as cleared when DBS Veterans UK issues a letter to the claimant informing them of the outcome of their claim, reconsideration, or appeal.

**Compensation and Pension System (CAPS):** The database on which all AFCS claim information is captured.

**DBS Veterans UK:** Defence Business Services Veterans UK administer the Armed Forces Pension Schemes and also the AFCS, compensation payments for those injured, ill or bereaved through Service. Before 2014, this was known as the SPVA (Service Personnel and Veterans' Agency).

**Guaranteed Income Payment (GIP)** is awarded for the most serious injuries (Tariffs 1 – 11). The GIP is tax free on award and paid for life. The level of GIP awarded reflects the overall impact of the injury on the individual's future ability to earn, including enhancement for loss of future military promotions. Under Band A (tariff levels 1-4) 100% of the individual's future earnings (pension and salary) are replaced. Under Band B (tariff levels 5-6), 75%. Under Band C (tariff levels 7-8), 50%. Under Band D (tariffs 9-11), 30%.

**IMEG:** The Independent Medical Expert Group, established as a result of the 2010 Lord Boyce review, is a sub-group of the CAC (see above) and advises on compensation for specific, relevant illnesses and injuries such as hearing loss, mental health, injury to genitalia and any new developments.

**Joint Personnel Administration (JPA) System:** The administrative system used to hold personnel information for the Armed Forces.

**Lord Boyce Review:** In 2010 a review of the AFCS was conducted under the independent chairmanship of former Chief of Defence Staff, Admiral the Lord Boyce.

**Lump Sum Award:** A tax-free lump sum payment is paid to a Service or ex-Service person as compensation for pain and suffering for an injury or illness that is predominantly caused or made worse by Service.

**Medical Discharge Claim:** Personnel medically discharged from Service will have a claim automatically registered under the AFCS if they meet certain criteria.

**MinDVRP:** Minister for Defence Veterans, Reserves and Personnel.

**Reconsideration:** If a claimant is not satisfied with the outcome of their claim they may ask Veterans UK for their claim to be reconsidered.

**Registered Injury/illness Claim:** A claim made by serving or former serving members of the Armed Forces for an injury or illness caused by Service on or after 6 April 2005. They include in-Service claims, medical discharge claims and post-Service claims. The registered date of a claim is the date on which DBS Veterans UK create the claim workflow on the CAPS.

**Rejected Injury/illness claim:** A claim classed as rejected when Veterans UK agree, based on the evidence provided, that the claimant's injury and/or illness was not attributable to Service on or after 6 April 2005.

**Spanning Cases:** Spanning Cases are claims relating to service which covers the periods both before and after 6 April 2005, considered first for entitlement under the Armed Forces Compensation Scheme, but passed to the War Pensions Scheme if the cause of the illness or injury clearly occurred prior to 6 April 2005.

**Survivor's Claim:** Claims made by surviving dependents of former Armed Forces Personnel where death was caused by Service on or after 6 April 2005. They include death-in-Service claims, death-post-Service claims and additional child claims. One awarded survivors' claim may result in multiple payments (e.g. to a spouse and children).

**Survivor's Guaranteed Income Payment:** A Survivor's Guaranteed Income Payment (SGIP) is a taxable payment designed to compensate an individual for loss of financial support following the death of their partner/spouse as a result of Service.

**SVPA (Service Personnel and Veterans' Agency):** the forerunner, until April 2014, of DBS Veterans UK (see above).

**Tariff of Injury Tables:** Claimants are awarded under one of nine categories or Tariff of injury tables for each awarded injury/illness:

- Table 1 - Burns
- Table 2 - Injury, Wounds and Scarring
- Table 3 - Mental Disorders
- Table 4 - Physical disorders (illnesses and infectious diseases)
- Table 5 - Amputations
- Table 6 - Neurological disorders (including spinal, head or brain injuries)
- Table 7 - Senses
- Table 8 - Fractures and dislocations
- Table 9 - Musculoskeletal disorders.

Full details of the Tariff of injury tables and the injuries / conditions that fall within each of the tables can be found online: <http://www.infolaw.co.uk/mod/docs/AFCS-2014-04-07.pdf>

**Tariff Levels:** Claimants are awarded lump sum awards based on the tariff level of each injury/illness. There are 15 Levels from 1 (most severe) to 15 (least severe). The amounts paid out under each Tariff level are presented in the Table at Annex C. The tariff amounts were uplifted following the Lord Boyce review, with claimants awarded prior to the review receiving top-up payments.

**WPS:** the War Pensions Scheme, the predecessor of the AFCS, introduced in 1917 and still in effect for claims relating to injuries or illness due to service before 6 April 2005.

## **ARMED FORCES COMPENSATION SCHEME QUINQUENNIAL REVIEW**

### **TERMS OF REFERENCE**

#### **Purpose**

The purpose of the Quinquennial Review is to ensure the Armed Forces Compensation Scheme (AFCS) remains properly fit for purpose providing appropriate recognition and financial support to those members of the Armed Forces who are injured, become ill or die as a result of service.

#### **Role**

Taking account of the schemes fundamental principles, the scope of the review will consider but not be limited to the areas below. These particular areas have been identified by MOD and external stakeholders as priorities:

- a) the scope of the AFCS, relating to what the scheme covers, including analysis of the categories of awards, rejections and appeals, and emerging trends, including in relation to the Reserves;
- b) the administration of the Scheme, including the levels and uprating of awards, application of rules on 'worsening', use of interim awards, and approach to mental health-related claims and;
- c) the relationship between the AFCS and the provisions of other schemes/processes, including comparison with injury descriptors and tariff levels under other Government funded schemes, and timing of awards in relation to medical discharge.

#### **Scheme Reviews**

The Scheme was last reviewed in 2009-10. That review was independently chaired by Admiral the Lord Boyce and while finding the Scheme fundamentally sound he identified steps that were significant improvements. Following the review, all of Lord Boyce's recommendations were implemented, and he subsequently concluded that, whilst future reviews of particular aspects of the Scheme could not be ruled out, a more fundamental design of the Scheme should not be required.

The intent is to review the policy aspects of the Scheme on a quinquennial basis as is common among government, academic, occupational and legislative authorities. This will be an internal MOD review with external validation through consultation with the Central Advisory Committee (on Compensation).

The delivery of compensation claim processing is undertaken by Defence Business Services (DBS) Veterans UK. Their work is the subject of separate consideration as part of the MOD HR Systems Modernisation and therefore will not form part of the AFCS review.

#### **Implementation**

The review is due to commence in early 2016 and complete within one year.

The review's recommendations are expected to reflect that the intent remains to have a scheme that is simple to administer therefore we will ensure DBS are involved in any changes) and which provides compensation transparently without undue burden or delay. The recommendations must also be evidence based, costed, sustainable and otherwise implementable.

### **Resources and Funding**

The Sponsor for the review will be the Head of Service Personnel Support. The review will be constituted for a maximum of one year (it is anticipated that it could conclude much sooner). The review team should comprise a senior manager, from within MOD, with support staff.

The primary stakeholders providing support for the review will be:

- SP Support, Armed Forces Compensation & Insurance
- Chief of Defence People Medical Adviser
- Central Legal Services
- Defence Statistics
- Reserve Forces and Cadets
- Defence Resources
- Single Service Pay Colonels
- DBS Veterans UK
- Other Government Departments

Funding of recommendations that may result in an increase to the overall cost of the AFCS will need the approval of Defence Resources and HM Treasury.

### **Milestones, Deliverables and Timelines**

The review lead will be responsible for developing a detailed programme plan.

Regular progress reports will be provided to the Head of Service Personnel Support.

A draft report, detailing findings with initial recommendations, is to be provided to the Head of Service Personnel Support no later than six months after commencement; this will be discussed with Central Advisory Committee on Compensation (CAC) members to ensure agreement with direction the review is taking.

A final report detailing recommendations that MOD should implement to ensure the AFCS is fit for purpose is to be produced no later than twelve months after the review's commencement. The report will be published on the [www.gov.uk](http://www.gov.uk) website, following submission to the Minister for Defence Personnel and Veterans.

### **Task of the Review Lead**

To conduct a review in accordance with these Terms of Reference. The review lead will engage with internal and external stakeholders in order to provide clear, evidence-based conclusions which are implementable by DBS Veterans UK.

The review lead will provide a report detailing costed, implementable and sustainable recommendations for the Assistant Chief of the Defence Staff(Personnel Capability) and Head of Service Personnel Support within one year of the review's commencement.

The review lead will provide written and oral briefings, as required, by senior MOD colleagues and Ministers during the development of the recommendations and once the report is finalised.

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Case study 1 details from the Royal Marines (RM) Poole

Rehabilitation is a complex process demanding a multi-disciplinary team (MDT) approach. The process varies from the provision of physiotherapy and exercise therapy at Primary Care level to the more specialised intermediate clinical activity at the Regional Rehabilitation Units (RRU) with secondary and tertiary care provided at the Royal Centre of Defence Medicine (RCDM) and the Defence Medical Rehabilitation Centre (DMRC) Headley Court.

The core principles of military rehabilitation are:

- Early assessment.
- Use of the multidisciplinary team.
- Active case management.
- Functional exercise-based rehabilitation.
- Rapid access to further specialist opinion.

Rehabilitation is delivered in a co-ordinated manner, which enables injured Service personnel to receive early and appropriate clinical management with a rapid return to duty. Many of these elements are delivered holistically at the RM Poole Musculoskeletal Rehabilitation Service; this is what makes them different from other rehabilitation units. One question might be, should other SP, not just the RM, have access to this?

What makes them different?

The staff at the RM Poole Musculoskeletal Rehabilitation Service are highly trained personnel, for example:

- Master of Science Sports and Exercise Medicine qualified
- Master of Science Physiotherapy qualified
- Postgraduate Diploma in Advanced Manual Therapy qualified
- Experienced Elite Sport and University Lecturers

They have RRU/DMRC Level of Equipment/Service, such as:

- Alter G Treadmill
- Diagnostic Ultrasound
- Podiatrist

This Service Provision at RM Poole also networks with many Military and NHS specialists including RRU, DMRC, local and national expert consultants. This engagement enables early treatment of musculoskeletal injuries, which is very important to prevent deterioration post-injury. To aid early treatment, deployments are also accompanied by medical officers, physiotherapists and podiatrists who are able to take rapid remedial action.

This Rehabilitation Service is also involved in a longitudinal health initiative entitled 'Project Trojan' operating for the entire career of an SP from badging (joining) to discharge. This initiative has enabled this Service to understand what they actually do well, and what they could do better, by looking at:

#### Case study 1 details from the Royal Marines (RM) Poole

- Maintaining operational effectiveness
- Reducing injury and illness (to an irreducible minimum)
- Addressing elements of the morale component
- 'Resilience Programme'

JSP 950, the Defence Medical Rehabilitation Programme, gives a strong background to the Service Provision procedures of timely, effective and expert treatment both at home and out of area (deployed):

[http://defenceintranet.diif.r.mil.uk/libraries/library1/DINSJSPS/20110714.1/20121011-8-AVB-JSP\\_950\\_2-22-1\\_Dec10.pdf](http://defenceintranet.diif.r.mil.uk/libraries/library1/DINSJSPS/20110714.1/20121011-8-AVB-JSP_950_2-22-1_Dec10.pdf)

**NOTE: This link is only accessible to Service personnel.**

The countermeasures taken by the RM are as follows:

- Early assessment and treatment of such injuries, very important to prevent deterioration post-injury
- To this end, deployments are accompanied by medical officers, physiotherapists and podiatrists able to take rapid remedial action
- "Project Trojan" is a "longitudinal" health study "from badging [i.e. joining] to discharge".
- The famed resilience of these SP can be counter-productive, as many personnel when injured opted to struggle on despite the injury, rather than appear to be letting the side down by presenting as injured (on the principle of "Squadron First"). By the time they do present (average 4 weeks after injury) it is quite likely that their condition will have worsened. Musculoskeletal injuries account for over 50% of reported injuries; over 70% have had at least 1 injury in previous 6 months. The greatest number of injuries involved the lower back.

**Table 1: Pre- and Post- Lord Boyce Review Lump Sum Award amounts by Tariff Level, £**

Tariff Level	Lump Sum Awards	
	Pre-Review	Post -Review
1	570,000	570,000
2	402,500	470,000
3	230,000	380,000
4	172,500	290,000
5	115,000	175,000
6	92,000	140,000
7	63,825	90,000
8	48,875	60,000
9	34,100	40,000
10	23,100	27,000
11	13,750	15,500
12	9,075	10,000
13	5,775	6,000
14	2,888	3,000
15	1,155	1,200

Awards

The AFCS awards non-taxable **lump sum** payments as compensation for pain and suffering according to the tariff. The values of the tariffs range from £1,200 (Tariff 15) to £570,000 (Tariff 1).

A **Guaranteed Income Payment (GIP)** is awarded for the most serious injuries (Tariffs 1 – 11). The GIP is tax free on award and paid for life. The level of GIP awarded reflects the overall impact of the injury on the individual’s future ability to earn, including enhancement for loss future military promotions. The scale of the payment is based on the severity of injury. Under Band A (tariff levels 1-4) 100% of the individual’s future earnings (pension and salary) are replaced. Under Band B (tariff levels 5-6) 75%. Under Band C (tariff levels 7-8) 50%. Under Band D (tariffs 9-11) 30%. See Tariff Levels, level if GIP and associated lump sums in the table below:

Tariff Level	Current Lump Sum Awards	Level of GIP Awarded
1	£570,000	Band A- tariff levels 1-4 100% of the individual’s future earnings (pension and salary) are replaced. It is considered individuals with
2	£470,000	

3	£380,000	these tariff level awards are so seriously injured that they will be unable to work again, therefore all future earnings salary and person income is replaced.
4	£290,000	
5	£175,000	<u>Band B- Tariff levels 5-6</u> 75% of the individual's future earnings (pension and salary) are replaced. It is considered individuals with these tariff levels awards will be able to work but at a significantly reduced earnings capacity, therefore 75% of future salary and pension income is provided.
6	£140,000	
7	£90,000	<u>Band C- Tariff level 7-8</u> 50% of the individual's future earnings (pension and salary) are replaced. It is considered individuals with these tariff levels awards will be able to work but their earning capacity will be reduced to around half, so 50% of their future salary and person income is provided
8	£60,000	
9	£40,000	<u>Band D- Tariff level 9-11</u> 30% of the individual's future earnings (pension and salary) are replaced. It is considered individuals with these tariff levels will be able to work but will experience a lower level of earnings due to their injury, so 30% of their future salary and pension income is provided.
10	£27,000	
11	£15,500	
12	£10,000	<u>Band E- Tariff Level 12-15</u> No GIP is payable as it is considered that the individual's future civilian earnings capacity will be unaffected by their injury due to no significant permanent effects.
13	£6,000	
14	£3,000	
15	£1,200	

Examples of severe injuries (Tariff Level 1):

- a) loss of both legs (above or below knee) and both arms (above or below elbow)
- b) brain injury with persistent vegetative state.

Examples of moderately severe injuries (Tariff levels 7-8):

- a) burns, with deep second degree, third degree, or full thickness burns to face or face and neck resulting in or expected to result in residual scarring and poor cosmetic results despite treatment and camouflage
- b) injury to chest, causing permanent significant functional limitation and restriction

Examples of the minor injuries (Tariff level 15):

- a) permanent minor peripheral sensory nerve damage.
- b) undisplaced fracture of nasal bones

**Dependents benefits** are payable to the surviving spouse/civil partner or eligible children on the death or a member of the Armed Forces or a former member of the

Armed Forces. These take the form of: an ongoing income stream paid for life to an eligible partner known as Survivors Guaranteed Income Payment (SGIP); an income stream for eligible children, known as a Child Payment; a one-off grant of up to £37,500 paid to an eligible partner or eligible child(ren).