The Independent Medical Expert Group (IMEG)

Report and recommendations on medical and scientific aspects of the Armed Forces Compensation Scheme

December 2017

Topic 1 – Armed Forces Compensation Scheme (AFCS) Quinquennial Review (QQR) Issues

Key Points

Topic 1 Infectious Diseases and Zika virus

1. Having considered the wide range of infection related disorders, potentially due to AFCS service, IMEG concludes that tariff Table 4, Physical disorders is able to accommodate any service acquired infection related disorder, the majority of which will be treatable to cure within a few weeks. As discussed in the report we do not recommend a specific list of infections.

2. If a serving member of UK armed forces acquires Zika due to AFCS service, an award might follow dependent on the severity and duration of disabling effects or complications.

Topic 2 Gender differences in AFCS awards

1. Based on data supplied by MOD Defence Statistics, IMEG finds no anomalies between male and female awards in the scheme to date.

2. As the face of the Armed Forces changes over the next few years, IMEG will routinely monitor final award outcomes for AFCS claims by women and keep in touch with emerging research, UK military personnel policy practice and training, and review both the general and military literature, on issues relevant to female musculoskeletal physiology and injury, both short and long term.

Topic 3 Worsening – see separate paper

Topic 4 Spanning – see separate paper

Topic 5 Interim awards

1. IMEG considered the medical aspects of interim awards and finds the logic and utility, sound. We also note and endorse Article 52 (8) (b) i.e. where the person's injury or disorder improves with treatment and a lower final payment is due, no recovery of benefit paid is recoverable.

Topic 6 Permanency

1. Article 5 of the AFCS Order 2011, as presently worded, clearly sets out the meaning of "permanent". We find the concept medically valid and in line with contemporary best practice clinical management and approaches to disability. No legislative amendment is required from the medical perspective.

Topic 7 Categories of Award – Mental Health

1. Following evidence review we remain content that contemporary evidence supported the recommendations and conclusions of the 2011 and 2013 IMEG reports, on Table 3 tariff descriptors and award values for mental health disorders, particularly the highest appropriate award.

2. In light of new evidence, clinical insights from the literature and discussion with senior clinical colleagues working in the field of traumatic psychological injury, we conclude that the Table 3 range of descriptors and tariff values for mental ill health should include an award at level 4 attracting a 100% GIP. As stressed by clinical colleagues and the literature, this level of disability will be rare. The descriptor will be tightly defined to address the small number of cases where residual functional impairment, following adequate courses of best practice treatment, including highly specialist tertiary interventions, and directly due to the mental health disorder remains incompatible with paid employment for the foreseeable future.

3. We recommend audit of decisions to make a level 4 award.

4. We would encourage studies of the long-term prognosis of veterans with mental health conditions, particularly related to employment outcomes and outcomes following particular treatments.

5. Diagnosis remains very important and should continue to be made by a psychiatrist or clinical psychologist at consultant level.

Topic 8 High Dependency or Exceptional Supplementary Award (ESA) – medical aspects

1. IMEG recognises that the intention behind the ESA is laudable but, would urge careful thought. A decision to have such a provision and subsequent criteria for its award should be uncontroversial and robust.

2. We acknowledge no direct relation between a sum of money and the adverse effects of disease or injury on an individual. Individuals and families react very differently to disease and injury with a wide spectrum of views as to what constitutes satisfactory care and support. Because care is given does not imply it is always medically necessary.

3. While by no means yet perfect we note, since the introduction of the AFCS, the enhanced publicly funded holistic healthcare and wider mental disorder support increasingly available to all who require them in the community, including injured veterans. We consider the widespread popular support for the Armed Forces, nationwide development of the Armed Forces Covenant and collaborative working, including with the charities, under successive governments as providing the basis of valid tools, lay and professional, for long term audit of standards and adequacy of provision of health care and social support both in general and locally to individual veterans. Any additional funding for the Scheme might be well invested in developing and implementing sustainable processes for audit and evaluation of care and other services provided under the Armed Forces Covenant.

Introduction

1. Lord Boyce's 2010 Review of the AFCS was the first review since Scheme introduction, and since neither during scheme development nor at its introduction was the subsequent high level of combat nor of survival from previously fatal traumatic injury anticipated, Government decided that the review should be far-reaching. To support him in the review, Lord Boyce had an independent scrutiny group made up of academics, legal, medical and military colleagues with expertise and an interest in personal injury compensation.

2. Lord Boyce's recommendations were accepted by ministers and his overall conclusion was that the scheme was fit for purpose and a need for future radical review and revision would be most unlikely. Successive UK governments are committed to evidence-based policy and individual decisions including military no-fault personal injury compensation. In line with this, Lord Boyce recommended the setting up of an independent group of medical experts, in specialities relevant to military life, to provide independent transparent evidence-based scientific and medical advice to ministers on AFCS. In 2012 the IMEG was constituted as a Non Departmental Public Body (NDPB) with expert members appointed according to Cabinet Office principles. To date IMEG has produced three reports with the fourth report due in Autumn 2017.

3. The 2016 AFCS QQR was led by a B2 MOD civil servant with no previous links to military compensation. The QQR Team interviewed a range of stakeholders, considered the issues and evidence, and produced a report. Amongst their recommendations they referred a number of topics for comment or further action by IMEG. The report highlighted several overarching themes including the continuing need for effective communications and awareness-raising about the scheme, its provisions and rules, and how and where claimants might get help. Several issues referred to IMEG were the subject of some misunderstanding and required further clarification rather than a need for revision of policy or legislative amendment. Where IMEG identified scientific or medical aspects of such issues it proposed close working with Armed Forces Compensation and Insurance (AFCI) policy, military and Defence Business Services (DBS) colleagues and the AFCS Communications Working Group on appropriate action e.g. review of the Joint Service Publication (JSP) 765.

Topic 1. Infectious diseases and Zika Virus

1. The QQR review team suggested that the AFCS provisions on infectious diseases were not entirely clear and clarification would be helpful e.g. exogenous infection.

1.1 Article 12 of the 2011 AFCS 2011 Order is headed "Injury and death – other exclusions". Article 12 (1) (f) (iii) and (iv) refer to endogenous and exogenous infections. Case law has established that, unless defined in the Scheme, words and terms should be interpreted as having their ordinary english meaning. The AFCS aims to be a generous occupation-related personal injury scheme, recognising the special circumstances of military service and able to address any disorder or injury, predominantly due to or worsened by service on or after 6 April 2005. For infections, it takes the view that infection acquired from within the person's own body, i.e. endogenous infection, should not attract awards, e.g. urinary infection. On the other hand, exogenous infections acquired due to exposures external to a person's body would be accepted if acquired due to deployed service in a non-temperate zone. If the exposure to the infection, e.g. influenza, was in a temperate zone and there was no outbreak in service accommodation or a work-place, no award would follow. This is because the risk to the person over that applicable to the general

public is not judged to have been increased by military service. Diseases which are part of an outbreak, taken to mean an acute increase in the expected number of cases of a disease in a particular location, and occurring in service accommodation or work-place in a temperate zone, would potentially be eligible for award. Article 12 (1) (9d) is also relevant providing that infection in any location due to consensual sexual activity and resulting in injury or death is also excluded.

2. The QQR Team asked IMEG to consider providing a list of "eligible" or even "entitled" infectious/infection disorders. IMEG considered this carefully.

2.1 Because UK no-fault military compensation schemes can accommodate almost any injury or disorder due to service within the relevant law, the principle of equity and consistency in awards is key. An aim of the AFCS is to maintain vertical equity so that amongst a category of injury or disorder the most disabling disorders receive the highest awards, and horizontal equity which means that across disorder categories the same award level reflects a similar level of disability. The disabling effects of a disorder, e.g. peptic ulcer, can be very different in different people and in the same person at different times. Awards in a full and final scheme like the AFCS aim to reflect the effects averaged over the person's lifetime when in a treated steady state. They depend less on precise diagnosis than on the functionally disabling consequences following an adequate course of best-practice treatment, the comparator being the functional capacity of a healthy person of the same age and sex who is not injured or suffering a health condition. (Article 5(6)(b) of the AFCS Order 2011 refers). For that reason, descriptors in Table 3 and 4, i.e. mental and physical disorders, are considered generically and not as a list of specific diagnoses. In addition, where lists of discrete diagnoses are published or incorporated in legislation, there is likely to be a need to regularly amend and extend the list. This is a risk with infections because of the numbers of infectious agents, viruses, bacteria and fungi.

Conclusion:

1) Having considered the wide range of infection-related disorders, local and systemic, potentially due to service on or after 6 April 2005, IMEG concluded that Table 4, Physical Disorders, is able to accommodate any service-acquired infection-related disorder, the majority of which will be treatable to cure within a few weeks.

2) IMEG is not dismissive of possible uncertainty amongst claimants and their representatives regarding the infection provision in the Order, and will be happy to work with AFC and I policy colleagues at the next revision of the Joint Services Publication 765 to further clarify the medical aspects of the AFCS approach and ensure accessibility.

3) This will include a review of terms used in legislation, e.g. temperate, non-temperate and outbreak and their meaning, and consideration of whether definitions might usefully be included in Part 1 Article 2 of AFCS Order 2011.

3. The Review team specifically asked for an IMEG view on Zika virus in AFCS.

3.1 Zika virus is a mosquito-borne virus that was discovered in 1947 in Uganda but was in the news from late 2015 because of a large outbreak in Central and South America, the Caribbean, South East Asia and the South Pacific. The infection is usually spread via mosquito bites with an incubation period typically of about a week-12 days. It can occasionally be sexually transmitted although precise details remain uncertain. In adults the infection is usually asymptomatic or very mild and self-limiting, lasting up to a week and rather like rubella. It can cause damage to a developing foetus, particularly in the first trimester. Treatment is symptomatic and supportive. There is no specific vaccine or drug to prevent or treat the disorder. Reports of severe illness and

complications of Zika in adults and children are rare but it can be followed by Guillain Barre syndrome, an autoimmune disorder in which the immune system attacks peripheral nerves. Guillain Barre is not unique to Zika but may follow any bacterial or viral infection, surgery or vaccine administration and may cause muscle weakness and loss of, or altered sensation in limbs and face. In more severe cases muscles involved in breathing, swallowing and speaking may be affected. While life-threatening cases require supportive care in intensive treatment units, mortality rate at 3-5% is low. Most cases recover fully but a few continue to experience continuing muscle weakness.

3.2 In late 2015 reports were received from the Brazilian Ministry of Health of an unusual increase in babies born with microcephaly and other central nervous system malformations. World Health Organisation (WHO) accept the scientific consensus that Zika exposure of the developing foetus may be causally associated with birth defects.

3.3 For UK military deployments HQ Surgeon General (HQ SG) and the chain of command follow national (Public Health England (PHE)) and international guidance on Zika prevention, including mosquito bite avoidance and contraceptive advice to prevent sexual transmission.

Conclusion:

1). If a serving member of the UK Armed Forces acquires Zika on balance of probabilities predominantly due to deployed service on or after 6 April 2005, an AFCS award may follow dependent on the severity and duration of disabling effects or complications.

2). Given military deployment policy and HQ SG policy on prevention of sexual transmission, the likelihood of a child being born to a service member or partner or spouse, affected in utero with Zika, is very small. The military no-fault compensation schemes including the AFCS do not include provision for personal injury in partners or children of serving personnel. As a scientific and medical NDPB this policy is not a matter for IMEG.

Topic 2. Gender differences in AFCS awards including future musculoskeletal awards

1. The QQR raised the issue of gender representation in AFCS awards. Defence Statistics' advice to the review was that from the start of the AFCS to 31 March 2016, of 35601 awards made, 57% were for male claimants with 50% for females. That has been the pattern since the scheme began. A higher percentage of males were awarded GIPs in some injury categories, notably Table 2 Injury wounds and scarring, Table 4 Physical disorders, and Table 6 Neurological disorders. There was no difference between male and female higher awards with Guaranteed Income Payments (GIPs), for Table 3 Mental health disorders, Table 7 Senses, Table 8 Fractures and Dislocations and Table 9 Musculoskeletal disorders.

2. From 2005 until the present, although the proportion of women in the UK regular forces increased from 5.7% in 1990 to 10.2% in 2017, absolute numbers of female personnel in the UK Armed Forces and their roles, compared with men, remained limited. At 1 May 2017 the total strength of the full-time trained and untrained UK Armed Forces was 156,539. Of these there were 15,270 (10.2%) women. The disparity between male and female AFCS awards where present is not great and reflects, firstly, the different proportions of men and women in the total force. In addition principal service occupations, and so exposures, are also

different for the genders. The awards made data quoted above are also based on initial claims outcome, and so may not accurately represent the final position, i.e. post reconsideration, review request or appeal. IMEG therefore consider that it is too soon to form a view of whether there is true disparity between the male and female claims success rate.

3. The QQR recommended that in the context of gender, IMEG should consider awards for musculoskeletal (MSK) injuries, risk type and treatment. It is of note that, while accepting the limitations of first award outcomes, Defence Statistics' data suggest that rates and types of MSK disorder awards have been to date no different from those of male colleagues. Given the introduction of the New Employment Model (NEM) and the prospect of women in ground close-combat roles from late 2018 these findings may change in the next few years.

4. The fourth IMEG report includes Part 1 of an overview of MSK disorders and awards in the AFCS. These are the most common causes of military medical downgrading and discharge, as well as the most common claimed and awarded injuries and disorders in the AFCS from the start of the Scheme in the three Services. The Review of MSK disorders looked at tariff descriptors and award levels, including the disabling impact of such disorders on function relevant to civilian employability. Literature scrutiny and discussion with experts confirmed that despite a vast international literature there remain many gaps in our understanding of the causes of disabling MSK disorders and the relative part played by constitutional and genetic factors, beliefs and expectations, compared with external influences such as physical loading, heavy work and sporting activity.

5. Published studies are almost entirely male-based. From overview of the literature and discussion with experts, we concluded that present epidemiological evidence does not make the case that work in the Armed Forces in general or in any service normally increases the risk of MSK disorders or any specific single injury. For the AFCS, claims must be considered on their individual merits.

6. The QQR also raised treatment of MSK disorders and whether the same treatments were appropriate for similar injuries in male and female personnel. Again, published studies are sparse and in general the same therapeutic interventions are applicable. The QQR confirmed that there were few studies evaluating therapeutic interventions and few disorders where the most effective and cost-effective treatment intervention was necessarily known or selected. We found none which compared treatment effectiveness in males compared with females.

Conclusion:

1). IMEG will routinely over the next several years monitor final award outcomes for AFCS claims by women, considering injury categories and award levels and comparing with males to detect trends and possible emerging evidence of increased risk of injury type.

2). Following the 2015/6 HQ SG Women in Close Ground Combat review, IMEG will keep in touch with emerging research, UK military personnel policy practice and training, e.g. on recruit selection and training, fitness testing, resilience building, etc., and routinely review both the general and military literature on issues relevant to female musculoskeletal physiology and injury, both short-and long-term.

3). As indicated by the findings, brief updates on the topic will be included in future IMEG reports.

4). Because of the size and complexity of the topic, IMEG plans to include Part 2 of a review of MSK disorders in the AFCS context in the next IMEG report.

Topic 3. Worsening

1. The QQR raised the issue of gender representation in AFCS awards. Defence Statistics' advice to the review was that from the start of the AFCS to 31 March 2016, of 35601 awards made, 57% were for male claimants with 50% for females. That has been the pattern since the scheme began. A higher percentage of males were awarded GIPs in some injury categories, notably Table 2 Injury wounds and scarring, Table 4 Physical disorders, and Table 6 Neurological disorders. There was no difference between male and female higher awards with Guaranteed Income Payments (GIPs), for Table 3 Mental health disorders, Table 7 Senses, Table 8 Fractures and Dislocations and Table 9 Musculoskeletal disorders.

Topic 4. Spanning

1. Spanning cases are identified at or beyond service termination and are where a person has served both before and after 5 April 2005 and the introduction of AFCS. Such members may be eligible to claim compensation under both the War Pensions Scheme (WPS) and AFCS. While the circumstance of spanning will eventually be time-expired – we are already more than 12 years from the last day of eligible Service Pensions Order (SPO) service – the last year has seen an increase in spanning claims. Claims processes need to be developed which are lawful, understandable to claimants and their representatives and administratively practical. As a principle of government accounting, they should also avoid double compensation and as far as possible make a single award under one scheme notifying a single appeal right. Certain categories of claim are particularly affected by spanning. These include hearing loss, musculoskeletal and traumatic physical injury and mental health disorders. A paper discussing the medicine and science of these issues and making recommendations re possible approaches to claims determination forms part of this report.

Topic 5. Interim awards

1. The issue of interim awards was raised with the QQR Team by stakeholders concerned that interim awards could lead to financial uncertainty and particularly, in relation to mental health disorders, might cause additional stress, impeding engagement with treatment. The QQR team asked MOD to consider the introduction of an automatic right to review of an interim award when a person is approaching discharge date if more than six months from date of the interim award notification.

2. Article 52 of the AFCS Order[1] relates to Interim awards:

   Article 52.—(1) An interim award may be made where the Secretary of State is satisfied that a person is entitled to injury benefit but—

   (a) the prognosis for the injury in that particular case is uncertain; and

   (b) it is not possible to determine which descriptor is applicable to it.

   (2) The Secretary of State is to select the descriptor considered to be the most appropriate descriptor at the date of the decision.

   (3) The Secretary of State must specify the period which the interim award has effect in accordance with paragraphs (4) and (5).

   (4) The period referred to in paragraph (3) is to be a maximum of 2 years starting from the date the award was first made.

   (5) Where the period specified is less than 2 years, the Secretary of State may extend and further extend the award but, subject to paragraph (6), a final award must be made within the period of 2 years starting with the date on which an interim award was first made.

   (6) Where paragraph (7) applies—

   (a) the interim award may be extended and further extended for a period not exceeding 2 years; and

   (b) a final award must be made within the period of 4 years starting with the date on which an interim award was first made.

   (7) This paragraph applies where—

   (a) the prognosis remains uncertain at the end of the initial 2 year period; and

   (b) the Secretary of State considers the extension just and equitable having regard to all the circumstances of the case.

   (8) Where the final decision is to award a descriptor at a tariff level which is—

[1] Armed Forces Compensation Scheme Legislation.

(a) at the same level or higher than the tariff level awarded in the interim award, account is to be taken of the amount of benefit paid in accordance with the interim award and only the difference between the amount of benefit paid in accordance with the interim award and the amount of the final decision is payable;

(b) lower than the tariff level of the tariff awarded in the interim award, no further amount of benefit will be paid in accordance with the final decision, and no amount of benefit paid in accordance with the interim award is recoverable.

3. A common criticism of civil litigation is the time taken to claim settlement. Like civil awards, the AFCS aims to make a full and final award as early as possible after the claim is made with subsequent limited opportunity for request for outcome review. In contrast to the WPS, AFCS claims can be made in service, and to date about 90% of AFCS claims have been made in service, often very soon after the injury or disorder comes to light.

4. The intention of full and final awards is to give early financial certainty and to allow the person to move on with his life. Full and final awards can be made when the person is in optimal medical steady state or prognosis is clear. This will follow appropriate clinical management of adequate duration. Particularly in complex or multiple injury cases, assessment and claim determination can take time and interim awards were introduced as a payment on account for cases where an injury or disorder can be accepted as, on balance of probabilities, caused by service on or after 6 April 2005, but where the ongoing functional limiting or restricting effects and their likely duration are not clear. Most commonly, these circumstances arise where a claim is made soon after an injury occurs or disorder presents but before treatment has either begun or an adequate course of best-practice treatment has been delivered. Such cases are not in steady state. Interim awards are reviewed within two years and a final award with notification of appeal right is made, if possible. Alternatively, and exceptionally, the interim award can be extended for a total of four years after which a final appealable award must be made. To date 3,390 initial interim condition awards have been made in the scheme, most frequently for mental health (1,345), musculoskeletal disorders (1,002) and fractures and dislocations (661).

Conclusion:

1). IMEG has considered the medical aspects of interim awards and finds that the logic and utility is sound. We also note and endorse Article 52 (8) (b), i.e. where the person's injury or disorder improves with treatment and a lower final payment is due, no excess benefit paid is recoverable.

2). On an automatic right of appeal, for the reasons set out above, we do not consider there would be any value in providing such a right automatically, if an adequate course of best-practice treatment has not been received.

3). IMEG notes that a significant proportion of the claims for which an interim award resulted were made soon after the injury or disorder, so that an adequate course of best-practice treatment could not have been delivered. Given the AFCS time limits, IMEG would be happy to input to any briefing or guidance to the charities and welfare staff who advise claimants on practical aspects of making claims including timing.

4). We will continue to monitor rates and type of interim awards.

Topic 6. Permanency

1. Related to interim awards is the concept of "permanency" in the Scheme. In the section of the QQR report headed Categories of Award, and under the topic Mental Health, the QQR review team requested IMEG guidance on the concept of "permanent" in the scheme. In contrast to the WPS, where awards are based on the medically-assessed degree of disablement, and the legislation requires assessment to be made for an interim period unless it can be made final, the AFCS aims to make full and final awards as early as possible after claims are made.

2. As the QQR report describes, Article 5 was introduced into the AFCS Order in May 2011. It is headed "Descriptor – further interpretative provisions", and sets out how a descriptor is to be construed and the meaning of terms such as "functional limitation or restriction" and how that should be assessed. It also at Article 5(7) defines "permanent functional limitation or restriction":

"Functional limitation or restriction is permanent where, following appropriate clinical management of adequate duration,

(i) an injury has reached steady or stable state at maximum medical improvement and

(ii) no further improvement is expected".

3. The WPS allows requests for review of assessment by the Secretary of State or the pensioner "at any time and on any ground". Such a wide gateway can be administratively demanding, expensive in terms of evidence-gathering and inconvenient to pensioners, and by and large does not reflect modern medical practice and the expected course of disorders. It may also dissuade pensioners from full engagement and commitment to treatment as to keep your pension you need to keep sick.

4. While after the Great War the natural course of almost all injuries and disorders was an inevitable worsening over time, that pattern does not reflect modern clinical management of most disorders and injuries, regardless of the age of the person. Today's clinical aim is to investigate and diagnose the patient's complaint and then as quickly as possible to support him or her to access an adequate course of best-practice treatment, reaching a steady state of maximum medical improvement within 18 months to two years on average. For more medically complex situations that time might be extended to a maximum of three to four years.

5. When this steady state is achieved the intention is that the patient can largely manage his disorder and that, unless through accidental injury or event, no further significant improvement or worsening will occur. For full and final compensation awards, it is in this state that the disorder can most fairly be assessed. This state of maximum medical improvement is synonymous with permanency.

6. Because unexpected worsening, although rare, can occur through trips, slips and falls, a further stressful event or experience etc., the AFCS does have some review provisions allowing, under certain conditions, review and revision of awards. This includes, where certain criteria are met, at service termination (Article 55 of the AFCS Order 2011). Article 56, headed "Review – exceptional circumstances within 10 years", provides for review and revision of an initial award within 10 years of the original decision where the worsening of the injury or development of a further injury is unexpected and exceptional, and finally Article 57 – "Final Review" applies more than 10 years after the

initial award, with revision of the award where the Secretary of State considers that it would be “manifestly unjust“ to maintain the effect of the reviewed decision, because the injury “has become worse or caused a further injury to develop and the worsening or the development is substantial, unexpected and exceptional ….”

7. Modern thinking on disability and chronic illness, particularly with a pre-injury young, physically and mentally fit population, is as far as possible to treat and rehabilitate people to re-engage maximally with life and living. Making full and final awards as early as possible and when the person is in a steady state of maximum medical improvement is in line with this. Once the award is finalised there will be no review or adjustment even if the person continues to make progress and further improvement. This contrasts with WPS, where, if the assessed level of disablement reduces, awards may be revised downward.

Conclusion:

1). IMEG finds that Article 5 of the AFCS Order 2011, as presently worded, clearly sets out the meaning of “permanent“ and that the concept is medically valid in terms of contemporary clinical management and approaches to disability. No legislative amendment is required from the medical perspective.

2). As appropriate, IMEG would be happy to contribute to any clarification of the JSP or other guidance.

Topic 7. Categories of awards – mental health, musculoskeletal and brain injury

1. The QQR Team noted that stakeholders continued to raise issues on the adequacy of awards and equity across various category of injuries, including mental health, musculoskeletal and brain injury.

Mental health

A. Parity of esteem

1. One issue discussed with stakeholders in the QQR was the desirability (and present perceived lack) of parity of esteem for mental health problems and physical disorders and injuries.

1.A.1.1 The term parity of esteem is most frequently used in the context of provision and access to health care and the desirability of similar investment for mental and physical health. On that ground some stakeholders felt that the highest awards payable for physical injuries and disorders and mental disorders should as a matter of course be the same.

1.A.1.2 A fundamental principle of the AFCS is that awards reflect the impact of the attributable injury or disorder on function especially for civilian employability. As set out in Article 5 of the legislation (Article 5 AFCS Order 2011), AFCS descriptors and awards aim to reflect the state of maximum medical capacity reached following the provision and engagement in an adequate course of best practice treatment, considered over the person’s lifetime. The comparator is “…the capacity of a healthy person of the same age and sex who is not injured or suffering a health condition”. Because the scheme aims to accommodate “any” injury or disorder due to AFCS service, important attributes of awards are consistency and equity, both horizontal and vertical. This means that the range and highest

award within any of the 9 Tariff categories cannot automatically include the highest available scheme tariff award but reflects the functional capacity, following adequate best practice treatment and when the injury or disorder is in optimum medical state. In other words, because of the very different nature of the disorder categories, the highest tariff available for each of the nine categories of injury or illness is likely to vary across the categories. For example, the functional restriction of the most seriously disabling fracture or dislocation in Table 8 is level 9, with the most serious neurological disorders like high cervical spinal cord injury, with quadriplegia, requiring ventilation being tariff level 1 in Table 6.

B. Mental health disorders due to AFCS service and civilian employability

1. In the current AFCS Order Table 3, the maximum award for a mental health disorder due to AFCS service is at level 6, a lump sum of £ 140,000 and a GIP based on 75% salary at service termination. Another descriptor was also added at level 8. These were recommended in the first IMEG report following the Lord Boyce Review and applied to claims made from the start of the Scheme. The 2013 IMEG report included detailed discussion of the thinking behind the level 6 recommendation.

B.1.1 A person's employability can be influenced by multiple factors beyond functional impairment due to injury or disorder, including availability of suitable quality work and personal beliefs and expectations. AFCS awards address the functional effects directly due to service accepted injury and disorders. Employment difficulties can arise directly from mental health disorders, particularly the severe and enduring disorders, such as schizophrenia, which are uncommon in the military and veterans' populations. They are also unlikely to be claimed or, on balance of probabilities, accepted as causally related to AFCS service.

2013 IMEG report

B.1.2 For PTSD and other common mental health problems often accepted as caused by service, literature scrutiny and expert discussion for the 2013 report led IMEG to the conclusion that, an adequate course of best practice treatment to optimum steady state should result in improved function and capacity for some type of civilian employment. Given the lack of longitudinal studies on progress and prognosis of these conditions particularly traumatic psychological injury, evidence from clinicians that functional improvement could still take place for individuals at some time in the future, even long after formal treatment, and the evidence, including for mental health disorders, that work is good for self-esteem, sense of purpose, meaningful social interaction, IMEG recommended a 75% GIP as the maximum award. We were also conscious that the implications of a 100% GIP, suggesting that such a person would be unlikely to undertake any employment for the foreseeable future, given the relative youth of the AFCS claimant group, risked unintentional effects such as negative self-image and loss of hope. In the 2013 report, IMEG also confirmed that the suggested upward revision of the two highest mental health awards maintained vertical and horizontal equity across the rest of the Scheme.

B.1.3 During the 2016 QQR some stakeholders suggested to the review team that in some cases, of disorders due to AFCS service, functional improvement in treated optimum steady state was not consistent with any paid civilian work and so the highest mental health award should include a Band A GIP based on 100% military salary. The QQR Team asked IMEG to comment.

IMEG investigation

B.1.4 We considered first whether there was new evidence supporting that proposal; i.e. there are circumstances where a mental health disorder caused by AFCS service could itself directly cause functional impairment incompatible with any civilian employment over a working lifetime. IMEG explored the literature, particularly from 2012, reviewed redacted exemplar mental health cases awarded the highest tariff, and discussed the issues with military and civilian, clinical and academic experts in traumatic psychological injury.

B.1.5 Clinical colleagues confirmed our impression that although the published peer-reviewed research base on psychological disorders, including military traumatic psychological injury, has increased significantly over the last few years, there remain many gaps.

B.1.6 These include a lack of studies on longitudinal course and prognosis of disorders and, important for AFCS, on functional effects and employability (1). Other topics with insufficient evidence or inconsistent findings are evaluation of treatments (2), whether employment outcomes are affected by treatments, form of delivery such as face-to-face versus internet delivered therapies, and what is an adequate or optimum dose and course duration. Where there are dual diagnoses or co-morbidities an issue may be the order of treatment, e.g. the need for stabilisation ahead of addressing trauma or can both be addressed together? Where does support into work fit in? There is accumulating evidence on the effectiveness of vocational rehabilitation even in severely disabling mental health disorders, especially using the supported employment Individual Placement and Support model (IPS)(3) and we note and welcome the increasing frequency of IPS services across the country.

B.1.7 The present NICE guidelines date from 2005 and we are aware that review and revision is expected shortly.

B.1.8 Although AFCS awards are not based on diagnoses, for awards to be made, the Scheme legislation specifies that mental health diagnoses should be included in either ICD or DSM classifications and made by consultant level psychiatrists and clinical psychologists. We note the recent publication of DSM V and that a new edition of ICD, ICD 11 is expected in 2018. The recent and current literature includes much debate on diagnostic criteria for stress and trauma related disorders. PTSD was first defined in DSM III in 1980 and since then there have been significant revisions and differences in criteria in successive editions of DSM, and between DSM and ICD. These are marked in the new DSM V and ICD 11 is likely to recognise PTSD, where re-experiencing, sense of threat and avoidance symptoms (i.e. trauma related) are dominant and differentiate it from a sub-group diagnosis, complex Post-Traumatic Stress Disorder (PTSD) which has in addition other symptoms (e.g. dissociation, affect dysregulation, negative self-concept and difficulties in relationships). These self-regulatory problems are shared with disorders included in previous editions of the classifications, Enduring Personality Change After Catastrophic Experience (EPCACE) (ICD10) and Disorder of Extreme Stress not Otherwise Specified (DESNOS) (DSM). In ICD 11 both PTSD and complex PTSD symptoms are likely to have to be present for several weeks and cause significant functional impairment.

B.1.9 There is much discussion in the literature (4) on the new classifications, and the concepts of PTSD and complex PTSD (cPTSD) as sibling disorders. Like EPCACE and DESNOS, complex

PTSD is linked to exposure to “sustained or multiple traumas from which escape is difficult or impossible”. Examples include chronic childhood physical or sexual abuse, domestic violence, torture, being a PoW or refugee. Factor analysis studies of the disorders are emerging (5). These support the view that PTSD and cPTSD are distinct categories with a lower prevalence of cPTSD.

B.1.10 Risk factors for the two forms seem to be different with chronic sustained or repeated stressors more frequently leading to cPTSD but on occasion this diagnosis may be associated with a single very severe exposure, e.g. gang rape, or the violent death of one’s child. Equally sometimes severe repeated traumas may lead to PTSD only. Factors such as resilience (itself related to previous traumas), genetics and social support are likely to modify responses. cPTSd is the more disabling diagnosis.

B.1.11 While not necessarily using the cPTSD terminology, clinical colleagues identified the difficult to treat or treatment resistant cases as most commonly having, from the outset at assessment, more severe symptoms of traumatic psychological injury, often complicated by co-morbidity, typically substance misuse and mood disorder. Although the overall risk of suicide in UK veterans is no greater than the general population, the risk seems greater in young veterans (6). PTSD itself may increase the risk of self-harm (7) and suicidal ideas (8), particularly when associated with other psychiatric disorders such as depressive illness.

B.1.12 The expert clinical view was that such cases were likely to need prolonged best practice treatment, involving stabilisation before trauma work, often lasting several years and requiring referral to tertiary trauma services. It was a small number of cases from this group who, in their experience, even following full engagement and commitment, they considered most likely to have such residual steady state functional limitation as to be unable to work longer term.

B.1.13 In light of these new findings, and while recognising the limits of contemporary evidence and the imminent further publications, we are sympathetic to the notion that in a few cases of mental health disorders accepted as due to AFCS service, functional impairment at treated optimum medical state directly due to the mental health disorder(s) may be incompatible with any civilian employment for the foreseeable future.

B.1.14 The type of case to meet this description will likely include i) multiple diagnoses including ii) comorbidities such as substance misuse and mood disorder, and will be iii) caused by a very severe single trauma or chronic multiple traumas from which escape was difficult or impossible and with iv) traumatic and self-regulatory symptoms. These will require v) best practice treatment for the co-morbidities i.e. stabilisation, ahead of vi) treatment for the trauma. They are likely to require vii) tertiary/highly specialist complex care. In addition, viii) time from initial specialist assessment to completion of adequate courses of best practice treatments of all disorders, is likely to be several years. Finally, ix) the treating consultant in charge will be of the opinion, based on reasons, that the person is treatment resistant and level of functional impairment is permanent (as defined in the AFCS) and incompatible with any civilian work for the foreseeable future.

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Conclusionsandrecommendations:

1). We do not agree, for reasons discussed, that the highest level of award available for the most severe and seriously disabling mental and physical disorders across the Tariff Table categories should be the same.

2). We remain content that contemporary evidence supported the recommendations and conclusions of the 2011 and 2013 IMEG reports, on Tariff values for mental health disorders, Table 3 and particularly the highest appropriate award.

3). In the 2013 report IMEG considered decoupling of lump sum awards and GIP based on individual case facts. We reviewed that (2017) and again conclude for the reasons given in 2013 that equitable decisions to support a model of disability which avoids perverse incentives and enables individuals to move on with their lives is best met by a single rule based system equally applicable to all disorders, physical and mental, and injuries in the Scheme.

4). In light of the new evidence and clinical insights from the literature and discussion with senior clinical colleagues working in the field of traumatic psychological injury, as discussed above, we conclude that the Table 3 range of descriptors and tariff values for mental ill health should include an award at level 4 attracting a 100% GIP. This would address the small number of cases where residual steady state functional impairment, following engagement and commitment to adequate courses of best practice treatment, including highly specialist tertiary interventions, remains incompatible with paid employment for the foreseeable future.

5). We would encourage studies of the long-term prognosis of veterans with mental health conditions, particularly related to employment outcomes and outcomes following particular treatments.

C. Diagnosis

1. The QQR raised mental health diagnoses in the Scheme and who should make them.

C.1.1 The 2013 mental health report contains a section headed, Robust Accurate Diagnosis going on to discuss an AFCS mandatory diagnostic classification system and specifically who should make the diagnosis. Following discussion of evidence to be collected to inform diagnosis and a possible mandatory classification system, in 2013 IMEG concluded that to support robust accurate diagnoses in the Scheme, diagnosis should be based on an evidence based clinical opinion from a clinical psychologist or psychiatrist at consultant grade.

C.1.2 These issues were again considered by IMEG for this report including discussion with clinical colleagues. The focus on mental health and expansion in awareness, stigma reduction and support services both in the military and wider UK community is welcome but has unintended consequences including possible increased demand for expert help but at the same time, shortages of trained specialists. This is common throughout the developed world at this date, cannot be solved overnight and there are many gapped posts. Another challenge to quality compensation decision making based on robust clinical evidence, is that new editions of both ICD and DSM classification systems have been published or are imminent. Pre-publication discussion and debate confirms that the many differences between the two in terms of disorders listed and diagnostic criteria including for the same disorder, have increased with a risk of apparently conflicting opinion and case formulation.

Conclusion:

1). In the 2013 report IMEG made other recommendations on mental health claims diagnosis and assessment including consideration of establishing a national panel of experts, routine inclusion in clinician reports of detailed information on clinical management and treatment perhaps using a simple AFCS protocol and use of a limited battery of psychometric tests particularly to judge progress over time. As yet these have not been taken forward. We suggest they are worth re-visiting.

2). In the meantime, for robustness we conclude that diagnosis of mental disorders in the scheme should continue to be by clinical psychologists or psychiatrists at consultant level.

D. Permanency and Interim Awards

1. The QQR report raised the issues of permanency and interim awards. IMEG comment on these issues is above at Topics 5 Permanency and 6 Interim awards. These comments apply equally to mental health, physical disorders and injuries, including where mental health disorders have delayed presentation or onset and are covered by the AFCS late onset provision (Article 3 AFCS Order 2011).

E. Multiple mental health diagnoses – one award or several?

1. Finally another issue raised with IMEG is how the Scheme approaches multiple mental health diagnoses due to the same incident or experience. Should one or several awards be made from Table 3?

E.1.1 The medical diagnostic process and classification of disorders attempts to confer some order on symptoms and problems. This first applied to physical conditions or diseases; i.e. objective pathologies. Here diagnosis is the description and name of a disease based on symptoms, signs and perhaps laboratory or radiology findings. If diagnoses are arranged according to similarities and differences we have a classification system grouping together similar conditions for treatment and prognosis and for research. While classification systems for physical diseases and injuries date back hundreds of years, those for mental health problems are more limited and more recent. There are today two systems: the WHO International Classification of Diseases and Related Health Problems (ICD), now in tenth edition with eleventh due in 2018, and the American Psychiatric Association Diagnostic and Statistical Manual DSM IV, recently replaced by a fifth edition.

E.1.2 There are other differences between physical diseases and injuries and mental health diagnoses and classifications. At this date, understanding of mental health disorders does not extend usually to knowledge of pathophysiology. In psychiatric disorders certain criteria or symptoms may be obligatory – others may be characteristic; e.g. depression or anxiety are symptoms recorded in many different discrete disorders, such as PTSD, anxiety disorder, adjustment reaction and depressive disorder itself. Similarly, some are discriminating symptoms e.g. delusions or hallucinations which may occur where a person has a psychosis, e.g. in schizophrenia. All this means that while criteria for diagnosis are similar in different classifications of injury and physical disorder, for the mental health classifications, ICD and DSM diagnostic criteria may be different and may change from one edition to the next.

E.1.3 As a result, and as is common in AFCS claims, different diagnoses and case formulations may be made in the same case by different clinicians. This becomes particularly complex because of the lack of consensus description of disorders in the ICD and DSM systems and the facts that some disorders are recognised by one classification system but not by another e.g. enduring personality change due to catastrophic experience or psychiatric illness is included in ICD but not in DSM including DSM V.

E.1.4 AFCS awards are based on the severity and duration of functional limitation or restriction for civilian employability. As different case formulation and diagnoses may be identified in the person by different clinicians and over time, AFCS's approach to mental health disorders is to avoid a list of conditions, but to use a generic approach. Where there are several discrete

diagnoses, apportionment of disabling effects on the basis of aetiology is not scientific or possible. As a result all functional compromise caused by mental health disorders included in a single claim and due to AFCS service, is accepted and the descriptor chosen, reflects overall functional compromise and its duration. Where there are several diagnoses the AFCS descriptor and award reflects the most functionally disabling disorder for the longest period.

Conclusion:

1. Table 3 of the AFCS Tariff is generic and a single award is appropriate even where there are several diagnoses resulting from the same incident or exposure.

Overall Mental Health Recommendations:

1). Present evidence including on disorders potentially attributable to AFCS service, and the need to maintain horizontal and vertical equity in the Scheme means the highest AFCS award for accepted mental health disorders should be revised to be level 4 with 100% GIP.

2). We will continue to monitor mental health claims trends.

3). We recommend at this time a continued requirement for mental health diagnoses to be made by consultant clinical psychologists or psychiatrists.

4). We will further consider the suggestions of the 2013 IMEG report to support quality decision making including the introduction of treatment protocols as part of clinical reports, a national expert panel and the use of psychometric measures to monitor progress.

5). We will continue to monitor the literature on mental health disorders and traumatic psychological injury including best practice guidelines and studies evaluating effectiveness of interventions.

6). We consider the "permanency" and "interim" concepts to be medically valid in the AFCS context.

Other issues raised in the QQR

Table 9 - Back injury and pain syndromes

1. The QQR requested IMEG to review the clarity of descriptors and award levels for back injury and pain syndromes in Table 9. These issues are discussed in the Part 1 Musculoskeletal Disorders (MSK) paper included in this report. Owing to the wide scope and complexity of MSK, further investigation and a Part 2 report is planned for IMEG's next report. This will include in depth review of pain and pain syndromes.

Conclusion:

1). At present as discussed in Part 1 of our review of MSK we believe the present approach of the scheme to descriptors and awards for back disorders (Table 9 AFCS Order 2011) is fair to claimants and medically valid.

2). We will continue investigation of back disorders and pain and provide further comment in Part 2 MSK in the next IMEG report.

Non Freezing Cold Injury (NFCI)

1. The QQR report highlighted the challenge that NFCI presents to AFCS and the many gaps in current understanding. Some stakeholders were of the view that the current descriptors and Tariff levels, whose basis is discussed in the NFCI section of the 2015 IMEG report, did not adequately reflect seasonal variation in symptoms. However, having considered the 2015 IMEG report and aware that the 2015 IMEG recommendations on descriptors were necessarily limited by available evidence, the QQR Team do not agree with this perspective.

Conclusion:

1). IMEG agrees that the current NFCI descriptors and awards reflect the limits of contemporary evidence and appropriately consider seasonal and any other seasonal variation in disabling effects.

2). We are unaware of longitudinal research being undertaken or planned anywhere in the world and will continue to monitor the literature.

3). Since AFCS was introduced almost 2000 awards have been made. It is of note that in 2016/17, award numbers declined.

NFCI AFCS awards based on the outcome of the latest claim

	2005/6	2006/7	2007/8	2008/9	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
Lump sum and GIP	0	1	0	1	0	4	5	4	6	2	2	0
Lump sum	0	3	19	45	65	161	350	281	297	330	216	118

Table 6 - Brain Injury descriptors

1. The QQR Team raised the issue of possible confusion between two brain injury descriptors in Table 6 These are, on current Tariff, item 17 at Tariff 4 and item 22 at Tariff 8.

Item 17 level 4

Brain injury where the claimant has moderate physical or sensory problems; one or more of 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.

Item 22 level 8
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 deficit, behavioural change or change in personality. (a)

(a) The claimant is unable to undertake work appropriate to experience, qualifications and skills at the time of onset of the illness, but able to work regularly in a less demanding job.

2. This issue is fully discussed in the Compensation Aspects of the Traumatic Brain Injury update which forms part of this report.

As discussed in the TBI paper, we do not share the QQR view that there is confusion/possible overlap between the two descriptors but have attempted some clarification of the descriptors to put beyond doubt the relative severity of the two injuries.

Recommended revised descriptors - Table 6

Item 17 level 4
Brain injury where the claimant has moderate permanent motor or sensory problems and one or more of permanent substantial cognitive, personality or behavioural problems and requires regular help or full-time supervision from others with activities of everyday living, but not professional nursing care or regular help from other health professionals.

Item 22 level 8
Brain injury from which the claimant has made a substantial recovery and is able to undertake some form of regular employment has no major motor or sensory deficits, but one or more of residual functionally disabling cognitive deficit, behavioural change or change in personality. (a)

(a) The claimant is unable to undertake work appropriate to experience, qualifications and skills prior to the brain injury, but able to work regularly in a less demanding job.

3. We have also reflected that Item 21A and 22 have similarities. In both, those affected have made substantial recovery, but are unable to undertake regular paid work at their previous level. Both can do some regular paid work; the one limited by substantial physical motor deficits and the other cognitive behavioural or personality problems. We propose revised descriptors as below and that both categories should attract a level 7 award.

Item 21A level 7
Brain injury from which the claimant has made a substantial recovery and is able to undertake some form of regular employment, has no major cognitive personality or behavioural problems, but with substantial functionally disabling motor deficit in upper or lower limbs or both (a)

Item 22 level 7
Brain injury from which the claimant has made a substantial recovery and is able to undertake some form of regular employment, has no major motor or sensory deficits, but

one or more of residual functionally disabling cognitive deficit, behavioural change or change in personality. (a)

(a) The claimant is unable to undertake work appropriate to experience, qualifications and skills prior to the brain injury, but able to work regularly in a less demanding job.

Conclusion:

1). We recommend the revisions to Table 6 descriptors and awards set out above.

Topic 8. High Dependency or Exceptional Supplementary Award (ESA) - medical aspects

1. The QQR Team recommended the introduction of an ESA for those AFCS recipients most seriously injured or made ill and dependent on 24 hour care to maintain life. They went on to ask IMEG to consider medical aspects of the concept and invited comment on possible criteria for award entitlement, including when the decision might be best made and by whom.

2. Since the QQR report there have been a number of relevant developments which suggest a need to consider carefully the proposed concept. A public consultation on an enhanced compensation scheme for combat injury has been held. The proposal is that, once entitlement is established, awards will be assessed as for civil damages, with the various heads of pecuniary and non-pecuniary damages, based on individual case specific facts and circumstances, including health and social care costs, housing adaptations, loss of earnings as well as general damages, covering pain and suffering and loss of amenity (PSLA). As the majority of the most serious injuries in AFCS to date and for the future, relate to combat, any enhanced scheme would be likely to impact an AFCS ESA.

3. The recent conflicts marked significant advances in acute critical care and casevaccing so that previously fatal combat injuries are now survivable although often the person is left in a severely disabled state. At the same time for the wider population, community based NHS led patient centred holistic care packages involving multidisciplinary working across NHS, Local Authorities, social services, and charities have been developed and become increasingly common. NHS Continuing Health Care (CHC) is a package of ongoing care arranged and funded by the NHS where the person has a primary health need. In MOD, work has also continued on the longer term in-service best practice management and rehabilitation of those with severe injuries including on the transition of injured and sick veterans to further medical care and social support in the civilian community. An important aspect of that is the development of a veteran specific NHS funded Integrated Care package (IPC4V) for this group.

4. Within the AFCS the highest (level 1) award for pain and suffering covers a range of injuries and disorders with different disabling effects. The QQR report states the suggested ESA is paid to those exceptionally disabled, for loss of dignity, embarrassment, fear of the future, loss of ability to pursue a normal life, congenial employment and hobbies and pleasures i.e. essentially loss of amenity. It is not for care or home adaptations. The QQR report suggests that payment should be made where an individual is dependent on others to remain alive - essentially in receipt of a level 1 award or equivalent value award and 24 hour support or care. The suggested level of payment is standard and has a degree of randomness. For entitled recipients, it is set at half the suggested revalorised Tariff 1 award and paid as a one off lump sum. The intention is that it will cover circumstances both at the time of award and for the future.

Medical points on the proposal

5. The Lord Boyce Review discussed in detail possible Scheme funding of private health care for AFCS recipients. A number of factors emerged. Many of the most serious injuries seen in the Scheme at that time were combat related and previously unsurvivable so that their long term health care and other support requirements were (and remain) unknown. Absolute numbers are much smaller than after earlier conflicts so maintaining visibility of this population in the general community over time is an issue. Another factor is the generally increasing long term survival for many serious injuries and disorders. Secure solutions, clinically suitable for the individual were considered imperative by Lord Boyce, despite the very high cost of likely interventions. The 2010 Lord Boyce Review concluded that best practice sustainable treatment reflecting technical advances would be most effectively funded and delivered by the NHS. As with AFCS, funded by MOD, this would form part of the nation's commitment to those who serve and are injured on our behalf and would reflect Sir William Beveridge's proposal in 1942 that treatment and care for injured ex-service personnel should be, as for the rest of the community, the responsibility of the NHS and social services.

6. We appreciate that the idea of the ESA is for pursuit of hobbies or pleasure but advise that for a person with such severe disability, likely to require the support of multiple carers and modified transport etc even £325,000 will be quite limited in funding visits over a lifetime. In addition, a sub group of potentially entitled injured personnel and veterans are those with severe TBI where conscious level and response to the environment means that their appreciation of loss and ability to pursue a normal life or to enjoy hobbies or the pleasures of life cannot be in any way restored to them.

7. Since 2012, IMEG members have much valued opportunity to meet severely injured service personnel and discuss their perspective on a range of issues. On every occasion we have been hugely impressed by their determination, resilience, one body ethos and the part played by mutual support amongst peers in getting back to as full a life as possible. We note that, at service termination, over 95% of injured personnel are independent in activities of daily living (ADL). We have some concerns that measures such as the proposed ESA might be the subject of misunderstanding. This might include being viewed as an inequity or disadvantage to those who have worked very hard for recovery. It might even be a disincentive to full engagement and commitment to treatment.

8. The supplement, may be interpreted as simply a top up award, raising level 1 awards or aggregated capped awards at level 1 value. As the Scheme focuses on impairment for civilian employability, GIP is paid at 100% salary replacement for any of award levels 1-4. Given the suggested value of the ESA, there could be representations re uprating awards at levels 2, 3 and 4 or for abolition of a ceiling for multiple awards at the level 1 tariff level.

9. The QQR Team emphasised the rarity of award of the ESA. From a medical viewpoint we are less sure of that. Advances in casualty recovery from theatre and treatments for severe combat injury are ongoing internationally and many of the interventions will be equally appropriate for severe non battle injury, much of which could be service attributable. Serious neurological injury, the category likely to lead to the most severe levels of disability, occurs commonly in young people including in the Armed Forces and frequently as the result of off duty road traffic accident or other non-service related events, some of which will not result in compensation, civil damages or insurance payment.

10. At a time when parity of esteem between physical and mental disorders is an important aim of government and raised by stakeholders in the QQR, consideration needs to be given to, if or how, an ESA might impact that concept. Both the NHS Continuing Health Care and Integrated Care Personal Budgets apply to people with mental health needs.

11. Finally the Review team asked IMEG for some comment on practical aspects of decision-making on ESA. This included advice on a) when should the decision on ESA be made? and b) by whom and on what basis?

12. We found these issues equally challenging. The longitudinal progress of many traumatic physical injuries and disorders is simply unknown. IMEG explored the available evidence on amputation/multiple amputation in the 2015 IMEG report, confirming that while there have been few longitudinal studies of amputees, the literature to date, suggests it would be unwise to consider the position at service termination as necessarily sustained over the rest of the person's lifetime. This lack of good information on prognosis of many conditions raises the dilemma of when a decision re entitlement to ESA should most robustly be made. Would it be fair to make it around service termination, if say five or ten years later the person is running into serious functional difficulties? We need also to take account of future life expectancy and the prospect of more people living longer, even a normal life span, but in an increasingly disabled state e.g. not necessarily level 1 but e.g. spinal cord injury or brain injury awarded quite correctly at level 2 at outset but over time disability gradually increases. Should ESA be available to this group, with unquestionably severe disability from a young age, at no matter what time interval after service termination?

13. In terms of who might make a decision on ESA, and on what basis, one option would be to have a defined protocol completed by a multidisciplinary group of treating staff. Judgement would then be an issue and rejected claims would go to appeal. This might be unattractive as in every case very ill or disabled claimants will be involved. An alternative might be to frame the decision mechanistically and on verifiable facts. These might include i) being in receipt of a level 1 award or equivalent ii) receiving 24 hour care and support or supervision with iii) decision to be made at service termination or within normal AFCS time limits i.e. seven years. This way award of ESA might appear automatic but appeals and dissent would still be possible against the gateways i.e. award level or receipt of NHS Continuing Health Care or Integrated Personal Care or the need for 24 hour care.

Conclusion:

1). IMEG recognises that the intention behind the ESA is laudable but urges careful thought. A decision to have such a provision and any subsequent criteria for its award should be uncontroversial and robust.

2). We acknowledge that there is no direct relation between a sum of money and the adverse effects of disease or injury on an individual. Individuals and families react very differently to disease and injury with a wide spectrum of beliefs and expectations, and opinions as to what constitutes satisfactory care and support. Because care is given does not imply it is always medically necessary.

3). While by no means yet perfect we note, since the introduction of the AFCS, the enhanced publicly funded cross government holistic healthcare and other support provisions increasingly available to all who require them in the community, including injured veterans. We consider the widespread popular

support for the Armed Forces, nationwide development of the Armed Forces Covenant and collaborative working, including with the charities, under successive governments as providing the basis of valid tools, lay and professional, to audit standards and adequacy of provision of publicly funded continuing health care and support, both in general and locally to individual veterans.

4). We suggest that any additional funding for the Scheme might be well invested in developing and implementing sustainable processes for audit and evaluation of care and other services provided under the Armed Forces Covenant.