JSP 770

Ministry of Defence

TRI SERVICE OPERATIONAL AND NON OPERATIONAL WELFARE POLICY

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MINISTRY OF DEFENCE
Directorate Service Personnel Policy

TRI SERVICE OPERATIONAL AND NON OPERATIONAL WELFARE POLICY

JSP 770

This chapter has been revised in accordance with the direction on the applicability of JSPs set out by the Defence Reform Unit

CHAPTER 1 – PRINCIPLES OF WELFARE

Part 1 - Directive

Introduction

1.1.01. The nature of military activity and way of Service life set Armed Forces communities apart from many areas of civilian society. The critical connection between welfare and operational effectiveness affirms that the support provided for Service personnel and their family[1] is "core" Armed Forces business.

Accountability

1.1.02. Welfare is a function of command and a key element of the moral component of fighting power and operational effectiveness. Therefore, Commanders at all levels in the Chain of Command are responsible for the welfare support of those under their command and within its community. Service personnel must be provided with an opportunity for face to face advice and guidance from their CO or representative, when the need arises. The provision of information is an essential element of the command function and must be capable of reaching all individuals according to their particular requirements. Overseas commands, where possible, are required to comply with the spirit of appropriate English legislation.

Definition of Welfare

1.1.03. **The MoD's definition of Welfare is**:

The provision of a widelyrecognised and accessible personal and community support structure that secures and improves the wellbeing of serving personnel and the Service community, is capable of adapting to societal, legislative and operational change and, in so doing, optimises the military capability and motivation of all Servcie men and women.

Aim

1.1.04. The aim of this JSP is to provide MoD's welfare policy and guidance to Commanders at all levels as well as welfare specialists and unit budget managers on the provision of both operational and non-operational welfare to entitled personnel both at home and overseas. The JSP will also give guidance on how welfare is to be funded.

[1] The definition of family differs depending on whether support is for routine matters, deployments or casualties. These definitions are included later in this document or signposted to the authoritative document.

1.1.05. This JSP, which is complemented by single Service regulations, instructions and guidance, will adopt a tri-Service approach, define best practice and use a common definition throughout. Indeed, the principles of welfare that underpin the tri-Service welfare policy are applicable across the 3 Services and are reflected in this publication. These are:

a. To underscore the primacy of the Chain of Command, who are responsible for the welfare support of those personnel under their command and their entitled families.

b. To provide guidance for the individual in their responsibilities and the pivitol role needed to ensure they communicate effectively with both their families and the Command in times of complex need.

c. To provide a widely recognised and accessible personal and community support structure which secures and improves the well-being of serving personnel and their families, and in doing so, optimises the military capability and motivation of Service personnel.

d. To provide welfare support, in both operational and non-operational areas, to secure the well-being of all Armed Forces personnel.

e. To have in place, ready for immediate activation when Armed Forces personnel are deployed, balanced, resourced and appropriate welfare packages.

f. To provide overseas, as far as is practicable, the services that are normally available in England[2], through Service specialist welfare organisations.

g. To provide, as far as practicable, an equal standard of welfare support for reservists in conjunction with Local Authority provision.

h. To limit, as far as practicable, those factors that are detrimental to the operational effectiveness of Armed Forces personnel.

1.1.06 As part of the Whole Force Concept, Reservists[3] deliver an important part of Defence capability. As for Regular personnel, provision of welfare support for Reserves and their families is the responsibility of the Chain of Command (CofC) and, alongside Statutory provision, Reserves and their families should have equivalent access to MOD welfare support. Increased MOD involvement / provision will be required leading up to mobilisation, with parity of support during mobilisation, accepting greater reliance on statutory support during other periods; signposted as required by unit welfare providers.

1.1.07 The different employment model for Reservists means that some may have less experience of the Service environment than their Regular counterparts, which may lead to a lower understanding of Service welfare provision and how to access it. This potential for unfamiliarity is also likely to be more prevalent for Reservists' families. Therefore, the CofC and welfare staffs are to ensure measures are in place to make sure Reservists and their families are aware of how to access

[2] Subject to any immigration controls imposed by the Home Office.

[3] Personnel with a liability for permanent service (it excludes those who are in the Cadet organisations).

Service welfare support, when needed, and confirm understanding that they may be signposted to statutory services provided by Local Authorities (as would be the case for Regular personnel)

1.1.08 **Principles**. In addition to other principles elsewhere in this JSP, the following principles will apply to the welfare support of Reservists and their families:

a. Operational Effectiveness. Service welfare provision is primarily intended to manage the critical connection between welfare and operational effectiveness. The Services have a greater role to play where a welfare issue is related to, or will have an impact upon, the Reservist operational commitment. Provision will range from professional support to signposting, according to the operational imperative; nevertheless, all Reservists and their families should be empowered to access Service welfare support to ensure the most effective decisions can be made.

b. Equality. Reservists are to be afforded an equal standard of welfare support to that of Regulars which can be utilised as and when required. This is not to say that the delivery or nature of welfare support will be the same in all cases; the aim is for the same supporting effect to be achieved, though this may be through different methods.

1.1.09. This JSP will also address the provision of welfare support in joint units to ensure that all entitled personnel receive adequate levels of welfare support regardless of their Service or unit. However, it is recognised that the individual Services will deliver some aspects of welfare policy in a unique way that satisfies the needs of the particular Service. JSP 770 will highlight the different approaches in delivery where appropriate.

Entitlement to Welfare Support

1.1.10. The matrix at Annex A provides details of those who are entitled to welfare support provided by the MOD.

a. **Statutory.** Statutory welfare provision is that which is provided by the state/local authorities as a result of legislation. Such support would include provision under the NHS and Social Services. In overseas commands the Theatre Commander is responsible for the provision of welfare services which, wherever practicable and manageable, conform in type, scope and standard to that required by statute in England (whilst taking into account variations in the welfare systems of Scotland, Northern Ireland and Wales).

b. **Non-statutory.** Non-statutory welfare provision is in addition to the statutory provision and is provided by the Services. It compensates for the unique circumstances Service personnel and their families are in. Non-statutory welfare includes HIVE, community centres, sporting facilities and messes.

Individual Responsibility

1.1.11. **Welfare starts with the Service Person**. Individuals have responsibility for their own immediate welfare and that of their family. Providing access to welfare support is a prime command responsibility and the chain of command is available and willing to engage in more complex welfare cases, however chain of command involvement should not be seen as the default setting for resolving low level welfare issues. It is incumbent upon individuals to maintain situational awareness of their personal welfare needs and the welfare needs of family members ensuring timely communication with the chain of command where personal welfare situations may affect functionality, availability or operational capability. The chain of command will ensure that appropriate welfare support and signposting is in place, to address issues beyond the capability of the individual, but each SP is responsible for maintaining the communication links between available support and their families alongside their requirement to ensure personal records are both accurate and up-to-date.

MOD Responsibility

1.1.12. Responsibility for developing and coordinating welfare policies, including those that derive from government legislation lies with the MOD and specifically within Chief of Defence Personnel area. Any major changes in policy that affect the Armed Forces are made by the Defence People and Training Board[4] (DPTB). The DPTB membership includes the three Service Principal Personnel Officers (PPOs) and COS JFC plus ad hoc members as required. Policy implementation is undertaken by the relevant Service policy branches. Commander Joint Forces Command (JFC) for Joint Units including the PJOBs, and Commander Land Forces (CLF)/Adjutant General (AG) for Land Forces Overseas Detachments, are responsible for implementing policies drawing upon full command support from the single Services. Within Joint Service units, support willl be drawn upon in accordance with the tri-Service Welfare agreement at Annex B.

1.1.13. The formation of policy is a 2-way process. MOD will instigate and develop policy that results from Central Government legislation. However, the single Services and JFC are responsible for feeding up to the Centre best practice and lessons identified so that tri-Service welfare policy can be formulated or amended as appropriate. The Services Welfare Steering Group (SWSG), membership of which includes OF5 representatives from Principal Personnel Officers (PPOs) and JFC, co-ordinates tri-Service policy across the families and welfare areas on a worldwide basis and reports to the the Group of Five (formerly Service Personnel Operating Board) . Specialist professional welfare business is managed through the Specialist Welfare Delivery Group (SWDG), which develops and shares best practice in specialist welfare delivery.

1.1.14. Tri Service welfare policy provides the policy framework for welfare delivery by the three Services and JFC. Details of the single Service and JFC welfare chains of command are at Annex C.

Command Responsibility

1.1.15. **Commands/Formations/Units/Garrisons**. Welfare is a function of command. The Commanders in Chief and theatre Commanders overseas are responsible for implementing policies within their own commands. There are in addition, a number of agencies with specified roles to play that must be recognised

[4] Replaces the Service Personnel Board

and supported by the chain of command. The effectiveness of welfare support is dependent upon the direction and co-ordination of the work of the various specialist agencies, charities and volunteer groups at the appropriate (normally local) level. This is to be achieved through a formal structure of welfare management committees, and reinforced where practical by the co-location of specialists, services and activities. Unit budget managers should be consulted to ensure value for money and affordability issues have been fully considered.

1.1.16. **Commanding Officer's Responsibilities to Service Personnel and their families within their area of responsibility**. Welfare support to all unit Service personnel and the Service community is the responsibility of the CO. This responsibility is exercised through the chain of command (CofC), utilising specialist advisors and welfare workers, and by providing community support assets. The Reservist's employing CofC and Parent Unit must jointly decide where primacy for the delivery and monitoring of welfare support lies, at any given time, and appraise the other when there is a welfare concern. This is an important 2-way conversation if coherent welfare is to effectively address areas of concern. Appropriate advice can be sourced from Single Service Specialist Welfare providers e.g. RNRMW, AWS and SSAFA.Commanders at all levels are to:

a. Where practicable, provide and maintain welfare and community support assets as detailed in Annex D.

b. Establish a stigma-free welfare culture that encourages personnel to seek advice at the earliest opportunity through the chain of command or directly through unit welfare personnel.

c. Provide or ensure access to welfare resources where normal civil society does not meet the need.

d. Ensure that all appropriate personnel undergo training suitable to meet their welfare responsibilities.

e. Ensure that all vital information, including full details of welfare and community support services, is communicated effectively to the Service community in a way that is suitable to meet their individual needs. This is to include details of the MoD's' Equality and Diversity Policy and MoD Harassment Complaints Procedures[5], ensuring that the welfare needs of the parties to a complaint (complainant and respondent) are properly considered and that they are protected from the stresses of their situation, see Part 2 paras 19-21.

f. Seek specialist advice where necessary. Timely advice and guidance should be sought from higher authority where required. Potentially high profile and contentious issues should be referred to higher authority for consideration before unit action is taken.

g. Maintain a close working relationship with specialist welfare organisations granting suitable access where required. The CO is to regularly hold formal welfare meetings run by unit welfare and specialist staff to address current

[5] JSP 763 The MoD Harassment and Complaints Procedures

welfare issues and ensure that a seamless and coherent welfare service is available.

h. Include welfare requirements within preparations for all exercise and operational deployments; this should apply equally to mobilised reservists attached to the unit.

i. Single Services may wish to publish a Welfare Plan/Charter that sets out the unit welfare strategy. The document should cover, as a minimum entitlement, delivery, responsibility and funding framework. An example is at Part 2 para 22.

j. Disseminate, as part of the induction process for personnel and their families newly arrived at a unit, the following information as a minimum:

(1) Details of the welfare chain of command. Personnel should be made fully aware of whom they or their families can contact.

(2) Assurances that the unit is a stigma-free welfare environment.

(3) MoD's Equality and Diversity policy and the MoD Harassment Complaints Procedures.

(4) Details of welfare facilities both on and off base. These should include the HIVE and community centre; education and sports facilities; social and retail facilities; and youth and childcare facilities and activities.

k. Reservist Family Members. The responsibility for delivery of specialist welfare support, including timely and relevant information to a Reservist's immediate family normally rests with the Parent Unit's CofC. The definition of Parent Unit may require clarification in certain circumstances, such as those called up on a Reserve liability commitment; nevertheless a clear responsibility must be identified on every occasion. The Parent / nominated Unit needs to communicate with the individual and their family to ensure they are informed about welfare provision and potential signposting to local agencies.

1.1.14. **Confidentiality**. A code of confidentiality is observed by those personnel providing specialist professional[6] welfare assistance to Service personnel and its community. Disclosure of confidential information can only take place if the prior permission of the individual has been obtained. If prior permission from the individual is not given and the CO judges that there might be serious consequences as a result of not disclosing confidential information the matter should be referred to higher authority for advice. For example, such circumstances might be:

a. Where there is a risk of harm to the individual or others. When assessing risk it is essential to consider fitness for armed duties (i.e. access to or in charge of a firearm), when deciding on disclosure of information to the Chain of Command. Any concerns relating to an individual's fitness for armed duties must be disclosed to the Chain of Command and line managers, and are to be recorded..

[6] The code that applies to specialist professional medical, welfare and chaplaincy staff does not apply to personnel staff, which operate to the need to know/Official Sensitive-Personal principles.

b. In order to prevent a serious criminal act.

c. If there is a serious contravention of military law.

d. If there is, or is likely to be, a serious breach of national security.

e. If the individual is no longer able to carry out their duties.

Annexes:

A. Entitlement to Welfare Provision Provided by the MoD
B. Tri-Service Welfare Agreement
C. Single Service Welfare Chains of Command
D. Welfare Charter

ENTITLEMENT TO WELFARE PROVISION PROVIDED BY THE MOD

Groupings	Statutory	Non Statutory	Remarks
Regular Service Personnel Serving in the UK.	X	√	
Regular Service Personnel Serving Overseas	√	√	
MoD Civil Servants Serving in the UK.	X	X	
MoD Civil Servants Overseas Locations	√	√	
Reserve Forces Serving in the UK	X	√	When mobilised reserve Forces will have access to the full range of sService welfare provision. At other times Reserve Services personnel may receive a service from the sService welfare organisations or be signposted to appropriate civilian services
Reserves when mobilised and serving Overseas	√	√	
Cadets Whilst on Duty in the UK	X	√	
Cadets on Duty Overseas	√	√	
Royal Gibraltar Regiment	√	√	
Exchange Military Personnel	REFER TO MOU		
MoD Contractors Working in the UK	X	X	
MoD Contractors	√	√	Refer to terms and conditions of

Working in Operational Environments and Overseas Locations.			contract. Statutory and Non statutory provision is generally provided whilst serving overseas and in operational environments
Service Entitled Families[7] living in the UK	X	√	
Service Entitled Families[8] Living Overseas	√	√	Statutory provision provided whilst overseas

[7] The definition of who is entitled to support will depend on the nature of support in question and differs between those entitled to routine support, support in relation to a deployment and that following a casualty being sustained.
[8] Entitled families overseas normally relates to those accompanying the Service person on the assignment and living in MOD provided accommodation; definitions can be found in JSP 752. Support in relation to deployments or casualties normally widens definitions. Case by case analysis is required for overseas nuances.

TRI-SERVICE SPECIALIST WELFARE AGREEMENT

INTRODUCTION

1. In principle, the provision of Specialist Welfare support is the responsibility of the parent Service but there will be occasions when another single Service welfare provider is better placed to meet the needs of the service user. Such occasions may include the proximity (and hence availability) of the welfare provider, the speed at which a welfare provider is able to respond, or where the personal circumstances of the service user are such that intervention by a different welfare provider is deemed more appropriate. This agreement outlines the arrangements whereby Service Personnel and their families may be the recipients of Specialist Welfare support services from one of the other single Service providers.

PARTIES

2. This agreement is between the Royal Navy / Royal Marines Welfare (RNRMW), the Army Welfare Service (AWS), and Royal Air Force Community Support[9]. (For clarity, in this document these Specialist Welfare organisations are referred to as 'agencies'; 'Service' refers to the single Services (Army, Navy, RAF); and 'services' to the various outputs that the agencies provide.)

SCOPE

3. This agreement covers services to Service Personnel (SP) and their families in the following circumstances:

a SP serving with a unit from another Service and their families, where appropriate, will be provided with Specialist Welfare services by the local Service welfare agency.

b Where services would be more appropriately provided by another agency because of geographic or other reasons.

c. Where service users, because of the specific nature of their situation, seek the assistance of a different single Service Specialist Welfare agency.

4. This agreement does not cover:

a. Work that is (or is likely to be) particularly sensitive, high profile or particularly complex, and hence have single Service implications[10]. Receiving agencies

[9] Specialist RAF Community personal and emotional support services are provided by SSAFA (RAF) under contract arrangements.

[10] Child Protection and Safeguarding cases, is a Local Authority lead in the UK and should only be dealt with by the respective single Service Specialist Welfare agency.

should be aware of such sensitivities and discuss them with the appropriate Service Agency at the earliest opportunity.

b. Counselling or other services purchased for specified individuals at public expense. Funding approval and associated costs lie with the parent Service.

c. Out-of-Hours services that may not be provided by other Specialist Welfare agencies[11].

d. Work that is outside of the normal working practices of the single Service agency.

CASE CONDUCT

5. Each agency will allocate work, carry out assessments and make recommendations in accordance with that agency's processes and criteria, consulting as necessary with other agencies. The case will be conducted as any other of the agency's cases including coverage within supervision and Confidentiality policies.

6. Where a recommendation needs funding, compassionate or executive action by the individual's Service, the individual's consent will be sought before information is passed to his/her own Service welfare agency who will refer to the appropriate Service authorities for action (modifying it to conform with own Service criteria if necessary). The decision on the recommendation in such cases remains with the individual's Service. If the individual withholds consent for information to be passed on, it will not be possible to recommend compassionate or executive action.

APPORTIONMENT OF RESOURCES

7. In situations where an agency is experiencing a high-level of referrals concerning personnel from one of the other Services, a report is to be submitted by the appropriate manager to the relevant Heads of Specialist Welfare. A decision will then be taken to identify a suitable solution such that the apportionment of single Service Specialist Welfare resources is appropriate to address the presenting need. The point at which an agency deems that there is an unacceptably high rate of referrals from another Service is indistinct; managers should monitor such rates of referrals closely and inform their single Service chain of command if they have concerns.

CONCLUSION

8. This agreement is a practical arrangement that allows more effective provision of Specialist Welfare support services to SP and their families by enabling access to the services provided by other single Service agencies. It does not undermine the responsibility that each single Service has regarding the provision of Specialist Welfare to SP and their families from their own Service. Should difficulties arise in the implementation of this agreement, the matter should be referred to the single Service Heads of Specialist Welfare.

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[11] RAF personnel, regardless of location worldwide, have access to the out of hours SSAFA telephone advice line (+44 (0) 20 7463 9358) provided under contract.

WELFARE CHAIN OF COMMANDS

1. **Royal Navy**. Responsibility for developing welfare policy for the RN rests with 2SL who is a member of the SPB. Whilst 2SL has responsibility for policy, implementation rests with the chain of command. Captain Personal, Families and Community Support is responsible for the development and dissemination of welfare policy within the Navy.

2. **Army**. Responsibility for developing welfare policy for the Army in those areas in which the single Services have discretion rests with AG, on behalf of the Chief of the General Staff. Responsibility for implementation rests with the chain of command. To assist in informing the construction and dissemination of Army welfare policy within the Army and the charities that support the serving and ex-Service community, DG Pers chairs the 6 monthly Army Welfare Forum (AWF). Director Personal Services (Army) (DPS(A)) is the designated Competent Army Authority (CAA) for the Army Welfare Services (AWS). PS4(A), a sub-Directorate of DPS(A), is the Army's welfare policy branch and AD PS4(A) chairs the 6 monthly Army Welfare Working Group (AWWG), which alternates with the AWF, to take forward detailed co-ordination of Army welfare.

3. **Royal Air Force**. Responsibility for developing welfare policy for the RAF in those areas where the single Services have discretion rests with Deputy Commander Capability (DCOM Cap) / Air Member for Personnel & Capability (AMP&C) who is a member of the Service Personnel Board. Whilst DCOM Cap / AMP&C has overall responsibility for welfare policy, implementation rests with the chain of command. DACOS Community Support is responsible for the development and dissemination of welfare policy within the RAF.

4. **JFC.** Joint Forces Command, through COS JFC, HQ J1 Policy Branch and the Global Support Organisation, provide input and advice to the development and review of welfare policy in order to meet the specific needs of joint / overseas locations within their AOR. For delivery of welfare support, JFC rely on either single Service leads or the Tri-Service Welfare Agreement[12] (Annex B) depending on location. JFC are represented at the DPTB, SWSG and associated WG/SGs.

[12] Further detail will be available following completion of the JFC Dependencies Matrix.

WELFARE CHARTER

INTRODUCTION

1. Service personnel are not merely civilians in uniform; there are few groups in our society who are required by the nature of their duties to risk potential emotional or physical injury or expressly sacrifice their lives for the nation. Thus they form a distinctive group within UK society with support needs that greatly differ from many of those prevailing in civilian life. Welfare is recognised as an important and integral element of operational efficiency and MOD has a duty of care to ensure that welfare measures are in place, within the funding confines, wherever personnel are required to serve. The measures should provide timely and effective assistance necessary to maintain operational effectiveness. Welfare is therefore core Armed Forces business and it will be delivered through a mix of public and Service non-public funds and charitable sources.

COMMANDING OFFICERS' DUTY OF CARE AND COMMITMENT TO PERSONNEL UNDER COMMAND

2. Welfare and community support of all unit Service personnel and their families is the responsibility of the Commanding Officer (CO). This responsibility is exercised by the chain of command, using specialist advice and welfare assets as required. In particular, a CO is required to:

a. Provide and maintain the standard of welfare and community support assets as detailed at para 1.2.07.

b. Establish a stigma-free culture that empowers personnel to seek welfare advice through the chain of command, or directly through unit welfare personnel when self help fails to resolve the issue.

c. Provide welfare resources where civil society does not meet the need.

d. Ensure that all appropriate personnel undergo suitable training to meet their welfare responsibilities.

e. Ensure that details of appropriate welfare services are communicated to all relevant personnel and their families.

f. Where required, provide Service personnel with an opportunity for face-to-face advice and guidance, either personally or through a representative.

g. Ensure that MoD's Equality and Diversity policy and the MoD Harassment Complaints Procedures are widely publicised. COs should also consider the welfare needs of the parties to a complaint (complainant and respondent) and protect them from the stress of their situation.

h. Intervene personally or through a representative to ensure individual welfare needs are addressed in an effective and timely manner.

i. Seek specialist advice where required.

j. Maintain a close working relationship with specialist welfare staff, granting suitable access where required.

k. Ensure all welfare is coordinated and effective.

OTHER WELFARE PROVISION

3. Deployed Welfare Support where appropriate (refer to Part 2 Chapter 1 of this JSP).

4. Welfare Information packages, induction courses, leaflets and guides (as per single Service guidelines).

REFERRAL/ACCESS ROUTES TO SPECIALIST WELFARE CARE

5. Personnel and their entitled families are encouraged to seek welfare advice or guidance through the chain of command or the appropriate welfare specialist directly.

6. The chain of command is to seek the advice of their welfare specialists where necessary. Case conferences (and reviews) involving all necessary welfare specialists should be convened where required, within the limits of confidentiality, and a record of discussions/decisions maintained. Individuals concerned should know that case conferences concerning them have occurred and they should be informed of what has been discussed and decided.

7. Timely advice and guidance should be sought from higher authority where required.

8. Confidentiality and the wishes of personnel are to be respected but exceptions are detailed in para 1.1.14 (Command Responsibiltiy).

SUMMARY

9. The nature of military activity and way of life set Armed Forces communities apart from civilian society. The critical link between welfare and operational effectiveness affirms that the support provided for Service personnel and their families is core Armed Forces business.

10. Welfare is a function of command; therefore, the Chain of Command is responsible for the welfare support of those under command and its community. Service personnel must be provided with an opportunity for face-to-face advice and guidance from their CO or representative, whenever the need arises. The provision of information is an essential element of the command function and must reach all individuals according to their particular requirements.

Part 2 - Guidance

Conceptual Framework

1.2.01. MoD provides welfare support as a core business function. As well as exercising its duty of care to Service personnel, it also recognises that welfare supports operational capability. This latter point applies to provision of welfare support to Service personnel and their families and recognises the impact of Service (largely mobility, dislocation from normal forms of support and separation). It is therefore essential that measures are in place, where practicable, wherever personnel are required to serve, to provide the timely and effective assistance necessary to maintain operational effectiveness.

1.2.02. Welfare is a broad concept that has both a direct and indirect bearing on almost every aspect of military activity. It concerns the wellbeing and motivation of personnel from each of the three Services including Reservists, both individually and collectively and in every sense: physical, material, moral and social. It also encompasses the serving person's entitled family and the entitled civilians working in support of the military when overseas (for the benefit of this JSP more commonly known as the Service Community[13]). In some cases, welfare support is provided to non-dependant family members; in particular support that is related to operational deployments or casualties. Welfare is not an end in itself but a key element of the moral component of fighting power and hence operational effectiveness.

1.2.03. The MoD acknowledges the special and changing circumstances of Service life and will ensure that those for whom the MoD has responsibility are not inappropriately disadvantaged; under normal conditions they should be entitled, where practicable, to the same support as any other citizen of the UK (with the development of devolution, support is based on that available in England)[14].

Categories of Welfare

1.2.04. For the purposes of this JSP, welfare is divided into 2 categories:

a. **Personal Support.** Personal support encompasses advice and counselling on a wide variety of individual and family circumstances, such as relationship difficulties, bereavement, post injury, harassment, addictions, financial difficulties, relocation, children's services and military separation.

b. **Community Support.** Community support is that support provided to individuals, groups and families throughout the military community and in some instances, particularly overseas, to the employed civilian. It will include amenities such as community centres and clubs, retail, leisure, educational, recreational and sporting activities, pre-school groups and youth activities.

Levels of Welfare Support

[13] The Service community is defined as UK Service personnel, UK Based Civilian's, Royal Gibraltar Regiment, Gurkhas, Service dependants, Reservists, Veterans and Cadets.
[14] Subject to any immigration controls imposed by the Home Office.

1.2.05. Welfare is provided by a number of organisations. It can be broken out into distinct levels of support.

a. **Statutory.** Statutory support is defined as the provision of support which is provided by the state/local authorities as a result of legislation. Such support would include provision under the NHS and Social Services. In overseas commands the Theatre Commander is, wherever practicable and manageable, responsible for the statutory provision in place of the LA in England.

b. **Primary.** Primary support is defined as the provision of welfare support generally available from within unit resources. Primary level support can be given by Commanding Officers, their Chain of Command and the unit administrative and welfare staff including pastoral and medical personnel.

c. **Secondary/Specialist.** Specialist welfare support is defined as that which cannot or should not be dealt with at the primary or unit level since it requires specialist trained staff. Such support is usually provided through the relevant Service Welfare Agency[15]

d. **Third Sector/Charity**. Third Sector/Charity support is defined as that which is provided by Charitable and voluntary organisations.

Welfare of Those Involved in Bullying and Harrassment Complaints

1.2.06. Being a party to a complaint, and, in particular, one regarding bullying and harassment, given the sensitivities and emotions that this can involve, can place considerable strain on morale and health. Commanders, or other officers, officially aware that someone is a party to a complaint, has a fundamental responsibility to consider their welfare needs and to protect them from the stress and strain of their situation. They must therefore ensure, without prejudice, that Respondents and Complainants are provided with the requisite level of support and guidance and that any welfare, pastoral and/or medical needs are being met. JSP 763 (MOD Complaints Procedures) outlines the options when dealing with bullying and harassment complaints.

Assets Available

1.2.07. Where practicable, Commanding Officers should provide or facilitate access to the following welfare assets for Service personnel and the Service community. Some assets will be provided at public expense, whilst others may be provided through non-public funds (Refer to Chapter 7 – Welfare Funding).

Personnel:

a. Chain of Command
b. Medical Personnel
c. Unit Welfare Officer[16]
d. Chaplaincy (including Civilian Chaplains to the Military (CCMs))
e. Community Development Staff[17]

[15] Royal Navy and Royal Marines Welfare / Army Welfare Service / SSAFA Royal Air Force

[16] Army only

f. Specialist Welfare Workers (RNRMW, AWS, SSAFA RAF)
g. Unit Personnel/Admin Staff
h. Equality and Diversity Advisers (EDAs)[18]
i. HIVE Information Officers
j. Service Community Support Officers[19]

Facilities:

a. Offices and supporting services for unit welfare specialists.
b. HIVE
c. Education and recreation library/internet facilities (both within the JSP guidelines and the terms set out in the CRL contracts if applicable)
d. Community centre
e. Catering, retail and leisure facilities
f. Sports, Recreational and training facilities
g. Place of worship

[17] RAF has separate Community Development Workers and Officers – RN and Army integrate the Community development role within their welfare organisations, ie AWS/RNRMW
[18] For military personnel only (including Reservists).
[19] RAF Stations Only

CHAPTER 2 - DELIVERY OF WELFARE

Introduction

1.2.01. The principles of welfare[20] that underpin the tri-Service welfare policy are applicable across the 3 Services. However, the 3 Services are responsible for delivering the policy in their respective organisations in a way that satisfies the needs of the particular Service. In addition, welfare provision overseas or on operations will differ to that delivered in the UK. This chapter will therefore outline non-deployed welfare provision both in the UK and overseas. Welfare provision when deployed on operations or exercises, overseas or in the UK is addressed in Part 2 of this JSP.

Common Factors

1.2.02. Although it is recognised that, in many respects, the delivery of welfare policy differs between the Services, there are a number of common factors:

a. **Commanding Officer**. Welfare is a function of command and, as such, COs have full responsibility for the welfare of the personnel and the Service community under their command. See Chapter 1.

b. **Officers/Warrant Officers/ NCOs**. All personnel within the chain of command have a key role in identifying, advising and referring personnel regarding welfare concerns and issues.

c. **Chaplaincy**. All Chaplains / Padres are to be actively involved in welfare support, principally in the context of pastoral care. Whilst they cannot offer specific religious care to members of a faith group different from their own or to those with no religion or belief, they are to offer independent advice and support to all personnel, including details of local faith group communities and centres of worship. They are to offer confidentiality according to their own Church discipline, advice and emotional support to all members of the Armed Forces and their dependants regardless of faith. The Armed Forces have appointed religious leaders (Civilian Chaplains to the Military (CCMs)) from the Buddhist, Hindu, Jewish, Muslim and Sikh faiths to act as advisers on matters specific to those faiths.

d. **Medical Staff.** Medical staff are present on all major military establishments and provide primary healthcare to all serving personnel and where applicable their families. They are the professional interface with the Local Authority (in the UK) and community health agencies on all medical matters.

e. **Personal Support**. All military personnel and their families have access to trained specialist personal support staff through the single Service specialist welfare organisations.

f. **Community Development Staff**. Community Development Staff are professionally trained civil servants whose primary role is to act on behalf of the Services to ensure that the Service Community has access to all the support to which

[20] Principles of Welfare are contained in the DCDS (Personnel) Personnel Policy Guidelines Issued 15 Sep 06.

it is entitled at local authority level. Community Development Staff are to adopt best practice, comply with Government legislation and guidelines, and in doing so promote a stronger sense of community and wellbeing.

g. **HIVE**. The HIVE is a publicly funded information service that provides information on local communities, relocation, education, housing, employment / training courses and health. It does so through face to face contact by trained HIVE Information Officers, a HIVE website and via leaflets available within the HIVE office. HIVE should be viewed as an essential element to the welfare strategy of a unit and commanders are strongly advised to ensure that this service is properly and fully utilised in accordance with single Service HIVE Instructions.

h. **SSAFA ForcesLine**. A free service operated by SSAFA which offers a supportive, listening and signposting service for serving personnel, their families and former members of the Armed Forces.

i. **Hospital Welfare Service.** The Hospital Welfare Service (HWS) is currently provided under contract to the Defence Medical Welfare Service (DMWS). The HWS assists commanders with the delivery of Primary Welfare to Service personnel in hospital and their families.

j. **Medical Social Workers.** The Defence Medical Rehabilitation Centre (DMRC) and Headley Court maintains a team of qualified social workers in order to assist injured Service personnel and their families cope with injuries and, where appropriate, prepare for discharge for medical reasons.

k. **Children's Education Advisory Service.** The Children's Education Advisory Service (CEAS) exists to provide information and support to Service families and eligible MOD civilians on all aspects of the education of their children in the UK and overseas.

l. **Joint Service Housing Advice Office.** The Joint Service Housing Advice Office (JSHAO) provides Service personnel and their families with information and advice on the increasingly complex range of civilian housing options. The JSHAO provides a focal point for housing information and advice to all Service personnel and their families in particular those about to return to civilian life, and to ex-Service personnel who are still in Service Families Accommodation.

m. **Veterans Welfare Service (VWS), Veterans UK part of MOD Defence Business Services (DBS)** The MOD's VWS provides help and advice to all veterans, bereaved Service and veteran families and those discharged medically or identified as vulnerable. They are able to direct them to a range of government and charitable services. VWS can also provide assistance to those claiming against the Armed Forces Compensation Scheme (AFCS) whether they are still serving or have left. More information can be found on http://www.veterans-uk.info/ or they can be contacted by calling the Veterans UK Helpline free on 0808 1914 2 18.

n. **Council for Volunteer Welfare Work (CVWW)**. The council and its member organisations are recognised under a MOD Charter[21]. Members of the CVWW are voluntary organisations and facilities can be provided for them on repayment terms. Volunteer workers are not public employees and therefore have no authority to commit public funds. The independence, initiatives and methods of work of the

[21] Army AGAI Volume 3 Chapter 100 (Welfare Organisations)

member organisations[22] are respected in the Charter. While the emphasis and style may vary due to local circumstances and the differing ethos of each organisation, the following characteristics are noteworthy:

(1) **CVWW Centres**. These provide an important 'non-military' environment in which friendships can be formed outside the formal chain of command and from which CVWW Centre Leaders can play a referral role to the appropriate agency if an individual requires support. Centres may provide canteen and newsagent services but are non-commercial organisations.

(2) **Alcohol Free Environment**. CVWW centres meet the desire of many commanders in establishing alcohol free facilities for their personnel. This characteristic is consistent with the aim of providing a social and spiritual welfare service.

(3) **Support to Chaplaincy and Christian Ethos**. Suitably qualified workers within CVWW organisations may be used by Chaplains to take services and character training periods. Other activities in which they may be deployed include: Sunday school work, school assemblies, Bible study groups, Christian foundation courses, hospital visiting, Christian conferences, teaching weekends and local evangelistic events.

o. **Unit Equality and Diversity Advisers (EDAs**) All Service units and establishments are required to have at least 2 EDAs (an increasing number have a network of EDAs and Assistant EDAs), who are available to provide impartial advice on all aspects of Equality & Diversity and, in particular, procedures for making complaints of discrimination harassment or bullying.

1.2.03. Explanation of single Service provisions is at Annex A. Although specialist welfare services are delivered differently across the Services, they all conform to common principles for achieving and maintaining professional standards. A tri-Service Specialist Agreement on Mutual Working and Areas of Responsibility exists to ensure a tri-Service commonality of specialist welfare provision.

Provision in Joint Units

1.2.04. J1 support overall, including welfare support, becomes potentially more difficult to manage in joint environments, where single Service differences can become exposed. The application of single-Service policies in each joint location is not always practicable, manageable in resource terms and may not offer best value for money. Furthermore JWP 1-00 (JOPA) does not fully delineate the division of responsibilities between Full Command (the PPOs) and the Operational Commander (OPCOM), and this impacts across more than just the Operational Theatres (OTs) and Permanent Joint Operating Bases (PJOBs). The policy for welfare provision within the differing joint units is as follows:

a. **Joint Units.** The list under this section is not exhaustive but include units within JFC, Joint Helicopter Command, Joint NBC Unit and will also be applicable to smaller organisations such as Army personnel attached to RM units. In all cases these units follow the policy of their command or established welfare practices of the unit. However, subject to agreement, TLBs may make additional arrangements at their own expense. Nevertheless, single Services should be prepared to offer specialist support

[22] Catholic Women's league, Church Army, Church of England Soldiers', Sailors' and Airmen's Clubs, Methodist Church Forces' Board, Mission to Military garrisons, Royal Sailors' Rests, Salvation Army Red Shield Services, Sandes Soldiers' and Airmen's Centres, Soldiers' and Airmen's Scripture Readers Association.

as required. Commanders of joint units are to ensure that this policy is disseminated to all personnel through induction briefs and unit orders.

b. **Joint TLBs**. Mostly based in the UK, these personnel should receive single Service welfare and community support. Therefore, the chain of command must ensure that they receive the support that they are entitled to.

c. **Operational Theatres**. The non-formed joint units within the OTs will be addressed in Part 2 of this JSP.

d. **PJOBs** (See also - Overseas Provision). The circumstances within the PJOBs (including BIOT) are not necessarily conducive to single Service delivery. The CBFs in BFSAI, Cyprus and Gibraltar are Joint Commanders and are supported by a single Joint Headquarters, whose J1 staff have theatre lead for welfare and community support. The remote PJOBs (BIOT and BFSAI) personnel are predominantly unaccompanied, but a small number of continuity posts in BFSAI are accompanied by families. Joint commanders are to formulate a Welfare strategy that reflects the requirements of this JSP and satisfies the needs of the Service Community as well as providing best value for money; they are to nominate the Welfare lead to deliver the required support strategy. Moreover, joint commanders are to ensure that their welfare strategy is suitably communicated to all personnel in theatre through induction briefs and unit orders.

Supportability Checking Prior to Overseas Assignment

AIMS

1.2.05. The aims of this policy are to ensure that Service personnel (SP) and their dependants[23] are made aware of the support which is available overseas before proceeding on accompanied assignments and to ensure that the MOD only takes on responsibility for Service dependants overseas that it can appropriately support.

SCOPE

1.2.06. This policy applies to all dependants accompanying SP ahead of a new overseas assignment. This includes posting from one overseas location to another.

1.2.07. This policy applies to medical, educational and social welfare needs. Medical checking of dependants will continue to be carried out in accordance with instructions[24] from the Families Section of Movement Support Services (MSS) for medical in confidence reasons, and will remain subject to review by the Surgeon General's department (SG).

BACKGROUND

1.2.08. When dependants accompany SP on overseas assignments, MOD seeks to replicate the support, such as health, education and social care that would normally be provided by the NHS and Local Authorities in the UK where reasonably practicable[25]; however this is not always achievable in all locations. Whilst the MOD is more likely to be able to make such provision in more developed countries and in established overseas locations, it is not always possible to do so in other locations, particularly in less developed

[23] For a definition of dependant, please refer to JSP 752: Tri Service Regulations for Allowances, Chapter One, Section Two, Para. 01.0202.
[24] The medical checking guidance and forms are contained in the MSS 'Family Travel Pack'.
[25] JSP 770: Tri Service Operational and Non Operational Welfare Policy, para. 0003.

countries or in less well established Service populated locations. In addition, where services can only be provided through the host nation, there may be language differences that affect accessibility (e.g. speech therapy). Some dependants have specific support needs, whether they are medical, educational or social, that cannot be properly met at all locations and, regrettably, there have been instances where dependants have had to return to the UK because support for their specific needs was not available locally. In other instances, dependants have struggled with the greater challenges at their new overseas locations and would have benefited from considering these before departure from their previous place of duty. Whilst these instances are few in number, the impact which they have on SP and their dependants can be great. It is important that SP and their dependants take advice and properly consider the implications of accompanied service overseas before they travel.

1.2.09. **Notification of Responsibility.** The Service appointing authorities (SAA) are to inform SP, at the time of the assignment order, or before if at all possible, that MOD cannot support every medical, educational and social welfare need in every location. The SAA are to direct SP to this policy, and particularly the need to complete and return the form at Annex C to this chapter, which outlines the types of dependants' needs that they may need to consider, declare and take advice on.

1.2.10. **Informing Service of Dependants' Needs.** SP are responsible for their dependants and must recognise that, whilst MOD will try to establish the necessary support for families' health, disability, educational and social welfare needs, this may not be possible in every location. SP are to raise, at the earliest possible time, any additional support needs or other matters which may affect the ability of their dependants to accompany them on overseas assignments. Tri-Service Disability and Additional Needs Policy JSP 820 [26] directs that 'Service personnel who have, or have dependants, with disabilities/additional needs are to register the fact with their SAA in accordance with single Service instructions'. Additionally, children with SAEN must be registered with CEAS immediately an overseas assignment is issued, even if provisional, if they are not already registered. In all cases, SP are to complete the form at Annex A, with their dependants, and use it to help them to fully consider their dependants' needs. SP are to return their completed form(/s) to their Chain of Command (CoC). Where no supportability issues are apparent, the CoC should sign the Annex A, to allow the SP to send to the Families Section of Movement Support Services (MSS).

1.2.11. **Evidence Gathering**. Where the SP identifies support requirements or concerns, the CoC is to discuss these with the SP and seek specialist advice. The CoC is to make an assessment, consulting specialist staffs, the gaining overseas unit, SP and their dependants, as to whether the necessary support can be provided in the overseas location to which they have been posted. For children's special educational needs, SP should be directed to contact the Children's Education Advisory Service (CEAS). Welfare needs should be discussed with the single Service welfare officers. This process should be started as early as possible and completed in a timely manner. The CoC is to inform the SAA as soon as it becomes apparent that there is a reasonable risk that a dependant may not be supported and then keep them updated whilst the matter is investigated. Once it has been determined what level of support is available in the overseas location, there should be a further discussion between the CoC and the SP and dependants, to enable their views to be considered regarding the suitability of available support. Having made an assessment of supportability, the CoC is to make a recommendation to the SAA.

1.2.12. **Decision.** The SAA is responsible for making a decision as to whether or not the dependants can be sent on accompanied assignment. The decision must support the Service need whilst striving to support SP and family aspirations. Each case must be judged

[26] JSP 820, Section 3, Para. 0105.

on its individual merits; however, where it is clear that critical support is not available, and cannot practicably be made available, then the family should not be authorised to accompany the SP at public expense. If it is determined that dependants cannot be supported, then the SAA are to make a decision as to whether the assignment is cancelled or the SP undertakes the assignment unaccompanied. The interests of the Service and the safety of dependants remain paramount. Where it is decided that MOD cannot take responsibility for a dependant at the overseas location, this decision is to be recorded in a revised assignment order and the rationale behind the decision should be recorded in the notes section within JPA. If the SP is reassigned elsewhere, every effort should be made to find a comparable alternative, striving to avoid disadvantage to career development where possible[27]. The SAA are to inform the CoC of the decision to allow them to sign off Annex C or support the family as appropriate.

1.2.13. **Making reasonable adjustments**. The MOD has a duty to take reasonable steps to provide the necessary support. Decisions about whether support can be provided are to take the following considerations into account:

a. Reasonable financial costs should not prevent the required support being established, though financial regulations may require a business case to justify these. The collective costs of all necessary adjustments should be considered together.

b. The practicality of providing the support must be considered; for example, it will be more practicable to set up bespoke support where the expected duration is longer, or where the support provision might benefit other families in future.

c. The impact of any disruption necessary to the operational output of the unit/establishment should be considered.

d. Whether the necessary support can be provided by a different organisation, facility of in a different manner.

e. Whether the adjustment would in actual fact overcome the substantial disadvantage they would face in that location.

EDUCATIONAL AND SOCIAL WELFARE CHECKING

1.2.14. The MOD's Children's' Education and Advisory Service (CEAS) offers a registration service for Service parents who have children with special and additional educational needs (SAEN) which allows potential difficulties surrounding assignment to be identified early and to offer parents relevant advice, information or support as required. Children with SAEN must be registered with CEAS immediately when an overseas assignment is issued or provisionally offered, if they are not already registered. For overseas assignments to locations where a Service Children's Education (SCE) School exists, CEAS will consult the school to help determine whether the child can be accepted. Where no SCE school exists, CEAS will also assist the family in determining what school provision may be offered. Further details can be found in JSP 820 Part 2.

MEDICAL CHECKING

1.2.15. Effective medical screening is an essential process with the principal aim of protecting the health of dependants; it is a shared responsibility between SP, their adult dependants and their GPs, and the MOD. It also seeks, so far as is possible, to protect SP from avoidable worry and stress. The MOD has a duty of care that must take account of

[27] JSP 820: Tri-Service Disability and Additional Needs Policy, Section 3, Para. 0105.

available medical and financial resources when considering whether adequate and appropriate medical support is in place.

1.2.16. Medical Checking Process. On receipt of an overseas assignment order, or provisional offer, SP are to contact the Families Section of MSS[28] to obtain a Family Travel Pack. Medical checks are to be carried out in accordance with the guidance in the Family Travel Pack, including completion of the medical form included therein, which involves a check up with the dependant's GP. SP cannot book travel for their dependants until the medical checks have been completed in full.

1.2.17. In reviewing the supportability needs of dependants whilst overseas, Defence Medical Services (DMS) are to use the following principles:

a. In carrying out medical screening, DMS will make every reasonable attempt to support the healthcare needs of dependants. Assessing the suitability of healthcare support can take several weeks and so processes must make every effort to allow adequate time for assessments to be carried out before committing dependants to posting.

b. Each location will have different medical capability and capacity; this means that medical conditions that may be safely managed in one location may not be supportable in another. In particular, some locations will have DMS facilities whilst others will not.

c. Dependants must not be allowed to travel at public expense to locations where it is clear that essential medical care is not available, and cannot practicably be made available.

d. Some locations will have detailed local posting orders designed to protect the health of all personnel including dependants (e.g. immunisation requirements and environmental health threats). This policy does not countermand such orders.

e. Where Service medical authorities are unsure whether appropriate medical support is available at the receiving location, investigation must be undertaken. For locations with DMS facilities, this must include the potential receiving Senior Medical Officer.

f. Medical information must be treated in confidence. Where medical information needs to be shared for the protection of the patient, patient consent must be obtained.

1.2.18. **Booking Travel:** The Families Section of MSS is responsible for booking certain types of travel for families. Travel will not be booked for dependants until MSS have received a signed Annex C. Once all checks are complete, Annex C is to be signed off by the CoC and forwarded by the SP to MSS. MSS is to keep a record of SP declarations.

1.2.19. Contact details for the Families Section of MSS are:

a. Tel: 030 679 81013 / 9679 81013

b. Email: DESLCSMSS-FAMSEC-GROUP@MOD.UK

[28] See paragraph 13 for contact details.

Overseas Provision

1.2.20. Overseas, Service personnel and their families should, where practicable, have access to the same welfare provision as those who serve in England. Commanders are to endeavour to replicate those services usually provided by the English Local Authorities wherever practicable and manageable. As such, the Services have a responsibility to ensure that a family's needs can be met before they accompany a Service person overseas. This is achieved through pre-departure screening and whilst it is the Service person's responsibility to inform the Services of any medical, social or additional need of any member of their family the SAA and losing Chain of Command must be firmly engaged with the screening process, prior to accompanying them overseas

1.2.21. In broad groupings the overseas locations can be summarised as:

a. UKSC which includes broader Europe.

b. OTs – covered in Part 2.

c. JFC PJOBs (BIOT, BFSAI, Cyprus, Gibraltar), EJSO/GSO

d. Army ROW (BATUS, Belize, Brunei, Nepal).

e. Defence Diplomacy including Attachés and Loan Service.

1.2.22. The following welfare capabilities should be provided wherever practicable and manageable whilst in the overseas community:

a. **Community Policing and Safety**. The Service police forces have obligations under agreements such as the Status of Forces Agreement (SOFA) to provide a primary policing service to Service personnel, their dependants, MoD UK-based Civilians and contractors employed under CONDO/CONLOG. These obligations include a number of direct and indirect tasks such as community safety, child protection, crime reduction. Service police policies and plans must consider the MoD Service community living both within MoD Service Families Accommodation estates or the local community. All personnel must feel safe and secure in their daily lives and within the environment that they work, live and socialise.

b. **Legal Services**. The Royal Navy, the Directorate of Army Legal Services and the Directorate of Legal Services (Royal Air Force) operate schemes for the assistance of servicemen abroad and, to a lesser extent, those at home, in legal matters of a non-criminal nature. Help is also given to next of kin who may have a legal cause of action as the result of the death of a serviceman. Advice given by Service lawyers is free of charge. The Services do not, however, provide financial assistance to cover travel to and from legal assistance offices or other expenses and fees, *e.g*. the cost of obtaining marriage certificates or other evidence and the fees of inquiry agents or solicitors' or court costs.

c. **Probation Service to UKSC**. A small probation service in UKSC provides professional advice and support services to those authorities concerned with disciplinary proceedings involving both Service and civilian offenders. In addition, it is responsible for the statutory supervision of civilian offenders made subject to Community Service Orders. It also prepares reports for UK (and

occasionally German) courts on Service and civilian defendants, and for family proceedings in the UK involving children.

d. **Health and Social Services**.

(1) **Healthcare**. The MoD will aspire to provide a community-based healthcare service that delivers a fully resourced service with effective and efficient medical supply, health promotion and health protection programmes aimed at all the Service community. Medical provision is to be easily accessible and responsive to the community's needs; for further details refer to Chapter 4.

(2) **Contracted Community Health and Social Services**. MOD provides a contracted Community Health and Social Work Service to families serving overseas. This service is made up of health visitors, community midwives and social workers all of whom are professionally qualified. Social Workers provide serving personnel and their families with a professional, comprehensive and confidential service relating to children and families, including children in need, children with disabilities and adoption and fostering matters. In Germany the British Forces Social Work Service (BFSWS) is delivered in its entirety by contract.

Education

1.2.23. **Service Children's Education (SCE)**. SCE is an agency of MoD which provides an educational service to meet the needs of dependant Service children from 3 to 18 years old, including the children of MoD UK-based civilians and sponsored organisations, when serving outside the UK. Where there is no SCE provision, the Children's Education Advisory Service (CEAS) provides an advisory service to Service personnel concerning the capabilities of local schools (Refer to Chapter 3 – Children, Young People and Families). Further details can be found in JSP 342 Education of Service Children.

Other Categories

1.2.24. **Welfare Provision to Service Personnel and Their Entitled Families Who Reside Away from Service Units**. Service personnel and their entitled families who reside on or close to their units have ready access to the welfare support infrastructure that COs are required to provide. Although it is impractical to provide the same welfare support to those who chose to reside away from their unit in private accommodation, COs are to ensure that, at the very least, such personnel are presented with a comprehensive welfare information package. The package should include as a minimum contact details of the relevant welfare specialists and advice on what to do in given circumstances.

1.2.25. **Members of the Brigade of Gurkhas and Royal Gibraltar Regiment and Their Entitled Family**. Members of the Brigade of Gurkhas, Royal Gibraltar Regiment and those whose terms and conditions of service (TACOS) differ from UK TACOS have, where practicable and manageable, a level of welfare provision tailored to take into account of their different needs.

1.2.26. **Reserve Forces.** Welfare support for Reserve Forces and their entitled families, when mobilised, should be aligned as closely as possible with that offered to Regular Service personnel to ensure that the specific needs of the Reservist are met. This is to include the support required by Reserve Forces and their entitled families before, during and after mobilisation including: communication, pay and allowances, pensions, medical, return to

work, injury, disability and death. Refer to JSP 753 (Tri-Service Regulations for the Mobilisation of Reservists).

1.2.27. **Personnel Under 18 and Recruits**. The policy regarding the management and welfare of recruits and Service personnel under 18 years of age is contained in DIN 2011DIN01-233: Policy on the Care of Service Personnel Under the Age of 18. Although the DIN provides advice on the care of Service personnel under 18 years of age, much of the advice could be applicable to older personnel who are new to the Services. The DIN provides additional advice to COs regarding the legal requirements associated with Service personnel aged Under 18 and, whilst maturity and experience vary considerably between individuals, it is clear that under 18s may be more vulnerable than those older, and their care may require particular attention.

1.2.28. **Care Leavers**. There will be individuals joining the Armed Forces who are care leavers and therefore subject to the provisions of the Children (Leaving Care) Act 2000. This seeks to ensure that young people aged 16-21 years, or older, if in an agreed training or education programme, who have had a significant period of being looked after by a Local Authority (LA), continue to receive advice, support and befriending for a period of time after they cease to be formally looked after full time by the LA. Under 18s who are care leavers may not have the family support that others enjoy and this may make them more vulnerable. COs are to follow the advice contained in DIN 2011DIN01-233: Policy on the Care of Service Personnel Under the Age of 18.

1.2.29. **Defence Diplomacy and Embassy Staff**. The single Services are responsible for the provision of personnel serving in designated defence diplomacy and embassy posts. It is recognised that the remote nature of these posts may complicate this support and assistance from FCO may sometimes be available.

1.2.30. **Other**. For those personnel who are Loan Service, Exchange personnel, Liaison Officers or International Officer students, welfare provision will be determined by the Memorandum of Understanding for Host Nation Support. This applies both to UK Service personnel working with other nation's forces and to Foreign personnel serving with UK Armed Forces.

1.2.31. **Casualty and Compassionate Cases**. For additional support available in the case of casualty and compassionate cases refer to JSP 751.

Welfare Organisations

1.2.32. There are a number of recognised organisations that provide welfare support to the Armed Forces and its Service community. Some of these organisations are publicly funded but many are funded by other means. The matrix at Annex A to Chapter 6 identifies those that are publicly funded.

1.2.33. In the UK there is a large amount of support, help and assistance out with the Service community. These organisations have a vital role to play in supporting Service / ex-Service personnel and community and commanders should seek assistance when necessary. Moreover, the existence of these services is to be advertised widely to the Service community. A list of these organisations is at Annex B.

Annexes:
A. Single Service Provision
B. Welfare Organisations

C. Self Declaration of Additional Needs.

ANNEX A TO
CHAPTER 2 OF
PART 1 TO JSP 770

SINGLE SERVICE PROVISION

1. All 3 Services have common welfare providers such as chaplains, medical staff and the Chain of Command. Welfare provision, which is single Service specific, is outlined below.

PRIMARY LEVEL SUPPORT

2. **Royal Navy.** The Divisional Officer and Regimental system is available and accessible to offer advice on Service, career, financial and other private matters, whilst being aware of the welfare organisations and funds available to assist ratings.

3. **Army:**

a. **Unit Welfare Officer (UWO).** The UWO is responsible to the CO for the support, assistance and welfare advice given to personnel in the unit and their dependants. Within a TA unit this role falls to the Regimental Operations Support Officer (ROSO).

b. **Regimental Administration Officer (RAO).** The RAO is responsible for all aspects of personnel administration including personal and pay documentation, finance, clerical and staff support, unit education procedures, resettlement and the administrative aspects of the disciplinary process. Responsibility for G1 matters and personnel management rests with the adjutant.

c. **Regimental Career Management Officer (RCMO).** The Regimental Career Management Officers will primarily deal with soldier career management related issues; officer career management will remain the responsibility of the unit adjutant.

d. **Padre.** Pastoral Care

e. **Medical Officer.** Healthcare

4. **Royal Air Force.** Officer Commanding Personnel Management Squadron (OC PMS) and the personnel staff are normally the focal point for specialist personnel advice on stations and can assist line-managers and individual Servicemen and women who cannot resolve problems from within their own resources.

SECONDARY LEVEL SUPPORT- SPECIALIST WELFARE PROVIDERS

5. Each of the three Services has its own specialist welfare provider. These organisations provide the Services with professional help and advice wherever appropriate. Serving personnel and their entitled family can access these organisations wherever they are serving. Although the organisations are Service specific, when serving in joint units, serving personnel and their dependants can access whichever welfare organisation is best suited to meet their particular need:

a. **Naval Personal and Families Service and Royal Marines Welfare.** The purpose of the Naval Personal and Family Service (NPFS) and Royal Marines Welfare (RMW) is to support the Royal Navy and Royal Marines, its personnel and

families in peacetime and war by helping prevent or reduce the effects of personal difficulties especially those which arise as a result of Service life. The NPFS/RMW is made up of qualified and registered social workers plus trained fieldworkers, and youth and community support workers. NPFS/RMW offers a comprehensive social work service to RN personnel and their families; a proactive Community Service, a professional Service to the RN Executive and Divisional System; a link between the service person and their family in times of difficulty; and an Information Service including RNCOM (http://www.royalnavy.mod.uk/Community/Royal-Navy-Community). A diagram of the NPFS is shown at Appendix 1

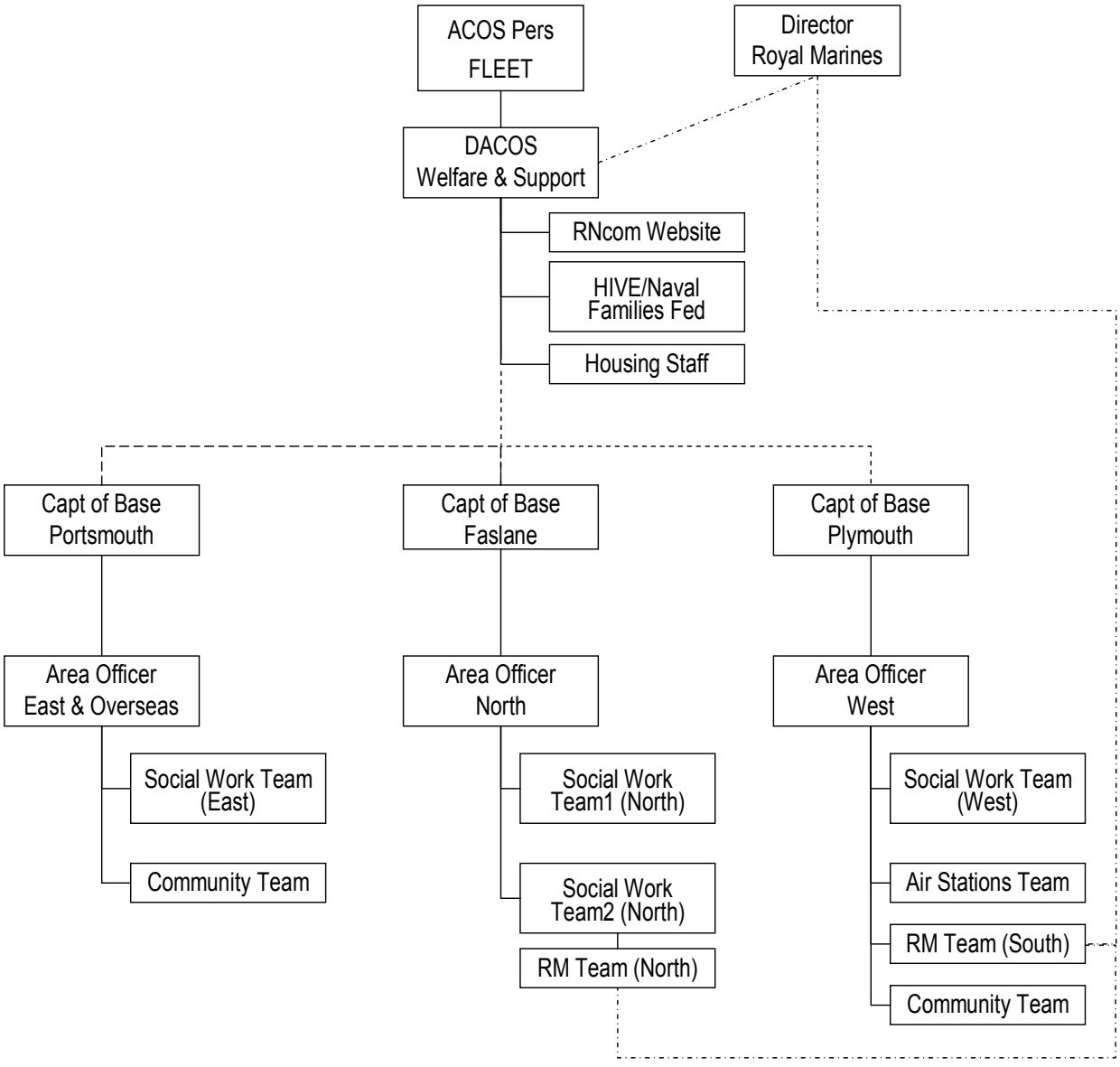
b. **Army Welfare Service (AWS).** The AWS provides the Army's second line welfare specialists. It delivers welfare support from locations based in the major Stations and Garrisons across the UK, BFG, and Brunei. AWS offers professional and confidential support to both serving soldiers and their families, working with, but not for, the chain of command. Its roles include the provision of Personal Support (PS), Community Support (CS), Information Support (through HIVE), civilian housing information support (through the Joint Services Housing Advice Office (JSHAO)) and liaison with Local Authorities and support bodies. PS is delivered by teams consisting of professionally trained military and civilian welfare workers, which includes a significant number of qualified civilian social workers, some of whom carry out the role of Casualty Key Worker. AWS CS is provided by a fully civilianised organisation with professionally qualified trained staff. A diagram of the AWS is shown at Appendix 2.

c. **RAF Personal Support & Social Work Service.** The RAF Personal Support & Social Work Service, currently contracted to SSAFA, provides an additional social work support service to RAF personnel and their families based in the UK. In particular it provides RAF personnel and their families with a professional social work service offering an all embracing service to the RAF community that is outside the normal Chain of Command. With a Head of Service located at HQ Air Command the service's 46 staff includes fully qualified Social Workers and Personal Family Support Workers who are able to deal with a broad range of social support issues within the Service environment in a confidential manner. The service is a vital means of ensuring that RAF personnel and their families are not disadvantaged and, more importantly, that they are properly supported by a professional and confidential service that meets their needs. A diagram of the community support structure is shown at Appendix 3.

Appendices:

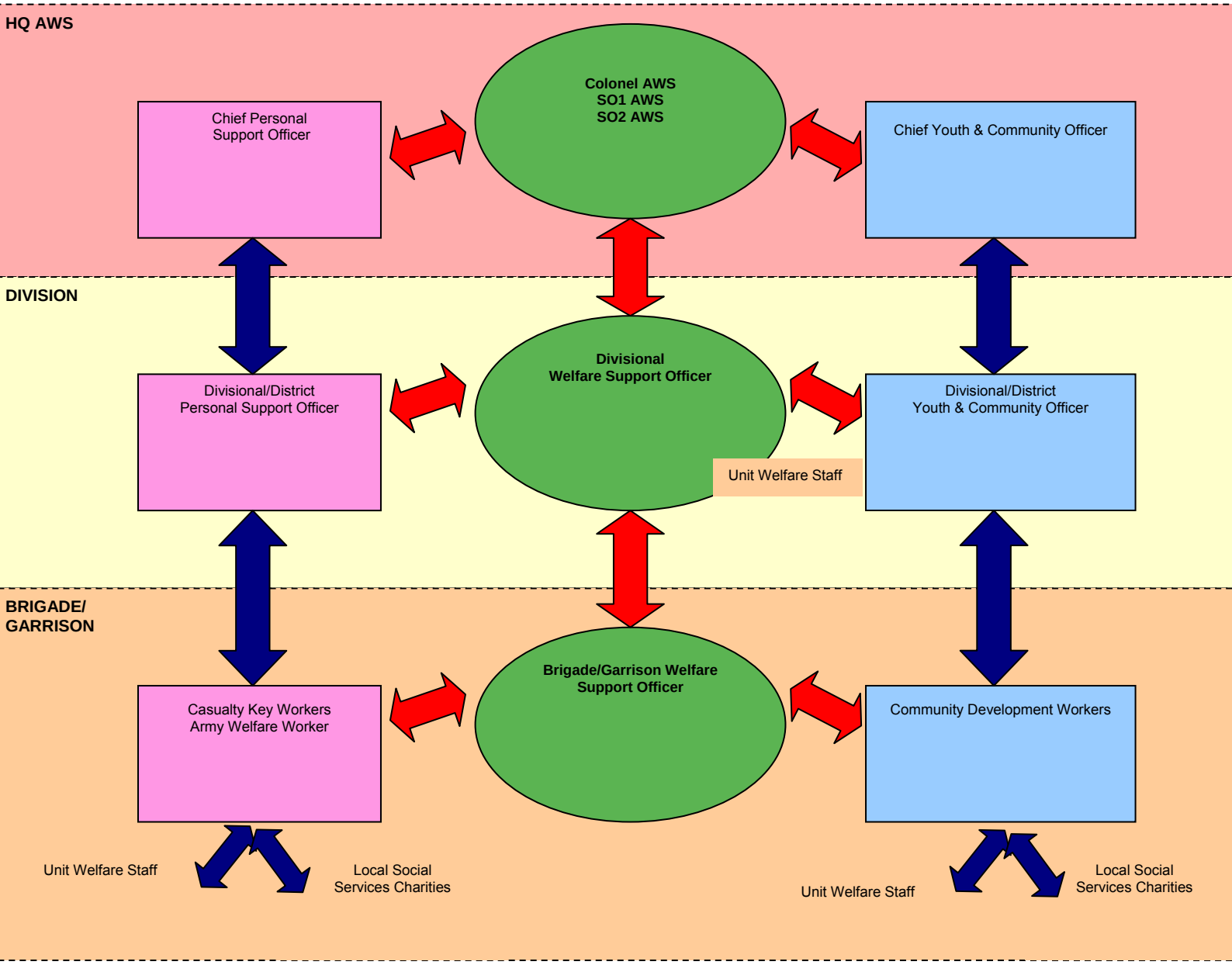
1. Naval Personal and Family Service
2. Army Welfare Service
3. RAF Community Support Structure

NAVAL PERSONAL AND FAMILY SERVICES



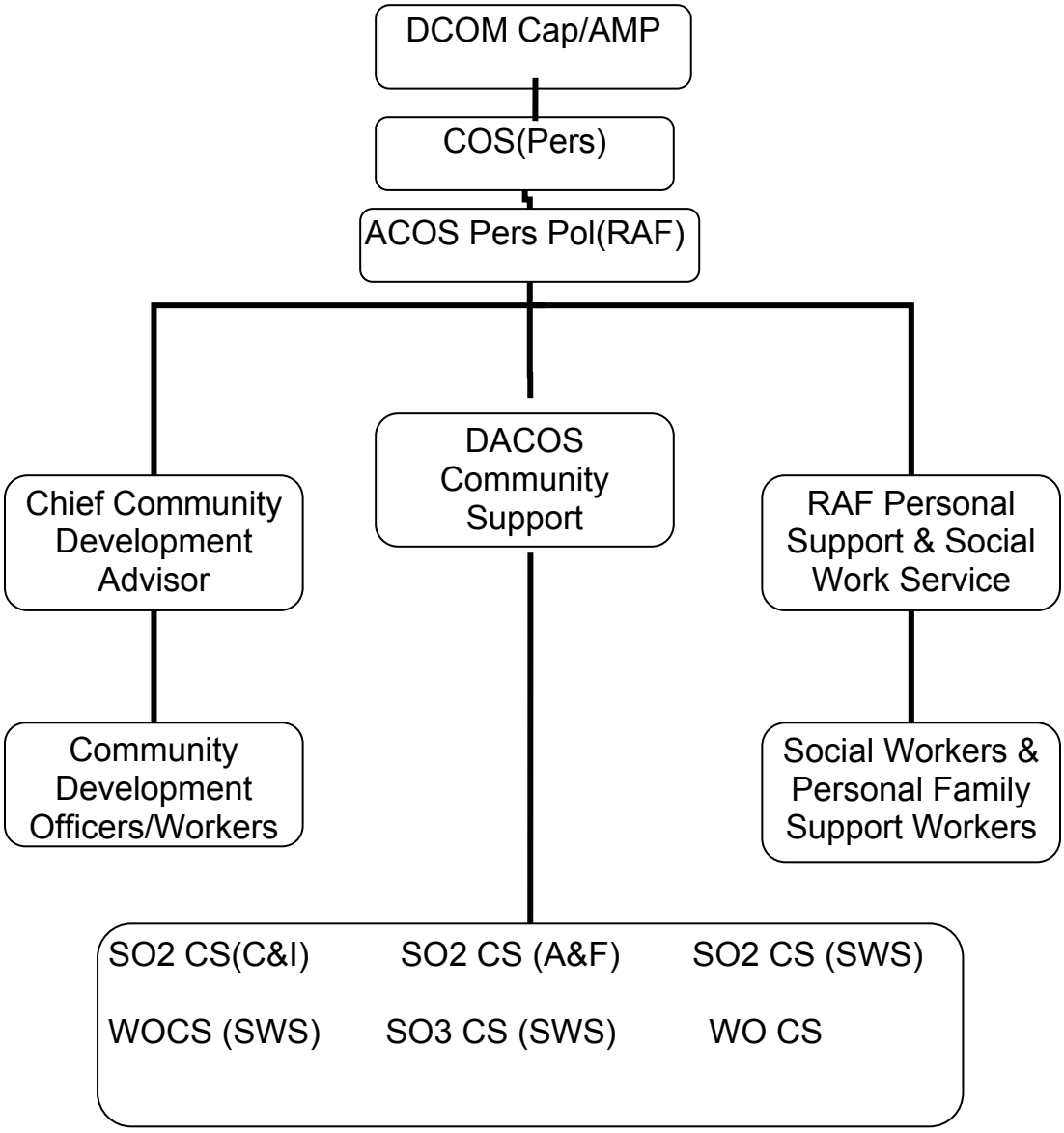
APPENDIX 2 TO
ANNEX A TO
CHAPTER 2 OF
PART 1 – JSP 770

ARMY WELFARE SERVICES



APPENDIX 3 TO
ANNEX A to
CHAPTER 2 OF
PART 1 - JSP 770

RAF SECONDARY WELFARE SUPPORT STRUCTURE



WELFARE ORGANISATIONS

MOD-FUNDED

1. **Services Sound and Vision Corporation (SSVC).** The Welfare support activities of SSVC include British Forces Broadcasting (BFBS) radio and television broadcasting to overseas locations where Service personnel are based. They are also responsible for Gurkha Radio and radio in Northern Ireland. For areas where broadcasting is not possible, a DVD service can be provided. SSVC are also responsible for the organisation of Combined Services Entertainment (CSE) shows. These services are provided through specific contracts. As a registered charity, SSVC also maintain the SSVC Operational Welfare Fund from which grants can be made. Details are available in 2006DIN02-004 The Services Sound and Vision Corporation - Operational Welfare Fund.

2. **Families Federations.** The Naval, Army and RAF Families Federations exist to give the families of the respective Services an independent voice. This is normally by working with the Chain of the Command or central MoD staffs as well as representing families' views directly at ministerial level. The Federations also provide a sign posting service to help families find the information and assistance they may require. The Navy and RAF federations are publicly funded. The Army Families Federation is funded equally through public and non-public sources. www.nff.org.uk / http://www.aff.org.uk / www.raf-families-federation.org.uk

3. **Veterans Welfare Service (VWS), Veterans UK part of MOD Defence Business Services (DBS)** The MOD's VWS is committed to enhancing the quality of life for veterans and beneficiaries of Armed Forces pensions and compensation schemes, and all their dependants. It also focuses upon providing support that will enable the seamless transition from Service to civilian life, assist bereaved families or respond to key life events that present welfare needs. It achieves this by adopting a **Single Central Coordinating** role that facilitates access to all appropriate services. The VWS provides a national caseworker approach that offers professional help and guidance through either telephone contact or a dedicated visiting service. Under Veterans UK the VWS works in collaborative partnerships with the Single Services, charities, statutory and non-statutory bodies, local community service providers and Veterans Advisory and Pensions Committees (VA&PC) to deliver a quality welfare service that promotes independence, maintains dignity and provides **Support Through Life**.

The VWS can be contacted via the website on www.veterans-uk.info, or by calling the Veterans UK Helpline free on 0808 1914 2 18

4. **Regimental/Corps Associations.** Each Regiment/Corps within the British Army has a small Headquarters (HQ) within the UK. These HQs provide the focus for personnel within their specific Regiment or Corps for aftercare when individuals leave the Army. Each HQ is notified by DBS of all personnel being medically discharged and they then write to each individual to make contact, ideally just prior to the medical discharge. Once contact is established they will look to offer welfare support, or signpost to other organisations better placed to provide that support, depending on the specific requirements and circumstances of each individual. Other individuals leaving the Army on compulsory or voluntary discharge are encouraged to make contact with their Regimental/Corps HQ and once contact is established the HQs will serve as a 'gateway' to aftercare support from a large number of ex-Service welfare organisations after first considering the Statutory support delivered by MOD's Veterans Welfare Service (VWS).

ORGANISATIONS NOT FUNDED BY MOD BUT HAVE ASSOCIATION

5. **NAAFI**. NAAFI can provide catering, retail and leisure services to the British Armed Forces and their families in some areas. It is NAAFI's aim to provide quality products, priced competitively, available consistently in attractive environments and served by trained, friendly efficient staff. NAAFI services are provided under contract.

NON MOD FUNDED ORGANISATIONS

6. A range of charities, some exclusively focussed on supporting the Service community, exist to support a wide variety of needs. Notable examples include SSAFA Citizen's Advice Bureau and Relate but Service personnel can identify the most appropriate organisation, by need and location, via the 'Start Here' application offered through HIVEs. More details of Service and ex-Service charities can be found at Chapter 7.

7. The MOD has signed an MOU with the Children's Commissioner to ensure that Service children living overseas as a result of a Service assignment may still access the support offered by the office of the Commissioner.

ANNEX C to
CHAPTER 2 OF
PART 1 - JSP 770

SELF-DECLARATION OF ADDITIONAL NEEDS

PART A – IMPORTANT INFORMATION

When your dependants accompany you on overseas assignments, the MOD seeks to replicate the range and quality of support that would normally be provided by the NHS and Local Authority in the UK where reasonably practicable[29]. This support includes services such as healthcare, education and social care. Whilst such provision may be more likely in the more established overseas locations, it is not always possible in other locations and cannot be guaranteed. This form is designed to capture education and social welfare needs. It is important that you complete this form with your family and return it to your Chain of Command, so that they can determine what support exists overseas for your dependants' needs. You should also contact the Global Removals and Family Services, who will instruct you on how to complete the medical screening process. More information on medical screening can be found at the bottom of this form.

PART B - DETAILS OF SERVICE PERSON MAKING DECLARATION *(PLEASE COMPLETE IN BLOCK CAPITALS)*

Full Name			**Rank**	
Date of Birth	/ /	**Country of Assignment**		
Contact Details	**House No. / Name**			
	Street / Road Name			
	Town / City			
	Postcode			
	Contact No.			

PART C - DETAILS OF DEPENDANTS

Please provide details of each dependant who intends to accompany you on your upcoming assignment. If you require additional space please use a second form.

[29] JSP 770: Tri Service Operational and Non Operational Welfare Policy, para. 0003.

Full Name		**Date of Birth**	/ /	**Relationship to MOD Employee**	
Full Name		**Date of Birth**	/ /	**Relationship to MOD Employee**	
Full Name		**Date of Birth**	/ /	**Relationship to MOD Employee**	
Full Name		**Date of Birth**	/ /	**Relationship to MOD Employee**	
Full Name		**Date of Birth**	/ /	**Relationship to MOD Employee**	
Full Name		**Date of Birth**	/ /	**Relationship to MOD Employee**	
Full Name		**Date of Birth**	/ /	**Relationship to MOD Employee**	
Full Name		**Date of Birth**	/ /	**Relationship to MOD Employee**	

Contact Details	**House No. / Name**	
	Street / Road Name	
	Town / City	
	Postcode	
	Contact No.	

PART D – PARTICULARS OF IMMEDIATE SUPERIOR IN CURRENT CHAIN OF COMMAND

Name _____

Position _____

Contact Telephone Number _____

PART E – SPECIAL EDUCATIONAL NEEDS (SEN) QUESTIONNAIRE

Please answer the questions below as "YES" or "NO" by ticking as appropriate. If you answer yes to any of the below questions, or if you have an concerns, please contact the Children's Education Advisory Service (CEAS). CEAS provides an advisory service to Service personnel concerning the capabilities of the local schools. If you have children with special or additional educational needs you should register them with CEAS immediately. In the case of Service Children's Education (SCE) schools there is a procedure in place for registration to CEAS; however for other overseas locations the MOD encourages all parents to register their children.

Has your child received additional support in school from outside professionals or has your child been statemented[30], is in the process of being statemented or is on a specialist internal register such as School Action or Action plus for any of the following?

YES NO

[30] To be changed in Summer 2014 with Children and Families Bill.

- Emotional or behavioural difficulties (such as making friends or behaving inappropriately at school) ___ ___

- Learning difficulties (such as acquiring basic skills at school) ___ ___
- Specific learning difficulties (such as dyslexia, reading, writing, number work or understanding information) ___ ___

- Sensory or physical needs (such as a hearing or visual impairment) ___ ___
- Communication needs or impairments (such as struggling to express themselves or understanding others' points of view) ___ ___

- Concentrating (Such as Attention Deficit Hyperactivity Disorder (ADHD)) ___ ___
- Any other medical/psychological condition that may require any form of extra support during schooling ___ ___

Please use the space below to provide details to the questions that you answered "Yes", and note which of your dependants the special educational needs relate to.

_____

_____

_____

_____

_____

PART F – SUPPORT FOR ACTIVITES OF DAILY LIVING

Have you had any required adjustments made to your home, such as:

	YES	**NO**
• Accessibility Ramps	___	___
• Stair Rails	___	___
• Stair Lifts	___	___
• Accessible Bathrooms	___	___
• Other	___	___

Please use the space provided below to provide details to the questions that you answered "Yes".

_____

_____

_____

_____

_____

Please provide any other relevant information regarding specific family needs, and use this space to tell us about any family welfare concerns you have:

_____

_____

_____

_____

PART G – ADDITIONAL NEEDS DECLARATION OF SERVICE PERSON

By signing this declaration:

- *I confirm that the information given above is accurate to the best of my knowledge and that no relevant information has been knowingly withheld. This includes any information relating to potential issues that may be shown to need educational or social welfare support in the future such as a suspected learning difficulty even if it is not yet proven;*

- I confirm that I understand the purpose of the attached/above form (delete as appropriate) and the reasons for the collection of my personal data, including sensitive personal data, and that I agree to my personal data being used to ascertain whether my needs can be supported overseas;

- *I consent to my/my child's details being scrutinised by Relocation Services and/or by an appointed Officer for the purpose of determining my/my child's fitness to travel and reside overseas. I understand that all information will be treated confidentially.*

SIGNATURE OF SERVICE PERSON_____DATE _____

Please return this form by:

Scanning and e-mailing to: [Relevant single Service contact details]

Fax to: [Relevant single Service contact details]

Post* to: [Relevant single Service contact details]

*Please only send by post if email and fax is not available. Please take a copy of the completed form in case of loss. Please send by Special post if you are due to travel within 4 weeks.

PART H – CHAIN OF COMMAND DECLARATION

I am satisfied that the above named has undertaken the necessary checks and that the information provided is accurate.

NAME (BLOCK CAPITALS) _____

SIGNATURE _____ DATE _____

POSITION_____

UNIT STAMP

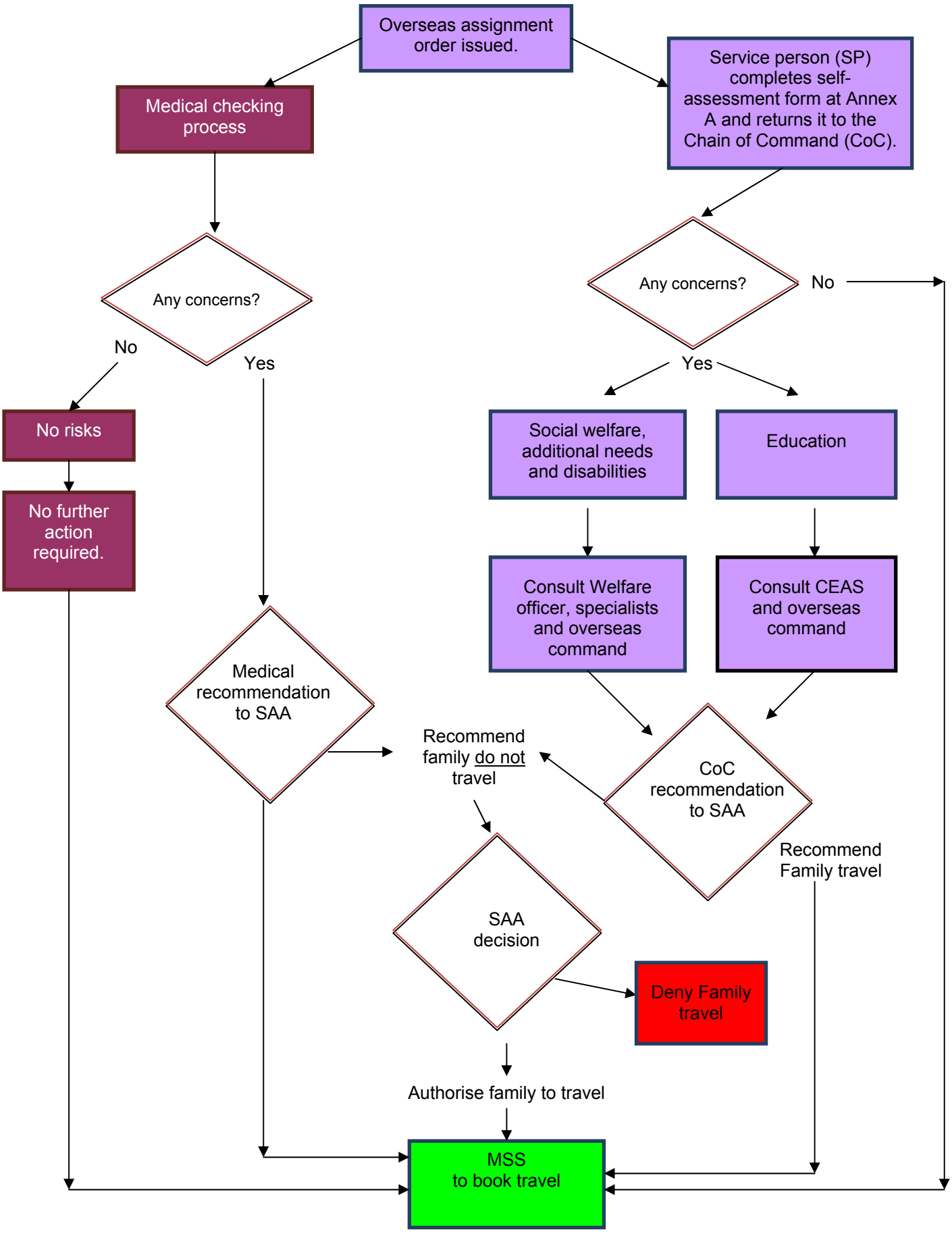
Once your Chain of Command signs to say that checks have been carried out and your dependants have been cleared to accompany you, please return this page to MSS.

ADDITIONAL INFORMATION ON MEDICAL SCREENING AND BOOKING TRAVEL

Immediately upon receipt of this form you are to apply for the Movement Support Services (MSS) Family Pack by completing an F/MOV/564e, Application for Family Travel. The form can be obtained via the Global Removals and Family Services web page.

The Family Pack contains the forms necessary to arrange families' travel to the overseas destination, and includes essential information about family visa and status stamp requirements. PLEASE NOTE: In order for MSS to try to guarantee that your family can depart on your first choice date when booking travel, they must have all necessary information, including this form, not less than 8 weeks prior to departure date.

MEDICAL, EDUCATIONAL AND SOCIAL WELFARE PRE-SCREENING OF SERVICE DEPENDANTS PRIOR TO OVERSEAS POSTING



CHAPTER 3 - CHILDREN, YOUNG PEOPLE AND FAMILIES

General Principles

1.3.01 Providing suitable care for people is as fundamental a principle in the case of children, young people and families as it is for Service personnel and applies as much in the MOD context as it does for appropriate authorities in the UK. There is a clear difference in roles and responsibilities for care of children, young people and families between the UK and overseas:

a. **UK.** MOD and Service support for the wider Service community is in addition to the routine delivery of services by the appropriate authorities. Local Authorities (in England) and devolved administrations (in Scotland, Wales and Northern Ireland) have the lead and the statutory responsibility for defined services. The MOD works with these bodies to ensure that the needs of the Service community are recognised. In certain cases the MOD can – and does – supplement this where appropriate.

b. **Overseas.** Local circumstances will be shaped by the nature of Status of Forces Agreements (SOFA), MOUs, bilateral agreements and any other arrangements made between the MOD and the Host Nation. As a general principle, however, the MOD will seek to replicate overseas the level and range of supporting services that would reasonably be expected to be available in England, wherever it is appropriate and practicable to do so. The MOD will take the lead and, though very little UK legislation is extra-territorial, will seek to deliver services to the same statutory levels and in as consistent a way as possible.

1.3.02 The definition of children, young people and families in a national context is driven by specific legislation and can vary depending on the circumstances; for example, the age of a child for access to services may depend on educational or employment status, on disabilities and additional needs and on the country of the UK in which they live. This, inevitably, has to be reflected in different MOD policies and therefore appropriate definitions are included in relevant JSPs and other policy documents. As a general rule, however, the following definitions apply:

a. A Service child is a child for whom a serving Service person has parental responsibility and who will them self, therefore, be PStatCat 1 or 2; this is normally described as “dependent child”. It does not include PStatCat 3 or 4 where, though there may be some financial responsibility, the Service parent does not have parental responsibility and the child does not live with the Service person or in the Service community.

b. A Service Entitled family is a serving Service person and their spouse or civil partner and any dependent children.

The Children Act 2004 (CA04)

1.3.03 The introduction of CA04 in England led to a significant change in the way in which services for children, young people and families are delivered. The

overall aim is to encourage integrated planning, commissioning and delivery of services as well as improving multi-disciplinary working, removing duplication, increasing accountability and improving the coordination of individual and joint inspections in Local Authorities. In general Children's Trusts have been formed and Directors of Children's Services appointed to bring together all services, particularly the 3 core services of education, health and social work. Children's Commissioners have been appointed in each country of the UK, who will act on behalf of all children in each country in reviewing services and requirements and providing advice and guidance or taking up cases where necessary.

1.3.04 Parallel structures and processes exist in the MoD in order to remain consistent with England, exploit best practice and reduce any discontinuity for Service families as they move between UK and overseas. In 2010 the Directorate of Children and Young People (DCYP) was formed to provide the professional lead for all matters relating to Service children and young people; more information on the role of DCYP can be found at www.gov.uk. A MOD Children and Young People Trust Board (MOD CYPTB) is in place with AG as Lead Member and an independent chair ensuring governance in place. The MOD CYPTB and supporting Steering Group provides overall guidance to Services, Commands and specialist agencies and organisations involved in delivering support or services to the Service community. DCYP have published the Children and Young People Strategy & Improvement Plan 2012-2013 which specifies those actions that need to be taken in order to secure the best possible outcomes for Service children and young people. Overseas Commands are responsible for maintaining Children and Young People's Plans (CYPP) in order to identify gaps in provision and new ways of delivering services in a more coordinated way.

Safeguarding Children (Including Child Protection)

1.3.05 The protection of children in the UK is secured through the statutory requirements placed on all children's services providers, whether provided through local or national Government. These requirements are similar, but not the same, in the different countries of the UK. The main body for exercising child protection in England is the Local Safeguarding Children Board (LSCB) and similar Boards operate in overseas commands. LSCB in England are expected to include Service representatives wherever there is a significant Service population in the Local Authority area. There are similar arrangements in the devolved administrations.

1.3.06 All staff that work with children and young people (and vulnerable adults) must have appropriate clearance to do so and suitable checks need to be completed by employers. MOD employees – both Service personnel and civilian staff – must receive clearances in accordance with the processes used in England, wherever they are serving. Further details are contained in the following publications:

a. JSP 834 - Safeguarding Children and Young People.

b. Working Together to Safeguard Children – www.education.gov.uk

c. JSP 893 – Policy on Safeguarding Vulnerable Groups

Disabilities and Additional Needs

1.3.07 Arrangements exist within the MOD to support and assist Service personnel and their entitled family who have disabilities and additional needs. There is an overarching Tri-Service policy and detailed single Service policies that give guidance on the range and type of assistance available and define the role of the single Services. In order for the MOD to meet its duty of care to Service personnel and their entitled family, Service personnel are to register the disability or additional need with their Service Assigning Authority.

1.3.08 The Forces Additional Needs and Disability Forum (FANDF) is a non-publicly funded body which is administered and supported through SSAFA. The aim of the FANDF is to keep Service families who have dependants with disabilities or additional needs in touch with issues that affect them, both within and outside Service life, and to provide advice, guidance and where possible additional support.

1.3.09 The MOD maintains a register of Service children with Special and Additional needs so that additional support and help can be made available when they move. This service is provided by the Directorate of Children and Young People's Children's Education Advisory Service (DCYP(CEAS)).

Further direction and information can be found in:

a. JSP 820 Tri-Service Disabilities and Additional Needs Policy

b. 2014DIN01-093 Forces Additional Needs and Disabilities Forum

Child Support

1.3.10 The MoD has a policy of encouraging parents to fulfil their responsibilities for their children at all times, including financially. These responsibilities are made quite clear to all Service personnel who are parents. Service personnel who fail to make proper provision for their children, the Child Maintenance and Enforcement Commission (CMEC) has the statutory responsibility for making child support assessments. Although Deductions from Earnings Orders (used in the case of most employees) do not apply to Service personnel because of pre-existing legislation for deductions from their pay, an MOU with the CMEC[31] supports the use of Deduction from Earnings Requests for the same purpose. Within the constraints of Minimum Drawing Rates (the minimum amount a Service person can receive after deductions), these arrangements put Service personnel in the same position as any other parent in employment. Interaction between the single Services and CMEC is facilitated by a network of Forces Focal Points. Further information on this can be found in 2006DIN02-246 The Child Support Agency.

Childcare

1.3.11 Ensuring that children are properly cared for remains a parental responsibility regardless of the use of collective or individual childcare or any other arrangements made by parents. It is recognised, however, that Service families – like all other families – need access to appropriate childcare and that, where appropriate, this childcare needs to be properly regulated. The MOD aim is to facilitate this either (in UK) in cooperation with the Local Authorities that have the

[31] This MOU also covers arrangements made under CMEC's predecessor the Child Support Agency that CMEC now administer.

lead or (overseas) as part of the overall welfare support provided to the Service community by Commands and MoD agencies. Funding of child care facilities is covered in Annex A to Chapter 7.

1.3.12 There are explicit standards for collective childcare for children up to the age of 18 years (or 23 years for those with disabilities) in England and these requirements are replicated overseas. The requirements are laid down in JSP819 - Delivering Early Years Foundation Services (EYFS) in Overseas Settings. There are 2 regulatory bodies for the registration of such childcare overseas: the British Forces Early Years Service (BFEYS – mostly operating in NW Europe) and SSAFA (mostly operating elsewhere overseas). Registration ensures mandatory requirements are met but also allows access to tax credits (Child Tax Credits and the childcare element of Working Tax Credits) where family income permits and to the Armed Forces Childcare Voucher Scheme.

1.3.13 **Childcare Vouchers.** The MOD operates the Armed Forces Childcare Voucher Scheme (AFCVS) which is regulated by HM Revenue and Customs and offers tax savings in order to make childcare more affordable. The scheme is operated by a contractor (currently Sodexo) and further details can be found at www.modchildcare.co.uk.

Adoption and Fostering

1.3.14 There are many Service personnel who are both willing and well suited to the adoption and fostering of children and at the same time there is a great demand for places for children. Given the length of time the process can take and the circumstances of Service adopters/fosterers, with high mobility and service overseas, Service families can experience difficulties in dealing with Local Authorities, devolved administrations or other UK agencies.

1.3.15 Whilst Service families are entitled to use any adoption service, such as an appropriate Local Authority, the additional complexities and mobility caused by Service life can cause complications. SSAFA offers a service that recognises the implications of Service life to help Service families wishing to adopt. The SSAFA Adoption Agency can act directly for Service families or can provide assistance in dealings with other adoption agencies. Once adopted, a child becomes a dependant in exactly the same way as any other dependant child of a Service person.

1.3.16 Fostering is in general a shorter term arrangement where a child taken into care is placed with a foster family on a temporary basis. The legal status is quite different and foster children are not dependant children. However, the MOD does not intend to stand in the way of such voluntary activity and will, where possible, support Service families in living their lives the way they want to. In particular, overseas commands have a need to identify and have available potential foster families in case they need to remove a child temporarily into care. This involves assessment and approval by command social work services and, where necessary, allocation of appropriate SFA.

Further guidance on these matters can be found in:

a. 2008DIN01-189 Adoption and Fostering
b. JSP 464 TSARS
c. www.ssafa.org.uk

Other Children's Services

1.3.17 Although not generally seen as welfare services, there are a number of other areas of support and service provision that directly affect the wellbeing of children, young people and families in the Service community. The most significant are education and health services, which will in any case become increasingly integrated under CA04. Whilst there is comprehensive policy direction on these services in other documents, they are summarised below:

a. **Education**. In UK, Local Authorities and devolved administrations have the lead responsibility for all education matters. Service Children's Education (SCE) provides a system of schools and educational support for entitled children overseas. SCE Schools are based in Brunei, Cyprus, Falkland Islands, Italy and Germany and they follow the English educational system and National Curriculum. Children's Education Advisory Service (CEAS), who are part of DCYP, are responsible for the provision of help and advice to Service families about to be assigned overseas or returning to the UK, including direct support for admissions and appeals for UK schools and, in particular, Special Educational Needs. Further guidance can be found at:

(1) JSP 342 Education of Service Children

(2) www.gov.uk/childrens-education-advisory-service

b. **Health**. In the UK, healthcare support for dependants is through the NHS, which has the lead responsibility and Service facilities are only used in a small number of cases where there is training value for the Service healthcare staff and where the spare capacity exists. Primary healthcare for Service families overseas is delivered through Service facilities or in combination with Host Nation facilities and local contracts where appropriate. Overseas commands and Service medical and dental staffs are responsible for providing a comprehensive Health Care service broadly equivalent to that provided in the UK by the NHS. In smaller or more isolated locations local arrangements will be made, typically through appropriate Host Nation or international facilities. Referral for treatment can also be back to the UK for NHS services where this is the most appropriate option.

Community Development, Youth and Play Work

1.3.18 The delivery of welfare policy[32] differs between the Services but there are common factors including Community Development Staff. Community Development Staff are professionally trained civil servants whose primary role is to act on behalf of the Services to ensure that the Service Community has access to all the support to which it is entitled at local authority level. Community Development Staff adopt best practice; comply with Government legislation and guidelines, and in doing so promote a stronger sense of community and wellbeing. Community Development Work describes a way of working with and supporting communities, to increase the skills, confidence, networks and resources they need to actively engage and grasp opportunities. This section provides MOD policy applicable to all officially recognised community development work, youth and play activities. These activities

[32] See JSP 770 Chapter 2

could take place at MOD Community and Family Facilities, Youth Centres, Youth Clubs, Projects, Play Centres, and Activity Centres, and within other official MOD locations such as Community Centres and gymnasiums[33].

1.3.19 The transient nature of Service life can often prevent an active community spirit from developing; the military ethos supports the establishment of strong communities and the use of its assets to help improve the quality of community life as is recognised by the Armed Forces Covenant: Today and Tomorrow[34]. The Community Covenant Scheme seeks to encourage local communities to seek out ways of partnering and sharing facilities and events with their local Armed Forces communities in order to achieve greater benefits than those possible from the sum of each community's individual efforts and one such area could be in community development.[35]

1.3.20 This section should be read in conjunction with those JSPs listed at Annex A, which provide guidance on the authority to undertake taskings in support of community development work, while this section deals more with entitlement. It is important to note that while welfare is core Armed Forces business that any undertaking in support of it should be properly and appropriately justified and that funding should be appropriately accounted for in accordance with the relevant JSPs (as listed at Annex A).

Requirement.

1.3.21 The introduction of the Children Act 2004 (CA04) in England led to a fundamental change in the way in which services for children, young people and families should be delivered with the overall aim being to encourage a more joined up planning, commissioning and delivery of services. The MOD, therefore, recognises the need to support the whole Service community, provide such services for the dependants of British Service personnel and entitled civilians serving outside GB[36] and for the dependants of British Service personnel serving in GB[37] . It is important to work in partnership with local authorities and charities, or where in-house provision is deemed to be the most effective way to deliver the desired outcomes. Youth work and Play work should provide children and young people with a varied curriculum of personal and social development opportunities, the primary objectives of which are educational, and designed to assist children and young people in developing into responsible members of society.

1.3.22 Effective Community Development contributes to making the Service community more resilient, mitigates the impact of mobility and deployment and provides parents and carers with respite during periods of operational deployment or extended lone parenting.

Policy Lead.

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[33] See JSP 315 Scale 25 for Service and Families Welfare facilities.

[34] Armed Forces Covenant: Today and Tomorrow announced by Secretary of State for Defence, Apr 2013.

[35] For more details on Community Covenant Scheme see: http://defenceintranet.diiweb.r.mil.uk/DefenceIntranet/News/BriefingNotes/MOD/5211LaunchOfTheArmedForcesCommunityCovenantScheme.htm

[36] JSP 770 Chapter 2 Para 1.2.05

[37] JSP 770 Chapter 3 Para 1.3.01

1.3.23 Responsibility for developing and coordinating welfare policies lies within the Chief of Defence Personnel area with policy implementation undertaken by the relevant Service policy branches. For MOD policy relating to Service children and young people AG acts as the lead Principal Personnel Officer, in consultation with the other Services, and exercises this duty through the MOD Director Children and Young People. The Chief Community Development Officer AWS is the MOD lead on 'Positive Contribution' within the MOD Children and Young People's Trust
Board, (MOD CYPTB) and responsible for Priority 5 of the MOD Children & Young People's Strategy & Improvement Plan.

Community Development

General

1.3.24 The nature of military activity and way of life for Serving personnel set Armed Forces communities apart from civilian society. Community Development Work within the MOD addresses the unique military environment and is based on the need to support the whole service community, providing, or ensuring access to, resources where civil society does not meet the need. The development of a strong sense of community and feeling of wellbeing amongst all personnel and their families supports the critical link between welfare and operational effectiveness. It confirms the strong sense of community and a feeling of well being translates into military readiness, operational effectiveness and retention.

1.3.25 Community Development, Youth and Play providers (Naval Personnel and Family Services (NPFS)/RMW, AWS, RAF CS (Community Support)) are committed to collaboration in integrated working practices, both within the Service and the wider community, in order to deliver improved provision for families of Service personnel. Community provision must be accessible to the entire military community and be available to all including single personnel, extended Service families and personnel/families in private accommodation as well as Service Family Accommodation (SFA) occupants.

Objectives

1.3.26 The objectives of Community Development Work are as follows:-

a. To support and enable members of the military community to positively adapt and respond to the pressures created by aspects of the military lifestyle.

b. To promote and develop a community which empowers individuals and groups to influence issues that affect them and their community.

c. To encourage principles of inclusion, equality of opportunity and anti-discrimination, acknowledging the diverse make up of the Service community.

d. To provide comprehensive information, education and support which enables people to take part in decision making.

e. To work in partnership with external organisations such as health and educational professionals to ensure that a comprehensive package of community support is achieved and resources are used effectively.

f. To enable and facilitate community based events, which provide opportunities to obtain local support, access information and networking to assist with problem solving and building resilience.

g. To build community capacity by effective collaborative working with user groups, enabling and empowering them to participate in order to promote change and development.

h. To support and educate deploying/deployed units by maximising their skills to take action and maintain quality links with Service families.

Methodology

1.3.27 The Services seek to achieve Community Development objectives through the following:

a. **Targeted and Closed** provision is developed where the specific needs of the Service community have been identified and participation is restricted to the target group.

b. **Targeted and Open** provision is developed where needs have been identified and is then openly advertised within the Service Community. This can be sub divided into two elements, one of which is "*Community Defined by Interest"* which would encompass everyone who is included in the wider Service community. The other is a *"Community Defined by Need*", comprising of groups of people who have specific needs caused or exacerbated by being part of the Service community.

c. **Universal** services are openly advertised within local communities, which are predominantly comprised of Service personnel and families but inevitably include some civilians within the catchment area[38]. This acknowledges the value of Service families integrating into the wider community. Universal services promote community engagement with the aim of encouraging mutual support and help to achieve integration, creating community networks and mitigating the effects of routine deployments.

Community Development Work

1.3.28 Community Development Work will include the following key areas:

a. Parents and Families of deployed personnel.
b. Families in SFA or equivalent.
c. Isolated Service Communities.
d. Isolated Service Families.
e. Children and Young people of Service families.
f. Single Service Personnel.

[38] JSP 368 – The MOD Guide to Repayment, Chapter 2 Annex 2.3 sets out the policy to be followed

g. Local Service Communities.

1.3.29 Community Development Work is planned using project development processes, including Community Needs Analysis, undertaken by professional staff, in consultation with the community, chain of command and other welfare providers. Provision will be reviewed on a regular basis in order to ascertain effectiveness and fitness for purpose.

Administration of Community Facilities

1.3.30 The administration of community facilities is a responsibility of the Commanding Officer. This responsibility is exercised through the Chain of Command, utilizing specialist advisors and welfare workers, and by providing community support assets. A list of the minimum standard of welfare and community support assets that Commanding Officers are to provide is contained in Annex C to Chapter 1 of this JSP.

Youth and Play work Provision

General

1.3.31 Youth and Play work is delivered through, for example, Youth Centres, YouthClubs, Play Centres, Activity Centres, Community Centres, Detached, Outreach, and Rural projects in each of the Commands. Provision is frequently made through partnering arrangements with Local Authorities, charities and commercial organisations. Youth and Play work offers a wide and varied curriculum which encourages personal development, interpersonal skills, problem solving/decision making, community action/involvement, health education, education for leisure, political education and equality of opportunity.

Objectives

1.3.32 Broadly the objectives of Youth and Play work are as follows:

a. To make significant contributions to the outcomes detailed in “Help children to achieve more“ and in policy documents of the devolved administrations.

b. To promote, secure and develop the provision of learning opportunities for children and young people.

c. To promote and organise social education opportunities for children and young people in order to assist with the development of mature and responsible behaviour.

d. To liaise with other agencies concerned with the welfare of children and young people.

e. To provide comprehensive information, education and support service for voluntary organisations and for children and young people.

f. To provide appropriate, safe meeting places where children and young people can meet peers and caring, responsible adults to discuss issues of concern.

g. To enable children and young people to manage their own affairs.

h. To foster participation by children and young people in communities and create an awareness of contemporary issues affecting them.

i. To develop appropriate recruiting, support and training strategies for voluntary staff.

Methodology

1.3.33 The purpose of Community, Youth and Play aims to achieve Social Educational and Individual Developmental objectives through a wide range of activities through partnering with other organisations, where appropriate, but principally through the following mediums:

a. **Clubs/Centres.** Youth Centres, Youth Clubs, Play Centres, Activity Centres and Community Centres run by appropriately qualified staff, supported by paid assistants, where applicable, and voluntary staff drawn from the local community lie at the heart of the provision. Youth and Playwork activities are to be managed in accordance with the instructions at Section 4 to this Section and in consultation with single Service delivery partners.

b. **Residential and Off-Site Activities**. The curriculum will include off site, residential activities and programmes.

c. **Young People's Achievement Awards.** Awards play an important role within the Service community and provide the opportunity for young people's achievements and contributions to the community to be recognised and accredited. The youth work "offer" will include opportunities to secure "recorded"[39] and nationally accredited[40] outcomes.

d. **International and Local Community.** Youth and Play work should encourage young people to develop a greater understanding of the world by participating in activities with children and young people from the local community and other nations. In particular overseas establishments promote understanding between British children and young people of the host nation, including ex-patriots, and any other armed forces stationed in the country. Members from local communities may be admitted and the numbers should be determined locally in agreement with the stakeholders[41]. Once agreed members in this category are entitled to all benefits listed above and must conform to all security and insurance

[39] A recorded outcome is achieved when an intervention by a worker leads the service user to do something which may not otherwise happen such as: take a course of training or be part of a project that has no accredited outcome, for example a drugs information workshop.

[40] These are achieved when a service user completes a nationally accredited award such as a Youth Achievement Award or a Duke of Edinburgh Award. Accredited awards must have creditability in the wider context and should have a link to employment, education or training.

[41] And in accordance with policy laid out in JSP 368.

requirements. Where relevant, parents must be made aware that they **may not** be entitled to medical care within military health centres.

e. **Provision of Area Activities**. Aimed at children and young people from their widely scattered and often isolated locations to increase levels of participation in decision making and for social, educational, recreational, sporting and cultural festivals, competitions and senior member training.

f. **Support to the Voluntary Sector**. Given the nature of the Service Community and the central welfare role of Youth and Play work, staff are expected to maintain close relationships with relevant community, youth and play organisations including uniformed groups. Although appropriately registered[42] voluntary organisations are fully autonomous they are eligible for access to use of premises[43], and support in the form of professional advice and training.

1.3.34 **Curriculum Development**. Further details and guidelines can be found in the publication 'Curriculum Development – Guidelines for Good Practice'.[44]

1.3.35 **Age Span.** The needs of local communities must be assessed, and age ranges determined by legislation and agreed locally. Given the wide range of ages, provision must be age-differentiated with the appropriate methodology; play work or youth work, being used with due regard to the regulations in the devolved administrations.

Conduct of Youth and Playwork Activities

Staff

1.3.36 Responsibility for the routine management and delivery of the function lies with the professional community development, youth and play work staff who are employed to ensure an appropriate and effective level of support to both children and young people. Where appropriate, they are assisted by paid/unpaid staff. These may be provided through a partnering agreement with the local authority, local Command and charity or other agencies. All staff working with children and young people must have met the requirements laid down in Safeguarding Children Policy (JSP 834) and Safeguarding Vulnerable Groups Policy (JSP 893).

Supervision

1.3.37 It is the responsibility of professional staff to ensure group leaders are aware of the requirement for suitable numbers of appropriately trained paid or unpaid staff to be available to provide adequate supervision of a full programme of activities.

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[42] In accordance with Government guidelines.

[43] JSP 770 Chapter 7, para 1.8.09 and JSP 362 Defence Lands Handbook provide guidance on this

[44] http://www.army.mod.uk/documents/general/Youth_and_community_support.pdf

Ratios

1.3.38 The staffing ratios specified below are the minimum for on site youth/play activities. When the majority of children or young people are at the younger end of the age range, smaller ratios will be required. Due regard should be given to the layout of individual Clubs/ Centres and other risk factors taken into consideration to ensure an appropriate level of supervision. In case of doubt the advice of professional staff should be sought. Ratios for residential and offsite activities are detailed in the relevant policy.[45]

	Centre Based	Off Site
Up to 8 years (Unless higher ratio determined by Ofsted or equivalent)	1:6	1:6
Up to 11 years	1:8	1:6
Over 12 years	1:10	1:8

1.3.39 In all cases it is necessary to ensure that a minimum of 2 adult workers are present, reflecting the appropriate gender balance. Where there is a mixed gender group a female worker should always be present. On rare occasions where this may not be possible, guidance must be sought from the line manager/professional supervisor, to asses the risks of not having a female member of staff present. Single gender groups can operate with the appropriate gender staffing ie. young women's group - two female members of staff. If only one member of staff is available the session must be cancelled or terminated. Every effort is to be made to avoid such occurrences and, where possible, the decision to cancel any activity should be made in consultation with the line manager/ professional supervisor. Lone working is not permissible for staff working with children and young people in line with current government guidelines.

1.3.40 **Administration of Youth/Play Facilities.** The effective administration and resourcing of youth/play facilities is the responsibility of the local Chain of Command

1.3.41 **Bus Escorts** Bus Escorts, where appropriate must be recruited locally to support the transportation of children and young people.

Residential, Off-Site and Hazardous Activities

[45] OfSTED Statutory Framework & NSPCC Guidelines on Staffing/Supervision Ratio's for Children and Young people's Activities.

1.3.42 Authorisation of Off- Site and Residential activities are detailed in the relevant single Service policy, including how they are to be funded. The categories of activities covered by the policy are:

a. **Off-Site** These are Non-Residential and Non-Hazardous activities, which take place away from the club, centre, project or unit location. They may include: day visits to sports and leisure facilities, rambling, conservation activities, sponsored activities, local expeditions, etc.

b. **Residential** These are Residential activities, of a Non-Hazardous nature. They may include: exchange visits, senior member training, and residential social educational workshops.

c. **Hazardous Activities** These may be Residential or Non-Residential, and may include: water-based activities, mountain walking, rock climbing, abseiling, skiing, pony trekking, caving, sea/lake/river bathing, mountain biking, cycle touring, snowboarding, etc

Staffing

1.3.43 The management, support and delivery of the Community Development Work, Youth Work and Play work requires the active involvement of well trained and motivated staff. Staff are employed on a full time or part-time basis by the MOD or partnering organisations. All staff, paid or unpaid, are to be appointed subject to enhanced clearance through the Disclosure and Barring Service (DBS) or in accordance with the requirements of the Devolved Administrations.[46]

1.3.44 In ***exceptional circumstances***, and with the prior approval of the employing Budget Holder with responsibility for funding training, who is to provide assurance that funding will be made available to fund training to the required level, then unqualified staff may be recruited to established Civil Service posts. Where this is the case, unqualified staff must be provided with supervision and training leading to a nationally recognised professional or vocational youth and community/community education/community development/play work qualification within an agreed timescale. Funding to meet the precise staffing levels outlined in this Section is the responsibility of individual Commands. Where staff are provided through partnering arrangements with external organisations these arrangements should be approved by Commands[47]. Recruitment and Selection for MOD funded posts. In accordance with Civil Service policy and procedures, all boards must have a professionally qualified representative.

Terms and Conditions of Service

1.3.45 Staff are employed as Specialist Analogue Grades within the Civil Service. For further information on the terms and conditions you should refer to the Policy Rules and Guidance (PRG) (PRG"Pay Details and Enquiries

[46] JSP 893 holds the detailed MOD guidance on CRB checks.

[47] Annex B to Chapter 1 of Part 1 of JSP 770 – sS Welfare Chain of Commands

Community Development Workers EDRM file ref 20080401-YandCWorkers Pay Details PRG-U") on the People Portal

Reporting

1.3.46 Reporting and appraisal of Civil Service Specialist Analogue staff is to be in accordance with the MOD Civil Service Personnel Development Reporting(PDR) Scheme.

Management and Co-Ordination

General

1.3.47 All work involving children and young people, including Youth and Play Work, within the MOD falls within the Directorate Children and Young People and forms part of the MOD Children and Young People's Strategy and Improvement Plan.

Club/Centre/Project Committees

1.3.48 Where appropriate, Comds should appoint Committees to oversee the affairs of each Club/ Centre /Project. However, Community Development staff, as the SME's, are responsible and accountable for the implementation of specific MOD policy.

Registration

1.3.49 Comds are to ensure that an annual register is maintained of all clubs, projects and units of voluntary organisations within their area of responsibility. This should be made available for scrutiny by single Service delivery partners on request.

Support

Funding

1.3.50 As per Annex D to Chapter 1 of Part 1 of JSP 770 Commanding Officers are to provide, or facilitate access to, a number of welfare assets which includes Community Development Staff[48].

1.3.51 This would include funding for:

a. Salary and related T&S Costs for:
   (1) Professional Staffing (with UKBC status overseas)
   (2) Asst/Supp Youth and Community Workers (including Assistants and Support Workers/interns).
   (3) Clerical and Administrative staff.

[48] RAF has separate Community Development Workers and Officers – RN and Army integrate the Community development role within their welfare organisations ie AWS/NPFS.

b. Purchase of miscellaneous items of equipment, subject to budget holder approval.

c. Training and staff development costs.

d. Payment in support of minor work services.

Audit and Control of Funds

1.3.52 A great deal of the community support activity that takes place is conducted by organisations whose finances are managed, in the army, as non-public funds by the Regimental Accounting Officers office; all Centres/Clubs/Projects and all expenditure from public funds and non-public funds are subject to regular audit in accordance with current MOD regulations.

Assurance

1.3.53 Welfare is a function of command, who are responsible for the establishment, operation and maintenance of community development work, youth work and play work activities within their boundaries. Responsibility for the public and non-public financing of these activities also rests at Command level, (Single Service). DACOS (Welfare Support) acts as senior professional advisor for RN/RMW, the Chief Community Development Officer (CCDO) Army Welfare Service (AWS) for the Army and Chief Community Development Advisor (CCDA) for the RAF. In Cyprus the Youth and Community Officer acts as the local professional advisor on all community development, youth and play matters.

Insurance

1.3.54 **Third Party Risks**. Commanders are to ensure that adequate insurance is affected against third party risks, indemnifying the MOD, themselves and all persons taking part in, or in any way connected with, such activities, including the members and servants of any such club or voluntary youth organisation. The policy is to be in the sum of: Employers Liability figure £10 Million and Public Liability £5 Million for any one claim, but unlimited as to the number of claims. Permission for the use of MOD-controlled land and facilities is to be conditional upon such insurance being affected.

Buildings and Equipment

1.3.55 **Buildings**. MOD buildings (or parts of buildings) are to be made available as official, entitled accommodation (not therefore encroachments) **for occupation by officially recognised community/youth/play clubs/centres/projects and individual voluntary youth organisations carrying out approved activities in support of MOD welfare ie core Armed Forces business**. Supervision and maintenance should be carried out according to the following guidelines:

a. An officer is to be appointed by the Commanding officer of an appropriate Service unit as officer in charge of each club/centre/ project.

b. No charge is to be made in respect of rent, rates, normal maintenance and the supply of water, lighting and heating.

c. MOD premises may not be altered or buildings constructed without the specific authority of the appropriate Service headquarters. If in doubt then Defence Infrastructure Organisation (DIO) Regulations should be consulted.[49]

1.3.56 Stores and Equipment.

a. Accommodation stores, including furniture, for officially recognised clubs/centres/projects and approved voluntary organisations are to be issued from Service sources free of charge within the limits of the appropriate scale. The items are to be held on inventory charge and normal accounting procedures are to be applied. The current scale is Scale 25 contained in JSP 315, which applies to all Community/Youth/ Play Clubs/Centres.

b. Camping equipment may be obtained on loan from Service sources if available locally. Charges will be raised for loss or damage due to factors other than fair wear and tear.

c. Equipment such as TV, Computer and Audio may be purchased using either public, Service non-public and locally raised funds.

Transport [50]

1.3.57 In carrying out the duties of delivering welfare provision[51] and subject to the availability of resources, MOD Transport may be used to move entitled people in the following circumstances and with the following restrictions:

a. MOD transport may be used to move adults, children and young people:

(1) Between local housing areas and local meeting places (Clubs/Centres) in order to attend officially recognised community/youth/play activities.

(2) For journeys beyond the local area for the purpose of attending rallies, festivals, sports competitions, leisure and recreation facilities, places of interest and other recognised youth activities.

(3) For the movement of stores and tentage to support recognised community/youth/play activities.

(4) For officially recognised training courses for professional and voluntary staff.

b. The provision of such transport and where necessary of bus escorts, is the responsibility of Stations/Garrisons and the following conditions will apply:

(1) The activity must be endorsed by the appropriate Community Development Officer and be part of a recognised community activity plan, which meets the objects of this Section.

(2) Entitled persons are MOD employees, an immediate family member of Service personnel, attached civilians (or immediate family

[49] JSP 362 Defence Lands Handbook

[50] JSP800 Vol 5 is the lead document regarding MOD transport and must be referred to in all cases.

[51] A Core MOD output. The delivery of which is primarily a sS and CoC responsibility.

member of the local civilian population who is an officially authorised and registered member of the group).
(3) All requests for transport are to be endorsed by the Community Development Officer, or delegated authority. A signature and control number are to be added to the transport request by the endorsing officer, before forwarding to the Chain of Command for authorisation.
(4) Where possible, available MOD transport is to be used, however, where this is not available or is unsuitable, periodic hire may be authorised by the sponsor Station/Garrison/Unit.
(5) Authorised drivers must be appropriately trained and licensed to drive the allocated vehicle.

1.3.58 Guidance on BFG Youth Service Transport can be obtained through:
http://cui1-uk.diif.r.mil.uk/r/677/BusinessArea/iHub/PolicyCentre/Policy%20Centre%20Documents/SOBFG_4301_55.doc

Domestic Abuse

1.3.59 **Domestic Abuse Policy.** This policy can be found in JSP 913 Tri-Service Policy on Domestic Abuse and Sexual Violence.

1.3.60 **Common Protocols.** Common Protocols have been agreed between the single Service Specialist Agencies directing what actions should be taken in response to Domestic Abuse. The protocol is at Annex A.

ANNEX A TO
CHAPTER 3 TO
PART 1 OF JSP 770

TRI-SERVICE DOMESTIC ABUSE PRACTICE POLICY

Terminology.

1. Throughout this Policy, the terms “Domestic Abuse” and “Survivor” are used in preference to the alternatives “Domestic Violence” and “Victim”. It is acknowledged that all of the above terms have their own merit.

Definition.

2. **Domestic Abuse** is defined in JSP 913 as:

> “Any incident of threatening behaviour, violence or abuse (psychological, physical, sexual, financial or emotional) between adults who are or have been intimate partners, or family members, regardless of gender or sexuality.”

References.

3. This policy has been devised with reference to the following:

The Domestic Violence, Crime and Victims Act 2004
The Children Act 2004
The Working Together to Safeguard Children Regulations
JSP 913 Tri-Service Policy on Domestic Abuse and Sexual Violence
AGAI Vol. 3 CHAPTER 083 Part 4
PLAGO 0412
LEAFLET 2414 – RAF Policy on Domestic Violence

Scope.

4. This policy sets out practice direction for workers employed in the Specialist Welfare Delivery (SWD) Agencies. These include:

a. Army Welfare Service
b. Naval Personal and Family Service and Royal Marine Welfare
c. Personal Welfare Service Northern Ireland
d. RAF Personal Support and Social Work Service

Aim of policy.

5. The aim of this policy is to achieve standardisation across the services, to provide direction for workers and most crucially to improve outcomes for service users via the development of good practice.

6. It is acknowledged that regional variations complicate the application of this policy. In order to ensure simplicity as far as is possible, this policy establishes a single set of practice standards which should meet (and in some places exceed) the minimum requirements in effect in some areas.

Background.

7. There is an acceptance that Domestic Abuse is no longer a private matter. The Ministry of Defence has established an attitude of zero tolerance towards Domestic Abuse in recognition of the profound effect within a relationship that such violence can have on others, especially children. According to the British Crime Survey statistics, Domestic Abuse accounts for 14% of all violent crime and 7% of women, 4% of men reported having experienced domestic violence.

Critical Outcomes.

8. The primary consideration of an intervention by an SWD Agency worker is the **safety** of the Domestic Abuse survivor or other people who may be at risk.

9. **Safety issues** will be affected by a number of factors which may include:

a. Pregnancy
b. Age
c. Communications barriers, including language barriers, sensory loss, etc
d. Disability
e. Social stigma (e.g. for male survivors)
f. Cultural norms
g. Geographical isolation
h. Previous history of abuse
i. The influence of alcohol or substance misuse
j. The mobile nature of Service communities

10. Where there is a child (under 18) in the household where a Domestic Abuse incident has taken place, or is believed by the worker to have taken place, the worker will automatically refer the case to the relevant Children's Services (CS). This also applies if the survivor of the Domestic Abuse is a pregnant woman.

11. Statutory provision will come from a variety of sources. Within the UK, Local Authorities are responsible for making this provision. Abroad, the following sources of Social Work support may apply:

a. RAF Personal Support and Social Work Service
b. Personal Welfare Service Northern Ireland
c. British Forces Social Work Service North West Europe
d. Personal Support and Social Work Service Cyprus
e. Social Work Service Gibraltar
f. Social Work Service Brunei.

12. The worker should acknowledge that the survivor may have disproportionate fears about the CS response. The worker must have the sort of relationship with the CS which will allow them to develop an understanding of their procedures and thus pass on to the survivor, or perpetrator, a reasonable sense of the likely outcomes of CS involvement.

13. A further aim in the worker's intervention is to support the service user to make positive choices. There may be occasions when the worker acts in a way contrary to their expressed wishes, for example reporting an incident because of the risk of harm. Nonetheless it is important for the worker to try and engage the service

user as far as possible in decision-making, to explain their actions clearly and offer choices wherever possible.

14. A range of difficult choices may need to be made by workers. They should discuss with their supervisor/ Team Manager/ Divisional Support Officer/ equivalent at the earliest opportunity any case where there is significant risk of harm to any individual, including Domestic Abuse.

15. A key area of work which supports these outcomes is good quality multi-agency co-operation and liaison inside and outside the MOD. Workers are under a duty to develop links with statutory and non-statutory organisations so that they understand the provision available and so that, when the need arises, communication will be smooth and effective. Consider a range of non-statutory agencies which might be relevant such as Relate, Victim Support, Rape Crisis, refuge providers, and so on. While awareness of locally available services will be important, remember that survivors may need to access to services in other parts of the country, or even world.

Case Management Issues.

16. From the beginning, the worker must ensure that service users understand the parameters of the Code of Confidentiality. This is particularly important because service users may not initially relate the "risk of harm" test to their own situation. The worker must also be clear and honest (with the service user and themselves) about the extent of their expertise. They must ask for help if they feel they need it.

17. The worker will have two main options available to them. **Option One** is to refer the service user's case to another agency. This might be civilian, either statutory or non-statutory, or military, e.g. the Chain of Command, probably via the Unit Welfare Officer or equivalent.

18. **Option Two** is to undertake direct work with the survivor. This might take a variety of forms, and may include providing ongoing emotional and practical support or monitoring while more specialist support is provided by another agency/ agencies.

19. Step One: As soon as the worker is aware that Domestic Abuse is an issue, their first priority must be to ensure that the service user has an effective **Safety Plan** in place. Guidance relating to Safety Planning is available at Annex A.

20. Step Two: Once the worker has completed Step One, they should work with the service user to develop a **Work Plan**, which must set out clearly the work which will be undertaken. This may be incorporated into the usual assessment paperwork, if the format allows. The Work Plan should include an agreement relating to the worker's actions should a service user fail to attend an agreed appointment, or stop attending sessions entirely without explanation.

21. Throughout contact with the survivor, the worker must be aware of the importance of providing them with reassurance and validation. Some good practice responses to Domestic Abuse are attached at Annex B.

22. Throughout all work with survivors, the need for clear and detailed recording is paramount. Workers must ensure that they use objective, non-judgemental language and take full account of strengths and risks. They should also ensure that separate case files are established for the perpetrator and survivor.

23. Reference has been made to supporting survivors to make choices. It is critical that survivors make informed choices, and in order to do so they need to fully understand the likely consequences of their actions. For example, the wife of a Foreign and Commonwealth soldier may derive her right to reside in Britain as a result of her connection to her husband. If, as a result of Domestic Abuse, she chooses to end the marriage she may need to apply for a visa in her own right to stay in the UK. The Immigration and Nationality Directorate will take note of Domestic Abuse in any application where evidence is provided. Each case will be judged on its merits. Nonetheless, she should understand that this is a process she may need to undertake.

24. All of the above guidance relates to circumstances where the service user is prepared to engage with the SWD Agency worker. It must be recognised that a worker may become aware of circumstances where Domestic Abuse has taken place and where it is not appropriate to approach the service user, or where the service user does not want to receive support. In these circumstances, the role of the worker is to liaise with the relevant agencies (Police, CS, Chain of Command, other SWD Agencies) in compliance with Local Safeguarding Children Board procedures to ensure as far as possible the smooth passage of relevant information. Again, the primary aim is to promote the safety of the survivor or others who may be at risk.

Work with Perpetrators.

25. None of the SWD Agencies undertake to deliver a specific Perpetrator Programme. Work may be undertaken with the perpetrator, but only where the worker has clearly identified expertise in this area and where the work plan is agreed by their professional supervisor.

Awareness Raising.

26. SWD Agencies should seek to contribute to raising awareness of Domestic Abuse within the Service communities. They may do this in a variety of ways and this practice policy document does not seek to define these activities. However, it does acknowledge the value of awareness-raising activities in supporting the reporting and addressing of Domestic Abuse within Service communities.

Summary.

27. Domestic Abuse is no longer a private matter. The position of the Ministry of Defence towards Domestic Abuse is one of zero tolerance. The SWD Agencies aim to establish consistent ways of working, to provide clear direction for workers and to improve outcomes for service users via the development of good practice. Workers are asked primarily to focus on the safety of the survivor or other people who may be at risk, by the use of a safety plan and to act consistently with the relevant Code of Confidentiality. They should then plan and undertake work as relevant, taking account of the needs and wishes of the survivor and ensuring that they draw on professional supervision.

Appendix 1: Safety Plan Guidance
Appendix 2: Good Practice Responses

Making a Safety Plan

A personal safety plan is a way of helping you to protect yourself and your children. It helps you plan in advance for the possibility of future violence and abuse. It also helps you to think about how you can increase your safety either within the relationship, or if you decide to leave.
You cannot stop your partner's violence and abuse - only they can do that. But there are things you can do to increase your own and your children's safety:

- Keep with you any important and emergency telephone numbers (for example, your local Women's Aid refuge organisation or other domestic violence service; the police domestic violence unit; your GP; your social worker, if you have one; your children's school; your solicitor; and the Freephone 24 Hour National Domestic Violence Helpline run in partnership between Women's Aid and Refuge: 0808 2000 247).

- Teach your children to call 999 in an emergency and what they would need to say (for example, their full name, address and telephone number).

- Are there neighbours you could trust, and where you could go in an emergency? If so, tell them what is going on, and ask them to call the police if they hear sounds of a violent attack.

- Rehearse an escape plan, so in an emergency you and the children can get away safely.

- Pack an emergency bag for yourself and your children, and hide it somewhere safe (for example, at a neighbour's or friend's house). Try to avoid mutual friends or family.

- Try to keep a small amount of money on you at all times - including change for the phone and for bus fares.

- Know where the nearest phone is, and if you have a mobile phone ensure that it is always charged and try to keep it with you.

- If you suspect that your partner is about to attack you, try to go to a lower risk area of the house - for example where there is a way out and access to a telephone. Avoid the kitchen or garage where there are likely to be knives or other weapons; and avoid rooms where you might be trapped, such as the bathroom, or where you might be shut into a cupboard or other small space.

- Be prepared to leave the house in an emergency.

Preparing to leave

If you have decided to leave your partner, it is best if you can plan this carefully. Sometimes abusers will increase their violence if they suspect you are thinking of leaving, so this can be a particularly dangerous time for you.

Plan to leave at a time you know your partner will not be around. Try to take everything you will need with you, including any important documents relating to yourself and your children, as you may not be able to return later. Take your children with you, otherwise it may be difficult or impossible to have them living with you in future. If they are at school, make sure that the head and all your children's teachers know what the situation is, and who will be collecting the children in future.

Thinking about leaving and making the decision to leave can be a long process. Planning it doesn't mean you have to carry it through immediately - or at all. But it may help to be able to consider all the options and think about how you could overcome the difficulties involved. If at all possible, try to set aside a small amount of money each week, or even open a separate bank account.

What to pack if you are planning to leave your partner

Ideally, you need to take all the following items with you if you leave. Some of these items you can try to keep with you at all times; others you may be able to pack in your 'emergency bag'.

- Some form of identification.
- Birth certificates for you and your children.
- Passports (including passports for all your children), visas and work permits.
- Money, bankbooks, cheque book and credit and debit cards.
- Keys for house, car, and place of work. (You could get an extra set of keys cut, and put them in your emergency bag.)
- Cards for payment of Child Benefit and any other welfare benefits you are entitled to.
- Driving licence (if you have one) and car registration documents, if applicable.
- Prescribed medication.
- Copies of documents relating to your housing tenure (for example, mortgage details or lease and rental agreements).
- Insurance documents, including national insurance number.
- Address book.
- Family photographs, your diary, jewellery, small items of sentimental value.
- Clothing and toiletries for you and your children.
- Your children's favourite small toys.

You should also take any documentation relating to the abuse - e.g. police reports, court orders such as injunctions and restraining orders, and copies of medical records if you have them.

Protecting yourself after you have left

If you leave your partner because of abuse, you may not want people to know the reason you left. It is your decision whether or not you tell people that you have suffered domestic violence; but if you believe you may still be at risk, it might increase your safety if you tell your family and friends, your children's school, and your employer or college what is happening, so that they do not inadvertently give out any information to your ex-partner. They will also be more prepared and better able to help you in an emergency.
If you have left home, but are staying in the same town or area, these are some of the ways in which you might be able to increase your safety:

- Try not to place yourself in a vulnerable position or isolate yourself.

- Try to avoid any places, such as shops, banks, cafes, that you used to use when you were together.

- Try to alter your routines as much as you can.

- If you have any regular appointments that your partner knows about (for example, with a counsellor or health practitioner) try to change your appointment time and/or the location of the appointment.

- Try to choose a safe route, or alter the route you take or the form of transport you use, when approaching or leaving places you cannot avoid - such as your place of work, the children's school, or your GP's surgery.

- Tell your children's school, nursery or childminder what has happened, and let them know who will pick them up. Make sure they do not release the children to anyone else, or give your new address or telephone number to anyone. (You may want to establish a password with them, and give them copies of any court orders, if you have them.)

- Consider telling your employer or others at your place of work - particularly if you think your partner may try to contact you there.

If you have moved away from your area, and don't want your abuser to know where you are, then you need to take particular care with anything that may indicate your location; for example:

- Your mobile phone could be 'tracked'; this is only supposed to happen if you have given your permission, but if your partner has had access to your mobile phone, they could have sent a consenting message purporting to come from you. If you think this could be the case, you should contact the company providing the tracking facility and withdraw your permission; or if you are in any doubt, change your phone.

- Try to avoid using shared credit or debit cards or joint bank accounts: if the statement is sent to your ex-partner, they will see the transactions you have made.

- Make sure that your address does not appear on any court papers.

- If you need to phone your abuser (or anyone with whom they are in contact), make sure your telephone number is untraceable by dialling 141 before ringing.

- Talk to your children about the need to keep your address and location confidential.

If you stay or return to your home after your partner has left, then you will probably have an occupation order or a protection order. If the injunction has powers of arrest attached, then do make sure that your local police station has a copy, and that the police know that they need to respond quickly in an emergency.

You could also consider the following:

- Changing the locks on all doors.
- Putting locks on all windows if you don't have them already.

- Installing smoke detectors on each floor, and providing fire extinguishers.
- Installing an outside light (back and front) which comes on automatically when someone approaches.
- Informing the neighbours that your partner no longer lives there, and asking them to tell you - or call the police - if they see him/her nearby.
- Changing your telephone number and making it ex-directory.
- Using an answering machine to screen calls.
- Keeping copies of all court orders together with dates and times of previous incidents and call-outs for reference if you need to call the police again.

If your ex-partner continues to harass, threaten or abuse you, make sure you keep detailed records of each incident, including the date and time it occurred, what was said or done, and, if possible, photographs of damage to your property or injuries to yourself or others. If your partner or ex-partner injures you, see your GP or go to hospital for treatment and ask them to document your visit. If you have an injunction with a power of arrest, or there is a restraining order in place, you should ask the police to enforce this; and if your ex-partner is in breach of any court order, you should also tell your solicitor. In an emergency always dial 999 and ask for the Police.

APPENDIX 2 TO
ANNEX A TO
CHAPTER 3 TO
PART 1 OF JSP 770

GOOD PRACTICE RESPONSES TO DOMESTIC VIOLENCE

DO give priority to ensuring her immediate safety.
DO recognise her need for a response and your support.
DO be sensitive and discuss her fears.
DO take her seriously, believe her.
DO reassure her that violence is not her fault.
DO let her know that she is not alone in being abused.
DO remember that her problems may be compounded by racist reactions, language and cultural barriers; or other reactions to her age, sexuality or disability.
DO remember that her options may be limited by lack of, or access to, resources.
DO consult with specialist agencies and individuals.
DO check if it is all right to send her letters or phone her at home **(Confidentiality is crucial)**
DO respect her wishes if she does not want you to make contact at all.
DO find out what she wants and find out if you can help her achieve it.
DO let her know that she does not have to leave home to talk to the women at the local refuge.
DO discuss the situation and any options open to her.
DO help her explore ways of maximising her safety, whether she leaves or not,
DO find out what other agencies have to offer and let her know.
DO take personal responsibility when referring her elsewhere.
DO keep in contact, if at all possible.

DON'T ignore your intuition if you suspect a woman is being abused.
DON'T insist on joint sessions with her and the man.
DON'T fob off a woman if she comes to you for help.
DON'T be flippant or cynical or sceptical.
DON'T ask her what she did to provoke the violence, just the facts.
DON'T just focus on what she alone can do in the situation.
DON'T make choices for her.
DON'T give up on her just because things are taking longer than you think they should.
DON'T give the man the address and phone number of where she is staying.
DON'T promise to give a letter or pass on a message to her from him or to facilitate contact in any way.

Adapted from work done by Norwich Consultants on Sexual Violence and by Jean Osborne L.S.E. Adapted for use by Hammersmith and Fulham Council and the Domestic Violence Forum (Hammersmith & Fulham)

GUIDANCE DOCUMENT 2

HOW TO ASK

Initial questions:

- Is everything alright at home?

- How are you feeling?
- Are you getting the support you need at home?

Follow up – direct questions:

- I noticed a number of bruises/cuts/scratches/burn marks: how did they happen?
- Do you ever feel frightened of your partner?
- Have you ever been afraid of your partner?
- Does your partner ever treat you badly such as shout at you, constantly call you names, push you around or threaten you?
- Have you ever been in a relationship where you have been hit, punched, hurt in any way? Is that happening now?
- Many people tell me that their partners are cruel, sometimes emotionally and sometimes physically hurting them – is that happening to you?
- We all have rows at home occasionally. What happens when you and your partner fight or disagree?
- Has your partner ever:
  - Destroyed things you cared about?
  - Threatened or abused your children?
  - Forced sex on you/or made you have sex in a way that you are unhappy with?
  - Withheld sex/rejected you sexually in a punishing way?
  - Used your personal fears to 'torture' you?
  - Stalked you?
- Does your partner get jealous and, if so, how does he then act?
- You mentioned that your partner uses drugs/alcohol.
- How does he act when drinking or on drugs?
- Your partner seems very concerned and anxious. That can mean he feels guilt. Was he responsible for your injuries?

CHAPTER 4 - MEDICAL

Introduction

1.4.01. Health is a state of complete mental, physical and social well being. The MoD health policy[52] is to ensure that every serving man and woman enjoys a level of health that is appropriate for the task that they are required to perform. The Defence health programme goal is to improve the operational capability of the Armed Forces and the confidence in health care by promotion, provision and maintenance.

Medical and Dental Care

1.4.02. In the home base, medical care is provided to uniformed Service personnel by the Defence Medical Services (DMS) as an entitlement. Medical care to MOD Civil Servants and entitled family members is provided by the NHS except in certain exceptions where dependants might be treated in a military primary care facility.

1.4.03. For personnel assigned overseas, medical care is provided free of charge[53] to all resident military personnel as an entitlement and their entitled dependants who are eligible. This includes provision of primary healthcare services (General Practice, Including Occupational Medicine), secondary/tertiary healthcare services (hospital level care) and aeromedical evacuation. Dental treatment for families overseas is provided to the same standards and criteria as under the NHS (in England). This level of provision is normally available to those who are entitled and/or of dependent status. Detailed clarification of which groups are entitled or eligible to DMS treatment overseas is included at Annex A and Annex B respectively.

1.4.04. The management of some chronic conditions could be compromised by an assignment especially overseas. Before deploying overseas, the assigned is to contact Movement Support Services to obtain a medical screening form and make a declaration concerning the health of their dependants. All long term medical conditions are to be declared in accordance with single Service procedures in order to allow the receiving theatre to make an informed decision as to whether a chronic condition can be appropriately managed in that Theatre. Where a condition cannot be managed, a decision then has to be made, by the assigning authority, as to whether the assignment can go ahead.

1.4.05. Exceptionally, healthcare is provided for parents or non-dependant children who travel to overseas commands at public expense in order to support families where at least one serving parent has deployed on operations. However, there is still a need to ensure that the needs of visitors can be supported before authority to travel at public expense is granted. Visitors will still require insurance cover and their European Health Insurance Card (EHIC) to cover any unforeseen circumstances. These could include instances where: a civilian specialist or other civilian medical services are called upon; where drugs, which are not obtainable through normal Service medical channels, have to be purchased or when a passage on a medical aircraft is authorised, or referral to hospital (overseas commands) may be required. Antenatal and obstetric treatment is not available to non-entitled

[52] DCDS(Personnel) Personnel Policy Guidelines – PPG 21

[53] Notwithstanding prescription charges in line with NHS in England

pregnant close relatives, except in a real and unforeseen emergency. Service personnel and those travelling with them are strongly advised to take out appropriate travel insurance before travelling anywhere at their own expense, as access to Defence Medical Services cannot be guaranteed even when locally available.

1.4.06. **Adventurous Training and Sports.** Military personnel undertaking correctly staffed and officially sanctioned adventure training and sports are entitled to all necessary medical care at public expense. However, in some countries where such activities take place, the civil health infrastructure cannot provide a suitable level of service. Private medical facilities that can provide the required level of Service might be available but proof of ability to pay is often required before treatment commences. Military teams venturing overseas are to be strongly advised to take out private medical insurance and refer to 2013DIN01-007 Insurance for Adventurous Training Activities.

1.4.07. **Reserves.** For members of the reserve component of the Armed Forces, undertaking officially sanctioned military activity be it sporting, adventurous training or military training, medical support is provided at public expense up to the point where the individual is fit to be discharged home to the care of their own GP in the home base. However, long term health care is not provided by MoD to manage the long term consequences of injury or illness sustained by members of the Reserve component unless sustained whilst mobilised for operations; that responsibility lies with the NHS. More detail is contained within JSP 753 Tri-Service Regulations for the Mobilisation of Reservists.

Medical Welfare

1.4.08. Service personnel admitted to hospital may require welfare support provided through normal Services structures as detailed in Chapter 5. A Hospital Welfare Service (HWS) is contracted[54] to provide primary welfare services in support of the chain of command to Patient Groups both on operations and in some peace time locations in UK and overseas on a constant basis. HWS support is provided under the following categories:

a. Welfare needs assessment subject to single Service protocols
b. Response to requests for welfare support
c. Emotional and practical support
d. Liaison and referral to other agencies as appropriate

1.4.09. Notwithstanding the existence of the HWS, the patient's chain of command is expected to remain fully engaged in the needs of the Service person undergoing hospital care. Arrangements are in place for linkage between the HWS and single Service Welfare organisations (NPFS, RMW, AWS and RAF PS&SWS).

1.4.10. **Dangerously Ill Forwarding of Relatives (DILFOR).** DILFOR is an allowance designed to help ease the emotional and financial burden of close family members of a Service person who is unexpectedly admitted to hospital. To be entitled to DILFOR the patient must have a recommendation from the medical authority concerned that states that a visit from close family members would be in the best interest of the patient's recovery. DILFOR is available to provide travel and subsistence, enabling the family to visit the Service person. Details of DILFOR are

[54] Currently Defence Medical Welfare Services (DMWS) holds the contract.

contained in Volume 1, Chapter 7 of JSP 751 Joint Casualty and Compassionate Policy and Procedures.

Long Term Sickness

1.4.11. Each Service has in place comprehensive long term sickness policies that ensure that Service personnel who are long term sick are properly tracked managed and supported. The links to these publications are:

a. Navy Management of Long Term Medical Absence and Pregnancy [55]
b. Army Sickness Absence Management policy[56].
c. RAF Long Term Sickness Absence Management Policy[57].

Annexes:

A. Matrix of Entitlement to Treatment at Overseas DMS Treatment Facilities
B. Matrix of Eligibility to Treatment at Overseas DMS Treatment Facilities

[55] DIN2006DIN02-154 Management of Royal Navy and Royal Marine Personnel on Long-Term Medical Absence (LTMA) and Pregnancy.
[56] Army AGAI Volume 3 Chapter 99- Sickness Absence Management
[57] RAF AP3392 Vol 5 Leaflet 125 – Management of RAF Personnel on Term Sickness Absence.

MATRIX OF ENTITLEMENT TO TREATMENT AT OVERSEAS DMS TREATMENT FACILITIES

Grey Scale indicates entitlement.

White Scale indicates no entitlement.

SER (a)	TYPE OF PATIENT (b)	DMS PRIMARY CARE (c)	DMS SECONDARY CARE (d)	DMS DENTAL CARE[58] (e)	DMS PHARMACY (f)	AERO MED TO UK[59] (g)
1	Regular Service personnel posted overseas (including those on terminal leave)					
2	FTRS (Full Commitment) posted overseas					
3	UK based Regular and FTRS (Full Commitment) and (Limed Commitment) personnel whilst on duty/on exercise overseas[60]					
4	Service personnel (including all categories of Reserve Forces personnel) travelling overseas at their own expense[61] for non-duty reasons					
5	Service personnel on officially approved Service sports tours / AT[62]					

[58]. Routine dental treatment is to be initiated at least 4 months prior to the completion of any overseas tour for all categories of entitled personnel (to ensure that the treatment is completed prior to the end on the tour).

[59]. Entitlement to Aeromedical Evacuation may be on a re-payment basis. AP3394 Leaflet 4-01 gives details and should be consulted before agreeing to entitlement.

[60]. Includes Service and civilian personnel on visiting RN ships (and military aircraft) and personnel landed awaiting aeromed evac from passing ships.

[61]. Service personnel are strongly advised to take out appropriate travel insurance before travelling anywhere overseas at their own expense, as access to DMS facilities cannot be guaranteed even when locally available. In exceptional circumstances, when a Service person who is on long term sick leave travels overseas to reside with a parent who is entitled to overseas DMS healthcare, the Service person is entitled to the same level of care from the DMS as their entitled parent.

[62]. Entitlement, including to aeromed evac, is only for new injuries / illness (not pre-existing disease processes) arising from formally approved prior to departure from UK and does not cover other privately arranged events. Groups are strongly encouraged to take out their own insurance / European Health Insurance Card.

6	FTRS (Limited or Home Commitment) Aircrew posted overseas					
7	FTRS (Limited or Home Commitment) personnel specifically appointed for service in Germany					
8	Volunteer and Regular Reservist called out or recalled into Permanent Service[63]					
9	Additional Duties Commitment personnel on duty/exercise overseas					
10	RNR / RMR personnel on duty/exercise overseas					
11	RNR / RMR personnel not on duty/exercise overseas					
12	TA personnel on duty/exercise overseas[64]					
13	TA personnel not on duty/exercise overseas					
14	RAuxAF personnel on duty/exercise overseas[65]					
15	RAuxAF personnel not on duty/exercise overseas					
16	RN/Army/RAF cadets and their staff on duty/exercise overseas, including formally approved Adventurous Training[5]					
17	Members of University Royal Navy Units, Officer Training Corps, University Air Squadrons on duty/exercise overseas, including formally approved Adventurous Training					
18	RFA Personnel[66]					
19	RFA Personnel when travelling overseas at their own expense.					
20	Reservists when not in Service					
21	MOD UK based civil servants (including SCE school teachers) posted overseas.[67]					

[63] Including Sponsored Reserves.

[64] Including Non-regular Permanent Staff (TA).

[65] Including members of the RAF VR(T).

[66]. When on articles or contract, RFA personnel and their spouses/civil partners will be afforded Service emergency medical and dental treatment when such facilities are available. Pre-existing conditions should be considered before deciding on whether to embark.

[67]. Only when part of British Forces overseas or if they have proceeded abroad under MOD officially approved arrangements and then retain the entitlement to MOD approved return passage.

22	UK based MOD civil servants on detached duty overseas for the duration of their detachment					
23	Members of Commonwealth Forces attached to UK Forces overseas[8]					
24	Members of other Overseas Forces attached to UK Forces overseas[8]					
25	Members of other Overseas Forces not attached to UK Forces overseas but when there are specific MOUs/SLAs which permit access to specific areas of DMS healthcare[8]					
26	UK based domestic servants of Service personnel posted overseas[8, 68]					
27	UK based domestic servants of entitled UK based civil servants posted overseas[8, 11]					
28	MOD Contractors when working overseas and when their contract with MOD stipulates access to specific areas of DMS healthcare (and on repayment if specified in the contract) in accordance with DEFCONS 697[69] and 76[70]					
29	Locally Employed Civilians overseas[71]					
30	NAAFI personnel (including Sponsored Foreign Nationals) serving overseas[72]					
31	NAAFI personnel serving in HM ships[3]					
32	Chinese "unofficials" serving in HM Ships[3]					

[68]. Providing they have been granted entitlements under the terms of JSP 752.

[69]. The Authority shall provide to the Contractor's Employees and Subcontractor's Employees, free of charge, medical treatment and emergency dental treatment equivalent to that provided to military personnel whilst deployed. The Authority shall provide, free of charge,
first aid treatment to Locally Recruited Workers (LRWs) whilst they are on duty.

[70]. "Out-patient medical treatment given to the Contractor's Representatives by a Service Medical Officer or other Government Medical Officer at a Government Establishment overseas shall be free of charge. Treatment in a Service hospital or medical centre, dental treatment, the provision of dentures or spectacles, conveyance to and from a hospital, medical centre or surgery not within the Establishment, and transportation of the Contractor's Representatives back to the United Kingdom, or elsewhere, for medical reasons, shall be charged to the Contractor at the appropriate local rate." Defcon 76

[71]. Occupational Health services may be provided.

[72]. The costs of providing such healthcare are currently to be reclaimed from NAAFI at the concessionary rate, in accordance with the NAAFI charter except where local SLAs / contracts specify different arrangements (e.g. PAYD in Germany). When a specific local SLA/contract states that certain groups/individuals working for NAAFI are not entitled to DMS Healthcare, such healthcare is not to be provided.

33	Members of the Royal Gibraltar Regiment (Regulars)					
34	Members of the Royal Gibraltar Regiment Reserves[73] on duty/exercise					
35	Members of the Royal Gibraltar Regiment Reserves not on duty/exercise					
36	SSAFA personnel serving overseas[74]					
37	UK based Foreign and Commonwealth Office Staff serving overseas[75]					
38	WRVS staff serving overseas					
39	UK based members of the Defence Medical Welfare Service serving overseas					
40	UK based members of the Council of Voluntary Welfare Work					
41	Retired members of the Armed Forces living overseas					
42	War Pensioners (retired members of the armed forces living overseas receiving war pension/AFCS award)[76]					
43	Prisoners held in Cyprus SBA civil prison or police custody or on RN ships not covered in other serials					
44	MOD employed BRITCON and UNFICYP Continuity Post personnel in Cyprus					
45	Members of the British UNFICYP Roulemont Regiment					
46	SSVC/BFBS[77] staff serving overseas					
47	Those attached to RAF Air Crash Investigation Teams deployed overseas					

[73]. Not members of the TA and not 'owned' by DRFC.

[74]. This may either be provided free of charge or on a repayment basis dependant on local contract arrangements.

[75]. The DMS have historically allowed access to FCO staff to DMS healthcare, where available overseas. This arrangement is to continue, but under the auspices of SLAs negotiated between the DMS and the FCO whereby costs incurred by the DMS to provide such treatment are recovered from the FCO. Locally employed FCO staff are not entitled to access DMS Healthcare overseas.

[76]. Such individuals are only entitled to treatment related to the accepted illness/injury. Any costs incurred by the DMS in providing such treatment must be recovered from Veterans UK via the approved agent. When, for Clinical Governance reasons, it would be inappropriate for the DMS to continue to treat a Veteran for his pensionable condition in isolation from any other, non associated, non pensionable conditions, the pensioner should no longer be treated for any (including pensionable conditions) by the DMS, and the pensioner should be advised to seek treatment for his pensionable condition from his normal GP. The pensioner can then reclaim any associated costs for such treatment from Veterans UK.

[77]. Whilst SSVC/BFBS staff are entitled to access DMS healthcare overseas, this may be on a repayment basis (dependant on local arrangements).

48	Participants in Directorate of Reserve Forces & Cadets Employers Abroad scheme					

MATRIX OF ELIGIBILITY TO TREATMENT AT OVERSEAS DMS TREATMENT FACILITIES

Grey Scale indicates eligibility.

White scale indicates no eligibility.

SERIAL (a)	TYPE OF PATIENT (b)	DMS PRIMARY CARE (c)	DMS SECONDARY CARE (d)	DMS DENTAL CARE[78] (e)	DMS PHARMACY (f)	AERO MED TO UK[79] (g)
1	Dependants accompanying FTRS (Limited or Home Commitment) personnel specifically appointed for service in Germany.					
2	Spouses/civil partners accompanying RFA personnel when embarked in an RFA.					
3	Service Dependants overseas.[80, 81 82]					
4	Dependants accompanying MoD civil servants (including SCE school teachers) posted overseas.[83]					
5	Dependants accompanying members of Commonwealth Forces[84] attached to UK Forces overseas.					

[78]. Routine dental treatment is to be initiated at least 4 months prior to the completion of any overseas tour for all categories of entitled personnel (to ensure that the treatment is completed prior to the end on the tour).

[79]. Entitlement to Aeromedical Evacuation may be on a re-payment basis. AP3394 Leaflet 4-01 gives details and should be consulted before agreeing to entitlement.

[80]. Eligible dependants overseas will be charged for dental treatment by the MoD; the charge will be equivalent to the normal NHS fees and charges as set out within current NHS regulations and exemptions.

[81]. This does not include holidays taken while abroad, for which it is recommended private health insurance should be taken out.

[82] Eligible dependants overseas will be expected to pay prescription charges equivalent to those charged in England with the same classes and categories of exemptions' being applied. For administrative reasons some locations may waive such charges.

[83]. Only when they have proceeded abroad under MoD-approved arrangements and retain the right to a MoD-approved return passage.

6	Dependants accompanying members of Other Overseas Forces attached to UK Forces overseas.					
7	Dependants accompanying members of other Overseas Forces not attached to UK Forces overseas, but when there are specific MOUs/SLAs which permit access to specific areas of DMS healthcare.					
8	Family members/relatives or other temporary visitors who do not have locally recognized “dependant” status visiting “accompanied” (i.e. residing with their entitled dependants) Service personnel or MOD civil servants overseas.					
9	Foreign born spouses/civil partners of Service personnel and their dependant children residing unaccompanied (due to Service exigencies) in their country of origin (and where DMS treatment facilities are locally available and where authority has been granted).					
10	Dependants accompanying MoD Contractors working overseas, when the Contractors’ contract with MoD stipulates access to specific areas of DMS healthcare (and on repayment if specified in the contract).					
11	Locally Employed Civilians overseas.[85]					
12	Dependants accompanying NAAFI personnel (including Sponsored Foreign Nationals) serving overseas.[86]					
13	Dependants of members of the Royal Gibraltar Regiment (Regulars).					
14	Dependants of the Royal Gibraltar Regiment (TA).					
15	Dependants accompanying SSAFA personnel					

[84]. Dependants of Commonwealth Forces and other Overseas Forces may be defined in the same way as for dependants of UK Forces personnel.

[85]. Occupational Health services may be provided.

[86]. The costs of providing such healthcare are currently to be reclaimed from NAAFI at the concessionary rate, in accordance with the NAAFI charter except where local SLAs / contracts specify different arrangements (e.g. PAYD in Germany). When a specific local SLA/contract states that certain groups/individuals working for NAAFI are not eligible to DMS Healthcare, such healthcare is not to be provided.

	serving overseas.[87]					
16	Dependants accompanying UK Foreign and Commonwealth Office Staff serving overseas.[88]					
17	Dependants accompanying WRVS staff serving overseas.					
18	Dependants accompanying members of the Defence Welfare Service serving overseas					
19	Dependants accompanying UK members of the Council of Voluntary Welfare Work working overseas.					
20	Retired members of the Armed Forces living overseas.					
21	Dependants accompanying MoD employed BRITCON and UNFICYP Continuity Post personnel in Cyprus.					
22	Dependants accompanying members of the British UNFICYP Roulemont Regiment.					
23	Dependants accompanying SSVC/BFBS[89] staff serving overseas.					

[87]. This may either be provided free of charge, or on a repayment basis, depending upon local contractual arrangements.

[88].The DMS have historically allowed access to FCO staff to DMS healthcare, where available overseas. This arrangement is to continue, but under the auspices of SLAs negotiated between the DMS and the FCO whereby costs incurred by the DMS to provide such treatment are recovered from the FCO. Locally employed FCO staff and their families are not eligible to access DMS Healthcare Facilities overseas.

[89]. Whilst SSVC/BFBS staff and their dependants are eligible to access DMS healthcare overseas, this may be on a repayment basis (depending upon local arrangements).

CHAPTER 5 – TRI-SERVICE RECOVERY POLICY

Service personnel remain entitled to welfare support from the Chain of Command (CoC) until their last day in Service. Commanding Officers must ensure that this support is tailored to either return a person to duty, or to prepare the Service Leaver[90](SL) for life after discharge. Every case where an individual is no longer fit for service as a result of their medical status will be assessed individually. No one will leave the Armed Forces until they have reached a point in their recovery where leaving the Armed Forces is the right decision.

PART 1 – DEFENCE RECOVERY CAPABILITY

1.5.1. **The Requirement.** The Defence Recovery Capability (DRC) is to deliver a conducive military environment within which all serving Wounded, Injured and Sick (WIS) personnel get the appropriate support to enable an effective return to duty or transition to a properly supported and appropriately skilled for civilian life. The DRC provides command and care for serving WIS personnel to both improve the deployability of the Armed Forces and discharge the CoC's duty of care to those under Command.

1.5.2. **WIS**. WIS personnel include all those Service men and women, including mobilised Reservists, who are unable to undertake their normal duties, within defined medical categories[91].

1.5.3. **The Capability.** The DRC is an MOD owned capability designed to deliver programmed, command-led and coordinated support to WIS personnel. It is delivered through single Services (sS) Recovery Pathways drawing on the resources of sS led Personnel Recovery Units (PRU), Personnel Recovery Centres (PRC) run in partnership with Service charities, and specialist centres such as the Battle Back Centre. The Recovery Pathways are aligned with clinical treatment and rehabilitation, but do not deliver mental or physical treatment or rehabilitation. Whilst charitable partners may own and/or operate specific Recovery Centres, the capability is a State function for serving WIS and the overall ownership of the capability remains an MOD responsibility.

a. The sS CoC s are responsible for, and have a duty of care to their serving WIS personnel. They will provide a single point of command (nominated personal recovery officer) for each WIS to guide the individual to their recovery outcome. Serving WIS personnel remain subject to sS administration and discipline.

b. As a 'Requirement Authority' the MOD, through the sS, will:

(1) Set the policy and plans for providing the appropriate support and recovery activities that enable and empower WIS personnel to achieve their individual recovery outcome;

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[90] JSP 534 The Triservice Resettlement Manual page 27 para 0302.
[91] In accordance with JSP 950 Medical Policy, part 6, chapter 7

(2) Determine the DRC delivery requirement for a conducive military environment and the appropriate support and services required by WIS personnel to achieve their recovery outcomes are to be delivered;

(3) Commission the relevant support and services from MOD sources and, where they are not available, from 'delivery partners';

(4) Provide assurance of the DRC.

1.5.4. **The Recovery Pathway.** The recovery pathway takes an individual from the point of wounding, injury or sickness to a recovery outcome which is either a return to duty or transition to a properly supported and appropriately skilled civilian life. The recovery pathway complements the clinical pathway[92]. The DRC is currently delivered through three related
but separate sS Recovery Pathways. WIS personnel in recovery must receive the same level of outcome, both in terms of optimising their recovery and preparation for discharge and transition to civilian life, should a return to Service not be possible; whilst allowing tolerable differences to reflect sS circumstances and ethos.

a. **Personnel Recovery Units.** Those WIS requiring support beyond the capability of their current unit will be assigned to a PRU which will own the command function to deliver their recovery. The decision to assign to a PRU lies with the sS chain of command. Everyone posted to a PRU to recover will be assigned a Personnel Recovery Officer (PRO).

b. **Individual Recovery Plan.** A PRO will work with the WIS under their command to create a tailored Individual Recovery Plan (IRP) to enable them to focus on their outcome. The IRP incorporates all aspects of an individual's recovery including medical, welfare, housing, education, re-skilling, work placements and employment opportunities.

c. **Activities**. The MOD, as the Requirement Authority, supported by SMEs will establish and state what is required of the capability and specifically what activities are relevant for an individual to achieve their recovery outcome. The sS will authorise, commission and coordinate delivery of all recovery activities. Activity will be delivered routinely by Service personnel.

When activity is more appropriately delivered by other means or when MOD resource is not available, the MOD will commission external organisations to deliver appropriate support and activity. Recovery activities fall into three broad strands or 'workstreams':

(1) **Workstream 1**. Courses and activity critical to an individual achieving their outcome are Core Recovery Events (CRE)[93], normally delivered by the MOD.

[92] An individual's Clinical Pathway is determined by clinical experts. The MOD has responsibility for ensuring that WIS personnel receive appropriate healthcare in order to reach their clinical outcome - either clinical recovery ('get better'), or clinical stability, or an ongoing managed clinical situation.
[93] The RN has a separate pathway but WIS personnel achieve CRE outcomes within their assigned recovery workplace.

(2) **Workstream 2**. Courses and activity that directly support Workstream 1. These are enabling activities that support individuals in moving towards the next step (next CRE) on the recovery pathway.

(3) **Workstream 3**. Any other activity that is included in the detailed individual recovery programme.

d. **Support**. Support will routinely be provided by the military CoC and MOD organisations. Where this support is not available from MOD sources, it will be commissioned by the sS from key delivery partners and other external organisations. Responsibility for ensuring the delivery of appropriate support remains at all times with the MOD/sS.

e. **Conducive military environment**. A conducive military environment, including an appropriate command structure, is provided for all aspects of the DRC. The environment will vary according to an individual's condition and the stage of their recovery journey. Judgment is required of the CoC, informed by subject matter experts and in consultation with partners, to set the right conditions. The default environment would normally be a PRC or appropriate garrison[94] facility but recovery officers have the following options:

(1) **Routine garrison facilities**. Where possible, WIS individuals will have an appropriate place of work within their parent unit's barracks or in suitable facilities within the local garrison. They might be directed to conduct specific activity within specialist MOD provided facilities further afield.

(2) **Personnel Recovery Centres**. PRCs provide a conducive military environment where WIS personnel can conduct recovery activity in support of their IRP. CRE will normally be delivered by the MOD in PRCs, with priority given to serving WIS personnel. Where capacity is not fully used by serving WIS personnel, key partners may use the PRCs for activity that falls within their wider charitable objectives when covered by MOD protocols and site-specific agreements. This will normally be for WIS veterans, who may be accompanied by supporting family members. PRCs are run either by the MOD or by key partners (TRBL and H4H) to deliver the following services:

(a) 'Hotel' (food, accommodation and leisure) services,

(b) Office and classroom facilities (administration, work and training),

(c) Physical development and 'well-being' facilities,

(d) A 'Support Hub' office and interview facilities for Veterans' Welfare Service (VWS) to undertake their mandated role of performing an initial triage of requirement with individuals, in addition to that available for external charities to use in support of WIS.

(e) Activities as specifically commissioned by the sS Recovery organisations.

[94] Or the RN and RAF equivalent.

(3) **Battle Back Centre Lilleshall**. The Battle Back Centre at Lilleshall is a specialist centre which runs multi-activity courses to develop confidence and self-esteem amongst the WIS during their recovery journey. It should be attended as early as possible in the recovery process and once assigned to a course attendance is considered a duty rather than optional.

(4) **Specialist facilities**. There will be individual WIS personnel for whom the routine garrison facilities and PRCs do not provide an appropriate environment. Externally provided specialist facilities will be commissioned by the sS Recovery organisations for use by these individuals as an alternative.

(5) **Home**. For the purposes of recovery, 'Home' is accommodation from which to commute to work; for leave; for personal administration; for directed clinical recuperation or specified recovery/rehabilitation activity. WIS personnel should ordinarily only work from home when their clinical condition precludes attendance at a PRC, specialist facilities or local garrison facilities. 'Sick at Home' is not to be the default setting for recovery activity; the preferred option to deliver a conducive environment is either garrison facilities or PRCs.

1.5.5. **Stakeholder Groups.**, Defence sets the User Requirement for recovery pathways through sS recovery policies, sS command serving WIS personnel as they recover and manage transition where required. The MOD is also responsible for monitoring and tracking the Armed Forces Covenant outputs, including those with a specific link to the transition of WIS personnel into civilian life. The DRC is also underpinned by a series of strategic partnerships and other relationships. The DRC stakeholder responsibilities are as follows:

a. **MOD.** Within the Department, internal stakeholders support various aspects of Defence Recovery:

(1) **Chief of Defence Personnel (CDP)**. Defence Authority for People and Health. Responsible for DRC policy which he exercises through Assistant Chief of Defence Staff (Personnel & Training) (ACDS (P&T)).

(2) **Surgeon General (SG)**. SG is the Defence lead within the MOD/NHS Strategic Health Partnership. This partnership provides a formal interface between MOD and the Department of Health (DH), NHS England and health authorities within the Devolved Administrations, providing a forum in which clinical pathway decisions may be undertaken.

(3) **ACDS (P&T).** Chairs the Defence Recovery Board.

(4) **Directorate of Defence Communications (DDC)**. Lead on strategic communications issues between MOD and the Service charities.

(5) **Defence Infrastructure Organisation (DIO)**. Manages DRC infrastructure issues, notably for aspects funded by the Service charities

(6) **The Veterans Welfare Service (VWS)**. VWS's purpose is to enhance the quality of life for veterans and their dependants. Under Veterans UK the VWS works in collaborative partnerships with the Services, ex-Service charities,

statutory and non-statutory bodies, local community service providers and Veterans Advisory & Pensions Committees to deliver a welfare service that promotes independence, within a veterans' community, but provides continuous support through life. It also provides support to enable the seamless transition from Service to civilian life for the more challenged groups. It achieves this by adopting a single central coordinating role that facilitates access to all appropriate services involved in transition.

(a) **Seriously Injured Leavers' Protocol**. The Seriously Injured Leavers Protocol (SIL) aims to ensure the identification and ongoing support for those Service leavers deemed likely to be medically discharged due to a severe physical or mental disablement. This identification is based upon defined major disabling medical criteria, whilst the support is achieved through the closer working of MOD in-Service and post Service welfare groups. VWS are proactive in intervention for 24 months and then maintain contact as required by the client, but at least yearly on the anniversary of discharge. http://www.veterans-uk.info/welfare/protocol_new.html

(b) **Transitional Welfare Requirement**. An additional protocol may be used for those leavers on an Administrative, Medical or normal discharge which it is deemed will have a Transitional Welfare Requirement (TWR). VWS are proactive at the point of referral, maintain contact as required by the client and are then proactive, yearly on the anniversary of the discharge. http://www.veterans-uk.info/welfare/referring_officers.html

(c) **Routine Medical Discharges**. With other medical discharges VWS initiate contact when JPAC notify of the discharge, maintain contact as required by the client and are then proactive, yearly on the anniversary of the discharge. The VWS provides a national caseworker approach that offers help and guidance in a professional manner through either telephone contact or a dedicated visiting service. The VWS can be contacted via the Helpline Freephone: 08001914 218, or email: veterans-uk@mod.uk

b. **Single Services.** The sS care for the serving wounded, injured and sick through recovery pathways that have bespoke entry criteria but common outcomes. 'Collectively they command 17 specialist recovery units and cells which are run by military personnel within 21 MOD bases. These recovery units provide the day to day recovery support for wounded, injured and sick personnel.

c. **NHS England.** Armed Forces' healthcare is commissioned by NHS England who support healthcare to the Armed Forces community through 3 Area Teams (AT)[95]. Each AT has Armed Forces' Networks (AFN) within its area. The responsible AT will facilitate and act as the NHS advisor to support a Multi-Disciplinary Team (MDT) approach through early engagement with the appropriate responsible commissioner. This is essential for those with complex health needs or the seriously WIS individual. This will include engaging with the receiving local authority for social care assessment as part of the MDT. Each AT has links to their

[95] Securing excellence in commissioning for the Armed Forces and their families March 2013

respective PRU to enable effective communication between the NHS and MOD. This will enable and facilitate the smooth transition of the SL. Further information relating to NHS England and Armed Forces ATs can be found at Annex A.

d. **NHS Scotland.** NHS Scotland is organised into geographically based NHS Boards, together with a number of national Special Health Boards. Health Boards are established on a residential basis and are responsible for the provision of secondary health treatment for military personnel[96]. Personnel should provide their unit address as their place of permanent residence. Each NHS board has a designated Armed Forces Champion[97]. The champion is responsible for leading and coordinating Armed Forces, their families and veterans issues in their Health Board area.

e. **NHS Wales.** NHS Wales comprises of 7 integrated Health Boards (LHBS) who plan, design, develop and secure the delivery of community and secondary health services, along with specialist and tertiary services for their areas. LHBs are responsible for securing the provision of secondary healthcare treatment for the Armed Forces with the responsible LHBs determined by where the person is usually resident, which in general is the unit in which the person is based[98].

f. **Northern Ireland.** The MOD has commissioned secondary healthcare from Belfast Health and Social Care Trust in order to fulfil the unique security requirements, providing a degree of anonymity to serving personnel. All non-elective care, maternity and cancer referrals and genital-urinary services are excluded from the contract. These services will continue to be commissioned by the Health and Social Care Board which operates through local commissioning groups.

g. **Charities**. The charitable sector plays a pivotal role in the delivery of the DRC. The Royal British Legion (TRBL) and Help for Heroes (H4H) are the MOD's strategic delivery partners for the PRCs. Their contributions are coordinated through the Defence Recovery Board (DRB).

PART 2 - THE DELIVERY OF DEFENCE RECOVERY

1.5.6. **Governance & Management.** The DRC is owned by the MOD. The PRCs are jointly delivered by the Partners - MOD, TRBL and H4H.

a. **Governance.** The DRB is a stakeholder group chaired by ACDS(Pers & Trg) on behalf of CDP and influences the MOD's Defence Recovery policy and delivery. The DRB is supported by the Defence Recovery Working Group (DRWG), Defence Recovery Medical Advisory Group (DRMAG), Defence Recovery Communication Group (DRCG) and sS Recovery and Welfare committees. Membership of these Groups is at Annex B.

b. **Assurance**. In order to deliver its duty of care to serving WIS personnel, the sSs must ensure that there is a 'safe system' for commanding, caring for, and providing the necessary support and activity to enable the WIS personnel to reach

[96] Establishing the Responsible Commissioner: Guidance and Directions for Health Boards, March 2013.
[97] Veterans Health Zone - NHS Champions | NHS Inform
[98] Responsible Body Guidance for the NHS in Wales

their recovery outcome, regardless of who is delivering a particular activity. Each Service has a duty to provide a safe and appropriate conducive military environment within which the support and activity can be delivered. The DRC must meet the stated Defence requirement. Legislation, Mandated Codes of Practice and MOD regulations/procedures must be followed and the capability must provide value for money. Partners are responsible for their own activities and ensuring that they meet at least the MOD specified requirement[99].

c. **Agreements.** A series of Service Supply Agreements, Service Level Agreements and Lease Agreements define bespoke management, operating and sustainment arrangements for each recovery site.

d. **Defence Recovery Sites**. Elements of the DRC are delivered within designated Recovery sites, such as the PRCs and Battle Back Centre. Where the charitable Partners have Principal Operator Status within a Defence Recovery site, they have responsibility for the management and daily functioning of the site as detailed in supporting commercial agreements.

e. **Healthcare**. Responsibility for primary healthcare and the co-ordination of all aspects of healthcare for serving WIS personnel within the DRC remains with the Defence Medical Services (DMS). NHS England is responsible for the commissioning of standard NHS secondary acute and some community care services (except where DMS have primacy). However, the Defence Recovery Sites are not medical treatment centres and no healthcare activity may be undertaken which would bring the site under the regulation of the Care Quality Commission (CQC) for healthcare delivery.

f. **Serving Personnel Admission Criteria to the DRC system.** The admission criteria to the DRC is driven by sS policy**,** and can be found in:

(1) **Royal Navy** – BR 3, Part 5, Chapter 33 – Recovery Pathway Policy.

(2) **Army** - AGAI, Vol 3 Chapter 99: Command and Care of Wounded Injured and Sick Personnel.

(3) **Royal Air Force** - AP 3392, Vol 5 Leaflets 125 and 135.

g. **Communication.** DDC are the custodians of all communication pathways and messages in relation to the DRC.

h. **Data Protection and Information Management**. All information pertaining to the treatment, rehabilitation and recovery of serving WIS personnel remains the property of the individual and those directly involved in the delivery of that care. The management of personal information is governed by the Data Protection Act and current MOD policy.

i. **Data Recording**[100]. SSs are to collect appropriate data such that they can track their personnel through the Recovery Pathway, measuring their progress and

[99] An external 3rd party assurance framework is being piloted 2014-2015.

[100] The Army and RAF use WISMIS, a command tool for the management of WIS personnel, to capture specific information relating to an individual's recovery pathway and alert the CoC to mandated actions. The RN use WISMIS in the Naval Service Recovery Centre only. Other RN Recovery Cells use the FECA (Flotilla Employment Capability Application) system that enables the management of WIS and non-WIS personnel that are temporarily employed ashore in the naval bases.

outcomes. This data must be suitable for managing demand for services, ensuring that the use of centres remains effective, and to answer appropriate information requests.

1.5.7. **Personnel Recovery Centre Usage.** Experience shows that the majority of injured personnel find a military environment conducive to recovery and part of the DRC provision is purpose-built PRCs. These are not hospitals, rehabilitation or physiotherapy centres. They provide residential accommodation for service personnel undergoing recovery who do not have suitable alternative accommodation either at home or in their unit. They assist Service men and women in their recovery and support the PRUs to deliver enhanced progress along the recovery pathway. PRCs are operated under Service Level Agreements with 3rd sector charities, within a Partnership Agreement.

a. **Admission Criteria to the PRC.** The following criteria and prioritisation will be applied to serving personnel, including reservists, prior to entry:

(1) WIS Serving Personnel allocated to the DRC;

(2) WIS Serving Personnel in any of the Armed Services not within the DRC;

(3) WIS Veterans, on a case-by-case basis and in accordance with the Veterans' Entry Protocol.

b. **WIS Veterans**. The DRC is resourced and designed by the MOD to deliver the command, care and support for serving WIS personnel. The objectives of the Partner charities include the extension of that support to WIS veterans. It is acknowledged that the Defence Recovery Sites will be of benefit to some WIS veterans. Where the charities have Principal Operator Status, WIS veterans may have access to those sites on a case-by-case basis in accordance with the relevant charitable objects and meeting the requirements of the Veterans' Entry Protocol. The Veterans' Entry Protocol to the Defence Recovery Sites is at Annex C.

c. **Access for Families.** It may be appropriate for family members of both serving and veteran WIS to attend PRCs, either on a daily basis or residentially. These civilians must be subject to a code of conduct, to be agreed between the policy branch of the sS lead for that PRC and the operating charity.

d. **Access to Garrison Facilities.** WIS Veterans attending PRCs, as part of an authorised programme and in conjunction with Annex C, may require access to garrison/base facilities[101]. Garrisons/Bases are to put in place arrangements to cover liability, charging, access, etc. All risks associated with the use of these facilities by veterans will be the liability of the Operating Charity.

e. **PRC use other than Recovery.** Activities undertaken within the PRC are to be restricted to those in direct support of the recovery or transition of WIS personnel. All media events must first be cleared through DDC. If an event involves marketing this must be cleared through that PRC's lead sS policy branch, in addition to DDC. When a charity wishes to conduct an event that is not directly related to the recovery of WIS, they are to request either a rolling exception or an exception for a one-off event, through that PRC's lead sS policy branch.

[101] Examples of facilities they may be eligible to access are; gymnasiums, swimming pools and vehicle transport, although this list is not exhaustive

1.5.8. **Medical and Employment Boards.** SS medical boards should be held as early as possible to determine an individual's likely recovery outcome and focus IRPs accordingly. Early medical board decisions provide clarity to the WIS individual and provide a timeframe for those designing continuing recovery and further support and enable the external agencies that will take over the care to make suitable arrangements. Service Manning Authorities should ensure that decisions regarding employability and discharge dates are either informed by, or undertaken concurrently with, an assessment of an individual's broader needs. This is critical where a medical board is recommending discharge and sS Manning Authorities are responsible for processing discharge. Those authorising discharge must be satisfied that they have full visibility of an assessment undertaken by the individual's CoC before identifying a discharge date and before notifying the individual. The principle is one of "informed decision making" so that an initial discharge date is based on the recovery and resettlement needs of the individual and not simply on entitlements to resettlement and terminal leave. For those individuals within Service Recovery pathways for whom discharge is recommended, these requirements will be captured and passed to Service Manning Authorities by Recovery Officers or Case Workers from the Recovery Unit. For those personnel within units who are not within a Service Recovery pathway, it remains a unit responsibility to ensure that all relevant information on an individual is passed to the Service Manning Authority before a discharge date is finalised and announced. As Recovery continues, the rigorous application of the 5 questions will indicate if a delay in a previously determined discharge date is appropriate. In that instance, an application to delay a discharge date shall be made to the sS Manning Authorities. A decision at a Medical or Employment board must not initiate a chain of events which leads to the automatic generation of a discharge date, independent of the needs of the individual.

1.5.9 **Medical Discharge Policy**. Advice to the employers on the medical fitness of an individual is provided through the award of a Joint Medical Employment Standard (JMES). The JMES is then used to inform the decision by the employer on whether that individual should be retained, if the functional ability associated with their medical condition permits, or whether their condition precludes future employment, in which case the Service as employer will arrange for termination of their service. Each case is considered on its merits.

1.5.10. **The 5 Questions of Transition**. In order to deliver the necessary consistency of outcome, the CoC shall determine that it is the right decision for someone to leave the Armed Forces by answering the 5 questions of transition:

a. **What is the individual's Permanent Medical Category?** Service Medical Boards should be conducted at a time that best meets the needs of the individual, as directed by the CoC and informed by clinicians. Early Medical Boards should be tailored to include potential review points where outcomes remain uncertain.

b. **What is the individual's employability within the Service?** sS Employment Boards will make the decision whether to retain an individual or direct their orderly transition out of Service, once the permanent medical category is clear. sS Employment Boards must be satisfied that all options to provide continued employment to WIS personnel have been explored, including transfer to alternative trades within a Service, or transfer to other career opportunities in another Service. Medical and Employment boards are to make decisions about a

person's future at the right time, early enough to maximise recovery or transition; this should not initiate a chain of events that will lead to an abrupt discharge.

c. **Has the individual's treatment been optimised or reached a plateau?** The clinical aspects of recovery must take primacy and WIS personnel must not be discharged until:

(1) The Service medical chain formally agrees that in-Service medical care and support (including rehabilitation) has been optimised;

(2) External agencies (NHS/Local Authority (LA)) required to provide care to the individual post-discharge have been fully engaged in the recovery process and assessment prior to discharge;

(3) The external agencies are deemed appropriate to accept responsibility for the WIS individual to meet their needs (health/social care) and are ready so to do.

d. **Has resettlement, training and education been completed?** WIS personnel must have the opportunity to undertake full resettlement, tailored where necessary, in order to best position the individual for civilian life, including adaptive living courses when appropriate. Discharge should not take place unless an IRP has been completed. Access to resettlement employment support, provided through the Recovery Career Services and the Career Transition Partnership, will be given at the earliest appropriate stage of the WIS Recovery Pathway as determined by a case conference, and need not await the outcome of the Full Medical and Employment Boards. This system ensures that WIS are 'job ready' on transition to an appropriately skilled, supported and sustainable civilian life.

e. **Is Society ready to receive the individual?** An individual should not be discharged until the Service is confident that society is ready to receive and support that individual. An assessment process must be in place to ensure that WIS individuals are given the best possible preparation for their transition to civilian life. Where assistance from external agencies is required during, or following transition, it is essential that those agencies be engaged as early as possible during the Recovery process. In more serious cases this may require the inclusion of the NHS, LAs, Third Sector Organisations / Charities and the wider patient stakeholder group within the case conference framework. Communication with external organisations is the responsibility of the assigned PRO for the individual.

1.5.11. **The Transition Process.** The transition of WIS personnel into civilian life can present a far greater challenge than that for non-WIS SLs. These challenges are recognised within each of the sS Recovery Pathways, enabling tolerable variation to exist within delivery to reflect sS ethos, but ensuring outcomes remain consistent. This is achieved through:

a. Formally managing WIS personnel into, through and out of Recovery;

b. Establishing regular case conferences to inform IRPs where appropriate.

c. Maximising options for WIS personnel to return to Service from Recovery;

d. Ensuring that those WIS personnel who will transition from Service to civilian life do so with the best possible preparation and enduring support, to enable common outcomes across the sS and ensuring that the receiving agencies are well prepared. The mnemonic HARDFACTS is to be used by the assigned PRO to ensure the best possible transition, taking into account the Recovery lines of development of 'mind, body and soul'. Annex D describes the breakdown of HARDFACTS in detail.

e. Assuring that VWS is actively engaged as a key business partner in the Transition process, delivering statutory responsibility for the provision of welfare to veterans. Also ensuring that other appropriate external agencies responsible for the continuity of care and support beyond discharge are aligned to the specific, individual requirements of WIS personnel.

f. For the most serious WIS cases, case conferences should be established before an individual enters a Service Recovery Pathway (e.g. at Royal Centre for Defence Medicine - Birmingham and Defence Medical Rehabilitation Centre – Headley Court). This should trigger consideration of early engagement with the NHS. All WIS personnel leaving the Service will be the subject of a final case conference prior to discharge, with the authority to recommend a change in the date of that discharge, if not satisfied that the 5 Questions of Transition have been fully addressed.

PART 4 – CARE TRANSITION

1.5.12. The Transition process will require cooperation from all elements responsible for delivering the Patient Care Pathway. The principles of clinical transition for Service Leavers are in JSP 950 Leaflet 1-3-4 which also covers the transition of more complex cases who may require NHS continuing healthcare (CHC).

1.5.13. The elements of Care Transition may include, but are not restricted to in-Service providers, the VWS, the NHS and other local government delivery agents[102]. The Transition Protocol reflects NHS policy and organisational arrangements in the United Kingdom, and is at Annex E. Where a Service Leaver has long-term care requirements and their primary need is one of health; following transition; the receiving Clinical Commissioning Group (CCG) will take responsibility for their health and social care under CHC arrangements. Where an individual's primary need is not one of health, following transition, the receiving CCG will continue to provide healthcare and the LA may have responsibility for supporting the individual in meeting their social care needs. The VWS has an enduring commitment to remain engaged in assisting veterans to access whatever support they need for as long as required.

1.5.14. **Nomination of MOD Case Coordinator**. A single MOD POC should be nominated by the individual's CofC to act as the MOD Case coordinator. It can be whomever the CofC deems the most appropriate[103] in order to support the service leaver and ensure good communications, both internally and externally. The Case Coordinator will need to be kept informed of all actions and requirements for the service leaver. This is not a clinical role, but a personnel

[102] Primarily LAs but also Department of Work and Pensions.
[103] Usually be the personnel recovery officer, but may be Recovery Unit's CO or OC.
Coy, CO PRU or CO Unit, OC PHF, or alternatively a Welfare Coordinator on behalf of the above.

function to provide a single POC to all those involved in the service leaver's case, both internally and externally.

1.5.15. **Identification of relevant NHS Support**. The MOD Case Coordinator is to make contact with the relevant NHS Armed Forces support Team (Annex D refers). The receiving NHS Region will primarily be determined by the SL's proposed GP registration, at the location of the SL's intended future residence (even if actual registration with the GP has not yet taken place).

1.5.16. **Assessment of NHS CHC.** The NHS definition of **'**Continuing care' means a package of ongoing care that is commissioned and funded solely by the NHS where it has been assessed that the individual has been found to have a 'primary' health need[104] provided to an individual aged 18 or over, to meet needs that have arisen as a result of disability, accident or illness. The NHS Continuing Healthcare Checklist (CHL), is a tool to be used to help practitioners identify who needs a full assessment for NHS CHC. It must be noted that the CHL threshold has been set very low to ensure inclusivity of a wide range of healthcare needs as the one framework applies to all care needs thus any onward referral to full assessment for NHS CHC is not an indication of the outcome of the eligibility decision. Completion of the CHL can happen at any time in a clinical pathway and must be considered for all individual's discharging on medical grounds. NHS England in conjunction with the local CCG will coordinate the completion of the CHL with the individual's clinical team, the MOD Case coordinator, the SL and their family should they wish to be involved.

1.5.17. **Young Persons to Adult Services (<18 years of age).** The National Framework for NHS CHC is used to determine what ongoing care services people aged 18 years or over should receive from the NHS. Legislation and the respective responsibilities of the NHS, social care and other services are different for those under the age of 18 years (young person) and those 18 years or more (adult). It is important that young people and their families are helped to understand this and its implications right from the start of transition planning. It is desirable and best practice that future entitlement to adult NHS CHC is clarified as early as possible in the transition planning process, especially if the young person's needs are likely to remain at a similar level until adulthood. Transition guide explains how all relevant services should work together with a young person to identify how they can best support that person to achieve their desired outcomes; early engagement with external agencies (NHS and LA) is crucial.

1.5.18. **Establishment of a Multi-Disciplinary Team for potential NHS CHC cases**. It must be borne in mind that the intention is for the CHL to be completed as part of the wider process of assessing or reviewing an individual's health needs . Therefore it is expected that all staff who apply the CHL are familiar with the principles of the National Framework for CHC and NHS-funded Nursing Care and with the Decision Support Tool (DST) for NHS CHC. MDT involvement in CHL is defined at sub-paras a-c below and further detailed within the flow diagram at Appendix 1 to Annex E:

a. **Multidisciplinary**: refers to when professionals from different disciplines (such as social work, nursing and occupational therapy etc) work together to address the holistic needs of their patients/clients, in order to improve delivery of care and reduce fragmentation. It is important that there is an appreciation of the different stakeholders in these meetings and that all Caldicott principles are upheld when sharing patient identifiable information.

[104] The national framework for NHS continuing healthcare and NHS-funded nursing care - November 2012 (revised).

b. **Multidisciplinary assessment**: an assessment of an individual's needs that has actively involved professionals from different disciplines in collecting and evaluating assessment information.

c. **Multidisciplinary team**: a team of at least two professionals, usually from both the health and social care disciplines and should include those who have an up-to-date knowledge of the individual's needs, potential and aspirations.

d. **NHS CHC Checklist**: The respective NHS Regional Team working in conjunction with the PRU, will agree the responsible commissioner who will then appoint a case coordinator to lead and facilitate the NHS CHL and CHC assessment process where required (Appendix 1 to Annex E refers). This will normally be the receiving CCG for the transitioned SL; however in exceptional circumstance such as End of Life; this may fall to NHS England. The SL's MOD Clinical Facilitator (or equivalent) and the CCG Case Coordinator will jointly arrange for an NHS CHL and any subsequent CHC assessment to be undertaken with appropriate attendees.

e. **NHS CHC Decision Support Tool (DST)**: A positive CHL will identify those who are eligible to go forward for a full NHS CHC Assessment; this will involve the completion of the National CHC DST tool and will include a review of records and identification of current health needs. The NHS MDT involved in the full assessment will then review the evidence and formulate a recommendation of eligibility or non-eligibility for NHS CHC funding clearly identifying the areas of primary health need. The responsible commissioner will then consider both the evidence and recommendations within the DST to confirm if there is a primary health need. If the SL is found eligible for NHS CHC funding, the responsible commissioner will subsequently commission a placement /package of care to be commenced at the right time for the patient. If an individual is found not to be eligible for NHS CHC, the MOD Case Coordinator, in conjunction with the VWS, will remain responsible for coordinating consideration of eligibility for other health and social care services from the responsible NHS commissioner and LA, both of whom should have been represented within the MDT.

1.5.19. **Timeline**. Transition planning depends on the individual's needs and will be iterative and requirements will emerge over time. The NHS CHL checklist[105] can prompt health, social and welfare matters that the MOD Case Coordinator and/or PRO and AT lead may wish to consider. Early contact will enable the Regional Team assist and identify the potential responsible commissioner. The initial case conference should also take place early in the process, especially for the more complex cases, and no later than 3-6 months prior to likely discharge for any case. This will allow sufficient time for health and social care arrangements to be put in place to support transition for the SL leaving the service. Where appropriate, early registration with an NHS GP in a locality of the SL's future residence is essential and can provide a useful link between the MOD and other elements of the NHS.

1.5.20. **Social Care.**

[105] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213138/NHS-CHC-Checklist-FINAL.pdf

a. **Means Testing.** Where the NHS CHC does not take primacy, an SL's income may attract means testing. The means testing is dependant upon the Service Leaver's circumstances.

b. **In-service Social Care**. In-Service social care is the responsibility of sS. When the Service is unable to provide the level of social care prescribed for an SL, any contracted social care will be paid for by sS TLBs. This provision includes those SLs who require residential care.

c. **Protection from Means Testing**. In all cases, capital from Armed Forces Compensation Scheme payments can be protected from means testing if placed in a personal injury trust. Guaranteed Income Payment (GIP) is disregarded from means testing under guidance from the Dept of Health. The different circumstances where means testing is/is not applied are detailed below:

(1) **Non-Residential Care whilst In-Service**[106]. An SL's salary is not means tested. The LA has the discretion to disregard State benefits from means testing.

(2) **Non-Residential Care when out of Service**. An SL's salary is not means tested. GIP should also be disregarded from means testing in accordance with DH guidance.

(3) **Residential Care whilst In-Service**. The cost of In-Service residential care should be met by the sS TLBs.

(4) **Residential Care when out of Service**. The SL's salary and State benefits (DLA) are means tested. Capital greater than £23,250, unless placed in a personal injury trust, is means tested. GIP should be disregarded from means testing iaw Dept of Health guidance.

1.5.21. **Prostheses**. If fitted with prosthetic limbs while serving, an agreement has been reached to ensure that the NHS will maintain the same high standard of prosthetic limbs to all veterans, when clinically appropriate. Prosthetic requirements must be discussed with NHS services to ensure that an appropriate NHS prosthetic service is identified[107]. The NHS operates prosthetic services for veterans with access to the latest technology and offer the highest quality of prosthetic care to veteran amputees. The devolved administrations have undertaken to provide similar provision.

1.5.22. **In-Service Access to NHS**. Members of the UK Armed Forces are entitled to access secondary and community healthcare at NHS hospitals on the same basis as other members of the public. Provision of primary healthcare and primary rehabilitation is the responsibility of the Surgeon General, as the Defence Authority for healthcare, though arrangements for NHS GP support should be arranged where appropriate.

1.5.23 **Mental Health Care.** Regular and mobilised Volunteer Reserve personnel are entitled to mental healthcare from Defence Medical Service (DMS) as well as services provided by NHS. Prior to discharge from service all personnel will undergo a Structured Mental Health Assessment (SMHA). If a mental health problem is identified during this assessment they will be entitled to access care in a DMS UK Department of Community

[106] For Service Leavers who request social care above and beyond that prescribed by sS personnel recovery assets.
[107] JSP950 2-22-3 The Provision Of Upper And Lower Limb Prosthetics For Service Personnel provides further detail.

Mental Health (DCMH) for up to 6 months after discharge[108]. Non Mobilised Volunteer Reserve will be entitled to access[109] the Veterans and Reserves Mental Health Programme (VRMHP)[110] for a full mental health assessment. If their condition is assessed as attributable to operational experience they will be entitled to access a course of treatment at a UK DCMH; otherwise they will be signposted to NHS provision[111]. Regular Reserves/Veterans are entitled to access the VRMHP for a full mental health assessment and on completion, a report giving guidance on care and treatment will be sent to their GP.

1.5.24. **Escalation Procedures**. The Transition Protocols will need time to bed in and become well understood. In order to maintain confidence in the system it is essential that during this period there is a rapid and effective method of resolving any issues concerning a lack of provision. Those patients in receipt of NHS CHC funding will have been assigned a named CHC case manager to work closely with them and their family to ensure the placement/package of care meets their needs. In the event that the patient or their family have any concerns relating to the care being provided; these should be raised, in the first instance, with the named CHC Case Manager and/or providers following the local processes in place. A network of NHS Armed Forces Leads and Regional Armed Forces Networks (Annex A) have been established in each AT where any lessons can be learned and best practice shared between interested parties should this be appropriate.

1.5.25. **Third Sector Contributions.** The sS Welfare Staff/VWS will ensure that third sector provision is considered where this can complement the statutory provision by the NHS or LA.

1.5.26. **Veterans' Access to NHS**. Resident veterans have full access to NHS services. If a Veteran has a health problem that could be related to their time in Service, their GP may be able to refer the individual more quickly for any treatment required. If suffering from a condition that has been caused by Service life, secondary care clinicians are asked to prioritise care over patients with similar clinical need. Veterans are not given priority over other patients with more urgent clinical needs.

Annexes:

A. Defence Recovery Groups.
B. Veterans' Entry Protocol.
C. Transition Pathway Tool - HARDFACTS.
D. MOD/NHS Transition Protocols.

Annex A to Chapter 5 of Part 1 of JSP 770

DEFENCE RECOVERY GROUPS

1. **Defence Recovery Board (DRB).** The DRB provides the strategic governance for the Defence Recovery Capability and constitutes the principal forum for monitoring and

[108] In these circumstances care within the DCMH cannot be undertaken unless the individual is registered with a civilian GP. Medication will not be funded by the MOD. Both Military Inpatient Service Provision (ISP) and aspects of military rehabilitation (e.g. graded return to work) with not be available.
[109] Individuals are entitled to self refer, however, contact is made with their GP before assessment occurs.
[110] VRMHP, Chetwynd Barracks, Chilwell, Nottingham, NG9 5HA.
[111] This would be their GP in the first instance and where appropriate, care advice is given.

delivering coherence in issues relating to requirement, implementation and development of the DRC across the MOD, in cooperation with key partners.

2. **Composition**

a. **Chair**: ACDS(Pers&Trg)

b. **Core Members**:

1) Naval Secretary (Royal Navy)
2) Director General Personnel (Army)
3) COS Personnel (Royal Air Force)
4) Director Med Pol & Op Cap
5) Head DIO SD Accommodation
6) Chief Executive, Help for Heroes (H4H)
7) Director General, The Royal British Legion (TRBL)
8) Chairman, Cobseo
9) Chairman, Recovery Career Services
10) Head Armed Forces Commissioning (NHS England)

c. **In attendance:**

1) Recent WIS representative.
2) Chair Defence Recovery Working Group (Defence Recovery Capability)
3) Deputy Head Service and Veterans Welfare
4) At Chairman's discretion where appropriate to support specific agenda items; a representative from leading charities engaged in the support of WIS and WIS veterans, including Combat Stress and BLESMA.

d. **Secretary**: SO2 Health & Wellbeing (SVW).

3. **Tasks**. The DRB is to:

a. Provide strategic direction on the requirement, implementation and development of the DRC across the MOD, in cooperation with key partners and stakeholders.
b. Ensure the effectiveness, continual improvement and value for money of the DRC through an appropriate assurance framework.
c. Act as arbiter on any Defence recovery issues with Third Sector partners, providing guidance and, if necessary, brokering agreements between stakeholders and monitoring progress of such agreements.
d. Assess the outputs from, and task as appropriate, the DRWG and the DRC Action Groups.
e. Monitor and manage risks to the DRC.
f. Provide a forum in which members raise general Defence recovery issues or concerns and seek resolution/arbitration

4. **Defence Recovery Working Group**. The DRWG is the MOD's forum for single Service recovery capability staffs and key partners to manage activities at a working / capability level.

5. **Composition**:

a. **Chair**: AD ARC

b. **Core Members**

(1) MOD: CDP-SVW SO1 Operational Welfare
(2) MOD: AD TESRR
(3) DMC: Ops PR
(4) Chair of the Defence Recovery Medical Advisory Group (DRMAG)
(5) Royal Navy: SO1 Casualty and Recovery Management
(6) Army: PR Branch, SO1 Ops/Plans
(7) RAF: Air Pers Pol, Community Support DACOS
(8) Help for Heroes (H4H): Chief Financial Officer
(9) The Royal British Legion (TRBL): Programme Manager
(10) COBSEO
(11) SPVA
(12) NHS LO

c. **In-Attendance**: Subject Matter Experts as required

d. **Secretar**y: SO2 LF PRC

6. **Tasks**. The DRWG is to:

a. Review, refine, implement and manage the Defence Recovery Action Plan (DRAP), updating the Plan as necessary.

b. Report progress regarding the Action Plan to the DRSG.

c. Identify issues for discussion, resolution or arbitration at the DRSG.

7. **Defence Recovery Medical Advisory Group**. The Defence Recovery Medical Advisory Group (DRMAG) is to support the medical component of Defence Recovery delivery, including Transition. It achieves this by providing focussed and timely medical and healthcare information and advice to the Defence Recovery Working Group, as well as supporting the development[112] and implementation[113] of relevant healthcare policy.

8 **Composition**:

a. **Chai**r: HQ SG ACDS StratPol Med Dpty

b. **Core Members**:

(1) Army PersSvcs-PRBr-ARC-MedSO1 – Sec
(2) HQ SG JMC Healthcare
(3) HQ SG JMC DMG Role 4
(4) DCDS Pers PCV Senior Medical Advisor
(5) SG ACDS MedOpCap-MedIS
(6) DoH Military Liaison Officer
(7) SG DPHC Representative

[112] Through the HQ SG Medical Policy Steering Group.
[113] By HQ SG, PJHQ, JMC, DPHC, JMTRA, sS Medical HQs and others

c. **Corresponding Members** (receive copies of agenda and RODs and attend as required):

(1) HQ SG Secretariat
(2) Defence Health and Wellbeing Strategy– DCA PH
(3) Devolved Administration NHS Representatives
(4) AIR COS Pers Pol RAF PRU
(5) NAVY Pers Representative

9. **Tasks.** The DRMAG is to

a. Advise the Defence Recovery Working Group (DRWG) and Medical Policy Steering Group (MPSG) on:

(1) The requirements of medical policy and process to support recovery, transition and related areas.

(2) The data requirements to support the medical aspects of recovery processes and outcomes.

b. Support the MPSG in the production of medical policy to support recovery and transition including monitoring relevant data.

c. Liaise with internal and external stakeholders as required.

10. Function of the DRMAG is:

a. Support and advise amendment and changes to transition policies (JSP 950 and JSP 770) which are:

(1) Coherent and congruent with the output and recommendations of the DRWG.

(2) Endorsed by the MPSG.

b. Supply relevant med/health data to DRWG/Others iot inform wider recovery and transition work

11. **Defence Recovery Communication Group**. The Defence Recovery Communications Group (DRCG) is to provide the overall communication governance, in regard to Defence Recovery, for the MOD. It aims are:

a. To devise and implement a suitable communications programme to promote and support the planning, creation and operation of the DRC.

b. To create awareness, understanding and support amongst stakeholders, both MOD and external, of the help being provided to WIS personnel through the programme.

c. To agree and implement branding and communication guidelines that enable all participating organisations to achieve their objectives and the DRC programme in an equitable, appropriate and mutually supportive way.

d. To create timely, accurate and compelling communications messaging that represents partners' involvement appropriately for use at specific events/milestones and on an ongoing basis.

12. **Composition**:

a. **Chair**: Col Public Relations (Army)

b. **Core Members**:

(1) ARC Project/Comms Manager
(2) MOD DMC Press Office representative
(3) TRBL Comms representative
(4) H4H Comms representative

c. Other co-opted members as required to provide SME input.

VETERANS ENTRY PROTOCOL Objective

1. The Veterans Entry Protocol (VEP) for veterans' use of Personnel Recovery Centres (PRC) is to ensure that:

a. cases are considered fairly and consistently between the Services and between PRCs, whilst allowing tolerable difference based on single Service ethos and taking account of the particular characteristics of each PRC and its supporting infrastructure;

b. appropriate control and safety measures are established, such that risks are minimised for all those attending, visiting and working in PRCs; residual risks are understood, and mitigation measures have been established;

c. the desired Service ethos and standards of good order and discipline are maintained as a primary purpose, to support the recovery of Service WIS, either to return to duty or to effect a managed transition to civilian life;

d. that the requirements of the charity partners to support veterans can be managed effectively.

Principles

2. The following principles are to be adopted:

a. Use of centres by veterans must be acceptable to the single Service owner of the recovery capability at that centre.

b. Veterans may only use spare capacity, once the primary needs of serving WIS Regulars and Reservists have been met.

c. Spare capacity is to be determined in a manner that is acceptable to both the lead single Service and the lead charity at that recovery centre, and coordinated with the Army Recovery Capability Allocation Board (or equivalent) process.

d. In line with the requirements placed on serving personnel, a veteran's use of a PRC is to be for a defined purpose and for a specified time, to ensure that expectations and outcomes are managed; and that place-blocking does not occur, thereby blocking a place for serving WIS.

e. PRCs are not healthcare facilities nor for the medical management of veterans or Service personnel. On the occasions when healthcare professionals choose to deliver a peripatetic service at a PRC, this is at the risk and under the governance of the healthcare provider; and the commissioning agent[114] is to assure that the provider is appropriately governed; and when the commissioning agent is not the

[114] **Commissioning Agent** is defined as the organisation arranging for attendance of the healthcare professional.

MOD, the PRC operating authority[115] is to ensure that such safeguards have been addressed.

f. Veterans attending a PRC shall agree a code of conduct to ensure that a Service ethos and standards of good order and discipline are maintained within the PRC.

g. A PRC's operating authority has overall responsibility for the veteran whilst attending the facility, in relation to the veterans' safety, and that of all others attending, visiting or staffing the PRC.

h. All costs of veterans at PRCs shall be the responsibility of the lead charity at the hosting PRC.

Eligible Veteran

3. A veteran may be eligible (but not entitled) to attend a PRC, either as a day visitor or as a resident, if they are:

a. a medically discharged regular or reservist having been injured, wounded or sick whilst in Service or as a result of Service, or has been through the recovery capability for an attributed reason; and are

b. within 2 years of their discharge date, for those still to complete or top-up elements of their IRP; or

c. within 5 years of their discharge date for those who require physical conditioning (post or pre-medical operation); or education and training.

4. These criteria are based upon the principle that the centres must be available for core Defence Recovery Capability work, maintaining the required Service ethos, but they are not absolute. It is envisaged that the lead charity at the relevant recovery centre will discuss with the lead Service Policy Division[116] exceptions to these guidelines on a case by case basis, so long as any such exception does not detrimentally impact on the primary purpose of providing for Serving WIS.

Entry Criteria

5. The following are the entry criteria which have to be met:

a. Fits veteran's eligibility criteria.

b. Residential veterans shall have a specific referral, with identification of the problems to be addressed and identified outcomes, with a specified timescale, and reflected in a Veterans IRP, which would be similar to the Serving IRP, and administered by the lead charity.

c. The veteran shall agree to an MOD approved code of conduct.

[115] **PRC Operating Authority** is the organisation delivering the day-to-day running of the PRC, for example, the Naval Service at Hasler Coy, or H4H at Tedworth House.
[116] Nav Sec, DG Pers and Air Sec.

d. The sponsoring charity shall prepare an overall risk assessment, engaging with professional providers as required, to address healthcare, social care and behavioural risks, including an assessment of previous convictions, so as to underwrite the safety of the veteran, other residents, visitors and staff; and establish an appropriate mitigation plan, before use of the PRC is granted to the veteran.

e. In particular those with managed mental healthcare needs shall have a risk assessment conducted by their current mental healthcare provider, and the sponsoring charity shall satisfy itself that the mitigation measures stipulated can be met, before use of the PRC is granted to the veteran.

f. Individual is registered with an NHS GP or is registered on arrival.

g. Childcare support and support for family is available outside of, and not dependent on a PRCs.

h. PRCs are not to be used as a routine or a permanent place of residence. i. Individual is self-medicating and not known to be an illegal drug user.

j. The OC PRC(Recovery) is able to ask for an application for a veteran to attend a Centre to be declined, or subsequently ask for a veteran to leave a Centre, if having examined all factors it is judged that the veteran's attendance is to the detriment of Service ethos, good order and discipline, or otherwise impedes the recovery pathways of Service personnel attending the centre

6. Any partner of the DRC can request a review of the protocol through the DRSG.

TRANSITION PATHWAY TOOL – HARDFACTS

1. **Introduction.** Once a decision has been made that an individual's recovery has been optimised or reached a plateau, the Personal Recovery Officer (PRO) will commence the transition process. In order to enable a common outcome, the PRO will utilise the mnemonic HARDFACTS. The use of the HARDFACTS model should be viewed as a positive experience, where the Wounded, Injured and Sick (WIS) personnel are encouraged to see the HARDFACTS as challenges and not barriers to their future lives, at whatever point they the transition to civilian life.

2. The HARDFACTS forms the framework of the Individual Recovery Plan (IRP). The model incorporates a network of interrelated factors, when brought together; address all the areas of an individual's life. The IRP is an adaptive personal development tool that contains two critical elements; a table to address and analyse each of the HARDFACTS and a calendar in order to manage the activities. It is an enduring document that needs to be effective for, and owned by, the individual.

3. **HARDFACTS outcomes**. To ensure as seamless as possible transition, the following factors are to be considered:

a. **Health**. The Serviceperson is clinically appropriate to enter transition (stable with no further remaining value in retention within the Armed Forces). The NHS is able and ready to accept the individual and their treatment regime. For some patients, especially the complex trauma, it can be very lengthy and involve multiple providers in the DMS, NHS and contracted agencies. The patient care pathway is an intrinsic element of the IRP and is managed by the unit medical staff. In complex cases, the Regional Occupational Health Team (ROHT) may take the lead. Patients remain able to undertake recovery duty iaw the IRP and UMOs/ROHT staff should advise on functional capacity, so that suitable activity can be identified. This may include periods at work in a military environment in order to inform medical rehabilitation and OH staff about functional capacity for work. These are for clinical purposes and overseen by clinical staff. This is not the same as work experience or work placements.

b. **Accommodation and Relocation**. This is to be safe and appropriate in the right region and which is a conducive environment, noting; health, training, education, employment, families and any other areas of significance. The Joint service Housing Advice Office (JSHAO) should act as the initial point of contact for housing matters for all WIS personnel. Some WIS personnel, who require specialist assistance, should be directed to other housing related services. This should take place at the most appropriate point in their recovery pathway, when determined by their RPO. Early engagement with D Infra is vital to identify a need for adaptation. The Haig Housing Trust is designated by The Confederation of service Charities (COBSEO) as the lead service charity for housing issues.

c. **Drugs and Alcohol (Stress)**. Conducive environment and appropriately supported. Transition to civilian life can bring concern about employment, housing, loss of status, loss of financial stability etc. Medical discharge can be more difficult

for the individual to manage than those planned under normal circumstances. Alcohol and drug abuse can be seen to alleviate the stress of difficult life events. These areas can be a significant factor in suicide vulnerability and early engagement with subject matter experts, including those within the 3rd sector, is essential. Confidential Support Line, contact numbers; UK: 0800 731 4880 Germany: 0800 1827 395 Cyprus: 080 91065.

d. **Finance and Benefits**. Financially independent, aware and able to support self and dependants with either a job or source of income. All service personnel receive an automatic forecast, of any ill-health pension benefits they are entitled to, normally no later that 6 weeks prior to their date of discharge. Generally, forecasts will be provided up to 3 months in advance of the individual's date of discharge where the FMB result has been received by SPVA and a discharge date has been set. For service leavers who require who require a forecast sooner, information is to be sought through their unit pay office.

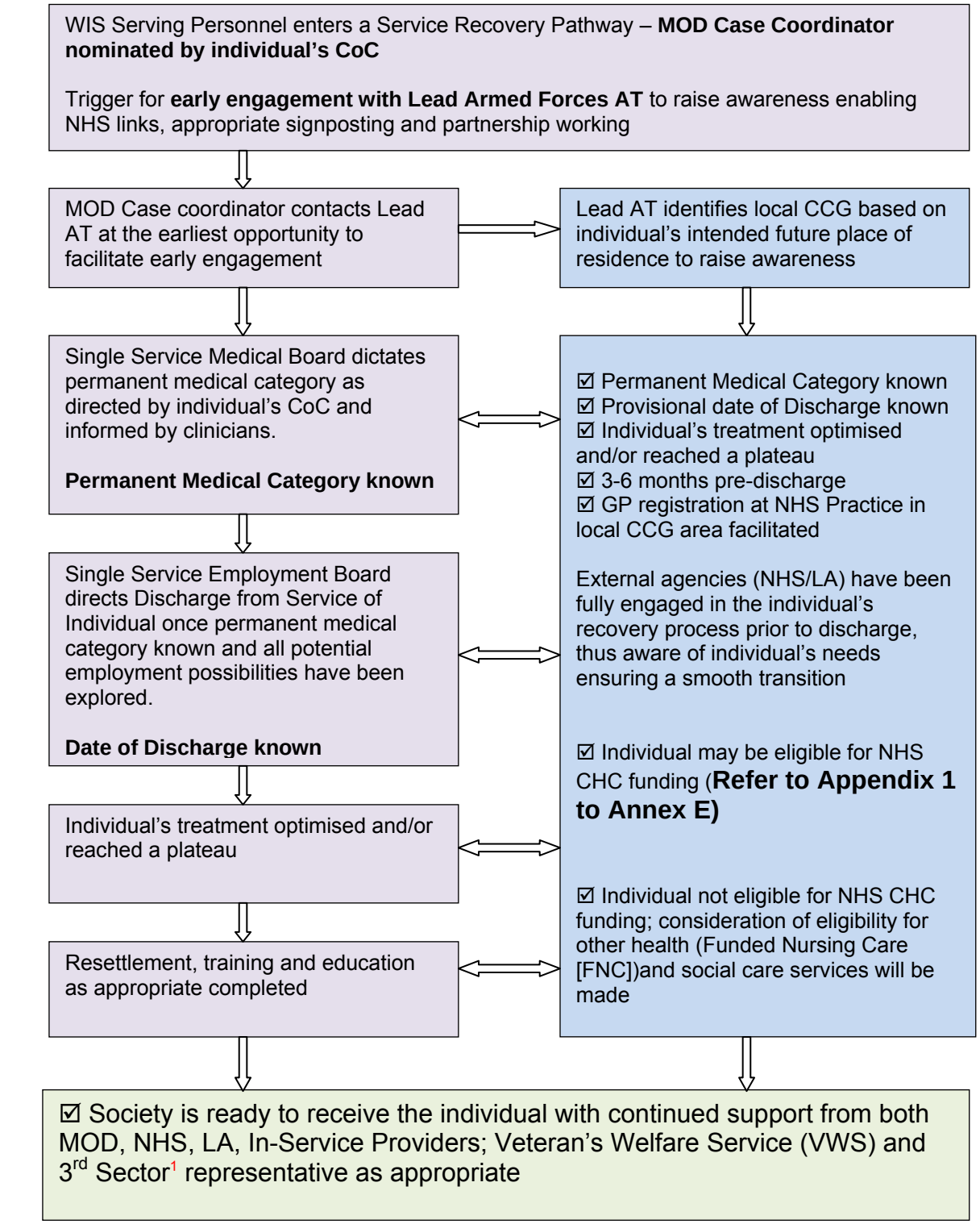
e. **Attitude, Thinking and Behaviour (Welfare)**. Self-reliant with a positive mental attitude, including engagement with appropriate welfare connections. A number of stakeholders are able to provide assistance within this area, first-line support and direction to other facilities should be made through the UWO. For those who are assigned to a recovery pathway, their RPO will be the first POC. The handover of welfare cases between organisations is a critical event and must be dovetailed to ensure that the provision of welfare services is maintained in a continuous and seamless manner.

f. **Children and Family**. Ensuring the needs of the family and any children are fully considered and appropriately supported. Vulnerable individuals should be identified as early as possible and referred to the appropriate organisation. Connection and engagement with the 3rd sector is essential in this area.

g. **Training, Education and Employment**. In employment, or full-time education. Able to gain CPD.

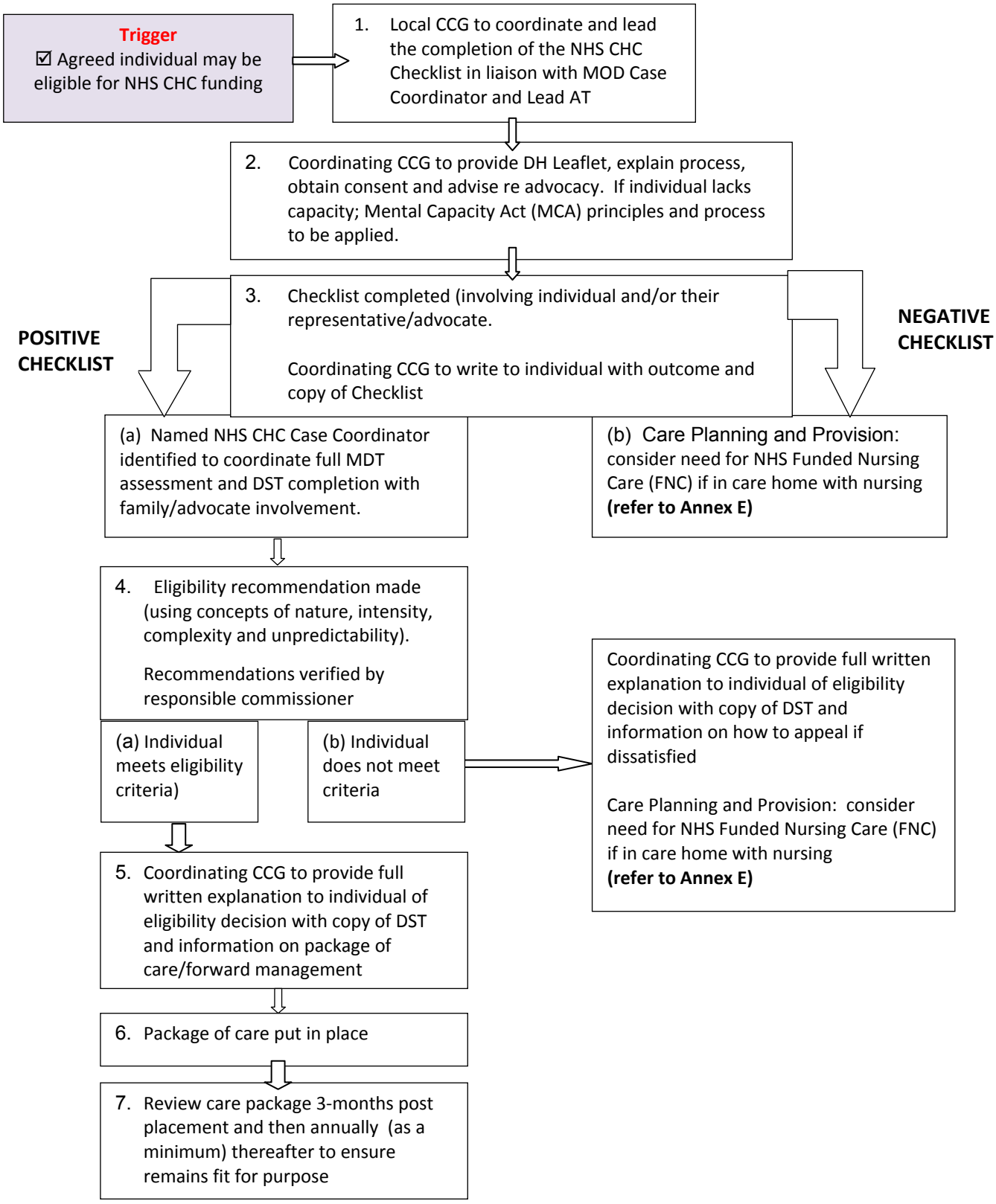
h. **Supporting Agencies**. Awareness of existing agencies' and a clear understanding of the system of access, including POCs and mentoring.

TRANSITION PROTOCOL PROCESS (ENGLAND)



[1] The Third Sector may well have been engaged with the provision of support prior to any decision to discharge. In such circumstances they will remain engaged throughout the process of Transition Planning

CHC TRANSITION PROTOCOL;
NHS CONTINUING HEALTHCARE PROCESS (ENGLAND)



TRIGGER **Whilst the NHS CHC framework is clear that the eligibility process is to be coordinated by the receiving responsible commissioner – it is done so in conjunction with the individual's MOD Case Coordinator and any other persons who have had input into the health and social needs of the individual as appropriate.**

Notes: CHC Practice Guidance (PG) 18 stated that a checklist should only be completed once an individual's treatment has reached the stage where their needs on discharge are clear.

The individual should be given reasonable notice of the need to undertake the Checklist. What constitutes reasonable notice depends upon the circumstances of the individual case.

(1) **PG 17:** whilst the checklist has been designed to be completed in a variety of settings; it is for the local CCG/AT/LA (as appropriate) to identify and agree who can complete the tool but is its expected that it is done so by trained, competent staff.

(2) **PG21: CHC explanation -** the DH patient information leaflet on NHS CHC should be given to the individual. Opportunity should be given for an explanation of the NHS CHC process to the patient and for dealing with any questions about it. It should be made clear that completion of the Checklist does not indicate likelihood that they will be eligible for NHS CHC. **PG 5: Confidentiality/capacity/consent -** states that where the individual has mental capacity; their informed consent is required before completion of the checklist to both participate in the CHC process and to share MDT information (please refer to sub-paras a-c of para 1.5.18 for definition of MDT). Should patient not have capacity; IMCA representation will be required – this will be coordinated and agreed by the receiving CCG/AT/LA (as appropriate).

(3) Whatever the outcome of the Checklist/DST – whether or not a referral for a full assessment for NHS CHC eligibility is considered necessary – the decision (including the reasons why the decision was reached) should be communicated clearly and in writing to the individual and (where appropriate) their representative, as soon as is reasonably practicable.

3(a) Positive checklist	**3(b) Negative checklist**
Individual named CHC Case Coordinator identified to work with patient and coordinate onward process; completion of NHS Decision Support Tool (DST).	Forward transition planning and provision considered (Appendix E refers) as is need for Funded Nursing Care if patient in care home setting with nursing

PG27: DST - defines the purpose of the DST to support the identification of eligibility for NHS CHC and is designed to collate and present information and evidence in relation to the care domains contained within to assist consistent decision making. **PG 28** discusses the constituent elements of a good MDT assessment as being the process of gathering relevant, accurate and up-to-date information about the individual's health and social care needs and applying professional judgment to decide what this information signifies in relation to those needs.

(4) **PG37** states the recommendation should provide a summary of the individual's needs in the light of identified domain levels; providing statements about the nature, intensity, complexity and unpredictability of the individual's needs whilst at the same time, giving an explanation of how the needs in any one domain may interrelate with another to create additional complexity, intensity or unpredictability. **PG33: Consistency of recommendations –** recommendation should be presented to the responsible commissioner, who should accept this, except in exceptional circumstances. These circumstances could for example include insufficient evidence to make a recommendation or incomplete domains.

(5)/(6) Coordinating CCG to provide full written explanation to individual of eligibility decision with copy of DST and information on how to appeal if dissatisfied. Confirmation of the care package to be provided could be included within the letter or, if not known at that stage, should be supplied as soon as available.

(7) Once an individual has been found eligible for NHS continuing healthcare, the local CCG is responsible for case management, including monitoring the care they receive and arranging regular reviews. Review is undertaken usually after 3-months then every 12-months. If needs have decreased it may be necessary to reconsider eligibility for NHS CHC

B: Should an individual be found not eligible to either go to full DST assessment or following DST assessment not eligible for NHS CHC funding; they will be informed of how to appeal if they are dissatisfied.

NHS ENGLAND ARMED FORCES HEALTH AREA TEAMS

1. The respective Regions/AT tables are:

Region	AT Armed Forces Commissioning Lead	Armed Forces Network
South	Bath, Gloucestershire, Swindon & Wiltshire	South West
South	Bath, Gloucestershire, Swindon & Wiltshire	South Central and SE Coast
South	Bath, Gloucestershire, Swindon & Wiltshire	London
Midlands & East	Derbyshire & Nottinghamshire	W Midlands
Midlands & East	Derbyshire & Nottinghamshire	E Midlands & East of England
Northern	North Yorkshire & Humber	Yorks and Humber
Northern	North Yorkshire & Humber	North East
Northern	North Yorkshire & Humber	North West

TRANSITION PROTOCOL (SCOTLAND)

Patient arrives in Scotland (usually from Queen Elizabeth Hospital or DMRC Headley Court)
following notification to Personnel Recovery Unit (PRU)

↓

Commanding Officer PRU develops and coordinates Personnel Recovery Plan for patient

↓

Casualty Key Worker arranges initial screening for NHS Continuing Healthcare in accordance with CEL 6 (2008) 'NHS Continuing Healthcare' guidance.

↓

Patient is registered with NHS GP in Scotland (ideally 3-4 months before expected discharge) – See Appendix 1 to Annex C for contact details of regional NHS Boards

↓

PRU contacts appropriate NHS Board in accordance with NHS CEL 6 (2013)
Establishing the Responsible Commissioner: Guidance and Directions for Health Boards, March 2013

↓

NHS Board convenes multi-disciplinary team (MDT) of health and social care professionals likely to be involved with individual's care

↓

Case conference between MDT, in-Service providers, Veterans Welfare Service (VWS) (and 3rd Sector representatives (Note 1))

↓

MDT completes Assessment Summary, using information from case conference, to determine CHC eligibility in accordance with CEL 6 (2008). (Note 2)

↓

NHS Board develops and commissions care package with CO PRU.

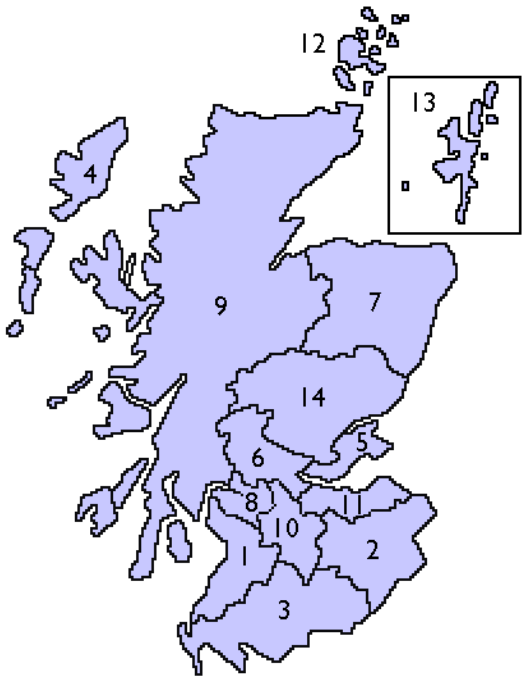
Notes:

(1) If already involved in care or if the PRU determines that 3rd Sector involvement would be beneficial and has been agreed by the patient and/or their representative.

(2) If individual is found not to be eligible for CHC, the NHS Board will still consider need for other health care services at the MDT case conference. Local authority social care services should be represented on the MDT so that social care needs can also be addressed.

NHS Scotland Organisational Structure

The NHS in Scotland is organised into 14 geographically-based NHS Boards, together with a number of national Special Health Boards. Hospitals are run by the acute division of the
NHS Board. GPs and pharmacies are contracted through the NHS Board, but work in Community Health Partnerships based largely on local authority boundaries and serving up to around 100,000 people. Some also provide social care under the umbrella of Community Health & Care Partnerships. Each NHS Board has an Armed Forces Lead.



	NHS Board	Armed Forces Contact
1	NHS Ayrshire & Arran	01292 614590
2	NHS Borders	01896 825507
3	NHS Dumfries & Galloway	01387 241346
4	NHS Western Isles/Eilean Siar	01851 708008
5	NHS Fife	01592 648143
6	NHS Forth Valley	01786 457208
7	NHS Grampian	01224 558505
8	NHS Greater Glasgow & Clyde	0141 8432646
9	NHS Highland	01583 421206
10	NHS Lanarkshire	01698 258781
11	NHS Lothian	0131 242 3300 / 3301
12	NHS Orkney	01856 888097
13	NHS Shetland	01595 743087
14	NHS Tayside	01382 632112 / 632321

TRANSITION PROTOCOL (WALES)

Ministry of Defence (MoD) Multi-Disciplinary Team completes initial assessment and Continuing NHS Healthcare Checklist [2]

↓

MoD Case Coordinator alerts relevant Local Health Board (LHB) Veterans' Armed Forces 'Champion' [3]

↓

MoD Case Coordinator also notifies Health & Social Services' Directorate General (H&SSDG) Veterans' Champion

↓

LHB appoints Local Case Coordinator and notifies appropriate GP.

↓

Local Case Coordinator convenes Multi-Disciplinary Team (MDT) of the health and social care professionals to be involved in individual's care. MDT undertakes necessary comprehensive and specialist assessments [4]

↓

Case conference between MoD, MDT, in-service providers, Veteran's Welfare Service (VWS) (and third sector representatives) to review comprehensive assessment [5] [6]

↓

LHB accepts responsibility if appropriate. Decide if individual does *not* meet criteria but *does* need a joint-care package

↓

MoD and LHB multi-disciplinary teams design individual care package. Coordinator/'Champion' to be informed of progress

↓

LHB works with Local Authority (social care) and other agencies to agree and implement care package

NOTES:

1. NHS Wales comprises seven integrated Local Health Boards who plan, design, develop and secure the delivery of primary, community and secondary care services, along with specialist and tertiary services for their areas.
All LHBs and NHS Trusts have appointed a Champion for Veterans and Armed Forces. From April 2010, LHBs have an all Wales Veterans' Health & Well-Being Service.

There are 22 Local Authorities in Wales responsible for social care. Appendices 1 and 2 to Annex D provide the details of the 22 Local Authorities, 7 Local Health Boards and 3 NHS Trusts in Wales. Each LHB Board also has a Local Authority Member

2. If an individual is found not to be eligible for CHC (at either Checklist or final decision stage), the LHB will still consider need for other healthcare services and the individual should also be referred to Local Authority (LA) social care for consideration of eligibility for their services (which is why LA social care should be part of MDT as this ensures they have already been involved in assessing the individual's needs thus preventing repetition of assessment).

If the individual disagrees with the decision on CHC eligibility, they can request that the LHB arranges an Independent Review Panel (IRP). An IRP will review the process used to make the decision and the application of the primary health need approach. If it finds deficiencies, it can either recommend that the LHB reconsiders the case or it can make its own recommendation on eligibility. LHBs are expected to accept IRP recommendations in all but exceptional circumstances.

To facilitate care planning, an early alert or referral to the Wales system is vital. Appendix 3 to Annex D details the internal process of the LHB for managing a referral.

3. This will be through a single point of contact at regional level (see contact sheet at Appendix 4 to Annex D). This person will also maintain a watching brief to ensure that response times etc are met.

4. The multi-disciplinary assessment should be completed in partnership with the patient and their family / carers. It should aim for as accurate a prediction as possible of future care needs.

5. The third sector may well have been engaged with the provision of support prior to any decision to discharge. Clearly, in such circumstances they will need to be engaged throughout the process of planning transition.

6. The Initial MDT Case Conference will review the assessment, agree likely timescales and begin the care planning process.

7. Implementation of the care package should also include the date of the first review.

LOCAL AUTHORITY AND LOCAL HEALTH BOARDS (WALES)

7 Local Health Boards in Wales:

Aneurin Bevan Health Board
Abertawe Bro Morgannwg University Health Board
Cardiff & Vale University Health Board
Hywel Dda Health Board
Cwm Taf Health Board
Betsi Cadwaladr University Health Board
Powys Teaching Health Board

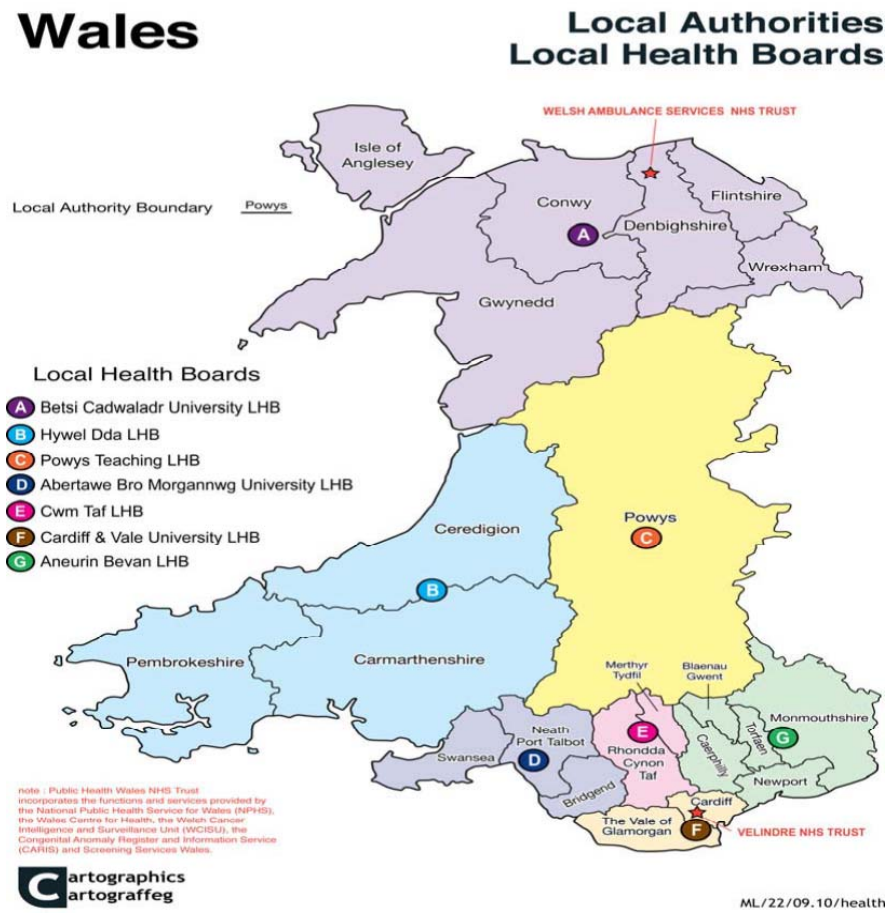
3 NHS Trusts in Wales:

Public Health Wales NHS Trust
Welsh Ambulance Services NHS Trust
Velindre NHS Trust

22 Local Authorities in Wales

Blaenau Gwent County Borough Council
Bridgend County Borough Council
Caerphilly County Borough Council
Cardiff Council
Carmarthenshire County Council
Ceredigion County Council Conwy
County Borough Council
Denbighshire County Council
Flintshire County Council
Gwynedd County Council
Isle of Anglesey County Council
Merthyr Tydfil County Borough Council
Monmouthshire County Council
Neath Port Talbot County Borough Council
Newport City Council
Pembrokeshire County Council
Powys County Council
Rhondda Cynon Taf County Borough Council
Swansea City and Borough Council
Torfaen County Borough Council
Vale of Glamorgan Council
Wrexham County Borough Council

LOCAL AUTHORITY AND LOCAL HEALTH BOARDS (WALES) – MAP



For information on Health Boards and NHS Trusts, including details of local services such as
GPs per area, please see:

http://www.wales.nhs.uk/ourservices/directory
http://wales.gov.uk/topics/health/nhswales/?lang=en

For information on Local Authorities, please see:

http://wales.gov.uk/topics/localgovernment/localauthorities/?lang=en http://www.wlga.gov.uk/english/authorities/

INTERNAL (WALES) PROCESS FOR MANAGING A REFERRAL

LHB and Champion receives alert / notification from MoD Case Coordinator

↓

LHB identifies Local Case Coordinator

↓

Local Case Coordinator liaises with MoD Case Coordinator

↓

Initial multi-disciplinary conference call / video conference

↓

Receiving LHB will co-ordinate comprehensive/specialist assessments in partnership with
MoD

↓

Development of care package and discharge plan

↓

Discharge to Wales

↓

On-going review of care package.

REGIONAL CONTACTS TO RECEIVE ALERTS OR INITIAL REFERRALS

Any initial queries should be
directed to: Richard Hockey
Health & Social Services Directorate General
Welsh Assembly Government
029 2080 1470
Richard.hockey@wales.gsi.gov.uk

Organisation	Name	Role	Tel number	Postal address
Abertawe Bro Morgannwg University Health Board	Prof Ceri Phillips	Veterans/Armed Forces, Non-Executive Director	01639 683670	Abertawe Bro Morgannwg University Health Board, 1 Talbot Gateway, Baglan Energy Park, Baglan, Port Talbot SA12 7BR
Aneurin Bevan Health Board	Cllr Brian Mawby	Independent Board Member (Local Authority)	01873 732732	c/o Aneurin Bevan Health Board, Mamhilad House, Block A, Mamhilad Park Estate, Pontypool, Torfaen, NP4 0YP
Betsi Cadwaladr Health Board	Dr Lyndon Miles	Independent Board Member	01248 384 384	c/o Betsi Cadwaladr Health Board, Ysbyty Gwynedd, Penrhosgarnedd, Bangor, Gwynedd, LL57 2PW
Cardiff & Vale Health Board	Stuart Egan	Independent Board Member (Trade Union)	029 2074 7747	c/o, Cardiff & Vale Health Board, Cardigan House, University Hospital of Wales, Heath Park, Cardiff CF14 4XW
Cwm Taf Health Board	Professor Donna Mead	Non-Executive Director	01443 744800	c/o Corporate Services Ynysmeurig House, Navigation Park, Abercynon CF45 4SN
Hywel Dda Health Board	Mike Ponton	Independent Board Member	01437 771220	c/o Hywel Dda Health Board Headquarters Merlins Court, Winch Lane, Haverfordwest, Pembrokeshire, SA61 1SB
Public Health Wales NHS Trust	Prof. Sir Mansel Aylward	Chairman	029 2022 7744	14 Cathedral Road Cardiff CF11 9LJ
Powys Health Board	Dr Sumina Azam	Lead officer for Powys	01874 711661	c/o Powys Health Board, Mansion House, Bronllys, Brecon, Powys LD3 0LS
Velindre NHS Trust	Paul Griffiths	Non-Executive Director	02920 196161	c/o, Velindre NHS Trust Corporate Headquarters, Unit 2 Charnwood Court, Parc Nantgarw, Nantgarw, Cardiff CF15 7QZ
Welsh Ambulance Services NHS Trust	Stuart Castledine	Non-Executive Director	01745 532900	Stuart Castledine, c/o, Welsh Ambulance Services NHS Trust, HM Stanley Hospital, St Asaph, Denbighshire LL17 0RS

TRANSITION PROTOCOL PROCESS (NORTHERN IRELAND)

Employment Board direct discharge from service of individual.

MOD Case coordinator contacts local Northern Ireland case officer.

Local Case officer organises for individual to be registered with a local NHS GP {ideally 3-4 months before expected discharge).

Local Case officer contacts Regional Disablement Services Centre managers to arrange delivery of NHS GP referral letter.

Local case coordinator convenes Multi-Disciplinary Team {MDT} with the Regional Disablement Service and individual to undertake comprehensive and specialist assessment of needs.

The MDT will design a Care Package for the individual and implement

The individual will then liaise directly w with the appropriate Health Care professionals at the Regional Prosthetic Service should any further needs be identified.

NHS Northern Ireland Organisational Structure

The NHS in Northern Ireland is organised into 5 geographically based Health and Social Care Trusts. All Trusts use the Regional Disablement Service which is located in the Belfast Trust.

Regional Disablement Service
RDS Building
Musgrave Park Hospital Belfast
Stockman's Lane
Belfast
BT9 7 JB
Telephone 028 95041747

CHAPTER 6 - CASUALTY AND HOSPITAL WELFARE SUPPORT

Background

1.6.01 The general framework for welfare support to Service personnel and their families applies equally in the casualty and hospital context where, though the setting and circumstances are special, the basic need for support is the same. It is likely also that the support required will extend beyond the hospital setting – this would not be unusual in support of families – and may involve agencies that are not typically seen as welfare providers. Welfare support to casualties and in hospitals therefore must be consistent with welfare support in general rather than artificially set in a separate context. In particular, the responsibility and lead for support to the Patient Group[117] remains with the chain of command.

Requirement and Principles

1.6.02 The requirement for support will vary dramatically depending on individual circumstances. Every case will be different and support must be based on the best outcomes for the Patient Group. This in itself is no different to the usual disparate demands for personal support given the complexity of life in the Service community but, given the additional (and sometimes compelling) clinical element, it will often raise the stress level. The key factors for Service personnel and their families are:

a. **Urgency**. It is human nature that most people do not think about – or even actively avoid thinking about – what might happen after a serious injury. Although comprehensive information is made widely available in advance it is unlikely that this will meet the needs of Service personnel or families faced with a sudden, generally catastrophic, change in circumstances. This leads to a requirement for early personalised briefing of the Patient Group.

b. **Confidence and Reassurance**. In a casualty context Service personnel and their families will be under considerable stress. Support must be offered in a way that instils confidence and trust. This demands a reliable, consistent, quick, accurate and reassuring delivery mechanism. Given fear and uncertainty, clarity at the earliest stage of the process is critical.

c. **Personalised Support**. Although an accepted framework and common understanding of what can be delivered and how it will be delivered is important it is not optimal to completely standardise the support provided. Provision must be based on need, which requires informed assessment of that need. It must be able to cope with wide variation and (potentially) different opinion of the support required. It needs, by definition, good personal contact/interface between the service deliverers and the recipients. This is the essence of the Patient Group-centric approach.

d. **Responsive rather than Intrusive**. Although initially there are pre-planned and automatically triggered aspects of welfare support, this must be controlled to avoid too much (quantity, breadth, number of supporting organisations) being forced onto Service personnel or their families before and unless they require it. “More” will often not be “better” but when the correct support to meet a need is identified it will need to be very responsive. This

[117] Patient Group – both the Service person and their NOK/immediate family, including partners, whose involvement is important to the well being and recovery of the patient (the definition endorsed by SPB).

requires a focused interface between the Patient Group and the service deliverers in order to provide them with authoritative advice and support, so that they know where they stand on key issues.

1.6.03 This leads to the following key principles for effective welfare support to all Patient Groups:

a. **Clear Responsibilities**. Many support staff from many specialist and generalist agencies will become involved in the provision of support to Patient Groups. All those involved will want to help and all will have different roles in providing that help. Nevertheless, the responsibilities for delivering support must be clear, must be published and must be observed by all involved. The intent of this is not to be obstructive, but to prevent a natural and well-intentioned enthusiasm for providing support proving counter-productive, a risk and reality that is observed on by those receiving support as much as by the supporting system.

b. **Coherence**. Given the variety of support services and the need to deliver these across a number of different locations, often at different times but sometimes simultaneously, there must be clarity and coordination of the total welfare support effort. This is not the same as reducing or constraining involvement. Where support is necessary or advantageous it needs to be provided but this must be coordinated and there must be clarity for the Patient Group.

c. **Assurance**. There is a need to ensure that casualty and hospital welfare support is provided effectively. The environment can be both highly stressed and high profile, the welfare need will often be compelling. This generates a requirement to provide assurance, both to recipients of support and to the chain of command on whose behalf the support is provided.

Outline Structure of Support

1.6.04 **Patient Care Pathway**. The Patient Care Pathway is the accepted description of the treatment route that an individual patient takes through the secondary healthcare system. It consists of discrete clinical, administrative and welfare components (pathways) with the clinical pathway pre-eminent, but the emphasis is on coordination between these 3 elements. It also establishes that: support for the whole Patient Group will be as important as for the patient alone; movement along the pathway should be seamless; and that it should be clear to the Patient Group exactly who is responsible for each component of the pathway at every step. There is no fixed pathway – it will depend on individual clinical need – but a simplified diagram of a typical Patient Care Pathway is at Annex A.

1.6.05 **Early Assessment of Welfare Need.** In common with the clinical pathway, there is no fixed approach for meeting the welfare need; it must be driven by Patient Group requirements. Urgency, the need for reassurance and the requirement for focussed, personalised support underpin the need for a deliberate, early assessment of welfare need. This assessment is conducted by welfare staff on behalf of the chain of command. Depending on the complexity of the welfare need – often, but not always, associated with the seriousness of the patient's injuries – the welfare assessment will be conducted by either primary[118] or secondary[119] welfare staff.

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[118] Primary: Unit/Station/Establishment, 1st Line, organic, under direct command and control, routinely available, typically generalist. Includes hospital-based primary welfare capability under command of COs of hospitals, such as Field Hospitals or MDHUs (including RCDM).

[119] Secondary: 2nd Line, more specialist role/training, on call rather than routinely available.

1.6.06 **Clear Focus for Welfare Support.** The critical step, particularly for complex and demanding cases, is the nomination of a single point of contact for coordination of the total welfare effort. This is the role of the Welfare Coordinator. Though accepting many different specialist and generalist support staff may need to become involved, ensuring there is a widely recognised and explicit welfare focus for each Patient Group addresses any uncertainty they may have in understanding from whom they should be receiving authoritative advice and support. This also provides the opportunity for more coherence with the rest of the care pathway.

1.6.07 **Cooperation and Shared Knowledge.** The fundamental requirement for a cooperative and coordinated effort in support of the Patient Group cannot be achieved without appropriate mechanisms. These are used to support the Welfare Coordinator in their key role. They include the use of welfare staff desk instructions, inter-Agency protocols, information sharing principles and common welfare assessment frameworks. See Section 6 for further details.

Responsibilities

1.6.08 **Chain of Command**. Commanders retain the ultimate responsibility for the personnel under their command regardless of the special circumstances of casualties and hospital patients and the needs of their wider families. The welfare support system is well developed, comprehensive and in some cases highly specialised. It always remains, however, in support of the chain of command in discharging their responsibility for their people. Welfare support staff remain responsible to commanders for the support they provide to users and are held to account by commanders[120] on that basis.

1.6.09 **Welfare Coordinator**. The Welfare Coordinator draws the threads of support from other contributors together, gives a clear and authoritative point of contact to the Patient Group, simplifies the interfaces with the other elements of the patient care pathway and provides more consistent case management over time. Inherent in improving continuity, consistency and coherence is the need to ensure that this focus for welfare support does not change unless it is categorically in the best interests of the Patient Group or is unavoidable. This is particularly important for the most complex and demanding cases. Unavoidable change – such as temporary absence or staff changes – must be carefully managed using the existing case management handover process. The Terms of Reference for the Welfare Coordinator are at Annex B.

1.6.10 **Standing Joint Commander (Medical) (SJC (Med))**. SJC (Med) is the commander of the UK Role 4 Medical Group. Responsibilities include the delivery of holistic care to those in the care pathway, establishing a clear point of entry to and exit from the pathway and managing a tracking system for those in the pathway. Much of this is accomplished through the Defence Patient Tracking System (DPTS), which plays a crucial part in the coherence of support, including welfare support, for Patient Groups (see Section 5).

1.6.11 **CO Hospital – Hospital Welfare Capability**. COs of hospitals[121] require a primary welfare capability in order to ensure primary welfare support for Patient Groups at the hospital, where the normal chain of command is unable to provide that support. This will most often be where the unit concerned is geographically remote from the hospital location such that providing primary welfare support becomes impractical. For example, for an

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[120] The command and control arrangements for patients at all points on the Patient Care Pathway have been articulated and endorsed in other work – see SPEG 5/08 dated Feb 08 et al.

[121] Field Hospitals, MDHUs and certain other specific facilities such as TPMH Cyprus.

operational casualty on Aeromed to RCDM Selly Oak where the unit is deployed in the operational theatre and the unit Rear Party is in Germany. The focus of this hospital welfare capability is wholly for primary welfare support in the hospital setting but in that respect it can play an important part in the overall welfare effort. This support is currently provided through a contract with the Defence Medical Welfare Service (DMWS). Like welfare providers in all other settings, however, they act in support of the Welfare Coordinator.

The Defence Patient Tracking System (DPTS)

1.6.12 **Defence Patient Tracking Application (DPTA)**. The purpose of the DPTA is to ensure that Service personnel in the care pathway can be effectively tracked through that pathway. This includes the location, triggers for key episodes (a significant event, such as the expectation of a move from one secondary healthcare facility, such as RCDM, to another, such as DMRC) and visibility of the key leads or coordinators of the clinical, welfare and administration components of the overall care pathway. The DPTA is the key tool for effective coordination and alignment of these different aspects of care and therefore accurate and timely population of the special purpose welfare fields is imperative. An example of these fields is shown at Annex C. The recording of the named Welfare Coordinator, including contact details, enables key staff – whether clinicians, the chain of command or other support staff – to take welfare support needs for the Patient Group into account at every stage of the care pathway.

1.6.13 **SJC (Med) Role Within DPTS**. SJC (Med) has responsibility for managing the DPTA, which is delivered through the Defence Patient Tracking Cell (DPTC), based at Headley Court. This includes ensuring DPTA data entry is complete and accurate, including the initial appointment (and recording of) the Welfare Coordinator for each Patient Group, with the support of single-Service secondary welfare agencies. As episodes (significant events) occur the DPTC, on behalf of SJC (Med), will confirm all key entries on DPTA whether for the clinical, administrative or welfare pathway thus facilitating continued alignment within the patient care pathway. The DPTC can also enable third-party data entry where proponents, including welfare staff, do not have direct access to DPTA. SJC (Med) will remain responsible for ensuring that the patient record is maintained on DPTA until the nominated leads for each component of the pathway (clinical, welfare and administration) have confirmed that all significant actions have been completed. Records can be closed and archived at that stage but must remain available for a further five years, on recall, for any further action.

1.6.14 **Welfare Agency/Staff Role**. Though SJC (Med) has the responsibility for the initial appointment (recorded on DPTA) of the appropriate welfare coordinator this can only happen with the active support of, and liaison with, the single-Service secondary welfare agencies. The welfare fields to support this data capture were defined as part of early DPTA design work and will be part of the regular review of DPTA. For the current fields, the responsibilities for data capture and provision of tracking information have been published[122]. Service Secondary Welfare Agencies have separate instructions for their involvement in the correct completion of welfare fields on DPTA.

Interaction and Coordination

1.6.15 **Continuity of Welfare Coordination**. Given the critical role of the nominated Welfare Coordinator in resolving difficulties, or reducing the risk of such difficulties arising, it is particularly important that any change of lead – which should only occur where this represents the best solution for the Patient Group or is unavoidable – is clearly identified and

[122] 2008DIN01-126 (Jun 08) "DPTS – Description and Allocation of Responsibilities".

immediately reflected on DPTA. This is in addition to the existing requirement for a case conference as the management tool for any handover. More generally, it is paramount that any welfare support for which provision moves from one individual or organisation to another, whether primary or secondary, retains clarity and continuity. There will be occasions of direct handoff between or within contributing organisations and, even though these may be often on a single-Service or intra-agency basis, the designated Welfare Coordinator with overall responsibility will need to be aware of such handovers and may need to facilitate them in order to mitigate any discontinuity.

1.6.16 **Protocols**. The use of a Welfare Coordinator will do much to address difficulties associated with Patient Group welfare support but very high standards of inter-agency cooperation are also required. This is at the heart of effective welfare support from multiple supporting organisations and between those concerned with the clinical, welfare and administration elements of the care pathway. Protocols at specific boundaries that have already been reviewed[123] have shown clear benefits in cooperation, mutual understanding and improved continuity for the Patient Group. All welfare agencies and organisations that have any interaction are to cooperate in the mutual production of relevant inter-agency protocols (template at Annex D).

1.6.17 **Information Sharing Principles**. Though the introduction of DPTS and Welfare Coordinators can do much to reduce risks resulting from complexity and can promote clarity and continuity, prompt sharing of appropriate information will also play a part. Confidentiality is a necessary aspect of both clinical and welfare support but this should not obstruct the overall flow of information required to achieve coherent and undisrupted support. An unnecessary focus on patient confidentiality to prevent or delay the passage of important information between supporting organisations when sharing such information is in the best interests of the Patient Group must be avoided. Information sharing principles promote a common understanding of need, reduce any difficulties or misunderstandings on sharing or passing on information and help professionals involved in service delivery to interact more effectively. Welfare support organisations should include relevant information sharing principles in their inter-agency protocols, covering the following key points:

a. Gaining consent to share information at the earliest opportunity, not leaving it until the need arises.

b. Ensuring there is a legitimate need to share the information.

c. Ensuring the appropriate information is passed on by making an explicit decision about what will be shared and why.

d. Recording the reasons why a decision has been reached on sharing, or not sharing, information.

1.6.18 **Common Welfare Assessment Framework**. A shared understanding of the welfare needs of a Patient Group is an important tool in reducing any disruption or dislocation in overall welfare support. Though there are some examples of common assessment forms these have not been universally adopted. Further work is being considered to identify a common welfare assessment framework for use by all Service welfare support staff. Until then inter-agency protocols should include, where appropriate, agreements on what common framework and forms will be used where it is likely they will both be involved in the support of individual cases.

ADAPTED ACCOMMODATION

[123] Such as between DMWS and Service secondary welfare agencies for clarity at RCDM and between Service secondary welfare agencies and Veterans UK for the transition from in- to post-Service civilian life.

1.6.19 The provision of appropriately adapted accommodation for Service personnel with disabilities is the responsibility of the MOD. This can occur in 2 instances:

a. **Temporary Provision.** During ongoing clinical care, Service patients will enjoy periods of leave from hospital during which they may stay at home. During these normally short periods, the long term nature of any disability my not have been established and hence expensive adaptations may be inappropriate. The Welfare Coordinator should ensure that the impact of the Service person's disabilities have been discussed with those who will look after his/ her during leave and that the proposed accommodation is appropriate. Certain mobility aids may be available for loan the Welfare coordinator should discuss this with the lead clinician well in advance of the leave period.

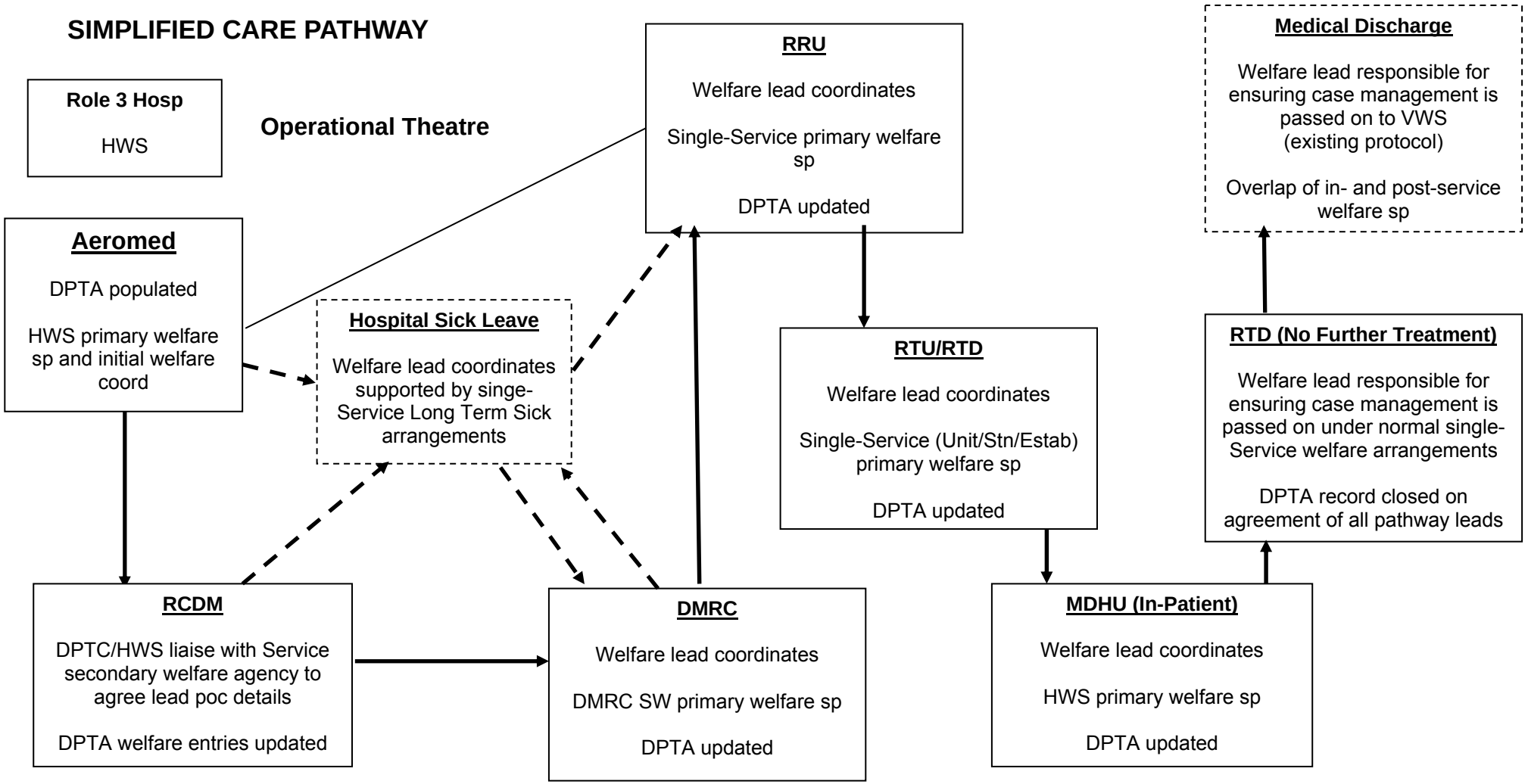
b. **Long Term.** Once the enduring nature of any disability has been identified, it may be appropriate to arrange for adaptations to the Service person's main home. Where a decision to discharge as been made, the appropriate local authority become responsible for the provision of adaptations. For all other Service personnel, these adaptations are a Service responsibility and the Welfare Coordinator should ensure that action to consider this is started as early as is practicable; normally in conjunction with Occupational Health staff at DMRC. The policy for adaptation of publicly funded accommodation is included in JSP 464 (Part 1, Annex F to Chapter 3). Where a Service person is living in privately owned accommodation, or adaptations are required in the parent(s) housing of single Service personnel, the Welfare Coordinator must arrange for an Occupational Health inspection and apply for funding authority from the appropriate single Service.

Annex:

A. Simplified Care Pathway.
B. Welfare Coordinator – TOR.
C. Inter-Agency Protocols - Template.

ANNEX A TO
CHAPTER 6 OF
PART 1 TO JSP 770

SIMPLIFIED CARE PATHWAY



Note: all moves are **key episodes** which demand a refresh of DPTA entries and a check that any necessary coordinating action to align the components of the care pathway has taken, or is taking, place

WELFARE COORDINATOR – OUTLINE TERMS OF REFERENCE

Introduction

1. Experience has shown that one of the most important considerations in an injured Service person's care pathway is to ensure that members of the Patient Group[1] have a single, named point of contact for welfare issues who remains as far as possible unchanged throughout the care pathway. This is very important for the Patient Group, who often report confusion in knowing who they should talk to and frustration in having to repeat their story each time they encounter a new welfare provider. It is also helpful to the chain of command who can experience similar confusion in contacting the appropriate source of welfare support, and to the welfare providers themselves who may not be fully aware of all others involved.

2. To ensure that each Patient Group has one consistent point of contact throughout the care pathway a named Welfare Coordinator will be nominated and identified on the Defence Patient Tracking Application (DPTA). Single-Service welfare instructions and other relevant policy will reflect this requirement.

3. For many, if not most, patients there will not be any exceptional demand for complex or specialist welfare support. Under those circumstances it can be assumed that welfare support will remain aligned with the normal arrangements through single-Service primary welfare resources. Typically this will be using unit welfare support staff[2], who will assume the role of Welfare Coordinator though with little likelihood of requiring significant involvement from other specialist staff. If, however, the Patient Group's situation is more complex and requires the involvement of more than one specialist welfare provider then the Welfare Coordinator will normally be a member of staff from the relevant single-Service Secondary Welfare Agency[3].

Role of Primary Welfare Staff as Welfare Coordinator

4. If the welfare needs of a Patient Group are not complex and, in particular, do not require integrated support from multiple welfare providers, typically the primary welfare support associated with the Service person's unit will take responsibility for welfare coordination. This is no different to the steady state position. In this situation the role of the Welfare Coordinator is to ensure that:

   a. The welfare needs of the Patient Group are met by the chain of command (or any Long Term Sick arrangements for responsibility on behalf of the chain of command) as required.

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[1] Patient Group – both the Service person and their NOK/immediate family, including partners, whose involvement is important to the well being and recovery of the patient.

[2] In the RN, responsibility remains with the ship/parent unit unless formally transferred or assigned to a Recovery Cell.

[3] RN/RM – NPFS/RMW; Army – AWS, usually an AWS Casualty Key Worker for more complex cases; RAF – usually OC PMS or Personnel Holding Flight (PHF) working in concert with the RAF PS&SWS Social Worker.

b. The needs of the Patient Group are kept under regular review and the Service Secondary Welfare Agency is contacted should those needs become more complex.

Role of Specialist Welfare Staff as Welfare Coordinator

5. If the Patient Group's welfare needs are more complex and require the integrated support of more than one welfare provider, the task of Welfare Coordinator becomes complex itself and, usually, beyond the knowledge, expertise and capability of primary welfare staff. In this case, a specialist Welfare Coordinator will be nominated. Often this will be determined at the start of, or very early in, the care pathway but a decision to appoint a specialist Welfare Coordinator can be taken at any stage.

6. The overarching role of the Welfare Coordinator in complex cases is to ensure that the Patient Group receives focused, seamless and confident welfare support. The Welfare Coordinator takes the lead in ensuring that services are coordinated, coherent and achieving intended outcomes and acts as the main point of contact for welfare issues.

7. In order to fulfil this role, the Welfare Coordinator will carry out the following functions:

a. Ensure that the responsible commander and key staff working on behalf of the chain of command are kept aware of the progress of the welfare component of the care pathway and of any other issues they have a need to know. Normal rules of confidentiality will apply as detailed in this JSP and single-Service guidance and instructions.

b. Act as a single point of contact for the Patient Group, who they can trust and who can engage them in making choices, navigating their way through the system and effecting change.

c. Coordinate the delivery of actions agreed by the welfare practitioners involved, to ensure that the Patient Group receive an effective service which is regularly reviewed. These actions will be based on the outcome of professional assessments and recorded in a support plan.

d. Reduce overlap and inconsistency in the services received.

8. Commanders retain the ultimate responsibility for the welfare of their people. The Welfare Coordinator supports the chain of command in discharging this duty and is responsible to the chain of command for doing so.

9. The main functions of the Welfare Coordinator are to:

a. Instil confidence and build a trusting relationship with the Patient Group in order to secure their engagement and involvement in the process.

b. Be a single point of contact for them and a sounding board for them to ask questions and discuss concerns.

c. Coordinate the effective delivery of an agreed set of actions which provide a solution-focused package of support and manage a process by which this will be regularly reviewed and monitored.

d. Identify where additional services may need to be involved and trigger action to engage those services.

e. Be a single point of contact on welfare matters for practitioners who are delivering services to the Patient Group.

f. Act as the welfare representative of the chain of command at all key case conferences or patient review meetings[4] and provide feedback to other welfare staff where this is necessary and appropriate.

g. Actively support the Patient Group through key transition points and ensure a careful and planned handover takes place if necessary and in their best interests.

h. Ensure, with the support of their own welfare agency, that the Defence Patient Tracking Application (DPTA) is kept fully accurate and up to date.

Selecting the Most Appropriate Welfare Coordinator

10. When integrated support from more than one welfare provider is required, it will be normal for a practitioner from the single-Service Secondary Welfare Agency to take on the role of Welfare Coordinator. This is consistent with their wider role in providing welfare support to personnel and families of their own Service, including existing arrangements for support during care pathways. It will align support from the agency best placed to understand the Service context, taking into account the need for in-depth knowledge of the broad based welfare needs of the Patient Group.

11. There may be, however, situations where it is more appropriate for another specialist welfare provider to be nominated as the Welfare Coordinator for the expected duration of the care pathway. Given the compelling need for continuity in this role, an early decision must take into account the enduring support requirement. But, if this is in the best interests of the Patient Group and the alternative nomination can give absolute reassurance that the role can be sustained throughout the care pathway, this is an appropriate arrangement. Single-Service Secondary Welfare Agencies must be party to any decision for the nomination of a Welfare Coordinator from an alternative organisation.

Notifying DPTA

12. The initial creation of a record and entry of key data on DPTA is the responsibility of SJC (Med), through the Defence Patient Tracking Cell (DPTC), based at Headley Court. Once an initial welfare assessment has been made and a decision on the Welfare Coordinator confirmed, further updates to welfare fields on DPTA become the responsibility of the Welfare Coordinator and the owning welfare agency, or the chain of command in the case of primary welfare support nominations. There are single-Service arrangements for the support of Welfare Coordinators in ensuring that DPTA is always up to date. But it is essential that Welfare

[4] At such meetings, where patient or Patient Group confidentiality will be a significant issue, it is preferable not to have multiple welfare representatives of the chain of command present.

Coordinators remain engaged in ensuring the accuracy of DPTA, which will be used by proponents of all elements of the care pathway and other key staff for critical contact and interaction. DPTA must be used also by Welfare Coordinators where there is a need to track a patient or identify and contact others engaged in the support of a Patient Group.

Accountability

13. The Welfare Coordinator acts on behalf of the chain of command in ensuring that a commander's responsibility for the effective welfare support of Patient Groups is discharged as effectively and coherently as possible, particularly in a multi-agency environment. This does not change the management chain for Welfare Coordinators, which remains through their own agency line management. Similarly, other specialists providing support to a Patient Group do so through the coordinating function of the Welfare Coordinator but they are responsible to their own agencies, not the Welfare Coordinator, for the professional standards, including quality, of that support.

14. Any problem in service delivery should and must be referred to the agency responsible for the specialist support provided, using that agency's mandatory complaints resolution process. Though a Welfare Coordinator can assist either a Patient Group or the chain of command in such action, it is not the Welfare Coordinator's responsibility to take such action.

INTER-AGENCY PROTOCOL – TEMPLATE AND KEY CONTENT

WORKING TOGETHER PROTOCOL BETWEEN [AGENCY 1] AND [AGENCY 2]

Background

1. This protocol recognises that both [AGENCY 1 full and abbreviated title] and [AGENCY 2 full and abbreviated title] have areas of specialist expertise and an important role to play in the provision of welfare support. Both organisations have wide experience and knowledge of working with the military community in the welfare field. Particularly pertinent to this protocol however, are the following specific areas of expertise:

   a. [AGENCY 1] *[short description of key roles and expertise]*

   b. [AGENCY 2] *[short description of key roles and expertise]*

2. Both [AGENCY 1] and [AGENCY 2] need to fully exploit their areas of expertise and, in working together wherever appropriate, provide the best possible welfare support to the Service community wherever and whenever needed. Underpinning this protocol is the fact that neither [AGENCY 1] nor [AGENCY 2] want to replace the role played by the other. The nature of welfare support is such that there will be some overlap from time to time which can benefit the service user, providing both organisations communicate effectively.

3. The purpose of this protocol is therefore to define how [AGENCY 1] and [AGENCY 2] can work together effectively to maximise the welfare support provided to the Service community. It is consistent with and takes into account the guidance set by the MOD in JSP770 (Welfare).

Process

4. [AGENCY 1] and [AGENCY 2] will work together to ensure that Service personnel and their families receive the best possible welfare support that, where appropriate, the combination of [AGENCY 1] and [AGENCY 2] can provide. To that end [AGENCY 1] and [AGENCY 2] will:

   a. Agree appropriate effective means of communicating between the two organisations on a senior management, regional and local level and ensure that all staff are aware of both the need and means to communicate. **Key: communicate.**

   b. Positively promote each other's service to individuals and outside agencies. This is to include the need to allow individuals to make an informed choice of the source of support when that is what they wish to do. **Key:**

mutual promotion and choice.

c. Take any decision on which organisation provides any particular support or takes any particular responsibility on the basis of the needs of the service user, not by rote. Such decisions, which can exploit flexibility for the benefit of the service user but can risk gaps or conflict by changing the typical boundaries of service provision, therefore must always be made on an all-informed basis. **Key: best interests of the user.**

d. At a local level assist each other in any appropriate way. **Key: mutual support.**

e. Build on the current good practice that exists between the organisations now. **Key: exploit existing good practice.**

f. Provide administrative local support where practicable and sensible. **Key: offer inter-Agency support.**

g. Include the appropriate representatives on local committees whenever possible. **Key: communicate to cooperate.**

5. Referrals between the two organisations will be made, with the agreement of the service user, when either organisation believes that the other is able to provide a more appropriate service or can complement that already being provided.

6. Referrals will be confirmed in writing with appropriate background information being shared. Referrals will normally be effected at local team level. Where this is not considered the most appropriate route, perhaps where the referrer is not aware of the team/staff covering the relevant geographical area, referrals will be made to the Headquarters of [AGENCY 1] or [AGENCY 2].

Confidentiality and Information Sharing

7. It is often important to share key information in order to provide the best support possible to the service user. This must be tempered by the need to observe legislative and professional requirements for user confidentiality. Both [AGENCY 1] and [AGENCY 2] will comply with all relevant legislation concerning the processing of personal information. In addition, each will comply with their own confidentiality policies and take appropriate steps to be consistent with the guidance in JSP 770 and *[single-Service policy reference]*.

8. Any personal information shared between [AGENCY 1] and [AGENCY 2], the decision on what (if any) information to share and the informed consent for sharing from the service user, will be confirmed in writing.

Liaison and Meetings

9. There is a need for a joint meeting which focuses specifically on developing the working relationship between the two organisations. [AGENCY 1] and [AGENCY 2] will meet together once a year at a senior management level to analyse what works and what does not and to develop further ways of working together to the benefit of soldiers and their families.

10. At *[Station/Garrison/Establishment]* and unit level *[and in hospitals, if relevant]*, local [AGENCY 1] and [AGENCY 2] *[staff/teams/branches/offices]* will liaise and meet as appropriate in order to ensure an effective working relationship between the organisations.

Casualty Care

11. Because of the often complex nature of providing welfare support for casualties, particular care needs to be exercised to ensure clarity of role and responsibility. This is important for welfare providers to avoid duplication of effort but also for the service users concerned, who often report confusion in knowing who is responsible for what and to whom they should turn with questions or difficulties. Under such particularly stressful circumstances it is vital they are clear on their primary point of contact; this must be the Welfare Coordinator.

12. The overall role of the Welfare Coordinator in complex cases is to ensure that the Patient Group[128] experiences a seamless and effective service in which one appropriate, named practitioner takes the lead to ensure that services are co-ordinated, coherent and achieving intended outcomes and to be the main point of contact for welfare issues.

13. *[Explain role of each agency with particular regard to involvement in support for Patient Groups. To include any typical responsibilities, such as likelihood of welfare coordination if a Service Secondary Welfare Agency or other typical specialist role; and any additional measures for sharing of information or procedures for one agency to involve the other in a particular case]*

Veterans Support *[if relevant]*

14. The support of Service personnel who are leaving, or who have left the Armed Forces is an important part of welfare provision. [AGENCY 1] should be advised, with the individual's consent, by the chain of command of any service leaver who has welfare needs. [AGENCY 1] will assess whether a referral to [AGENCY 2] is appropriate for the individual. If needed, [AGENCY 1] will make a referral to [AGENCY 2] without delay and preferably while the soldier is still serving, in order to ensure that [AGENCY 2] are able to provide support in a timely manner with a seamless transition of responsibility once the soldier is discharged.

15. [AGENCY 1] will continue to provide welfare support as appropriate but this remit will normally cease a maximum of 3 months post discharge, having ensured that an effective care plan is in place.

Contact and Helplines

16. *[Include full details of the inter-Agency contact options, including telephone, fax, email and website options where relevant. Any Agency helpline contact details should also be listed to underline any opportunity for cross-signposting where relevant]*

Summary

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[128] Patient Group – both the Service person and their NOK/immediate family, including partners, whose involvement is important to the well being and recovery of the patient.

17. This protocol defines the intent of [AGENCY 1] and [AGENCY 2] to work together in a positive and constructive manner and which does not conflict with the other's areas of responsibility but which recognises and respects the other's experience and expertise. It demonstrates [AGENCY 1] and [AGENCY 2]'s recognition that effective liaison and information sharing is the most professional way in which to ensure that service users receive the most benefit. This underpins the purpose and existence of both organisations: to offer the best possible support to the user.

Signed

Relevant senior signatory with responsibility for welfare service [AGENCY 1] Date

Relevant senior signatory with responsibility for welfare service [AGENCY 2] Date

CHAPTER 7 - WELFARE AND COMMUNITY SUPPORT FUNDING

Introduction.

1.7.1 Welfare is provided through a combination of public (core) and non-public (non-core) sources as well as (in the UK) Local Authority provision. Welfare support is separately delivered by a mixture of Service and civilian personnel and organisations, with varied levels of qualification and professional standing, against a variety of procedures and quality standards. Moreover, there is a combination of public and non-publicly funded facilities that are essential to the welfare of Service personnel and their dependants. This Chapter provides some guidance to commanders and unit budget managers to reduce confusion. This Chapter should be read in conjunction with JSPs 368, 462 and 315 as well as single-Service regulations pertaining to Service non-public funds. The line between public and non-public funding is not always clear and, the aim of this Chapter is to bring clarity to this division of responsibility to ensure that public funds are properly protected only spent in approved areas. Notwithstanding this if there is any doubt, commanders should consult their single Service finance staffs before they commit public funds.

Public / Non Public Funding.

1.7.2 Annex A lists the Services' welfare provision that may be publicly funded. Although some welfare and recreational facilities are scaled for public funding, many have been funded through non-public sources such as the Nuffield Trust. This list serves to give commanders a flavour of how welfare support is funded. Moreover, even though there may be a provision for a facility in JSP 315, furnishing and equipping such facilities may have to be provided from non-public funds. Annex A is not to be taken as the authority to commit public funds it merely indicates the types of facilities and services that can be publicly funded. Funding approval should be sought through the unit budget manager before any commitment is made. .

Other Funding.

Tri-Service Regulations – Commanding Officer' Public Fund (CPF)

1.7.3 The Commanding Officers Public Fund (COPF) is available to COs for the benefit of Service personnel within the work place with the aim of promoting the smooth running and efficiency of their units.

Eligibility.

1.7.4 The CO of any self accounting Regular or Reserve unit, is eligible to claim this allocation.

Rates.

1.7.5 **Allocation**. COPF is allocated on the basis of actual Service strength as at 1 April each year., No account is to be taken of civilian employees

1.7.6 **Special or Exceptional Allocation** Where the organisation or function of a Service establishment has exceptional, special or unusual features, or where assessment of the allocation based on strength would produce an inadequate amount for its annual cash need, the CO may apply, through normal channels, to the next higher budget holder for a special allocation.

1.7.7 **Enhanced COPF.** An Enhanced COPF (ECOPF) may be claimed by COs, subject to budgetary constraints, for any Regular or Reserve Army personnel on their strength[129].

1.7.8 **Principles**. A number of overriding principles are to be followed:

a. COs are to note that all requests for funding must comply with JSP 462, with particular attention drawn to Chapters 18 and 19.

b. COPF/ECOPF is public money and is to be managed on the public account. The mixing of public and non-public funds is generally to be avoided, but may be allowed in certain circumstances[130]

c. Activities should have an aim and effect, should be moderate and realistic in terms of planning, and benefit the greatest number of Service personnel in the Unit.

d. All requests for funding are to be approved by the Budget Manager who must ensure that funds are available and the request complies with financial regularity and propriety. The request must then be approved and signed by the CO personally.

e. All activities must be within the guidelines for financial regularity and propriety. COPF/ECOPF must not be used to circumvent rules set down for any activities such as rules regarding Commemorative Events[131] and Official Hospitality[132]. In addition, COPF/ECOPF may not be used to increase public funding for activities for which there are prescribed limits in accordance with primary policy such as maximum per capita limits for winter sports travel.

f. Where ECOPF is available to COs of Defence, Tri-Service or Joint units, it is on condition that it should be spent primarily on their Army personnel. Where the costs of a project, such as installing white goods in the communal area of an accommodation block have been met by ECOPF, the benefits should not be denied to RN or RAF personnel that live in that block. However, it would be appropriate for either the costs to be split so that the other Service(s) make available proportional levels of funding, or, another discrete retention or welfare project, that Army personnel may have equal access to is funded. Army units under RN or RAF command are to obtain guidance from

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[129] Army manpower figures for non HQ Army TLB units, such as Defence, Tri-Service, Joint or Army units under RN or RAF command, have been included within manpower assumptions and therefore such units are also eligible to claim the ECOPF. ECOPF is designed to enfranchise as many Regular Army and TA personnel (including FTRS, Soldiers and Officer Cadets within initial training, Officer Cadets within UOTCs, Mobilised TA, MPGS and NRPS) as possible. The allowance for mobilised TA is to be claimed by the unit to which they are attached, not the parent unit unless that TA unit is itself mobilised.

[130] JSP 462 - Financial Management Policy Manual; Chapter 18, Annex A, Mixing of Public and Non-Public Funds on the Defence Estate.

[131] JSP 368 The MOD Guide to Repayment.

[132] JSP 915 Tri-Service Domestic Assistance Policy & Official Hospitality Policy for the Armed Forces and Civilians.

their own TLB budgetary staff on how expenditure is to be captured at unit level.

1.7.9. Permissible Expenditure. The following are examples of what the COPF/ECOPF may be used for; the list is not exhaustive but should act as a guide whilst giving COs flexibility in the way that they can utilise the fund. If a CO has an initiative which they believes is within the spirit of improving the quality of life or retention in their unit, then advice can be sought from budget staff or the chain-of-command.

a. Equipment and Consumables.

(1) White goods and electrical appliances such as microwave ovens, kettles, fridges, televisions and radios for communal use.

(2) Pictures and plants for communal areas.

(3) Wreaths, but only in the event of the death of a local civic dignitary who had close connections with the unit.

(4) TV licences for televisions and radios in communal living areas where the equipment has been purchased by public funds. Not for individually owned equipment, TVs purchased by non-public funds or for TV or entertainment packages, such as Sky TV, in commercial or retail establishments.

(5) Modest, non-cash prizes, for official unit events.

(6) Provision of internet facilities within communal livings areas coupled with interactive software (e.g. Skype) for telephone calls.

b. Activities.

(1) Travel and Subsistence (T&S). T&S at public expense is only permitted in line with current departmental policy.

(a) Adventure Training (AT)[133]. T&S for AT if public funds are not available within current budgetary constraints. To benefit the maximum number of unit personnel. Contribution from COPF/ECOPF per head must not exceed funding received per head and must not exceed the maximum allowable publicly funded contribution for AT.

(2) Transport Costs.

(a) Sports[134&135]. Transport costs, such as the hire of a minibus, for officially organised MOD or single Service sporting events[136] where a group of individuals travel together. Funding must not exceed the maximum allowable publicly funded contribution for

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[133] JSP 419 -Joint Service Adventurous Training (JSAT) Scheme .

[134] JSP 752 - Tri-Service Regulations for Allowances; Chapter 4 Section 8 Sports Travel.

[135] 2013DIN01-083 Status of Sports in the Services.

[136] JSP 800 Defence Movement and Transport Regulations; Volume 5, Paragraph 2.2.101.

sport travel[137]. Not for individual refunds for travel expenses and not to be used for travel to events where attendance is as a result of tickets being subsidised, donated or gifted by external organisations.

(3) Unit Cohesion. Subsidising unit and sub-unit events where the overall effect is to achieve unit cohesion[138]. Such events include barbeques, battlefield studies and military education.

c. Infrastructure Works. Minor infrastructure works that would normally be delivered under the Regional Prime Contract, are to be approved using the standard process.

d. Infrastructure Works – Self Help. If a CO wishes to use their COPF/ECOPF money to undertake a self help project (for example the painting of communal areas within single accommodation) they are to seek guidance from the Site Estate Representative (SER) to ensure that they do not compromise the Regional Prime Contract. If such agreement is given in writing by the SER, the CO is to ensure that all aspects of current Health and Safety legislation are adhered to.

1.7.10. Prohibited Expenditure. The COPF/ECOPF is not to be used for:

a. Increasing the emoluments or personal entitlements of any person.

b. Procuring supplies or services for which financial approval has previously been refused on grounds of policy or where such expenditure is not a proper charge against public funds.

c. Services which might eventually create a continuing liability to public funds.

d. Defraying entertainment costs or the provision of alcohol and funding seasonal festivities[139] such as Christmas or Bonfire Night parties or meals, decorations, Christmas trees, carol concerts etc.

e. Defraying costs in publishing unit magazines.

f. Defraying costs for business cards and headed stationery.

g. Purchase of wreaths except as provided in paragraph 5 above.

h. Purchase of Christmas cards or associated postage costs.

i. Increasing or contributing to non-public accounts or charities.

j. The payment of barrack damages.

k. The purchase of equipment normally supplied through Service channels.

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[137] 2013DIN10-014 Travel at Public Expense for Army Sport.

[138] JSP 915 -Tri-Service Domestic Assistance Policy & Official Hospitality Policy for the Armed Forces and Civilians; Chapter 3, Annex A, Serial 3, Unit Cohesiveness.

[139] JSP 462- Financial Management Policy Manual; Chapter 19, Seasonal Festivities

m. Support to unit social activities that includes families or members of the public.

o. Support to civilians.

1.7.11 Running Costs. The cost of maintenance and replacement of articles purchased from the fund are to be met by the fund. However; costs such as consumption of electricity, a coat of paint or a simple repair job that can be carried-out within Service resources, need not be set against the fund.

1.7.12. Applications. All applications for COPF/ECOPF funding are to be made using the form at Annex B and approved by both the Budget Manager and CO. The approved application forms are to be regarded as accountable documents and therefore retained by the unit for seven years. For non-consumable items the application form should be cross referred to the particular item in the COPF/ECOPF property book. Application forms are to be supported by relevant documentation such as the original receipt, nominal roll etc, and confirmation that any property has been taken onto account.

1.7.13 Rates. The Service rates are as follows:

a. COPF RN - £4 per head per annum.

b. COPF Army - £1.50 per head per annum.

c.. COPF RAF - 50p per head three times a year.

d. ECOPF Army - £31 per head per annum, raised to £50 for FY 13/14 only. The rate will be reviewed annually and issued by PS4(A) to the Chain of Command. PS4(A) will also copy the rates to the RN and RAF Pay Colonels staff, as well as to the Centre and other TLBs.

1.7.14 Accounting Arrangements. Expenditure from the Fund is to be met from the Unit cash or Imprest account as and when incurred, in accordance with local budget delegations. COs are to abide by the regulations in JSP 332, the Low Value Purchasing Manual. Expenditure is to be charged against the control account.

1.7.15. COPF Property Book. Articles purchased are to be treated as public property and all non-consumable items are to be entered in the COPF/ECOPF Property Book, see Annex C. The book, which is to be maintained by an officer appointed by the CO, is to include a record of physical checks carried out. A loan card is to be raised for each item and signed by the individual who is charged as having custody of the particular item. Loan cards are to be cross referred with the entry in the property book and retained by the appointed officer. An independent property check of the COPF/ECOPF property is to be conducted annually in line with local material accounting regulations, and should include:

a. Asset verification.

b. Impairment review.

c. Formal reporting of discrepancies to the CO.

1.7.16. Loss or Damage. The normal procedure for investigating loss or damage to Service property is to apply to items purchased and brought on ledger charge. No adjustment to the fund allotment is to be made in respect of any recoveries.

1.7.16. Amalgamation or Disbandment. Units under notice to amalgamate or disband are to confine their expenditure to meeting outstanding charges and normal domestic expenses only. A proportionate amount based on the number of complete months still to run in the Financial Year will be claimed where two units amalgamate to form a new unit; the balance of both existing allotments will lapse. The CO of the new unit will claim as for a new unit. The allotment will be calculated in the first instance on the anticipated average strength, but will be adjusted as soon as the correct entitlement is known.

1.7.17. Balance of Allotment. Expenditure incurred by COs in any one financial year is not to exceed the allotment to which they are entitled. Any unspent balance of the allotment remaining at the end of the financial year is to lapse.

Tri-Service Regulations-The Accumulated Welfare Fund (AWF)

1.8.01 The purpose of the AWF is to help COs to enhance unit welfare amenities. Accordingly, COs are authorised, at their discretion, to incur expenditure from the fund in order to improve unit welfare facilities (including single living accommodation and retail leisure facilities) subject to the restrictions listed under paragraph 5. In doing so, COs are to endeavour to spend their fund in such a way as to benefit the greatest number of unit personnel. Consequently, any application that would benefit only a small number of individuals should be subject to particular scrutiny. COs should appoint a welfare committee comprising those individuals best able to provide welfare advice to determine the best form of allocation. The Welfare Committee should include the CO, the Budget Manager and any local welfare officer as a minimum

1.8.02 The following are examples of what the AFW may be used for; the list is not exhaustive but should act as a guide whilst giving COs flexibility in the way that they can utilise the Fund:

a. White goods such as microwave ovens, kettles, fridges, televisions and radios

b. Computers, for welfare facilities

c. Pictures and plants

d. Furniture for Service welfare facilities

e. Decoration and minor refurbishment of Service welfare facilities

1.8.03 The cost of maintenance and replacement of articles purchased from the fund are to be met by the fund. However; costs such as consumption of electricity, a coat of paint or a simple repair job that can be carried out within Service resources, need not be set against the fund

1.8.04 The AWF is **not** to be used for:

a. Increasing the emoluments or personal entitlements of any person

b. Procuring supplies or services for which financial approval has previously been refused on grounds of policy

c. Services which might eventually create a continuing liability to public funds.

d. Increasing or contributing to non-public accounts or charities and activities.

e. Gifting

f. Defraying entertainment costs. (Includes the purchase of foodstuffs or drink either for serving personnel civilians or guests)

g. Defraying the costs for the following:

(1) Publishing unit magazines.

(2) Business cards and headed stationery.

(3) Purchase of Christmas cards or to cover associated postage costs.

(4) Fire-work displays.

1.8.05 **Application Form**. An application form must be completed for all purchases. An example of the application form is at Annex D. The approved application forms are to be regarded as accountable documents and, therefore, maintained at the unit for seven years. For non-consumable items the application form should be cross referred to the particular item in the AWF property book. The application is to be approved by the CO.

1.8.06 **Allocation of Funds**. One fund will normally cover each Unit that is self-accounting for cash, and all Units affiliated to it for cash purposes. However, TLBs may authorise a separate fund for a detached Unit if local circumstances make this desirable.

1.8.07 **Accounting Arrangements**. Expenditure from the Fund is to be met from the Unit cash account as and when incurred in accordance with local budget delegations. Financial approval must be obtained in advance of purchase, using the form provided at Annex D, and this form should be authorised by the CO and the local budget manager. Expenditure is to be charged against the control account.

1.8.08 **AWF Property Book**. All non-consumable items obtained or manufactured are to be entered in the AWF Property Book in accordance with local accounting regulations. The book, which is to be maintained by an officer appointed by the CO, is shown at Annex E and is to include a record of physical checks carried out. A loan card is to be raised for each item and signed by the individual who is charged as having custody of the particular item. Loan cards are to be cross referred with the entry in the property book and retained by the appointed officer. An independent property check of the AWF property is to be

carried annually in line with local materiel accounting regulations, and should include:

a. Asset verification.

b. Impairment review.

c. Formal reporting of discrepancies back to the CO.

Use of the Defence Estate

1.8.09 **Encroachment**. A number of welfare activities that are non-publicly funded operate from public buildings and, therefore, constitute an encroachment. An encroachment is the authorised temporary use of MoD land and buildings by off duty personnel, MoD civilian employees or Department associated bodies such as Cadet Forces and wives clubs as well as recognised recreational sporting and welfare purposes beyond agreed Service scales. The term does not include land or buildings used for the purpose of bringing a unit or establishment up to JSP scales or occupied under commercial lease or licence. Further guidance on encroachments can be found in JSP 362 Defence Lands Handbook.

1.8.10 **Mixing of Public and Non Public Funding on the Defence Estate**. Both government accounting regulations and JSP 462 Financial Management Policy make it clear that the Department has no delegated powers to incur expenditure of a novel or contentious nature without the prior approval of HM Treasury. Chapter 40 sets out the financial boundaries for the funding of buildings used for non-core Service activities on the MoD estate. It highlights the regulations that are in place regarding the use of public funding on non-public buildings and facilities. Commanders should seek advice from single Service Customer Estate Organisations or Defence Estates for further guidance.

Secondary Duties - 'Stand Behind' Policy

1.8.11 Any Service person engaged, as part of their duties, in Service non-public funds activities in support of unit welfare obligations, would be acting in the course of their employment with MoD or the Armed Forces. As such the MoD would be vicariously liable for an individual's actions in the pursuance of his/her duty. Nevertheless, MoD will not underwrite the activities of the non-public organisation and commanding officers and budget managers must ensure that the department is properly protected against any legal costs compensation claims and employment tribunal costs. It is essential that personnel read and fully understand 2007DIN02-193 Service Charities/ Non Public Funds - Welfare Activities and Service Personnel Duty Status that outlines the policy on this important issue.

Annexes:

A. Service Welfare Provision Funding
B. Commanding Officers Public Fund – Application Form
C. Commanding Officers Public Fund – Property Book
D. Accumulated Welfare Fund – Application Form
E. Accumulated Welfare Fund – Property Book

ANNEX A TO
CHAPTER 7 OF
PART 1 - JSP 770

SERVICE WELFARE PROVISION FUNDING

(This list must not be used as the authority for the commitment of public funds)

Serial	Welfare Provision	Provider	The supported	Remarks
1	Ship/Unit/Station Welfare Offices		The Service Community	As per single Service requirements Regular/ Reserve and in accordance with JSP 315.
2	Ship/Unit/Station Chaplaincy Pastoral Care	Single Services	The Service Community	Includes chaplaincy service (including officiating fees) and place of worship in accordance with JSP 315.
3	Ship/Unit/Station Medical Services	Single Services	Service Personnel in UK and the Service Community overseas	Includes the Service community overseas and some training practices in the UK. In certain overseas locations this will be provided by Host nation or contract.
4	Ship/Unit Regimental Career Management Officers	Single Services	Service Personnel	
5	Ship/Unit Regimental/Stn Administrative Personnel	Single Services	Service Personnel	*Families during deployments
6	Single Services Specialist Personal Welfare Service	Single Services	The Service Community	RN – NPFS; RM – RMW; Army – AWS; RAF – RAF PS&SWS
7	Deployment Welfare Support	MoD	The Service Community	
8	Community Development Workers (Civil Servants)	RAF	The Service Community	For Navy and Army CDW roles are subsumed within the NPFS and the AWS respectively. Office accommodation and associated equipment

Serial	Welfare Provision	Provider	The supported	Remarks
				including IT support
9	HIVE	Single Services	The Service Community	HIVE IO, office accommodation and associated equipment including IT support. JSP 315
10	WRVS	Single Services	The Service Community	(Funded through grant in aid). Accommodation from where the WRVS can operate. http://www.wrvs.org.uk
11	Education, training facilities, library and internet access	Single Services	Service Personnel	JSP 315
12	Sports and training facilities	Single Services	Service Personnel	Includes Services Sports Control Board. Refer to JSP 315 and sporting activities that exist to contribute to the unit welfare objectives. Refer also to: 2007DIN02-193 Service Charities/ Non Public Funds - Welfare Activities and Service Personnel Duty Status, 2007DIN01-105 Status of Sports in the Service and 2009DIN01-050 Insurance for Adventurous Training Activities, JSP 362
13	Community Centre	Single Services	Service Community	Not withstanding CRL facilities normally furniture, coffee shop facilities for example would be non-publicly funded. JSP 315
14	Community Activities (clubs etc)	Single Services	The Service Community	Activities that exist to contribute to the unit welfare objectives. Refer to JSP 315, JSP 462 and JSP 362 and 2007DIN02-193 Service Charities/ Non Public Funds - Welfare Activities and Service Personnel Duty Status.
15	Welfare Communication and information support structures	MoD and single Services	The Service Community	MoD, Single Service Overseas, station, Garrison, unit: Internet/intranet material, guides newsletters, publications and continuous attitude surveys.
16	Catering Retail and Leisure facilities			Some facilities such as sports bars, coffee shops are not scaled and therefore not publicly funded.

Serial	Welfare Provision	Provider	The supported	Remarks
				However, rest facilities (crew rooms) for example can be publicly funded. Reference should also be made to SLA and MAC, SMAC and PFIs that may exist. JSP 315
17	Childcare - day care and childminding provision. MOD Child Care Voucher Scheme	Single Services	The Service Community with responsibility for children	Encroachments/lettings/New builds. The organisation will have to be self funded as far as operating costs are concerned. This will include salaries and equipment. JSP 315
18	Legal Services	Army	Service Community overseas	Queens Regulations for the Army
19	CVWW	CVWW	Service Community	Public accommodation can be provided on an encroachment basis.
20	British Forces Statutory Social Work Service Overseas	Overseas Commands	The Service Community Overseas	Taking account of special arrangements for Northern Ireland
21	RELATE	RELATE	The Service Community	Army - publicly funded in Germany and Northern Ireland, grant from non-public funds in GB for limited consultations. RAF – Non-publicly funded.
22	Hospital Welfare Service	Defence Medical Welfare Service (DMWS) St John and Red Cross	The Service Community	Hospital based primary welfare service provided under contract
23	SSVC	MoD Single Services	The Service Community	Under contract. BFBS radio and television broadcasting to overseas locations where Service personnel are based. They are also responsible for Ghurkha Radio and radio in Northern Ireland.

Serial	Welfare Provision	Provider	The supported	Remarks
				For areas where broadcasting is not possible a DVD service can be provided. SSVC are also responsible for the organisation of Combined Services Entertainment (CSE) shows.
24	SSVC Welfare Fund	SSVC	The Service Community	Under contract arrangements. Provision of BFBS radio and television broadcasting to overseas locations where Service personnel are based. They are also responsible for Ghurkha Radio and radio in Northern Ireland. For areas where broadcasting is not possible a DVD service can be provided. SSVC are also responsible for the organisation of Combined Services Entertainment (CSE) shows.
25	UWO (TA)/ROSO/ROSW /NRPS posts	Army	The Reserve Forces Community	UWO(TA) on mobilisation
26	Service Accommodation	MOD/DE	The Service Community	Families and Single Living Accommodation, Messes, Personnel not on duty to pay non-entitled rates in public accommodation such as messes and SLA. Welfare accommodation can be provided from misappropriated families' accommodation.

Serial	Welfare Provision	Provider	The supported	Remarks
27	Joint Service Housing Advice Office	Army	The Service Community	JSHAO provides Service personnel and their families with information and advice on the range options available for of civilian housing. JSHAO also provides help and information to ex-Service personnel who are still in Service Families' Accommodation. http://www.mod.uk/DefenceInternet/DefenceFor/ServiceCommunity/Housing/
28	Service Cotswold Centre	Single Services	The Service Community	Temporary housing for families of Service personnel from all 3 Services who may be between assignment, retiring from the Services, be in need of a family holiday or weekend break or any other reason including welfare or emergency evacuation from overseas.

COPF/ECOPF APPLICATION FORM

To_____ (Officer authorised to commit expenditure)

From_____ (Details of applicant)

Description of Request:

Cost_____ (If authorised and purchased a copy of the receipt should be attached to the application form)

Justification for Request:

Has financial approval for the procurement of Item/service been previously refused on grounds of policy? Yes/No

Signature of
Applicant_____

Budget Manager Approval_____ (Budget Manager to check that funds are available and that request meets financial regularity and propriety criteria)

Authorising Officer_____ (To be signed by the CO)

Date and Serial No of Entry in COPF Property Book _____

EXAMPLE OF COMMANDING OFFICER'S PUBLIC FUND (COPF) – PROPERTY BOOK

Date (a)	Ser No (b)	Item Description (c)	Item Value (d)	Item Location (e)	Entered By (f)	Property Book Check (g)
(Note 1)	(Note 2)	(Note 3)	(Note 4)	(Note 5)	(Note 6)	(Note 7)

Notes:

1. Date to cross-refer to loan card.
2. Ser No to cross-refer to loan card.
3. Complete and unambiguous description of item.
4. Items value at purchase date.
5. Exact location of item and details of item custodian (to be amended if item is moved or custodian changes).
6. Signature of COPF Property Book custodian.
7. Signature of independent checker and new COPF Property Book custodian on takeover of duty.

Annex D to
Chapter 7 to
Part 1 - JSP 770

ACCUMULATED WELFARE FUND (AWF) – APPLICATION FORM

To: _____ **(Note 1)**

From: _____ **(Note 2)**

Description of Request

Cost: _____ **(Note 3)**

Justification for Request

Has financial approval for the procurement of item/service been previously refused on grounds of policy? Yes/No[140]

Signature of Applicant: _____

Decision of AWF Committee: **Approved / Not Approved** **(Note 4)**

Budget Manager Approval: _____ **(Note 5)**

Authorising Officer: _____ **(Note 6)**

Date and Srl No of Entry in COPF Propert Book:

Notes:

1. Officer authorised to commit to expenditure from the AWF.

[140] Delete as applicable.

2. Details of Applicant.
3. If authorised and purchased a copy of the receipt should be attached to the application form.
4. If the CO decides to have a AWF Committee the entry should be cross-referenced to the Committee meeting minutes.
5. Budget Manager is to check that funds are available and that the request meets the property and regularity criteria.
6. To be signed by the Commanding Officer.

EXAMPLE OF ACCUMULATED WELFARE FUND (AWF) – PROPERTY BOOK

Date (a)	Ser No (b)	Item Description (c)	Item Value (d)	Item Location (e)	Entered By (f)	Property Book Check (g)
(Note 1)	(Note 2)	(Note 3)	(Note 4)	(Note 5)	(Note 6)	(Note 7)

Notes:

1. Date to cross-refer to loan card.
2. Ser No to cross-refer to loan card.
3. Complete and unambiguous description of item.
4. Items value at purchase date.
5. Exact location of item and details of item custodian (to be amended if item is moved or custodian changes).
6. Signature of AWF Property Book custodian.
7. Signature of independent checker and new AWF Property Book custodian on takeover of duty.

CHAPTER 8 - CHARITABLE ORGANISATIONS

Introduction

1.8.01 There are many Service/Ex-Service Charities that exist solely to provide assistance to military personnel and their families in times of need or crisis. Many of these charities form an essential provision of serving and ex-Service personnel.

The Confederation Service Charities (COBSEO)

1.8.02 COBSEO is established to represent, promote and further the interests of Service and ex-Service personnel of all ranks, and their dependants by all practical, legal and proper means including:

a. Exchanging and co-ordinating information internally.

b. When necessary, acting as a point of contact for external agencies to the members of COBSEO.

c. Identifying issues of common concern, particularly welfare matters, and co-ordinating any necessary and appropriate action.

d. Representing and supporting the needs and opinions of its member organisations, individually and collectively, at Central and Local Government levels and with other agencies.

1.8.03 The Government is committed to working closely with COBSEO and other Service charities both formally and informally. The major Service-related charities contribute to and promote public debate with respect to the Armed Forces Community.

1.8.04 The MOD welcomes the assistance of Service charities, but given the large number in recent years, it is not possible for engagement with all at a central level. In this respect the work of COBSEO in coordinating Service charities is invaluable.

1.8.05 The MOD does work with certain charities on key projects and CDP has worked with the Principal Personnel Officers (PPOs) and other key stakeholders including the voluntary and community sector (through COBSEO) to design a process for identifying and staffing projects over £1 million (and those of lower values that are novel and contentious) to the PPOs and then to the Service Personnel Board for prioritisation in attracting charitable assistance. It is intended that this will encourage project sponsors to consider the various aspects of sustainability, longevity and applicability across the whole of Defence and encourage early engagement of key stakeholders. Defence Instruction Notice (DIN) (DIN2011DIN01-212) (*Coordination of Charitable Donations to meet Service Community Welfare Needs)* has been published

Details of COBSEO Members

1.8.06 .A list of COBSEO Executive Members can be found at Annex A. A list of all COBSEO members can be found on the COBSEO website.

Annexes:

A. COBSEO Executive Members

ANNEX A TO
CHAPTER 8 OF
PART 1 - JSP 770

COBSEO EXECUTIVE MEMBERS

1. **ABF The Soldiers Charity**. ABF The Soldiers Charity (previously The Army Benevolent Fund) is the Army's national charity and is committed to providing financial and practical support to soldiers, former soldiers and their families in times of need. It works in partnership with Regimental and Corps Benevolent Funds and in co-operation with other Service charities in identifying, investigating and primarily giving financial support to eligible cases in "real need". This support is given in two ways:

   a. Financial support is given to individuals through Regimental and Corps Benevolent Funds and normally takes the form of an ABF grant to supplement whatever the Regiment or Corps has the resource to provide.

   b. Help is also provided through the substantial financial grants which the ABF makes on behalf of all Regiments and Corps of the Army to the charitable organisations which provide for the special needs of the soldier, ex-soldier and his or her family.

www.soldierscharity.org

2. **Blind Veterans UK**. Blind Veterans UK (previously St Dunstan's) was established in 1915; Blind Veterans UK provides essential training and rehabilitation for ex-Service men and women who are now blinded due to war, age, accident or illness. This includes mobility training, cooking skills, IT training, sports and recreation, nursing and respite care.

www.blindveterans.org.uk

3. **British Limbless Ex-Servicemen's Association (BLESMA).** BLESMA is a National Charity specifically for limbless and paraplegic ex-Service personnel and their dependants and widows. The objectives of the Association are to promote the welfare of all those who have lost a limb or limbs or one or both eyes as a result of service to their country and to assist their dependants. Today, BLESMA is aiding thousands of amputees of all ages, from those who served during WWII, to recent conflicts and peace keeping missions.

www.blesma.org

4. **The Ex-Services Mental Welfare Society (Combat Stress).** The Ex-Services Mental Welfare Society, also known as Combat Stress, is the only charity dedicated to giving care, comfort and reassurance, backed by skilled clinical support, to men and women of all ranks and all Services suffering from varying degrees of mental illness as a result of traumatic battle experiences.

www.combatstress.org.uk

5. **Forces in Mind Trust**. The Forces in Mind Trust seeks to enhance UK-wide support and advocacy for Service personnel, veterans and their families to make a successful transition back to civilian life. Each year up to 20,000 people leave the Armed Forces and the Trust has commissioned research to improve knowledge of the issues affecting veterans and their families. In due course, the Trust will also undertake awareness raising campaigns, provide advice and support to those charities and organisations that directly support the Armed Forces community, veterans, their families and dependents.

www.fim-trust.org/

6. **Forces Pension Society**. There are 3 primary objectives of the Forces Pension Society:

a. Secure equitable and justified conditions in the Armed Forces Pension Scheme for all ranks of the 3 Services both serving and retired and for their widows, widowers and dependants.

b. Seek resolution of the iniquitous legacy issues, from which certain pensioners and their dependants continue to suffer.

c. To advise and assist members of the Society on Service pension problems and related issues.

www.forpen.org

7. **Help for Heroes.**H4H supports veterans and serving personnel who have been wounded or injured, or have become sick, as a result of serving their country. Additionally their families and dependents receive support from the Charity as they care for their loved one, and adapt to the new challenges that they face. Our primary focus is on those affected by recent and current conflicts due to the urgency and extent of their needs. Anyone is welcome to apply for support and will be considered on a case by case basis and referred to our charity partners where appropriate. H4H is a tri-service military charity, providing support to full time, reservist Servicemen and women and veterans from the Royal Navy, Army and Royal Air Force.

www.helpforheroes.org.uk

8. **The Officers' Association**. The Officers' Association is a charity dedicated to assisting officers who have retired or about to retire from Her Majesty's Armed Forces. The Association was founded in 1919 and received the Royal Charter in 1921. The Association's work falls into three main categories: employment, residential accommodation and benevolence.

www.officersassociation.org.uk/

9. **The Poppy Factory** - The Poppy Factory is a charity which helps wounded, injured and sick ex-Service men and women back to work. They provide advice, information and guidance to those ex-Service men and women who have experienced difficulty entering the civilian workplace.
They assist in finding supportive employers who understand the value of employing skilled ex-Service personnel and are able to offer funding to the employer during the first year of employment to ensure a smooth transition.
Their ethos is that of long-term commitment to our clients and our employers.
They have a personalised approach to supporting wounded, injured and sick ex-Service personnel, treating each as an individual who will have differing employment needs.

www.poppyfactory.org

10. **Royal Air Forces Association (RAFA).** Under its motto of 'Comradeship, Welfare, Opportunities', RAFA provides support to both current and former members of the RAF, drawing on its network of branches worldwide as well as the RAFA Liaison Officers appointed on all RAF stns and in many other locations where RAF personnel are serving.

www.rafa.org.uk

11. **The Royal Air Force Benevolent Fund**. The Royal Air Force Benevolent Fund exists to provide assistance to those of the extended Royal Air Force Family who need support as a consequence of poverty, sickness, disability, accident, infirmity or other adversity. This extended

family embraces all ranks, male and female, who are serving or have served in the Royal Air Force or its associated Air Forces, their widows, widowers and dependants.

www.rafbf.org

12. **The Royal British Legion**. The Royal British Legion is the UK's leading charity safeguarding the welfare, interests and memory of those who have served in the Armed Forces and their dependants. It provides financial, social and emotional support to millions, including respite and residential care homes, and its benevolence spans all age groups from the oldest to the very young.

www.britishlegion.org.uk

13. **The Royal Navy and Royal Marines Charity.** The Royal Navy and Royal Marines Charity exist to provide a better quality of life for serving and former Naval Service personnel. This includes the Royal Navy, Royal Marines, Maritime Reserves, QARNNS (Queen Alexandra's Royal Naval Nursing Service), and the Royal Fleet Auxiliary and former members of the Women's Royal Naval Service.

www.rnrmc.org.uk

14 **Seafarers UK**. (Formerly known as the King George's Fund for Sailors) This is a national maritime charity - the only one which raises money for all seafarers and their dependants. Each year over £3 million is raised and distributed to benevolent organisations caring for anyone who has served at sea and their dependants who are in need, for example - fishermen, the Royal Navy and Royal Marines, the Merchant Navy etc - and their dependants.

www.seafarers-uk.org

15. **Soldiers, Sailors, Airmen & Families Association - Forces Help**. The national charity helping serving and ex-Service men, women and their families in need. The range of services SSAFA provide includes housing, financial aid and advice and friendship visits. They also deliver professional healthcare and social work services to MOD under contract.

www.ssafa.org.uk

16. **Stoll** Stoll provides rehabilitative support to vulnerable and disabled ex-Service men and women, acknowledging the sacrifices they have made for our country. Stoll provides intensive support for individuals that tackles not only the basics of accommodation, income and physical and mental health but also offers an array of services that facilitate their full and active participation in civilian life such as back-to-work programmes, apprenticeships, a wider range of health and wellbeing programmes as well as a range of advocacy and grants.

www.stoll.org.uk

17. **Veterans Scotland.** Veterans Scotland is concerned with the enhancing the welfare and well-being of the Veterans community in Scotland by encouraging cooperation and coordination between the ex-Service charities in Scotland; engaging where appropriate with the UK and Scottish governments on matters relating to veterans affairs and acting as a point of contact for government and other agencies for all matters relating to veterans policy.

www.veteransscotland.co.uk/

17. **War Widows Association**. The War Widows Association is essentially a pressure group that exists to improve the conditions of war widows and their dependants in Great Britain. It works

with a number of Government Departments petitioning for improvement in pensions, the administration of benefits and other issues affecting war widows.

www.warwidowsassociation.org.uk

PART 2 - DEPLOYMENT WELFARE SUPPORT

CHAPTER 1 - DEPLOYMENT WELFARE PACKAGE

Introduction

Effective personnel welfare support underpins the moral component of fighting force, directly enhancing the individual's ability and willingness to fight; it is the moral component and the morale of the force that will most often prove decisive.

2.1.1 Deployment Welfare Support (DWS) Policy[221] is the framework within which the MOD provides both its military and civilian personnel with the fullest possible support to safeguard their psychological and physiological well-being, set against, and consistent with, the deployment environment and the availability of resources. A deployment is defined as including operations, exercises and other deployments away from the permanent place of duty[222], including activities in the UK and involving Entitled Personnel (EP).

2.1.2 Deployment welfare should not be viewed in isolation and nests among a host of mutually supporting enablers in the delivery of operational capability, including allowances and the wider Real Life Support (RLS) in place; its doctrine is vested in JDP 1-05. Welfare support should, therefore, be delivered at an appropriate level to ensure that EP are physically and mentally motivated to give their best as individuals and as part of teams. This is crucial for success if welfare support is to play its role in enhancing operational effectiveness through the maintenance of the moral, physical and conceptual components of fighting power.

2.1.3 Guidance for reservists can be found at Annex B.

Aim

2.1.4 The aim of this policy is to set the framework and principles to enable the planning and consistent delivery of welfare provision that will optimise and sustain operational effectiveness, irrespective of the nature of the deployment.

Effects-Based approach to determining DWS

2.1.5 DWS[223] is founded on a common set of effects-based concepts that allow the implementing authority (PJHQ, SCs, JFC or SJC) maximum freedom to formulate a focused and cost-effective Deployment Welfare Package (DWP) tailored for the specific circumstances of each deployment[224]. The DWP is to be derived through a structured estimate process led by the Operational Commander using Annex A as a handrail.

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[221] Formerly Operational Welfare Support (OWS) Policy.

[222] Or Base Port for maritime units.

[223] Better Value for Money, targeting and satisfaction.

[224] In addition, the unique nature of maritime deployments is taken into account.

a. **Connect.** To enable deployed EP to retain contact with family, friends and remain connected to their personal lives, whilst also serving to ease reintegration at the end of a deployment. All indications are that the positive aspects associated with the ability to stay connected whilst deployed outweigh any potential negative impacts, and therefore communications are the highest priority for delivery of deployed welfare. Examples may include, but must not be limited to, communication in the form of: telephony; correspondence (electronic and physical mail); messaging; video calling[225]; access to the internet and community web portals; and physical connectivity via: Post Deployment Leave.

b. **Entertain.** To provide for the leisure and relaxation needs of deployed EP. Examples may include, but must not be limited to: TV, radio; newspapers, magazines, movies, games and books; internet surfing; live entertainment; and recreational sports and leisure activity[226].

c. **Sustain.** To maintain the wider physiological and psychological needs of the deployed EP (and their families and friends). Examples may include, but must not be limited to: physical training equipment; retail; postal courier services; grants and allowances[227]; spiritual and pastoral support; home-based activity programmes for families and friends; and Rest and Recuperation Periods.

Core Welfare Principles

2.1.6 Operational-level commanders and staffs must determine the DWS needs of EP and be guided by the following principles:

a. **Operational Effectiveness.** Welfare support is intended to enhance operational effectiveness through maintenance of the moral component. It aims to compensate field conditions and displacement from elemental facilities but does not seek to fully re-create or match the levels of amenities and services enjoyed in the home base. Individual expectation and understanding must be managed accordingly.

b. **Priority.** The DWP will seek to provide in order of priority, and where practical and appropriate:

(1) Telephony and Internet; and Physical Training facilities.
(2) Postal Courier Services; TV and radio; access to a variety of newspapers, magazines, movies, games and books; and Pastoral Support.
(3) Retail & Communal Recreational facilities; and
(4) Live Entertainment.

c. **Consistency.** The nature and methods of provision will vary between location and environment but Commanders should seek to provide the most comprehensive welfare package consistent with the aim of DWS and framework of this policy. Where fundamental levels of provision are not achieved, the reasons must be clear to all EP.

d. **Use of Local Infrastructure.** Land-based operations should make innovative use of local infrastructure or coalition capabilities where possible in order to seek cost-effective

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[225] "Young people are now growing up in a world in which they have significant greater access to globalised media…and young people are using new media to form and sustain transnational connections…New media technologies offer new possibilites for transnational connectedness and dialogue" – Buckingham David et al (2012). *Youth cultures in the age of global media*. Basingstoke: Palgrave Macmillan (forthcoming).

[226] "…several studies suggest that engaging in physical activity or exercise programs (sic) can also benefit emotional well-being. Multiple studies indicate that physical activity improves mood and reduces symptoms of depression and anxiety" – Penedo, F et al (2005). *Exercise and well-being: a review of mental and physical health benefits associated with physical activity*. Current Opinion in Psychiatry (18).

[227] JSP 752 refers.

solutions and achieve early welfare effect, subject to appropriate risk analysis and assurance. Operational planning should draw on subject matter expertise, including contractor and partner, to advise from the outset on local commercial solutions. Planners should also consider the need for additional welfare facilities to be provided in support of maritime deployments during port visits. Internet and voice communications systems provided by MOD must afford levels of personal security comparable to that given by UK commercial providers however.

e. **Innovation/Digitisation.** Digital provision of communication and entertainment via the internet as a single means of delivery is preferable to physically despatching newspapers, magazines, movies, games and books. Where real-time internet is either limited or unavailable, alternative ways of delivering certain welfare effects are to be examined including cached content.

f. **Internet**. The following principles are to be applied to the provision of internet access:

(1) **Bandwidth.** Wherever possible, internet should be provided at a bandwidth comparable to that which can be purchased privately, in order to support the full spectrum of digital connectivity and digital media.

(2) **Duty of Care**. Welfare internet and voice communications systems provided by MOD must afford levels of personal security comparable to that given by UK commercial providers.

(3) **Internet Access**. Unrestricted internet access will only be provided through systems in place solely for welfare usage, the security and access protocols required by JSP440 for systems used in the workplace or where bandwidth is necessarily provided through operational gateways are to remain in place.

(4) **Personal Responsibility.** Uninhibited access to online content beyond that controlled by commercial internet providers places the same emphasis on personal responsibility when deployed as when using the internet privately in the home base. Nothing in this policy removes the MOD's right to monitor the internet separately for breaches of security or irresponsible activities by EP.

g. **UK Deployments[228].** Provision of DWS for personnel deployed within the UK will normally be limited to that required to compensate displacement from the publicly-funded facilities usually enjoyed at their permanent base. Public funding will not be available where there is access to local amenities that would reasonably be expected to be purchased privately when not deployed.

h. **OpSec.** Nothing should undermine the ability of the local commander to effect Op MINIMISE nor lessen individual responsibility towards OpSec. The emphasis is to be on a robust system of education as MOD may not always have direct control over commercially or locally sourced communications bearers.

i. **Family Support.** SCs are to ensure family support measures are in place for deployed units and individuals. The Families Welfare Grant (FWG) and Families Concessionary Travel Allowance (FCTA) exist within the DWS framework in order to support activities in the home base[229].

[228] Potential UK deployments are primarily focussed on Military Aid to the Civil Authority which includes; Military Aid to the Civil Power (MACP)[228], Military Aid to Other Government Departments (MAGD)[228] and Military Aid to the Civil Community (MACC).

[229] Home Base constitutes a UK wide geography.

Funding

2.1.7 DWS is to be provided against the following funding principles:

a. DWS within the framework of this policy is an appropriate charge to public funds.

b. DWP is to be provided against the principles of VfM where operationally viable, and operating costs are to be charged to the appropriate operational funding line.

c. CDP is to ensure that the following deployable core welfare capabilities are in place through a combination of those held at readiness through enabling contracts designed to promote rapid, agile delivery of effect and foster product innovation, or those necessarily retained within Defence[230] :

(1) Telephony & Data connection incl. irreducible UK Central Charges[231].
(2) Physical Training Equipment.
(3) TV & Radio content and distribution.
(4) Entertainment material including but not limited to:
  (a) Newspapers & Magazines.
  (b) Movies.
  (c) Games.
  (d) Books.
(5) Postal Courier Services.
(6) Retail services & Recreational facilities.
(7) Live Entertainment.

d. The Families Welfare Grant (FWG) and Families Concessionary Travel Allowance (FCTA) are appropriate public charges within the DWS framework.

Eligibility

2.1.8 **Qualifying Deployments**. Deployments qualifying for DWP are defined as:

a. Operations overseas, expected to last for 7 days or more, with a designated name and under the operational command of PJHQ, for which a CDS directive has been issued.

b. Maritime deployments away from base port expected to last for 7 days or more.

c. Other operations, exercises and deployments away from the permanent place of duty both in the UK and overseas expected to last 7 days or more, by formed and non-formed units under the operational command of NATO, JFC, PJHQ, HQ SJC(UK) or the single-Service Commands. This definition includes deployments (but not assignments) to the JFC PJOBs[232].

2.1.9 **Entitled Personnel.** EP comprise all serving military and MOD civilian personnel and entitled contractors attributed to a qualifying deployment, including visitors for periods of over 7 consecutive days.

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[230] A contractual approach that creates broader (Statements of Requirement that enables provision of a service or effect (not a quantity)).

[231] Running costs, telephones and switching; equipment refresh and upgrade; and Service Wrap including billing systems, fault reporting, communication material, permanent staff, and Customer Call Centre.

[232] CDP are the authority to grant DWP for exceptional deployments not covered under the standard qualifying criteria.

2.1.10 **Use by Foreign Nationals.** Shared use of welfare facilities may be extended to others, such as Coalition Partners, under Command arrangements that are to be formally agreed through Memoranda of Understanding (MOU) setting out arrangements for cost-sharing or, exceptionally, for charges to be waived. UK personnel must be able to continue to access the DWP for which they are eligible however facilities may need to be upgraded or up-scaled as a result of the increased demand placed upon them by sharing.

2.1.11 **DWP and LOA.** LOA[233] will generally not be paid where individuals are in receipt of DWP unless LOA/LOSLOA is a necessary element of the RLS package and adjusted accordingly to remove the element apportioned for welfare provision. There may be cases where personnel in receipt of LOA may be entitled to elements of the DWP, specifically the Deployed Welfare Grant (DWG). The award of the Families Welfare Grant (FWG), and consequently the simultaneous award of Concessionary Travel for Families, will be determined on a case by case basis by the Operational Commander.

Governance

2.1.12 CDP, through PersTrg SVW SO1 Op Welfare is responsible for setting overall DWS policy in consultation with stakeholders. DWP requirements for specific operations will be set by PJHQ, SCs and SJC(UK) as appropriate and through an estimate process. Once deployed, the responsibility for delivering DWP lies with the in-location Commander.

a. **Deployments under CJO's OPCOM.** PJHQ J1 will be responsible for conducting the initial J1 Estimate for DWP provision, including the requirement for J1 staff in the OET, and subsequent periodic reviews.

b. **Foreign Deployments under Service Command OPCOM.** SC Pers HQ elements are responsible for conducting the initial Estimate of DWP provision and subsequent periodic reviews. Where numbers permit, it is important that the appropriate N1/G1/A1 staffs are included in the deployed establishment at the outset. DWP Standing Operating Instructions and policy guidance are the responsibility of these deployed staff. SC HQs normally define the DWP staff responsibilities and entitlement in the deployment directive.

c. **UK Deployments under Service Command or SJC(UK) OPCOM.** SC Pers HQ or SJC(UK) elements are responsible for conducting the initial Estimate of DWP provision and subsequent periodic reviews. Where numbers permit, it is important that the appropriate N1/G1/A1 staffs are included in the deployed establishment at the outset. DWP Standing Operating Instructions and policy guidance are the responsibility of these deployed staff. SC HQs and SJC(UK) normally define the DWP staff responsibilities and entitlement in the deployment directive.

DWP provision is to be set out in the Operational Commander's Directive for all deployments.

DWP Evaluation and Review

2.1.13 PersTrg SVW SO1 Op Wel is to conduct a biennial review and evaluation of the DWS policy using focus group feedback, AFCAS results, demographic and trend analysis, inter-theatre benchmarking, coalition partner comparison and academic reviews.

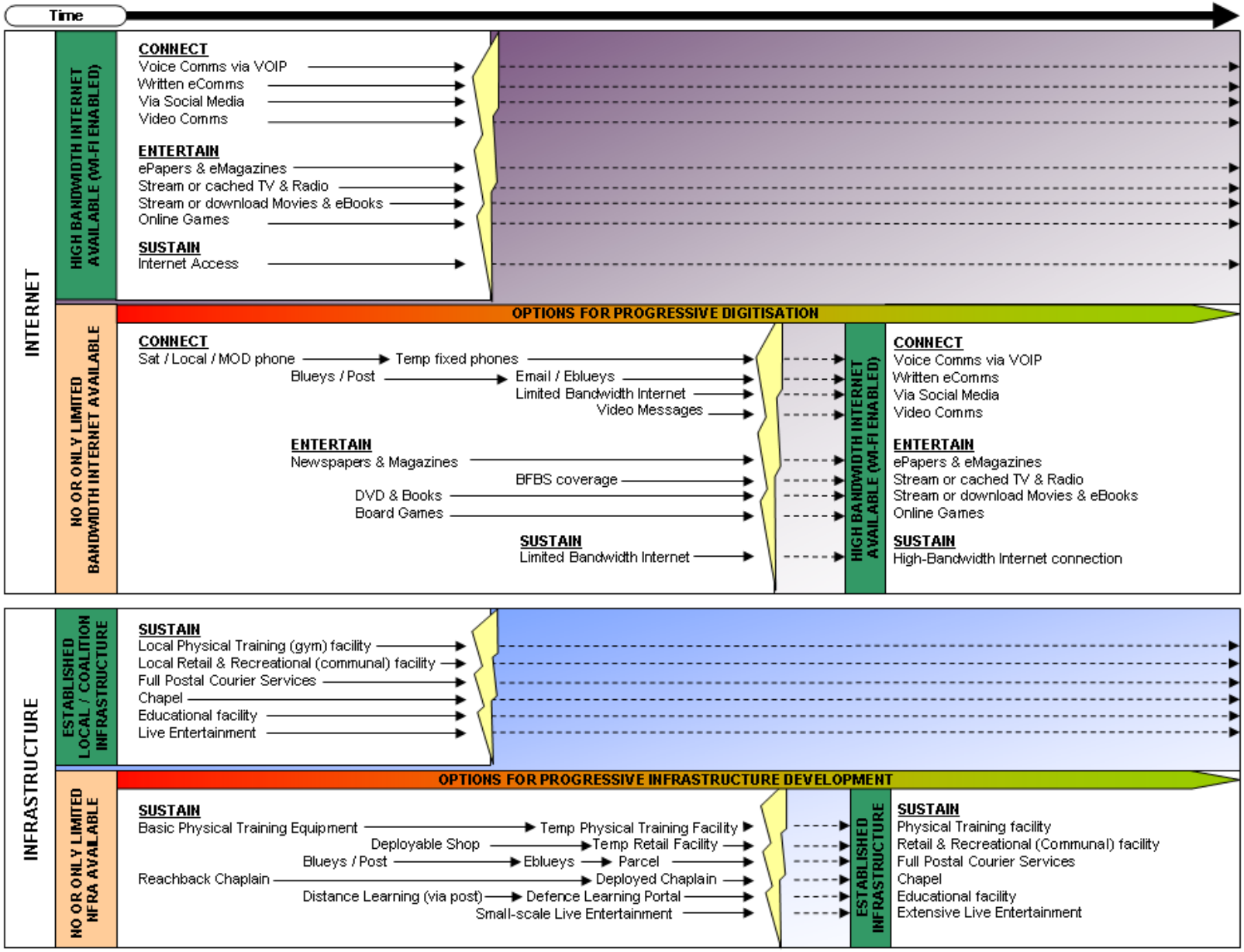
[233] LOA is a non-taxable allowance paid to Regular and Reserve Service personnel in certain locations overseas. It is a measure of the amount by which average essential expenditure on day-to-day living in the overseas station differs from that in the UK, taking account of local lifestyle.

2.1.14 Checks and balances at the tactical/operational level will be conducted at the PJHQ-chaired Joint Operations Personnel Working Group (every 4 months), with feedback submitted to SVW for evaluation as part of the biennial review.

Annexes:

A. DWP Delivery Model.
B. Reservists.
C. Bandwidth & Internet.
D. Voice Communication – Planning Guidelines
E. Deployed Physical Training (Equipment) – Planning Guidelines
F. Written Communication (Emails, Eblueys & Forces Mail) – Planning Guidelines.
G. Newspapers & Magazines – Planning Guidelines.
H. TV & Radio – Planning Guidelines.
I. Movies, Games & Books – Planning Guidelines.
J. Video Communication – Planning Guidelines.
K. Pastoral & Spiritual – Planning Guidelines.
L. Retail & Recreational Facility – Planning Guidelines.
M. Live Entertainment – Planning Guidelines.
N. Deployed Welfare Grant.
O. Families Welfare Grant.
P. Families Concessionary Travel Allowance.

DWP DELIVERY MODEL



RESERVISTS - GUIDANCE

1. Reservists, depending on their engagement type, are likely to have less experience of the Service environment than their Regular counterparts which could potentially lead to increased uncertainty and a reduced understanding of the types of welfare support available and how to access it.

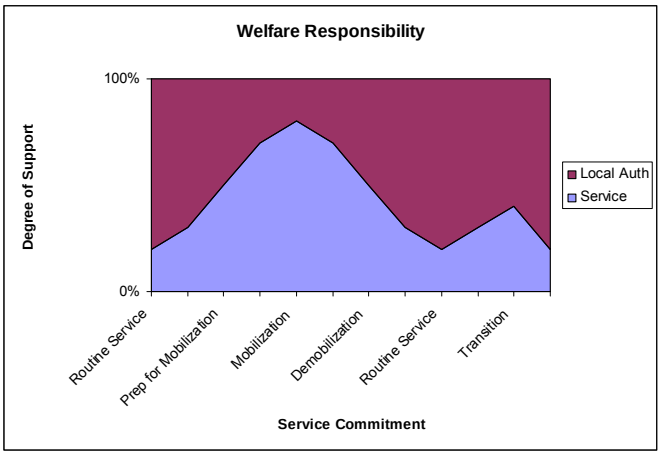
2. Reservists' families are far less likely to have a deep rooted connection with the Armed Forces and the 'wider military family'. Therefore, access to Service welfare provision may be a less familiar process. To overcome this potential disadvantage, it is vital the CofC and welfare staffs pay particular attention to the needs of those Reservists and their families when planning and delivering support. Key to this will be effective and consistent communication and information availability to the Reservist and their family.

3. Other Government Departments, Devolved Administrations and Local Authorities have statutory obligations to citizens, including Reservists (and Regulars) and their families. Full use must be made of the statutory services provided by Local Authorities. Where a Regular, or Reservist's welfare issue is unrelated to their service, and is unlikely to impact on Service duties, it is appropriate for the lead for welfare provision to lie with the Local Authority. Case-by-case judgements will be required to determine the degree to which support should be provided by the Service and what would be more appropriate from other sources. In all cases, any Service welfare support for an issue where other organisations hold a statutory responsibility must be provided in conjunction and consultation with those organisations; allowing them to take primacy where appropriate.

4. The following guidance will assist in these decisions:

a. Evidence from previous operations and deployments has identified the need for support to Reserves. More Service welfare support will be provided where the issue is caused or exacerbated by Service obligations; and/or, where the issue is having (or is likely to have) an impact on operational effectiveness (i.e. the Service person is mobilising or is mobilised).

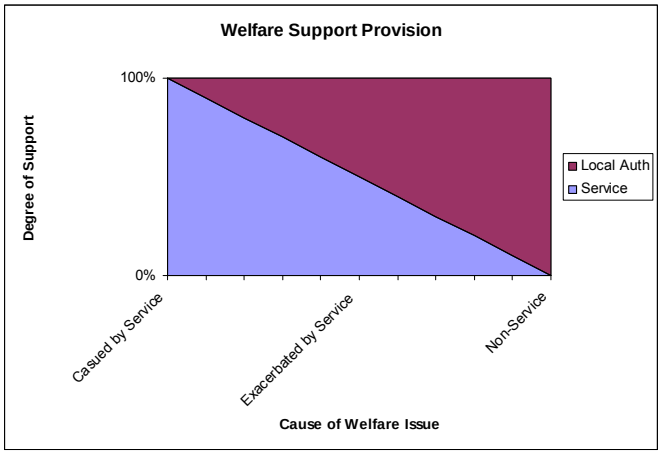
Diagram 1



b. The presumption is that less Service welfare support will be provided where there is a statutory obligation on another Government Department; Devolved Administration or Local Authority to provide the service – particularly where they have primacy over the matter (e.g.

child protection). See Diagram 1. Statutory authorities have primacy although exceptionally this may not be the case if the Reservist is WIS.

Diagram 2



5. **Type of support**. Welfare support can be broadly divided into 3 areas: Reactive Intervention (reactive during a crisis); proactive engagement (to build and sustain community); preparatory resilience building (to inform, prepare and strengthen). The first of these will be available to all Reservists and their families when the need arises (Service welfare provides for an issue arising from Service only). See Diagram 2. The other forms of proactive assistance will be offered on a needs basis according to whether the Reservist is attending for training or other duties or mobilised (i.e. more around mobilisation and less around routine service).

INTERNET & BANDWIDTH

1. High bandwidth internet sits at the heart of welfare provision, enabling an array of services:

   a. **Communication** in the form of; VOIP telephony, online messaging services (emails, eblueys and social media messaging), video calling and;

   b. **Entertainment** in the form of access to; epapers, emagazines, TV & radio material, ebooks, online gaming and general internet surfing.

   c. **Sustainment** in the form of access to the internet allowing EP to conduct their personal administration.

Internet access is therefore to be provided to EP at public expense as early as practical in the deployment.

2. **Provision of internet services.**

   a. **Terrestrial Data Networks**. Provision of bandwidths comparable to that enjoyed commercially in the home base, in order to maximise the opportunities for digital provision of welfare services, will be provided where a local internet service exists whose system assurance can be guaranteed and VfM demonstrated. This may be through HN, coalition or commercial bearers.

   b. **SATCOM Networks**. The cost of high bandwidth internet via SATCOM bearers is prohibitive and, in the case of a bespoke system, compounded by in-theatre infrastructure and support costs. Where SATCOM is the only option for internet provision, welfare bandwidth will necessarily be limited unless the cost benefits of digital provision over elements of welfare that would have otherwise to be delivered physically can be demonstrated.

Welfare internet will be provided in accommodation and communal recreational areas, where possible. A limited number of publicly-provided terminals may be provided where considered necessary but it is expected that the majority of EP deploy with their own User Access Device (UAD) and welfare provision will be focused on enabling their individual access to the internet.

3. **Controlled Access**. Access to the internet via systems used solely for welfare will be subject to the same access controls required or in place for UK based commercial providers. Individuals will be responsible for their own activities online and are to ensure that they act in accordance with Service Guidelines and Codes. The MOD retains its right to monitor social media and the like externally for breaches of conduct. Access to the internet via EGS will remain subject to the security and user restrictions prescribed in JSP 440 as this is not primarily a welfare system and in direct support of the DWP.

VOICE COMMUNICATIONS – PLANNING GUIDELINES

<table>
<tr><td>PRIORITY</td><td colspan="2">HIGH</td></tr>
<tr><td>EFFECT</td><td colspan="2">CONNECT</td></tr>
<tr><td>PROVISION OPTIONS</td><td colspan="2">Telephony services enabled via:
1. Locally sourced connectivity; <u>or,</u>
2. Deployable capability (via Astrium SATCOM); <u>or,</u>
3. Deployable operational network.</td></tr>
<tr><td>ADDITIONAL GUIDANCE</td><td colspan="2">• Locally sourced provision must be assured, satisfy a VfM Business Case and have robust billing procedures in place.
• Where possible, connectivity should be provided via VOIP.
• The in-location commander must ensure an ongoing programme of education and deterrence to maintain OPSEC.</td></tr>
<tr><td rowspan="5">PUBLICLY-FUNDED ENTITLEMENT TO CALLS (Where possible)</td><td><7 days</td><td>10 mins / person / week to any destination, world-wide, including mobile phones.</td></tr>
<tr><td>7 days to <9 months</td><td>30 mins / person / week to any destination, world-wide, including mobile phones.</td></tr>
<tr><td>9 months to <12 months</td><td>60 mins / person / week to any destination, world-wide, including mobile phones.</td></tr>
<tr><td>>12 months</td><td>120 mins / person / week to any destination, world-wide, including mobile phones.</td></tr>
<tr><td>Christmas</td><td>An additional 30 mins / person for personnel deployed over all or part of the Christmas period (defined as 22 Dec–2 Jan inclusive). This provision should be sufficiently flexible to deliver effect at other times according to other faiths or traditions.</td></tr>
<tr><td>INFRASTRUCTURE</td><td colspan="2">Telephony (PSTN):
• Welfare phones will be provided at a ratio not less than 1 handset / 40 individuals. This should be increased in areas of limited internet access.
• Individual areas that offer a degree of privacy (booths).
• Shelter from extremes of weather and, where appropriate, the provision of an environment that allows the sustained and effective operation of DWP equipment.

VOIP:
• Welfare internet will be provided in accommodation and communal recreational areas, where possible.
• A limited number of publicly-provided terminals may be provided where considered</td></tr>
</table>

	necessary but it is expected that the majority of EP deploy with their own User Access Device (UAD) and welfare provision will be focused on enabling their individual access to the internet[234].
AUTHORITY	• PJHQ J1 is responsible for submitting requests for welfare telephone services for eligible deployments under the command of CJO. The respective N1, G1 or A1 branch assumes this responsibility for eligible deployments not under the command of CJO.
ACCOUNTABILITY	• In deployments where access to welfare communications is via contractor-supplied welfare cards (Account for Life), administrative staffs are to enable/disable entitlements in accordance with procedures. • All contractor-owned equipment is to be accounted for and managed by unit staff. Unit Commanders are to ensure that equipment is audited on a monthly basis and, in the case of Joint Deployments, this should be carried out by in-location J1.
POC	WelComE Service Owner, DE&S ISS Networks, Hawthorn Site, MOD Corsham, SN13 9NP (96927 3730 / 01249 853730)

[234] Not less than 1 laptop/terminal/tablet / 50 individuals & Not less than 1 handset / 40 individuals.

ANNEX E TO
CHAPTER 1 OF
PART 2- JSP 770

DEPLOYED PHYSICAL TRAINING (EQUIPMENT) – PLANNING GUIDELINES

<table>
<tr><td>PRIORITY</td><td colspan="2">HIGH</td></tr>
<tr><td>EFFECT</td><td colspan="2">SUSTAIN / ENTERTAIN</td></tr>
<tr><td>PROVISION OPTIONS</td><td colspan="2">Access to Physical Training opportunities enabled via:
1. Local infrastructure / capability; <u>or,</u>
2. Deployable Physical Training Equipment (DPTE).

<u>And,</u> access to Physical Training guidance enabled via:
3. Physical Training information (online/pamphlets/posters); <u>or,</u>
4. Deployed Physical Training Instructor.</td></tr>
<tr><td>ADDITIONAL GUIDANCE</td><td colspan="2">• Locally sourced provision must be assured, satisfy a VfM Business Case and have robust billing procedures in place.
• Consideration should be given to the provision of integrated fitness solutions that support the functional requirements of deployed personnel without the need for power and which is easily transportable.
• For enduring locations, the requirement for electrical power, appropriate supporting facilities and maintenance solutions will require early consideration.
• All individuals must be trained in use of the equipment by a suitably qualified individual prior to use.</td></tr>
<tr><td rowspan="3">PUBLICLY-FUNDED ENTITLEMENT (Where possible)</td><td>Fitness</td><td>Access to a selection of fitness equipment that will enable the maintenance of physiological strength and conditioning.</td></tr>
<tr><td>Recreational</td><td>Provision of recreational leisure equipment and spaces that foster both physiological and psychological strength through social interaction, relaxation and entertainment[235].</td></tr>
<tr><td>Common</td><td>Provision of a bespoke physical training facility.</td></tr>
<tr><td>INFRASTRUCTURE</td><td colspan="2">• Austere Locations. Units/Detachments are to deploy with DPTE[236]
• Local Facilities may be used to complement DPTE where the facility and equipment can be assured and appropriate technical agreements are in place.
• Expeditionary Infrastructure. As operations move to a campaign footing, provision of gym facilities is to be included in the overall infrastructure development plan.</td></tr>
<tr><td>AUTHORITY</td><td colspan="2">• HQ Air, 22 Trg Gp SO2 PEd Delivery is the Service lead for the provision of DPTE for PJHQ or SJC(UK)-owned deployments. Using existing enabling contracts (DE&S-owned which includes maintenance support), 22 Trg Gp will, when required, procure</td></tr>
</table>

[235] This may include but must not be limited to: 5-a-side goals, volleyball and tag-rugby sets.

[236] Scaling iaw xxxxxxx. This may include but must not be limited to: CV machines and free weights.

	DPTE against PJHQ or SJC(UK) allocated funding and set against the bespoke deployed requirement. In delivering DPTE, HQ AIR is to ensure the effective management of all DPTE, including provision of reserve stocks. • SCs are responsible for the provision of DPTE for their own deployments. NAVY COMMAND HQ (Pers) is responsible for ensuring that DPTE for embarked forces deploying to an operational theatre in maritime units are properly resourced from the date of embarkation.
ACCOUNTABILITY	• Where deployed, the PT Subject Matter Expert, in liaison with the local Logistic Support staff, is to advise on the distribution of equipment dependent on deployment circumstances, co-ordinate maintenance provision, enforce health and safety requirements and track/record in-location DPTE holdings. • Where a PT SME is not deployed, all contractor-owned PTE is to be accounted for and managed by unit staff. Unit Commanders are to ensure that PTE is audited on a monthly basis and, in the case of Joint Deployments, this should be carried out by in-theatre J1. • On completion of a deployment, a VfM judgement will be made on the recovery or disposal of in-locations holdings. In circumstances where the value of the item is less than the cost to return, local disposal may be authorised.
POC	N/A

WRITTEN COMMUNICATIONS (Emails, Eblueys & Forces Mail) – PLANNING GUIDELINES

<table>
<tr><td>PRIORITY</td><td colspan="2">HIGH</td></tr>
<tr><td>EFFECT</td><td colspan="2">CONNECT / SUSTAIN</td></tr>
<tr><td>PROVISION OPTIONS</td><td colspan="2">Digital written communication services enabled via:
1. Local infrastructure / internet capability; <u>or,</u>
2. Deployable internet capability (via Astrium SATCOM).

<u>And,</u> non-digital written communications enabled via:
3. Deployable capability (via BFPO); or,
4. Local arrangements through Embassies</td></tr>
<tr><td>ADDITIONAL GUIDANCE</td><td colspan="2">• Locally sourced digital provision must be assured, satisfy a VfM Business Case and have robust billing procedures in place.
• Early engagement with HQ BFPO during the planning phase is essential as the activation of new BFPO numbers with Royal Mail can take up to six weeks.
• Where appropriate to the scale and duration of the deployment, forward basing PCS staff should be considered in the context of the full suite of postal & courier services that could be provided within the overall DWP.
• The in-location commander must ensure an ongoing programme of education and deterrence to maintain OPSEC.</td></tr>
<tr><td rowspan="9">PUBLICLY-FUNDED ENTITLEMENT (Where possible)</td><td rowspan="4">Digital</td><td>Ability to send and receive electronic written communication (email).</td></tr>
<tr><td>Ability to compose communication material off-line.</td></tr>
<tr><td>Ability to write and send eblueys (via BFPO).</td></tr>
<tr><td>Ability to receive eblueys within 24 hrs of being printed.</td></tr>
<tr><td rowspan="4">Non-Digital</td><td>1. An in-theatre delivery system that enables receipt of mail.</td></tr>
<tr><td>2. Ability to send and receive Free Forces Air Letters (via BFPO)[237].</td></tr>
<tr><td>3. Ability to send parcels up to 2kg in weight to DWP locations[238].</td></tr>
<tr><td>4. Postal Courier Services incl. staff in fixed locations.</td></tr>
<tr><td rowspan="2">Common</td><td>Access to a customer care facility including helpline (via BFPO).</td></tr>
<tr><td>Information material detailing facilities available through BFPO.</td></tr>
<tr><td>INFRASTRUCTURE</td><td colspan="2">Digital Communication:
• Welfare internet will be provided in accommodation and communal recreational areas, where possible.</td></tr>
</table>

[237] For entitled Foreign & Commonwealth personnel, the ability to send FFALs to their country of origin. The sending of FFALs to an entitled location at public expense is not available from to outside the UK or at a location where a BFPO is not established.

[238] Enduring Families Free Mail Service (EFFMS). Parcels may be sent from families or friends to named EP.

	• A limited number of publicly-provided terminals may be provided where considered necessary but it is expected that the majority of EP deploy with their own User Access Device (UAD) and welfare provision will be focused on enabling their individual access to the internet[239]. Non-Digital Communication: • Secure areas for the collection, processing and distribution of post and eBlueys must be in place.
AUTHORITY	• Whilst the provision of deployed Postal & Courier Service (PCS) operators is an Army lead for Joint operations, the responsibility for planning lies with PJHQ, SJC or the respective SC. • Responsibility for the E2E technical coordination of Forces Mail rests with HQ BFPO who is to provide advice and direction to PJHQ J1/J4 at all stages of an operation.
ACCOUNTABILITY	• The flow and delivery of mail is to be kept under close review and commanders are to be made aware of any significant delays so that EP can be kept informed. • All contractor-owned equipment is to be accounted for and managed by unit staff. Unit Commanders are to ensure that equipment is audited on a monthly basis and, in the case of Joint Deployments, this should be carried out by in-location J1.
POC	HQ BFPO, DES BFPO-DPS-FMO (02085 893386)

[239] Not less than 1 laptop/terminal/tablet / 50 individuals & Not less than 1 handset / 40 individuals.

NEWSPAPERS & MAGAZINES – PLANNING GUIDELINES

<table>
<tr><td>PRIORITY</td><td colspan="2">HIGH</td></tr>
<tr><td>EFFECT</td><td colspan="2">ENTERTAIN</td></tr>
<tr><td>PROVISION OPTIONS</td><td colspan="2">A selection of digital newspapers and magazines available via:
1. Local infrastructure / internet capability; <u>or,</u>
2. Deployable internet capability (via Astrium).

<u>Or,</u> a selection of non-digital newspapers and magazines available via:
3. Local capability for physical delivery; <u>or,</u>
4. Despatched from UK (via UK contractor).</td></tr>
<tr><td>ADDITIONAL GUIDANCE</td><td colspan="2">• Where possible, access to newspapers and magazines is to be via digital means and via local capability.
• Locally sourced provision must satisfy a VfM Business Case and have robust billing procedures in place.
• The selection of newspapers and magazines delivered physically is to take into account the Host Nation’s cultural and religious sensitivities.
• The provision of newspapers should reflect the composition of force; for instance Gurkhali transmissions when there is a significant Gurkha presence.</td></tr>
<tr><td rowspan="2">PUBLICLY-FUNDED ENTITLEMENT (Where possible)</td><td>Newspapers</td><td>Access to a selection of newspapers[240].</td></tr>
<tr><td>Magazines</td><td>Access to a selection of magazines[241].</td></tr>
<tr><td>INFRASTRUCTURE</td><td colspan="2">Digital:
• Welfare internet will be provided in accommodation and communal recreational areas, where possible.
• A limited number of publicly-provided terminals may be provided where considered necessary but it is expected that the majority of EP deploy with their own User Access Device (UAD) and welfare provision will be focused on enabling their individual access to the internet[242].

Non-Digital:
• Secure areas for the collection, processing and distribution of newspapers and</td></tr>
</table>

[240] Not less than 1 newspaper / 10 individuals / week when provided in hard-copy.

[241] Not less than 1 magazine / 5 individuals / month when provided in hard-copy.

[242] Not less than 1 laptop/terminal/tablet / 50 individuals & Not less than 1 handset / 40 individuals.

	magazines must be in place.
AUTHORITY	• PJHQ J1 is responsible for authorising the provision of current affairs material for eligible deployments under the command of CJO. The respective N1, G1 or A1 branch assumes this responsibility for eligible deployments not under the command of CJO.
ACCOUNTABILITY	• In locations where physical material is delivered, deployed administrative staff will be responsible (in conjunction with PCS if deployed) for its distribution. • All contractor-owned equipment is to be accounted for and managed by unit staff. Unit Commanders are to ensure that equipment is audited on a monthly basis and, in the case of Joint Deployments, this should be carried out by in-location J1.
POC	N/A

TV & RADIO – PLANNING GUIDELINES

PRIORITY	MODERATE	
EFFECT	ENTERTAIN	
PROVISION OPTIONS	TV & Radio services available via: 1. Local infrastructure / internet capability for online content; ***or,*** 2. Deployable internet capability for online content (via Astrium); ***or,*** 3. Deployable capability for delivery of content (via BFBS infrastructure/VSAT); ***or,*** 4. Deployable capability for physical delivery of content (via BFBS DVD packages).	
ADDITIONAL GUIDANCE	• Where possible, access to TV & Radio content is to be via digital means (i.e. live streaming and historic download historic content). • Locally sourced internet provision must be assured, satisfy a VfM Business Case and have robust billing procedures in place. • The provision of entertainment material is to take into account the Host Nation's cultural and religious sensitivities. • Entertainment material is to reflect the composition of force; for instance Gurkhali transmissions when there is a significant Gurkha presence.	
PUBLICLY-FUNDED ENTITLEMENT (Where possible)	TV	Provision of BFBS DVD packages for locations not under the satellite footprint.
		Access to BFBS TV Channels iaw Future Force Broadcasting Contract (Core & Contingency (8+4 channels)).
		Provision of TVs & Digital Terrestrial Television (DTT) set-top boxes[243].
		Provision of large screen TVs or small projectors for communal areas supporting large numbers of personnel (especially in the UK).
		Access to the BFBS iPlay system and downloadable media content.
	Radio	Access to radio[244] (capable of receiving the BBC World Service or BFBS transmissions).
		BFBS live radio (Channel 1 and 2) will be provided from the earliest stages subject to approved broadcasting rights; a practical and technically possible and cost effective solution.
		Provision of speakers and amplifiers may be utilised for communal areas supporting large numbers of personnel
	Common	Access to the BFBS iPlay system and downloadable media content.
		Access to online BFBS content to enable streaming.
INFRASTRUCTURE	High-Bandwidth:	

[243] Not less than 1 TV & DTT / 30 individuals where required.

[244] Not less than 1 radio / 20 individuals where required.

	• Welfare internet will be provided in accommodation and communal recreational areas, where possible. • A limited number of publicly-provided terminals may be provided where considered necessary but it is expected that the majority of EP deploy with their own User Access Device (UAD) and welfare provision will be focused on enabling their individual access to the internet[245]. Limited Bandwidth: • In locations with insufficient bandwidth, early engagement will be required to facilitate the planning approval and frequency clearances for a BFBS installation. • Provision of TVs and communal spaces.
AUTHORITY	• PJHQ J1 is responsible for authorising TV & Radio services for eligible deployments under the command of CJO. The respective N1, G1 or A1 branch assumes this responsibility for eligible deployments not under the command of CJO.
ACCOUNTABILITY	• All contractor-owned equipment is to be accounted for and managed by unit staff. Unit Commanders are to ensure that equipment is audited on a monthly basis and, in the case of Joint Deployments, this should be carried out by in-location J1.
POC	SSVC (BFBS)

[245] Not less than 1 laptop/terminal/tablet / 50 individuals & Not less than 1 handset / 40 individuals.

MOVIES, GAMES & BOOKS – PLANNING GUIDELINES

<table>
<tr><td>PRIORITY</td><td colspan="2">MODERATE</td></tr>
<tr><td>EFFECT</td><td colspan="2">ENTERTAIN</td></tr>
<tr><td>PROVISION OPTIONS</td><td colspan="2">Access to a selection of digital movies, games and books available via:
1. Local infrastructure / internet capability; <u>or,</u>
2. Deployable internet capability (Astrium).

<u>Or,</u> a selection of non-digital movies, games and books available via:
3. Local capability for physical delivery; <u>or,</u>
4. Deployable capability for physical delivery of content (via contractors).</td></tr>
<tr><td>ADDITIONAL GUIDANCE</td><td colspan="2">• Where possible, access to entertainment material is to be via digital means.
• Locally sourced provision must be assured, satisfy a VfM Business Case and have robust billing procedures in place.
• Locations requiring physical material will receive an initial entertainment pack[246].
• The provision of entertainment material is to take into account the Host Nation's cultural and religious sensitivities.
• Entertainment material is to reflect the composition of force; for instance Gurkhali books and movies when there is a significant Gurkha presence.
• Movies, games and books are interchangeable at a ratio to be determined by PJHQ, SJC, SCs on a per deployment basis.</td></tr>
<tr><td rowspan="5">PUBLICLY-FUNDED ENTITLEMENT (Where possible)</td><td rowspan="2">Movies</td><td>Access to not less than 1 movie / 10 individuals / month.</td></tr>
<tr><td>Provision of not less than 1 DVD player / 30 individuals / location.</td></tr>
<tr><td rowspan="2">Gaming</td><td>Access to not less than 1 game / 10 individuals / month.</td></tr>
<tr><td>Provision of not less than 1 video console / 30 individuals.</td></tr>
<tr><td>Books</td><td>Access to not less than 1 book / 10 individuals / month.</td></tr>
<tr><td>INFRASTRUCTURE</td><td colspan="2">Digital:
• Welfare internet will be provided in accommodation and communal recreational areas, where possible.
• A limited number of publicly-provided terminals may be provided where considered necessary but it is expected that the majority of EP deploy with their own User Access Device (UAD) and welfare provision will be focused on enabling their individual access to the internet[247].</td></tr>
</table>

[246] Not less than 1 DVD player + 10 DVDs + 1 video console + 2 video games / 30 personnel.

[247] Not less than 1 laptop/terminal/tablet / 50 individuals & Not less than 1 handset / 40 individuals.

	Non-Digital: Secure areas for the collection, processing and distribution of movies, games and books must be in place.
AUTHORITY	• PJHQ J1 is responsible for authorising the provision of entertainment material for eligible deployments under the command of CJO. The respective N1, G1 or A1 branch assumes this responsibility for eligible deployments not under the command of CJO.
ACCOUNTABILITY	• In locations where physical material is delivered, deployed administrative staff will be responsible (in conjunction with PCS if deployed) for its distribution. • All contractor-owned equipment is to be accounted for and managed by unit staff. Unit Commanders are to ensure that equipment is audited on a monthly basis and, in the case of Joint Deployments, this should be carried out by in-location J1.
POC	N/A

VIDEO COMMUNICATIONS – PLANNING GUIDELINES

<table>
<tr><td>PRIORITY</td><td colspan="2">MODERATE</td></tr>
<tr><td>EFFECT</td><td colspan="2">CONNECT</td></tr>
<tr><td>PROVISION OPTIONS</td><td colspan="2">Video communication services enabled via:
1. Locally sourced connectivity; <u>or,</u>
2. Deployable internet capability (via Astrium SATCOM).</td></tr>
<tr><td>ADDITIONAL GUIDANCE</td><td colspan="2">• Locally sourced provision must be assured, satisfy a VfM Business Case and have robust billing procedures in place.
• The in-location commander must ensure an ongoing programme of education and deterrence to maintain OPSEC.</td></tr>
<tr><td rowspan="3">PUBLICLY-FUNDED ENTITLEMENT (Where possible)</td><td>Message</td><td>Ability to send and receive video messages online.</td></tr>
<tr><td rowspan="2">Call</td><td>Provision of sufficient bandwidth to enable real-time video calling subject to fair usage policy.</td></tr>
<tr><td>Access to real-time video calling software / sites.</td></tr>
<tr><td>INFRASTRUCTURE</td><td colspan="2">Digital:
• Welfare internet will be provided in accommodation and communal recreational areas, where possible.
• A limited number of publicly-provided terminals may be provided where considered necessary but it is expected that the majority of EP deploy with their own User Access Device (UAD) and welfare provision will be focused on enabling their individual access to the internet[248].</td></tr>
<tr><td>AUTHORITY</td><td colspan="2">• PJHQ J1 is responsible for submitting requests for welfare telephone services for eligible deployments under the command of CJO. The respective N1, G1 or A1 branch assumes this responsibility for eligible deployments not under the command of CJO.</td></tr>
<tr><td>ACCOUNTABILITY</td><td colspan="2">• In deployments where access to welfare communications is via contractor-supplied welfare cards (Account for Life), administrative staffs are to enable/disable entitlements in accordance with procedures.
• All contractor-owned equipment is to be accounted for and managed by unit staff. Unit Commanders are to ensure that equipment is audited on a monthly basis and, in the case of Joint Deployments, this should be carried out by in-location J1</td></tr>
</table>

[248] Not less than 1 laptop/terminal/tablet / 50 individuals & Not less than 1 handset / 40 individuals.

POC	WelComE Service Owner, DE&S ISS Networks, Hawthorn Site, MOD Corsham, SN13 9NP (96927 3730 / 01249 853730)

PASTORAL & SPIRITUAL – PLANNING GUIDELINES

PRIORITY	MODERATE	
EFFECT	SUSTAIN	
PROVISION OPTIONS	Pastoral & Spiritual support available via: 1. Appropriate reachback support with accompanying supporting information; ***and/or*** 2. Deployed chaplain.	
ADDITIONAL GUIDANCE	• Where appropriate to the scale and duration of the deployment, a chaplain is to accompany the force. • In the absence of a chaplain, EP are to be made aware of reachback pastoral & spiritual support available to them, the POC will be nominated during the Estimate. • For enduring operations, a chaplain is to be deployed alongside EP to provide pastoral & spiritual support and consideration given to establish a chapel, prayer room, quiet area or similar facility to enable prayer or reflection. • For maritime deployments, it is likely that a chaplain should deploy alongside EP for at least part of their deployment.	
PUBLICLY-FUNDED ENTITLEMENT (Where possible)	Literature	Access to pastoral and spiritual information packs.
	Chaplain	Access to a chaplain to offer spiritual & pastoral support.
	Facility	Provision of a suitable facility (e.g. chapel or recreation space).
INFRASTRUCTURE	• During the earliest stages of a deployment, packs containing pastoral and spiritual guidance and information (e.g. separation from home, morality of war) for EP and their families will be available for distribution. • Where possible, a quiet space should be made available for personal reflection. • In locations with limited enabling infrastructure, it is acceptable to share a facility (e.g. recreational area) until more permanent infrastructure is established.	
AUTHORITY	• PJHQ J1 is responsible for determining the requirement for a chaplain for a deployment under the command of CJO. In liaison with the respective SC Chaplains, a chaplain will be nominated to provide support to EP deployed in that location. The respective SC Chaplain Heads assumes this responsibility for eligible deployments not under the command of CJO.	
ACCOUNTABILITY	• Deployed chaplains are accountable in the first instance to the Unit Commander	

	and also to the Senior Chaplain (if deployed). For single chaplains, Unit Commanders assume responsibility with respective SC Chaplain Heads managing their professional development and assignments.
POC	N/A

RETAIL & RECREATIONAL FACILITY – PLANNING GUIDELINES

PRIORITY	MODERATE	
EFFECT	SUSTAIN	
PROVISION OPTIONS	A retail service that provides a core range of toiletries, foodstuffs and personal items enabled via: 1. Locally contracted services / coalition capability; ***or,*** 2. Deployable capability. ***And***, for enduring operations, a retail and recreational facility enabled via: 3. Locally contracted services / coalition capability; ***or,*** 4. Deployable capability.	
ADDITIONAL GUIDANCE	• Locally contracted or coalition solutions must provide a range and quality of items suitable for UK personnel at reasonable prices. • Locally contracted solutions must satisfy a VfM Business Case and have robust billing procedures in place. • Coalition solutions must have appropriate Technical Agreements in place. • Where local solutions are unavailable or impractical, bespoke capability will be deployed from UK. • For maritime deployments, NCS must be engaged to provide suitable retail support throughout. • For UK deployments, SC or SJC staffs can engage NAAFI and/or local suppliers to develop an appropriate solution. • Where appropriate to the scale and duration of the deployments, the retail solution should include a recreational communal facility.	
PUBLICLY-FUNDED ENTITLEMENT (Where possible)	Retail	Access to a core list of products and services.
	Recreational	Provision of a Wi-Fi enabled retail & recreational space.
INFRASTRUCTURE	• In locations with limited enabling infrastructure or remote or high-threat areas, a capability will be deployed from the UK. • **Expeditionary Infrastructure**. As operations move to a campaign footing, provision of a recreational communal facility is to be included in the overall infrastructure development plan.	
AUTHORITY	• PJHQ J1 is responsible for authorising services for eligible operations,	

	deployments or exercises under the command of CJO. The respective N1, G1 or A1 branch assumes this responsibility for eligible deployments not under the command of CJO. • Local commanders are authorised to restrict alcohol provision in deployed locations.
ACCOUNTABILITY	• Commercial accountability is to be determined within any contracted solution for stock provision and transit (where appropriate). The Operational Commander is to maintain and enforce fair pricing.
POC	NAAFI (NCS)

LIVE ENTERTAINMENT – PLANNING GUIDELINES

<table>
<tr><td>PRIORITY</td><td colspan="2">LOW</td></tr>
<tr><td>EFFECT</td><td colspan="2">ENTERTAIN</td></tr>
<tr><td>PROVISION OPTIONS</td><td colspan="2">1. Deployed capability for provision of live entertainment (via CSE).</td></tr>
<tr><td>ADDITIONAL GUIDANCE</td><td colspan="2">• Will normally only be provided once the deployment is on a sustained footing and a secure environment with appropriate supporting infrastructure exists.
• The show format is to be innovative, representative of popular trends and composition of force, cognisant of cultural sensitivities and varied.
• For maritime deployments, live entertainment may be provided in a locally sourced venue and include a sit-down buffet meal.</td></tr>
<tr><td rowspan="2">PUBLICLY-FUNDED ENTITLEMENT (Where possible)</td><td>Contractor</td><td>Provision of live entertainment that may include but must not be limited to: musicians, ventriloquists, comedians, dancers and illusionists; and personality visits.</td></tr>
<tr><td>In-Service</td><td>Provision of in-Service bands.</td></tr>
<tr><td>PLANNING CONSIDERATIONS</td><td colspan="2">1. For deployments under CJO OPCOM, the NSE J1 staff (if established) or in-location commander is responsible for proposing to PJHQ J1 the time window in which either a show or personality visit should take place.
2. SCs and SJC will determine the suitability of live entertainment and the most appropriate period within the deployment programme in liaison with units.</td></tr>
<tr><td>INFRASTRUCTURE</td><td colspan="2">• Wherever possible, the Contractor will provide staging but may be required to use in-location infrastructure.</td></tr>
<tr><td>AUTHORITY</td><td colspan="2">• PJHQ J1 is responsible for authorising live entertainment shows and personality visits for eligible deployments under the command of CJO. The respective N1, G1 or A1 branch assumes this responsibility for eligible deployments not under the command of CJO.</td></tr>
<tr><td>ACCOUNTABILITY</td><td colspan="2">• All contractor-owned equipment is to be accounted for and managed by unit staff. Unit Commanders are to ensure that equipment is audited on a monthly basis and, in the case of Joint Deployments, this should be carried out by in-location J1.</td></tr>
<tr><td>POC</td><td colspan="2">SSVC (CSE)</td></tr>
</table>

DEPLOYED WELFARE GRANT

INTRODUCTION

1. HMT have authorised the £5.00 Welfare Grant per person per week as a legitimate charge to the public purse for the provision of DWS to personnel on UK deployments[249]. The justification for the grant is the requirement to provide equipment to relieve the boredom experienced by personnel during long hours on stand-by or in anticipation of taking part in an activity. MOD Fin Pol is responsible for issuing the instructions for capturing any costs involved and in the recovery action from OGDs. However, MOD is responsible for maintaining an auditable record of all items purchased, including tracking and final disposal action.

AIM

2. To provide welfare equipment via public funds to personnel on UK deployments or based within the UK in support of overseas deployments.

ELIGIBILITY

3. The Deployed Welfare Grant is available for UK based personnel for which the DWP has been authorised.

IMPLEMENTATION

4. Commanders are authorised to claim a maximum of £5 per week (or part thereof) per eligible Service person[250]. It is to be paid collectively (i.e. not to the individual) and is to be available from day one of the deployment or when pre-deployment training commences.

5. Justification for its need, use and amount is to be decided by the Jt Comd based on the circumstances on the ground and sustaining operational effectiveness[251].

FUNDING

6. The authority for payment of the Welfare Grant and where appropriate, the potential provision for out-sourced 'life support' requirements is given by this policy. The Jt Comd (UK)'s J1 staff in consultation with the single-Service allowance policy divisions will propose the appropriate allowances. The allowance package will then be forwarded from the Jt Comd J1 staff to CDP (Rem) Allowances Policy for approval as soon as possible and ideally during the pre-operation planning phase. For those deployed in UK in support of overseas operations, discussions between SP Pol P and A, PJHQ and the single Services will determine appropriate allowances.

7. For MAGD operations this grant must be negotiated between the provision provider (i.e. MOD) and the 'customer' Department as the grant will be chargeable to the OGD requesting support.

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249 Examples of which are MACA and MACP support, Op PICTCHPOLE, Op OLYMPIC and single Service mounted deployments.

250 Where appropriate and during the initial phase of an operation, consideration should be given to providing up to 3 weeks' worth of welfare grant in advance to enable welfare equipments to be purchased.

251 Individuals deployed on operations may find themselves spending long hours on duty or standing-by to take part in activity. There is a requirement to provide welfare equipment (such as TVs and DVDs) to relieve boredom during these periods.

8. When the welfare grant is provided from funding from an OGD, it is vital to agree the disposal intentions. The subject is to be raised and decided during initial negotiations between MOD and the OGD and promulgated. In these cases, the preferred option is that the welfare equipment items purchased will be retained by MOD. If MOD retention is not acceptable to the OGD, then the OGD will need to provide precise details of what types of equipments are to be returned, when and how and at no cost to MOD.

ACCOUNTING FOR WELFARE EQUIPMENT

9. The Commander is to put a process in place to administer welfare equipment purchased from the welfare grant so the equipments can be tracked centrally. This will ensure that:

a. Their whereabouts is known and can be audited and;

b. Allow equipments to be drawn forward for subsequent deployments should the need arise. Clearly, availability will depend on any reasonable deterioration of the equipment over time and the practicality of recovering and redeploying welfare assets.

10. Although the type of records may vary according to the size and type of deployment a description of the item purchased, the value of the item, the current location and details of the authorising officer must be included.

FINAL DISPOSAL OF EQUIPMENT

11. Although the MOD are not necessarily ultimately responsible for paying for equipment purchased from the Welfare Grant (depending on the type of deployment), funding is still coming from the public purse. As a result, it has been agreed by HMT that once the deployment is over the MOD can retain any items[252], which cost less than £5K, purchased using the Deployed Welfare Grant; however, the items must continue to be used for general use and not be issued to individuals; public rooms in messes and HIVES, etc, are ideal locations. The disposal of items costing more than £5K is subject to negotiation with MOD Fin PoI staffs. The Lead Command is responsible for dividing all items purchased equally between the Services involved in the deployment (i.e. to SCs). Items which are beyond economical repair should be written-off. Disposal instructions should be clearly annotated in the equipment register.

[252] Any maintenance or servicing costs associated with the upkeep of such items is the responsibility of the receiving unit.

FAMILY WELFARE GRANT

INTRODUCTION

1. The Family Welfare Grant is designed to assist Home/Parent Units in providing welfare support to families of Service personnel on qualifying deployments[253].

AIM

2. To provide enhanced communication and engagement with families during deployments in order to make them feel informed, and to instil a stronger sense of community whilst alleviating some of the stress of separation.

ELIGIBILITY

3. The Family Welfare Grant is available to commanders or their representatives at Home/Parent Units whose personnel are on DWP-qualifying deployments. Home/Parent Units are defined as the permanent place of duty or, for maritime units, the base port from which the Service person has been deployed. This must not limit the use of grants to these locations since the need to support geographically dispersed families may be greater. This definition includes other organisations that have prime responsibility for deployed personnel, including Reserves.

IMPLEMENTATION

4. Commanding Officers or their representatives are authorised to claim £4.40 per week for each of their deployed Service personnel who are in receipt of DWP support. The chain of command is to determine how the payment should be made and are authorised to use this scheme in order to support activities at the home base that enhance communication or relieve hardships that have been generated by the deployment.

5. Commanding Officers at qualifying Home/Parent Units are also authorised to continue claiming Family Welfare Grant monies for operational casualties who are hospitalised outside of operational theatres. This eligibility will remain for the duration of that unit's deployment.

6. Where units deploy individuals in support of another unit's deployment but families remain supported by the losing unit, the losing unit should liaise with the receiving unit to determine the apportionment of the funds with the needs of the family being paramount. Subsequently the Commanding Officers or their representatives should mutually agree an appropriate level of FWG expenditure be used by the losing unit in accordance with the guidance in this Annex.

7. Commanding Officers may exercise judgement in determining the priorities for family welfare support, in order to meet the aim of FWG. However, they will be required to ensure the expenditure is consistent with current guidance on financial propriety[254], and meets with accepted Services Values and Standards. Examples of acceptable expenditure include but are not limited to:

a. Provision of communications equipment (Internet facilities and telephone lines) for HIVEs and Community Centres.

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[253] D/SP Pol/2/45 dated 25 Apr 03.

[254] JSP 462 and the advice of BLB Budget Managers. Best value for money should always be sought and this may mean use of service facilities in the first instance.

b. Meeting the cost of extended Community/Welfare communications (Internet line usage to the deployment area).

c. Assistance towards the costs of producing and posting welfare information (leaflets, flyers, web pages and social media with due regard to security).

d. Meeting costs of children's activities (e.g. provision of a crèche during family briefings/meetings).

e. Provision of refreshments at unit organised briefings/meetings related to the deployment.

f. Provision of transport for attendance at briefings/meetings; to include use by wider family.

g. Provision of transport for welfare activity in direct support of families of deployed personnel such as unit organised social events and trips to attractions[255].

8. Particular consideration should be given to engaging and communicating with families that are geographically dispersed from the Home/Parent Unit. This will include families of regular and reservist personnel. Commanding Officers may wish to consider running activities away from the Home/Parent Unit for the benefit of these families as they are likely to require additional support during deployments; and the recent doubling of the grant was aimed at improving outreach to this group of harder to reach families.

9. Use of White Fleet (WF) is subject to availability and may not take precedence over other entitled journeys. No automatic civilian hire entitlement exists if WF is not available. However, costs for hire of civilian vehicles may be funded by the FWG. Hire costs are not permissible against unit travel budgets. In addition it must adhere to current legislation and policy[256].

10. The FWG is exempt from the restrictions placed on Festival Activity spending as laid out in JSP 462, Chapter 19, i.e. use of the FWG to fund Christmas Welfare activities is permitted.

11. Units are entitled to charge welfare activity in advance of the actual deployment date, such as the production of a pre-deployment pamphlet or the running of a families briefing day, against their anticipated entitlement to grant income. Such charges may be made up to six months in advance of a tour. Equally, units may also spend welfare grant income on welfare activities after the tour for a period up to two weeks after Post Operational Tour Leave is completed. Neither spending in advance nor after completion of the tour, alters the overall entitlement which remains tied to the actual period that personnel are deployed.

12. Units should pay the allowance in recompense for a specific welfare activity. The invoice should be charged to or split between operation names and it is recommended that a nominal roll of those members of the Unit deployed should be retained with the invoice. Single Service advice is available from Navy Command (Navy Pers-Busman – 93832 8717), Army HQ, DPS(A) (PS4(A) SO2 Personal Support - 94391 7743) and HQ AIR (Community Support SO2 - 95221 6584).

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[255] Commanding Officers may consider that this is most appropriately for immediate/close family as defined in JSP 752.

[256] JSP 800 Vol 5 – Provision of Welfare Transport.

CONCESSIONARY TRAVEL FOR FAMILIES ALLOWANCE

1. A number of key welfare enablers have been identified by deployed personnel as being of great importance when separated from their families. One of those enablers was the ability for the families of Service personnel deployed on operations for extended periods to stay in contact with their parents, parents-in-law or their nominated NOK/Emergency Contact (EC). Full details on entitlement can be found in JSP 752, Chapter 4, Section 4.

CHAPTER 2 – TRAUMA RISK MANAGEMENT (TRiM) POLICY

INTRODUCTION

2.2.1. Aim. TRiM is a Tri-Service endorsed strategy for providing support to Armed Forces personnel involved in a traumatic event,[177] whether on Ops or in any other circumstance. Tri-Service TRiM policy was formerly detailed in Defence Instructions and Notices (2009DIN01-097), and to a limited extent in JSP 375 (Leaflet 25). This TRiM policy supersedes both the DIN and JSP 375.

2.2.2 TRiM is a chain-of-command function that depends on good leadership and robust Human Resource management. It is conducted by members of the individuals' peer group, rather than by medical or welfare specialists.[178] The intention is to help individuals use their own coping mechanisms in order to keep them operationally effective, and to identify if further help is needed. In relation to Operational Stress, TRiM is not a substitute for effective stress management during the *normalisation phase* of recovery from operations, nor does it replace any requirement for medical intervention. Those identified as psychologically injured should be referred for professional assessment through the medical authorities.

2.2.3 Single Service Policy. TRiM policy can be found in the following single-Service publications:

a. RN. BR 3 Chapter 34, Annex H.

b. Army. LFSO 3217.

c. RAF. AP 9012, Chapter 10.

Notwithstanding the nuances of single-Service operations, and in recognition of the increasingly Joint operating environment, the mental well-being of Armed Forces personnel must adhere to Tri-Service policy and strategy. The delivery of TRiM policy must therefore conform to a common set of principles, standards and governance[179] which are set out in this policy.

BACKGROUND

2.2.4 Stress Management Training (SMT). Operational stress and exposure to traumatic events is an unavoidable part of military operations and can be considered an occupational hazard for all UK Armed Forces personnel. In 2005, the Overarching Review of Operational Stress Management (OROSM) produced its final report[180] which formed the basis for SMT.

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[177] Includes Reserve personnel. A traumatic incident is any event that can be considered to be outside of an individual's usual experience, and which has the potential to cause physical, emotional or psychological harm. A key feature of traumatic incidents is that there is no universal response to them; individuals respond to incidents in different ways.

[178] TRiM is primarily a joint administrative (personnel) initiative, supported by specialist medical agencies (such as the Defence Mental Health Services) for managing the non-physical impact of a traumatic incident on personnel.

[179] Regulated by the Joint Stress and Resilience Centre (JSARC) (Training Delivery Agency), Defence Academy of the UK, Shrivenham, to ensure consistency across the Armed Forces.

[180] Over-Arching Review of Operational Stress Management: Phase 2 – Training and Communication Strategies (dated 28 Apr 05).

2.2.5 The OROSM recommended the establishment of a 'Traumatic Stress Practitioner' (TSP) to deliver the highest, most specialised level of non-medical advice. OROSM directed that a TSP would be able to identify those at risk of developing poor psychological health after exposure to traumatic events. A TSP would also be able to carry out non-medical interventions, involving the chain of command (where necessary), aimed at providing an optimised environment for recovery.

2.2.6 Applicability. Following a trial in 2006/7,[181] TRiM, which was already in use by the Royal Marines (RM), was deemed to be an appropriate tool to meet the TSP requirement identified in the OROSM. TRiM was judged to contribute to operational effectiveness because it ensured a timely and demonstrable 'front-line' response to the welfare needs of those Service personnel who had been exposed to traumatic events. In addition to meeting the individual's needs, TRiM also aims to reduce the stigma associated with mental health issues. It is a tool to assist commanders in discharging their responsibilities for managing stress in traumatic circumstances. It fulfils the MOD's obligations to ensure that, where possible, psychological risks in both the operational and non-operational environments are mitigated. Commanders at all levels must therefore be able to:

a. Identify a potentially traumatic incident.

b. Determine the level of trauma-related pressure experienced by those under their command.

c. Identify potentially-traumatised personnel and make support and treatment available to those individuals, as appropriate, through use of the TRiM process.

CONCEPT OF EMPLOYMENT

Terminology

2.2.7 Traumatic Incident. A traumatic incident that may prompt a TRiM response is defined as:

a. Any event which leads to an individual experiencing significant helplessness, horror or fear and, as a result, has the potential to cause emotional or psychological harm.

b. Any event that can be considered to be outside of an individual's usual experience and causes physical, emotional or psychological harm.

Such incidents will often be associated with one or more of the following elements:

(1) Sudden death.

[181] "A cluster randomised controlled trial to determine the efficacy of TRiM in achieving a positive culture change, reducing organisational distress and improving unit response to traumatic events". Surg Cdr Neil Greenberg RN, Consultant and Senior Lecturer in Military Psychiatry published in TRiM in the FLEET Command - FLEET Pers Ops 02/07 (dated 11 Dec 07).

(2) Serious injury.

(3) Disablement or disfigurement.

(4) Multiple traumas.

(5) Near miss.[182]

(6) When individuals are encountering overwhelming distress, (examples include disaster relief and body-handling duties).

(7) Engagement with child enemy combatants.

2.2.8 TRiM - Practitioner. TRiM Practitioners carry out the functions of the TSP. They are carefully selected, non-medical personnel (who should be volunteers) in units and formations who receive training to enable them to identify psychological risk factors that might otherwise go unnoticed. Such personnel are drawn from across the rank range to ensure, whenever possible, that a potential sufferer is supported from within their own peer group. The number of TRiM practitioners within any particular unit will be determined by the parent Service. Factors such as the raison d'etre of any particular unit, its size, the number of sub-units involved, its geographical dispersal and variations in rank structures, must be considered to enable an appropriate evaluation of any TriM requirement. In order for TriM implementation to be successful, it is necessary for units to apply and maintain an appropriately robust 'selection' programme to ensure that those personnel selected for training are suitably experienced to undertake the TriM Practioner role.[183]

2.2.9 TRiM – Team Leaders.[184] Team Leaders are TriM practitioners who have received additional training to enable them to deliver wider management functions for the supervision of a TriM response to a traumatic incident, on behalf of the chain of command. Team Leaders provide an extremely valuable function, and units are therefore to link such a qualification to individual appointments and duties. Where possible, such personnel should be experienced officers, warrant officers or senior non-commissioned officers who have previous experience as practitioners.

Context

2.2.10 First Line Support. Use of the TRiM process provides commanders with a number of options on how best to deal with any traumatic event(s). TriM allows commanders to be informed about the psychological health needs of their personnel in order that they can plan the provision of the appropriate levels of support. This may include practical support (assurance of physical safety, acknowledgement of the stressful event, group discussions, etc.) and the provision of information and advice about stress reactions, rather than detailed psychological interventions. For minor incidents, commanders may choose to empower TriM practitioners to provide an appropriate reporting mechanism for enhancing managerial awareness and improving operational efficiency.[185]

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[182] A Near Miss (or Near Hit) is defined as an uncontrolled event which did not [physically] injure any person, but if it had, could have resulted in serious injuries.

[183] See Annex A.

[184] (TRiM) Team Leaders are also known as 'Team Managers' or 'co-ordinators'.

[185] Having peers who have some skills in psychological risk potentially allows for an initial 'unit-led' approach, without fear of 'stigma' and possibly without medical / psychiatric referral. This discreet approach is still classified as a 'TRiM intervention' and details must therefore continue to be recorded.

2.2.11 Second Line Support. For major incidents, particularly if they involve death, the unit TRiM team may be deployed in addition to medical, pastoral and welfare services. TriM aims to assess the initial impact of traumatic stress and to reassure the command chain that any vulnerable personnel are quickly being identified, 'signposting' to specialist support as required.[186]

2.2.12 TRiM Strategy. There are 3 strands to TRiM strategy:

a. **Education.** Pre-incident *awareness* education is particularly relevant to operational environments where the probability of any traumatic occurrence is considered greater than would normally be expected.

b. **Individual / Group Risk Assessment.** Following any incident, assessments will be conducted after 3 day, 1 month, and when considered necessary, at 3 monthly intervals. Such assessments enable the facilitation of *early referral* for treatment, where necessary.

c. **Mentoring.** The mentoring process enables access to a TRiM Practitioner(s) to compliment the education and assessment strands of TRiM, and allows further discussion to deal with any issues arising from any particular traumatic incident(s).

2.2.13 Following any traumatic incident(s) and the corresponding requirement to implement TRiM, the decision as to whether an individual *accepts* the offer of TRiM is his / her decision alone. Whilst advice and support will be given (including the initial briefing), the chain of command can only *offer* TRiM - it is up to the individual(s) concerned to accept or decline this offer. This is no way diminishes the duty of care that the unit or Service has towards that individual. The TRiM Leader must:

a. Continue to engage (throughout the assessment periods) with any personnel who decline the offer of TRiM.

b. Notify commanders of any individuals considered to be at risk to themselves or others.

2.2.14 Confidentiality. The peer-delivered approach to TRiM is based on trust. It is therefore critical that confidentiality is maintained. This requirement must be clearly articulated to TriM-trained personnel. During risk assessments and interviews, TriM-trained personnel must explain the principle of confidentiality, and outline the circumstances in which it may be breached.[187]

Principles of Employment

[186] The TRiM process requires that, as soon as practicable but within 3 days of any traumatic incident, a planning meeting is to be convened to determine the appropriate strategy for the management of the incident and that of the affected individual(s).

[187] Confidentiality may be broken only in the following circumstances: self-harming; if there is a perceived danger to others; should any serious crimes (civil or military) or breaches of security be uncovered; or, if the effectiveness of personnel is being compromised in the course of their duties.

2.2.15 TRiM is consistent with the objectives of military mental health provision and employed in accordance with the following principles:

a. **Simplicity.** The TRiM principles should be easy to teach and implement. Such a programme should enable commanders at unit level to manage personnel when they have been exposed to potentially traumatic events.

b. **Command function.** TRiM is a command activity. It should be initiated by local commanders and be delivered by peers not healthcare professionals[188].

c. **Peer delivered.** Support (including the offer of TRiM) should be provided at unit level, by appropriately skilled and trained peers, wherever possible.

d. **Voluntary.** The TRiM Risk Assessment is voluntary.

e. **Immediacy**. TRiM Practitioner assistance should be in place in the immediate aftermath of any event. TRiM practitioners will provide advice and assistance following a traumatic incident that is deemed to require a TRiM response. Formal individual or group risk assessments should not be initiated until at least 3 days after such an event;[189] earlier intervention is not recommended as it could induce the individual to 'relive the event' which might prove detrimental to psychological wellbeing.

f. **Expectation.** Personnel should be made aware that they may be expected to continue their normal duties, regardless of the nature of their traumatic experience, however, when personnel are unable to function due to overwhelming distress, temporary removal to a rear area may be appropriate. Providing TRiM assistance at the unit level reinforces the expectation that most people's responses are manageable and will resolve spontaneously. Such responses are not a sign of weakness, neither are they an indication that formal medical attention needs to be sought or that medical evacuation may be required.

g. **De-Stigmatising.** The provision of early, simple and peer-delivered support for mental well-being of personnel who have experienced traumatic event(s) should enable the de-stigmatisation of mental health issues.

Documentation and Reporting Arrangements

2.2.16 Documentation. All incidents involving the intervention of a TRiM Practitioner are to be fully documented in a TriM Incident Log Book. The log book is to record details of the incident and those personnel both directly and indirectly involved. It is also to capture the details of decisions made at the planning meeting and those personnel who were in attendance. The names of individuals invited to be risk assessed, their decision on whether the offer was accepted or not, and the subsequent risk assessment checklist scores and action(s) taken must also be

[188] Healthcare force elements may have healthcare professionals who are TRiM practitioners, but the duty is not a healthcare duty.

[189] This is not a 'do nothing' option, but good management practice whereby the individual is *encouraged* to follow their normal routine. Whilst some individuals will be more susceptible following any particular traumatic incident, it is normally better to allow this *state* to subside naturally before any more formal intervention is undertaken.

recorded. Once initiated, TriM Log Books are not to be destroyed but must be retained and archived in accordance with standard operating procedures.[190]

2.2.17 Reporting (and use of JPA). There is a requirement to collate TRiM intervention data, both to provide evidence of its efficacy and to meet departmental accountability and transparency obligations. Furthermore, operational tracking mechanisms (OPLOC) require that individuals' exposure to hazards that *might* give rise to future health effects to be recorded and tracked on JPA;[191] TRiM provides the appropriate *trigger* to identify such potential psychological hazards. It is recognised that recording sensitive details against individuals' records on JPA could undermine the TRiM model, which relies on confidentiality and voluntary engagement to reduce the stigma associated with mental health issues. Therefore, the minimum OPLOC requirement to record the incident details (in the form of a cross-reference to the TRiM Incident Log Book), time and location against the individuals' names is to be applied.[192] Under no circumstances should details of the incident or individual TRiM scores be recorded on JPA. Details of whether individuals were invited to be risk assessed and / or whether they declined assistance are to be recorded in the TRiM Incident Log Book, but only the *offer* of a TRiM intervention is to be recorded on JPA. This decision places heavy reliance on careful stewardship of TRiM Incident Log Books within units and commands, and a similarly robust mechanism is required for JPA administration.

MEDICAL CONSIDERATIONS AND COMMAND FUNCTIONS

2.2.18 Mental Health Research.[193] The National Institute for Health and Clinical Excellence (NICE) has issued guidance on the management of post-traumatic illnesses.[194] At the core of the guidelines is the principle of 'not making a meal' of normal levels of post-incident distress. For most individuals, post-incident distress is not a medical problem and does not necessarily require complex interventions. NICE suggests that, for the first month after an incident, a policy of 'watchful waiting' should be employed for all individuals who *may* have been exposed to a potentially traumatic event.[195]

2.2.19 Within the UK Armed Forces, the moral and physical component of TRiM lies within the Command / Executive hierarchy of any unit. As such, commanders must take the lead in the delivery and initial management of those formations and personnel most likely to be at risk. The Surgeon General (SG), the Competent Authority and Inspector for TriM,[196] directed that:

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[190] JSP 441 Defence Records Management Manual.

[191] JSP 756 - Tri-Service Personnel tracking and Operational Location Policy: Part 2 (Operational Tracking).

[192] JPA (Release 8) provides a suitable functionality known as 'Recording Exposure to Hazards' (E2H) to meet this requirement.

[193] The Academic Centre for Defence Mental Health (ACDMH) acts as the 'uniformed' focus for military mental health research for the UK Armed Forces. The centre aims to gather, assess and report on information that will enhance the health and operational effectiveness of the United Kingdom's Armed Forces. ACDMH staff also work to support the research efforts of the Defence Mental Health Services and other organisations or institutions that work to better understand and improve the health of serving and ex-Service personnel.

[194] NICE - Post-traumatic Stress Disorder (PTSD): The Management of PTSD in Adults and Children in Primary and Secondary Care. London (2005).

[195] Such exposure is not necessarily restricted to those perceived to have been directly at the scene of the incident, but should also account for combat support and combat service support formations and personnel.

[196] Through the Armed Forces Mental Wellbeing Steering Group (AFMWSG).

a. All military primary-care medical providers and all military mental health practitioners must understand their role in supporting the personnel that deliver TriM in the field or through the provision of TriM training.

b. Mental Health professionals should provide input to aid the development of TriM training and, specifically, to detail how TriM providers can access professional opinions for those identified as being at risk (following any particular exposure).

c. Academic Centre Defence Mental Health (ACDMH) would monitor emerging scientific evidence, to ensure that the TriM 'system' is kept up-to-date. The centre would also update governing TriM literature, where required, and to liaise with the JSARC, Shrivenham, to ensure that TriM training remains current.

TRAINING REQUIREMENT, DELIVERY AND POLICY

2.2.20 Governance. The Stress Management Training (SMT) policy (of which TRiM training is part) is laid out in JSP 898, Part 3, Chapter 13.

a. **Training Requirement Authority (TRA).** The TRA for Armed Forces SMT is Joint Warfare Directorate (JWD), Joint Forces Command.

b. **Training Delivery Authority (TDA).** The TDA for Armed Forces SMT is Joint Stress and Resilience Centre (JSARC), Defence Academy of the UK, Shrivenham. JSARC ensures coherence and consistency in the management and delivery of TriM T&E on behalf of the joint Training Requirement Authority.

2.2.21 Training Levels. SMT policy originally set out training requirements organised within 4 discrete levels. As part of the Armed Forces Mental Health Strategy (AFMHS), this policy was further revised to the following 5 levels:

a. **Level 1**. Includes initial training for all personnel new to the Armed Forces. Aimed at ensuring that personnel recognise stress in themselves and others, and to understand how to seek appropriate sources of help, should the need arise.

b. **Level 2**. Aimed at Armed Forces personnel who manage others. To ensure that such personnel are able to recognise signs of pressure and stress in themselves and in their subordinates.

c. **Level 3**. For Armed Forces personnel with a responsibility for managing stress at an organisational level, in order to maintain operational and / or business effectiveness.

d. **Level 4**. Targeted at non-medical Armed Forces personnel in posts that may have specific stress management responsibilities.

e. **Level 5**. Given to Armed Forces personnel at the 3 distinct stages of operational deployment: pre, during (if required) and post deployment. This

includes training delivered as part of OPTAG, Decompression and during the 12-Week Post Operational Stress Management (POSM) briefing.

2.2.22 TRiM, predominantly falls within Level 4 training. However, the wider strategy of TriM should ensure that TriM education permeates all 5 levels of training.

2.2.23 TRiM-trained personnel are ideally placed to be the *deliverers'* of Operational Stress Management Training, and to promote mental health awareness with their respective units. In conjunction with medically-qualified Mental Health professionals, TriM-trained personnel should be the first port of call for such activity.

2.2.24 Training Delivery Units (DUs). TriM training within the Armed Forces is currently delivered by the following Dus:

RN. Operational Stress Management (OSM) training team based at Naval Command HQ.

Army. TriM Training Cell (Army) (TTC(A)) based at the FASC Camberley.

RAF. Stress Management And Resilience Training Team (SMARTT) based at RAF Halton.

CONCLUSION

2.2.25 The mental health and wellbeing of personnel remains a key focus for our Armed Forces personnel. Based upon experience and over 15 years use by the RM, it is the military judgement of senior commanders that TRiM will continue contributing to the effective management of traumatic incidents on operations and in the workplace.

2.2.26 The greatest benefit of TRiM is perceived to be derived by those units deploying on *war-fighting* operations, or those serving within the front-line commands (and therefore more likely to be exposed to high-threat environments). However, the benefits of TriM are equally applicable to Combat Support and Combat Service Support units. Moreover, through the use of an appropriate management strategy following any traumatic event, examination and possible intervention must be afforded to <u>all</u> those likely to have been involved in the incident.

2.2.27 TRiM can also be of great value in most other situations, notably, non-operational traumatic incidents, training accidents and other challenging events encountered within a wider Service context. Therefore, irrespective of the raison d'etre of any particular formation or unit, exposure to traumatic events is an unavoidable part of military operations and it therefore must be considered an occupational hazard for all UK Armed Forces personnel. TRiM lies at the centre of command and executive functions for all units, and it is therefore in the interests of all 3 Services to ensure that the application of Tri-Service TRiM policy is implemented and managed through appropriately accurate, robust and sustainable single-Service publications.

CHAPTER 3 – POST OPERATIONAL DECOMPRESSION (DcN)

Introduction

2.3.01. By their very nature, certain military operations are stressful for all those involved. In order to allow Service personnel and MoD Civilians, returning from operational theatres to re-adjust to routine military and family life in a graduated and controlled manner, particularly where they have been exposed to high levels of intensity and risk[197], a period of Decompression (DcN) is to be provided.

Aim

2.3.02. The aim of DcN is to allow personnel a period of rest, relaxation and reflection, within a safe and controlled environment, in order to facilitate reintegration to the Home Base.

Effects

2.3.03. DcN forms one element of the Operational Stress Management[198] package and is to deliver the following effects:

a. **Relaxation.** Relaxation cannot be enforced through a single process. Maximising activities with the emphasis on (but not exclusively) group involvement, allows individuals to choose their preferred method of relaxation. The key tenets are to minimise responsibility at every level, maximise enjoyment through carefully planned activities, efficient administration, clear communications and the right environment.

b. **Rest.** Resting, even for a short period of time, will allow an individual to physically and mentally recharge their batteries before facing the demands that will inevitably be placed on them by family and friends on their return.

c. **Reflection.** Self-reflection or group reflection is to be encouraged through education rather than orchestration. Many individuals will reflect on their experiences without even knowing that they have done so. Rest, relaxation and time without physical or mental pressures will aid reflection. Reflection will be a continuous theme throughout the normalisation process.

Supporting Tasks

2.3.04. The Effects are delivered through Supporting Tasks. **Recognition** is the task of identifying the need for DcN, **Transition** is the planning process of moving from one environment to another and **Monitoring** is an assurance task prior to the Reintegration into the Home Base, represented graphically as:

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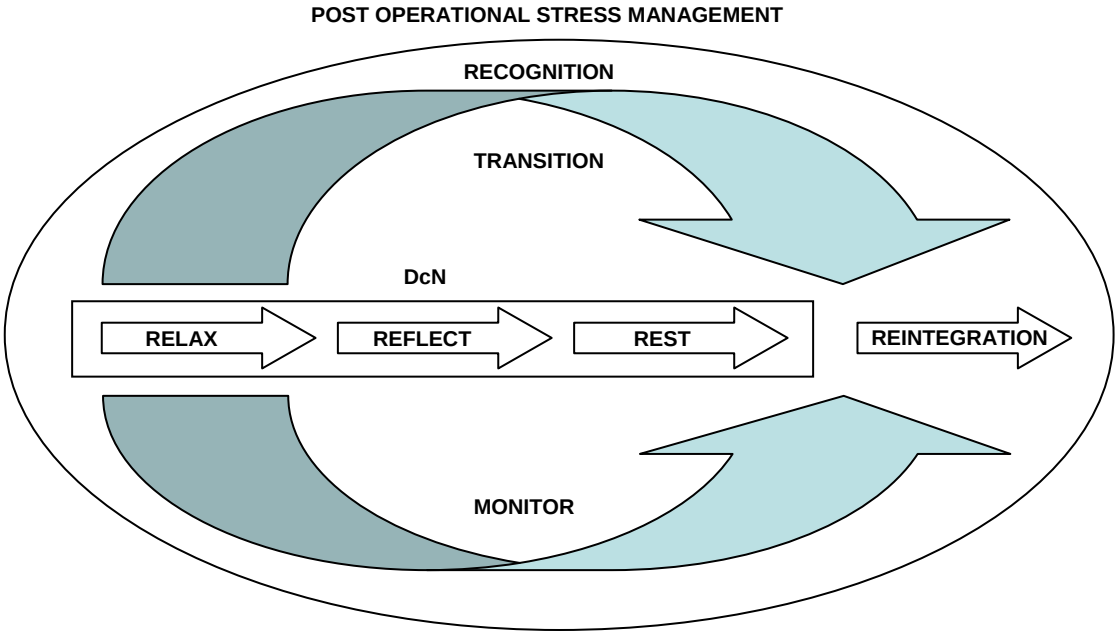
[197] Not all operational theatres warrant DcN. PJHQ will determine the requirement for DcN based on the risk and rigour of the operations.

[198] JSP 898, Part 3, Chapter 13 – Defence Stress Management Training Policy.

Decompression Effects



a. **Recognition.** Recognising the need for DcN is a PJHQ responsibility. The need is based on the levels of activity and risk that deployed personnel are exposed to during an operational tour. Some operations will be very traumatic whilst others may be stressful or physically or mentally demanding. Through DcN, the MoD is also recognising that there is a need to invest in the maintenance of mental wellbeing through a normalisation process that begins with a distinct separation from the operation.

b. **Transition.** Moving from a high tempo, high risk and austere environment directly to the home environment needs careful management; family relationships may need to be rebuilt and there may be a gulf in understanding of what has occurred from both ends of the family spectrum and in expectations. Returning personnel may experience a range of emotions, including guilt and resentment, particularly if they experienced personnel grief and trauma. Transition is the process of moving from one environment into another; breaking clean from the operation and reintegrating into the home environment, usually through a third location.

c. **Monitoring.** Throughout the DcN process, all personnel need to be monitored in a controlled environment. Some personnel will need more obvious help than others so professional help such as psychiatric nurses and chaplains must to be readily available.

Reintegration

2.3.05. The aim of DcN is to achieve a positive return home for deployed personnel. Conducting an effective DcN programme is wasted effort if the reintegration to the home base is ill-conceived. Good administration, a clear understanding of what to expect (from both the returnees and family and friends) and a seamless link into SC led Post Operations Stress Management (POSM) must be

achieved to maximise the effects of DcN. The link into the normalisation process must be orchestrated by the SC in conjunction with PJHQ.

Delivery & Governance

2.3.06. DcN is best delivered in a controlled environment by a single package lasting approximately 24-36 hours but the precise format of DcN will be driven by a number of factors including; the nature of the operation, the location of DcN, the availability of strategic transport and the need to return personnel to their home location within an expected period of time.

2.3.07. CJO is responsible for determining the requirement for DcN and responsible for the planning and execution of its delivery. CJO retains OPCOM of deployed personnel whilst they are undertaking DcN. The implementation of Operational Stress Management policy remains the responsibility of SCs[199], therefore CinCs retain Full Command of decompressing personnel and are responsible for their seamless reintegration into the normalisation process.

Eligibility

2.3.08. In order to allow for routine visits to operational theatres to take place only personnel who have been deployed for more than 31 consecutive days in-theatre will be required to conduct DcN. However, those who have deployed for less than 31 days may be considered if CJO / Service Commands believe that DcN will have a positive effect on mental well-being.

DcN Waivers

2.3.09. In exceptional circumstances COs or personnel may apply for a DcN waiver. Waivers will only be granted by CJO after consultation with the relevant Service Command. The relevant SC will either be responsible for the delivery of a mitigating package for those personnel who are granted waivers or will assume the resultant risk within the OSM process from bypassing DcN.

DcN for Injured Personnel

2.3.10. Injured personnel are not to be forced to attend DcN. However, injured personnel[200] who have been designated fit to travel, are physically independent and who do not require specialist medical treatment are entitled to carry out DcN with their unit prior to the unit returning to the UK or home base. The movement of patients under medical supervision (in-patients and out-patients) may be authorised in exceptional circumstances.

Summary

2.3.11. Personnel on operations exposed to levels of risk and rigour that are significantly above that which is associated with normal military activities must be reintegrated into the home base and normal levels of activity through DcN. This judgement sits with CJO in conjunction with the SCs. DcN is to deliver **REST**,

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[199] Departmental Guidelines are set out in JSP 375 – Annex D to Leaflet 25 – Stress Management.

[200] Injured personnel are defined as those personnel who have been RTU'd from the Op, due to injuries sustained, and have not been able to re-join their Unit in Theatre.

RELAXATION and **REFLECTION** as part of the Operational Stress Management continuum and to set the conditions for Reintegration. The delivery of DcN is the responsibility of CJO who will consider the optimum solution within the operational planning process.