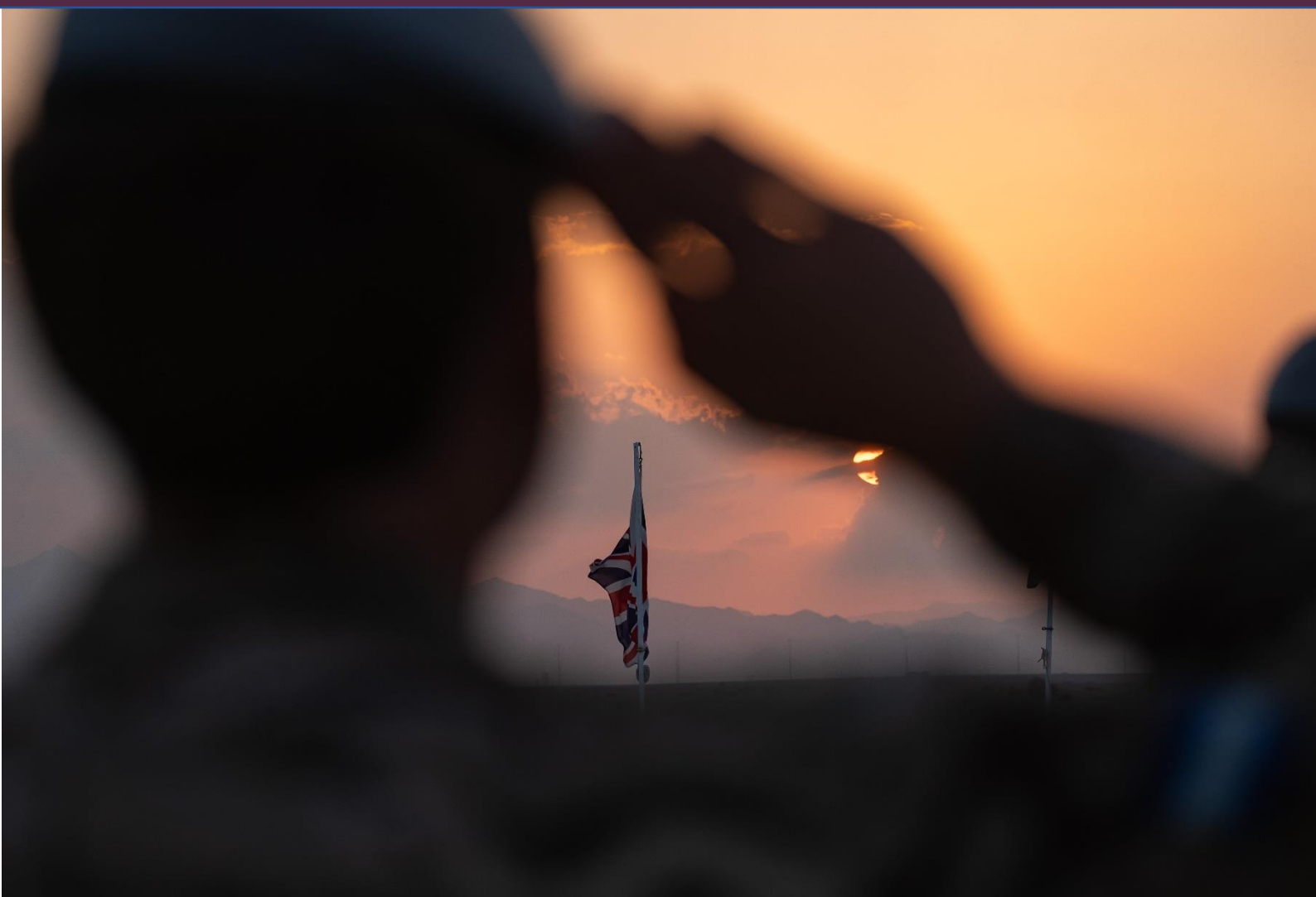
Ministry of Defence

ARMED FORCES COMPENSATION SCHEME

QUINQUENNIAL REVIEW 2022/23



EXECUTIVE SUMMARY

CHAPTER 1 BACKGROUND— Provides a summary of the evolution of the Armed Forces Compensation Scheme, the scope of the scheme and the underpinning principles. The reviewer provides an overview of the claims process, possible outcomes and the mechanisms that enable the Ministry of Defence to deviate from the standard procedure when calculating payments.

This chapter also outlines the Quinquennial review process, including the strategies used in research and data gathering, stakeholder engagement and development of the report. Finally, the overarching concerns raised by stakeholders with regards to the Armed Forces Compensation Scheme are set out. These include, a perceived lack of empathy, inefficiency with regards to resourcing and inconsistency in awards as a result of inconsistent application of the principles, lack of transparency, independence, and resilience within the Scheme.

PART I: THE ARMED FORCES COMPENSATION SCHEME IN PRACTICE

CHAPTER 2 GUIDING ASSUMPTIONS— Addresses the assumptions made by different stakeholders to the Armed Forces Compensation Scheme, focussing on the detrimental implications for the relationship between the Ministry of Defence and the armed forces community of the differences in expectations of the Scheme.

Recommendations in this Chapter seek to provide all stakeholders with clarity by defining the objectives and primary elements of the Scheme, with a view to unifying expectations.

CHAPTER 3 INFORMATION: AVAILABILITY AND ACCESSIBILITY— Similar to the findings of the Armed Forces Compensation Scheme Quinquennial Review 2016/17, highlights that communications regarding the Scheme are failing to reach their target audience and adequately inform claimants. The effect is that many with potentially legitimate claims either do not know about the Scheme or are insufficiently informed and ill-prepared to advocate for themselves throughout the process.

Recommendations include revisions to the presentation of information on relevant websites as well as signposting to government services and organisations able to provide support to claimants throughout the claims process.

CHAPTER 4 MAKING A CLAIM—focussing on the totality of the claimant's claims journey, the reviewer examines the challenges faced by claimants and raises concerns relating to the nature of their interactions with the MoD. Of primary concern in this Chapter is the lack of communication between the Ministry of Defence and the claimant throughout the claims process, resulting in decisions the claimant does not understand or disagrees with. Consequently, claimants are more likely to recourse to their right to request a reconsideration or lodge an appeal, prolonging the time it takes to finalise their claims and increasing the resource burden on the Department.

Recommendations focus on improving communications between claimants and caseworkers throughout and affording claimants more agency in their individual claims processes.

CHAPTER 5 THE CASEWORKER— Considers whether the caseworker role as it is currently conceptualised (i.e., as collector of evidence as opposed to decision-maker) is consistent with the description of the role in JSP 765 Armed Forces Compensation Scheme Statement of Policy (wherein the caseworker participates significantly in the decision-making process). The reviewer identifies a number or policies and practices that constrain the ability of the caseworker to exercise their judgement in individual cases, sometimes resulting in inequitable outcomes for the most vulnerable claimants.

Recommendations in this chapter aim at empowering the caseworker to successfully fulfil their role— one which is central to the success of the AFCS, including through targeted training and work planning.

CHAPTER 6 SUPPORTING GOOD DECISION-MAKING— Explores the mechanisms that support or constrain good decision making. The reviewer highlights the interdependence between policies and processes (e.g., data collection and analysis), and supporting caseworkers in making 'good decisions' on individual cases.

Recommendations in this Chapter are aimed at ensuring that Armed Forces Compensation Scheme policy and processes are informed by (i) robust and independent advice and (ii) mechanisms for monitoring and evaluating the Scheme, as well as transparent and collaborative.

PART II: POLICIES

CHAPTER 7 CALCULATING AWARDS— Focusses on whether the methods for calculating different types of awards (i.e., lump sum and Guaranteed Income Payments) enable officials to achieve the objectives of the Scheme, particularly when deciding on complex cases. In addition, the reviewer analyses the various formulas and supplementary tools that are used to calculate an award, concluding the result is an unjustifiably complex system lacking in transparency.

Recommendations are made to ensure equitable outcomes for claimants and the simplification of the method for calculating Guaranteed Income Payments and lump sum awards for claimants suffering multiple injuries, illnesses and/or disorders resulting from a single incident.

CHAPTER 8 SEEKING PARITY— Explores three issue areas concerning parity: (i) between disorders and injuries; (ii) between mental disorders and other injury, illness and disorder types; and (iii) between and within all the tariff tables (each of which pertain to different injury, illness, and disorder types, e.g., Table 1 Burns). This Chapter focusses particularly on the treatment of claims pertaining to mental disorders, including the obstacles claimants with mental disorders face in achieving equitable outcomes and the disproportionate use of interim awards.

Recommendations are designed to achieve parity in outcome between all the different injury, illness, and disorder types captured in the tariff tables, including in the processing of each claim type by the Ministry of Defence.

CHAPTER 9 INEQUITABLE LIMITATIONS— Delves into the adverse impacts of limitations placed on claimants and recipients by the provisions of the Armed Forces Compensations Scheme comparative

to the benefits to the Ministry of Defence, including limitations on eligibility, financial assistance, and the right to request a review.

Recommendations in this Chapter seek to remove limitations that are disproportionately detrimental for claimants and do not provide benefits beyond easing the Departments administrative burden.

CHAPTER 10 BURDEN OF PROOF— Looks to unpack the obligations of the claimant and the Ministry of Defence throughout the claims process as determined by the burden of proof provisions in the legislation and JSP 765 Armed Forces Compensation Scheme Statement of Policy. Particular consideration is given to the lack of clarity on the part of claimants regarding their obligations, despite the consequences of the failure to fulfil these.

Recommendations focus on ensuring the obligations of all parties to a claim are clarified in the legislation and policy documents, as well as adequately communicated.

Chapter 11 LUMP-SUM UPRATING— The Armed Forces Compensation Scheme Quinquennial Review 16/17 report recommended the Ministry of Defence annually uprate the lump sum amounts in Table 10, Schedule 3 of The Order in accordance with the Consumer Price Index. However, the lump sums have not been reviewed since 2018, despite their value reducing in real terms in that time period.

The reviewer recommends the instigation of an automatic, periodic process for uprating the lump sum amounts, particularly in light of recent unprecedented cost-of-living increases.

CHAPTER 12 SPANNING— Draws attention to the persistent issue of cases which span the legacy War Pensions Scheme and Armed Forces Compensation Scheme as a result of difficulties in ascertaining whether an injury, illness, or disorder was caused by an incident pre-dating the Armed Forces Compensation Scheme.

The reviewer recommends a specific audit of spanning cases to understand the principles by which these cases have been decided and produce publicly available guidelines.

CHAPTER 13 CONCLUDING REMARKS— In recognition that the 67 recommendations contained in this report will have varying degrees of impact, the reviewer concludes the Quinquennial Review by highlighting the most significant recommendations, accompanied by an assessment of the value of each.

ACKNOWLEDGEMENTS

The completion of the Armed Forces Compensations Scheme Quinquennial Review 2022/23 would not have been possible without the active and extensive participation of over one hundred individuals to whom I would like to express my gratitude.

Firstly, to colleagues in the Ministry of Defence for supporting the review process itself, conducting research, reaching out to and liaising with respondents, and reviewing the numerous iterations of this report.

Secondly, to all the respondents to this review, including officials from across government and the third sector, for engaging in this process earnestly and each dedicating hours to discussing the intricacies of the Scheme, some on multiple occasions. Also, for reinforcing that the will to ensure the Armed Forces community truly benefit from the Scheme is the same within and out with government.

Finally, to the claimants who shared some of their most difficult experiences with me in detail: all your stories proved invaluable in the design of the recommendations in this report. In particular, thank you to 'Nicky', 'Charlie' and 'Sam' for giving me permission to represent your stories in this report. I hope I have done them justice.

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1 BACKGROUND

1.1 In acknowledgement of the risk taken by those who serve in the UK Armed Forces, the UK government has historically put in place a scheme for compensating those who suffer injury, illness, disorders[1] or death as a result of service. The compensation is intended to be sufficient to ensure that individuals who suffer the injury, illness, or disorder and/or their dependents (particularly in the case of death attributable to service) do not experience a disadvantage as a result of their service. In 1998, the UK government announced a joint Ministry of Defence (MoD) and Department for Social Security (now Department for Work and Pensions (DWP)) review of the UK armed forces compensation arrangements with the aim of introducing a modern, fairer and easier to administer scheme.

1.2 The review found that the War Pensions Scheme (WPS)—the scheme governing compensation for injury, illness or death and death caused by service at that time—was no longer adequate in the modern context. Thus, the Armed Forces Compensation Scheme (AFCS) was designed and implemented in 2005 with a view to retaining the core principles of ensuring:

- Service personnel are compensated adequately for injury and death caused by service and that they are not disadvantaged as a result of service; and,
- The compensation scheme is appropriate in the modern context, accommodating significant developments in medical treatment, technology and societal perceptions of disability.

The Armed Forces Compensation Scheme 2005

1.3 The AFCS is a 'no fault' scheme that compensates for injuries, illnesses, disorders and death predominantly caused or worsened by Service from 6 April 2005. The AFCS applies equally to both serving and former members of the Regular and Reserve forces.

1.4 The underpinning principles are:

- **Be fair:** The arrangements guarantee a fair deal for all those who are entitled to compensation. The unique nature of military service is reflected by the nation's continuing commitment to those who have been injured, with an appropriate recognition for their sacrifice. The arrangements deliver consistent and equitable outcomes, with due recognition to the needs of those most seriously injured who receive higher awards than those less seriously injured.
- **Be understandable, accessible, and transparent**: Every effort is made to ensure that claimants are able to understand the basic elements of the Scheme and the claims process. Transparency is a key consideration, with widely available clear information and guidance enabling claimants to successfully access the Scheme. Information concerning claimants' overall compensation package is to be straightforward and comprehensible to all.
- **Be contemporary and joined-up**: The arrangements reflect contemporary best practice in relation to disability, by supporting people to look forward in their lives, empowering them

[1] Here on in, 'injury, illness and disorder' will be used to refer to the types of conditions compensated for under the AFCS and WPS. However, in official MoD documents pertaining to both Schemes, only injury and illness are referred to. The reviewer has opted to expand the terminology to reflect that disorders (Tables 3 and 4, Schedule 3, The Order) are equally eligible for an award under the Scheme.

and enhancing their capability. Reflecting this ethos, the Scheme is one element in a coordinated range of services, benefits and programmes provided by the responsible government departments, devolved administrations and delivery agencies working together to maximise the individual's well-being.

- **Provide security:** Compensation is fixed at realistic and sustainable levels. For those most seriously injured who may be unable to work again after service there is lifetime financial support and security.
- **Encourage employability:** As work is generally good for health and well-being, awards should not act as a disincentive to those who are able to work, or to engage in treatment.
- **Be compatible with human rights and fairness at work:** The arrangements are consistent with the Government's commitment to human rights and to being a modern and fair employer.
- **Be sustainable:** The arrangements are sustainable, realistic, and fair also to the taxpayer. This includes ensuring the arrangements are affordable (Para. 1.4, p. 1, *JSP 765 Armed Forces Compensation Scheme Statement of Policy* (2022)).

1.5 When a claim for an injury, illness, or disorder (or worsening of) is deemed successful, the AFCS provides either a tax-free lump sum payment or a tax-free single lump-sum and a Guaranteed Income Payment (GIP) depending on the severity of the injury.

1.6 The amount payable as a lump sum is determined by matching the injury claimed for to a tariff descriptor in Schedule 3, The Armed Forces and Reserve Forces (Compensation Scheme) Order 2011 (The Order) (Annex D), each of which describe an injury type. Each descriptor corresponds to a tariff level, and each of these levels, in turn, correspond to a predetermined pound sterling amount, payable to the claimant (Table 10, Annex D). The tariff levels range from 1 to 15, with Level 1 reflecting the most serious injuries and thus warranting the highest compensation payment. The amounts are set with reference to the Judicial College Guidelines (which governs injury compensation in the civil courts) but are adjusted to reflect the armed forces cohort they apply to (i.e., fitter than average men between the ages of eighteen and fifty).

1.7 The most severe injuries, illnesses, and disorders (i.e., those with long term effects), in addition to the lump sum, are compensated with a monthly tax-free, inflation-proof payment for life to be made once the claimant leaves the Armed Forces (the GIP). This payment is intended to enhance or replace the income lost as a result of the injury, illness or disorder the individual claims for. The amount payable is calculated by considering: the service person's age, salary, pension entitlement and their earning capacity. For example, where an injury, illness, or disorder means the recipient is unable to earn any form of income in future, the GIP is 100% (i.e., a full replacement of income). If the injury, illness, or disorder leaves the individual able to work part time only, a proportion of their future earnings are replaced to reflect this.

1.8 The percentage GIP payable is calculated with reference to the same tariff levels the lump sum amounts are calculated by:

- **Band A – tariff levels 1-4**: 100% of the service person's future earnings are replaced, which includes pensions and salary.
- **Band B – tariff levels 5-6:** 75% of the service person's future earnings are replaced, which includes pensions and salary).

- **Band C – tariff levels 7-8:** 50% of the service person's future earnings are replaced, which includes pensions and salary.
- **Band D – tariff levels 9-11:** 30% of the service person's future earnings are replaced, which includes pensions and salary.
- **Tariff levels 12-15:** No GIP is payable as it is considered that the service person's future civilian earnings capacity will be unaffected by their injury. (Para. 3.13, p. 15, JSP 765, 2022)

1.9 Where multiple injuries attracting a GIP are sustained, only one GIP is payable, determined by the most serious injury. However, if more than one injury is sustained in one incident and the two most serious injuries fall into the same GIP band, the GIP is increased by one band. For example, where there are two tariff level 7 injuries, a 75% GIP rather than a 50% GIP will be awarded to reflect the increased severity of the ongoing effects of the combination of the two injuries in comparison to those of a single tariff level 7 injury.

1.10 There are a number of mechanisms that enable the MoD to deviate from the standard procedure for calculating and administering compensation for specific circumstances:

- **Temporary awards**. Where an injury, illness, or disorder does not match a descriptor but is deemed compensable, the Secretary of State may issue a temporary award and the tariff table will be amended thereafter to include this injury, illness, or disorder. (Paras. 3.32- 3.35, p.19, JSP 765, 2022)
- **Supplementary awards.** Where an injury, illness, or disorder, or the effect of one, may not impact on future employability but has a significant effect on another aspect of the recipient's life, such as self-image or confidence, a Supplementary Award may be granted. For example, where an injury to the genitalia results in infertility. (Paras. 3.9- 3.10, p.14, JSP 765, 2022)
- **Fast payments**: Made to claimants seriously injured in hospital or undergoing rehabilitation to provide rapid financial assistance. These payments must be claimed within six months of the injury and are subject to a strict set of criteria. These fast payments (currently £61,800) can be paid early in an individual's treatment and recovery process. (Paras. 3.56- 3.60, p.23, JSP 765, 2022)
- **Interim awards:** The claimant must have a diagnosis and reached a steady state in their recovery or treatment for a final pay award to be granted. However, where the claimant does not meet these criteria, an interim award may be paid. The most appropriate descriptor at the time the interim award is made is used to ascertain the amount payable. Usually, a final award is made within two years, however the MoD may extend the interim award for a further two years if necessary. (Paras. 3.36- 3.38, pp. 19- 20, JSP 765, 2022)
- **Multiple injuries:** In the event that a single incident leads to multiple injuries, a multiple injuries ranking calculation is applied to the lump sum calculation to ensure those most seriously injured receive the highest awards, those with a large number of minor injuries receive less than those with a lesser number of more serious injuries, and that the claimant receives some compensation for each injury sustained. (Paras. 3.39- 3.50, pp. 20- 22, JSP 765, 2022)

1.11 A claim for compensation for death attributable to service is successful where:

- The death occurred in service; or,

- The death occurred within seven years from when service ends and was caused by:
  i. An injury caused by service; or
  ii. A pre-existing injury worsened by service or an injury that arose during service which was not caused by service; or,
- The death occurred more than seven years after service ends and:
  i. The death is caused by a late-onset illness which was caused by service
  ii. The predominant cause of death is an injury for which an AFCS award has been made where the lump sum fell within pay award levels 1-9 of the tariff. (Para. 4.7, p.28, JSP 765, 2022)

1.12 In these cases, the award is made to eligible dependents[2] and reflects the financial loss suffered as a result of this bereavement. Bereavement awards are made in three ways:

- **Survivor's Guaranteed Income Payment (SGIP)**: ongoing taxable payments paid for life to an eligible partner to financially compensate for the loss of the deceased partner's earnings. Payments are increased in line with inflation each year. This compensation arrangement is an enhancement to any service pension payable to the partner in relation to the deceased. (Paras. 4.9, p.28; 4.15-4.17, pp.29- 30, JSP 765, 2022)
- **Child Payment (CP):** ongoing monthly taxable payments for an eligible child/ren to financially compensate for the loss of their parent/guardian/person on whom they were financially dependent. Payments are stopped when it is considered that the child/ren would cease to be financially dependent on their parents. (Paras. 4.10, p.28; 4.18- 4.28, pp.30- 31, JSP 765, 2022)
- **Bereavement Grant (BG):** a one-off tax-free payment of up to £37,000 paid to an eligible partner or child/ren (Paras. 4.29- 4.37, pp.31- 32, JSP 765, 2022).

1.13 Where a death occurs during an individual's service, the MoD automatically consider the death for compensation under the AFCS. If determined eligible for compensation, the dependent will receive SGIP, or CP backdated to the date the deceased's salary stopped being paid.

1.14 If a death occurs after the individual has left service, dependants must submit a claim for bereavement compensation to the MoD. If successful, payments will commence from the date of the claim. If a claim is made within three months of the date of death, payments will be backdated to the day after date of death.

1.15 As at 31 December 2022, there were an estimated 570,000 individuals eligible to apply for compensation under the AFCS. This estimate includes those who left service between 6 April 2005 and 30 November 2022 and those who were in service as at 31 December 2022. This estimate takes into account the proportion of those who may have died since leaving service; does not account for specific eligibility criteria or time limits to claim under the AFCS; and, may include individuals who

[2] Defined as a spouse or civil partner (the marriage or civil partnership must have been in place for at least six months at the time of death), an individual who lived with the deceased as partners in a substantial and exclusive relationship, whom the deceased was not prevented from marrying or forming a civil partnership, and who was financially dependent on or interdependent with the deceased, or a child (including a birth child, adopted child or one that is financially dependent on the deceased).

have already made a claim under the AFCS as it is still possible that these individuals will go on to make further claims in the future.

AFCS Administration

1.16 The Scheme is administered by MoD Defence Business Services (DBS). Upon receipt of a claim, DBS allocate a caseworker to the claim, who will liaise with medical advisors to determine whether the injury, illness, disorder or death being claimed for is predominantly attributable to service. If so, an award is made based on the descriptors and corresponding tariff level, or an interim or temporary award is made in accordance with the circumstances. If not, the claim is rejected.

1.17 If the claimant is unsatisfied with the justification for either the rejection of their claim or the tariff level awarded, they can apply for a reconsideration (an internal process to the MoD) (Paras. 8.9- 8.11, p.42, JSP 765, 2022) or appeal to the First-tier Tribunal (War Pensions and Armed Forces Compensation Chamber) (the Tribunal) (Paras. 8.23- 8.37, pp.45- 47, JSP 765, 2022). Interim awards are not subject to appeal. If the claimant is satisfied with their award but their circumstances change, the claimant is able to apply for a review at a later date. Reviews are subject to certain criteria which become more stringent as time passes. (Paras. 8.12- 8.22, pp.42- 45, JSP 765, 2022)

Previous Reviews

1.18 Adjustments were made to the AFCS between 2005 and 2009, largely as a result of the emergence of different injury types and advancements in medical treatment. For example, service people on operations in Iraq and Afghanistan survived injuries which previously would have been fatal. Therefore, the multiple injury rule was adjusted, and lump sum amounts were increased. In addition, however, there have been two extensive reviews of the AFCS since it came into force, each of which prompted improvements to the Scheme.

1.19 The Review of The Armed Forces Compensation Scheme, 2010. Former Chief of the Defence Staff, Admiral the Lord Boyce, conducted a wide-ranging review in 2010 (the Boyce Review), encompassing the fundamental principles of the Scheme, the compensation it provides and how the Scheme evaluates claims. Overall, Lord Boyce concluded that the basic principles were correct, and the Scheme was an improvement on the WPS. Nevertheless, many recommendations were made to improve the policy and operationalisation of the Scheme, all of which were agreed by the members of the Independent Scrutiny Group and accepted by the Secretary of State for Defence.

1.20 The most significant changes to the AFCS implemented following the recommendations of the Boyce Review were:

- An increase in the amounts payable to reflect the average number of promotions someone of a particular age would achieve had they not been injured, reflecting that most now retire at 65 rather than 55. As a result, for example, a 21-year-old Private who suffers life changing injuries received a 35% increase in their monthly payments.
- An increase in the bereavement grant provided for death attributable to service. For most recipients, this rose from 20,000 to 25,000.

- The body zoning method for calculating multiple injury claims, entailing the grouping of injuries by five zones (head and neck, torso, upper and lower limbs, senses and mental health), ensuring all injuries are compensated for.
- The establishment of a new Independent Medical Expert Group (IMEG) to provide specialist advice, including on the fairness of awards for specific injuries (e.g., hearing loss, injuries to genitalia and mental health).
- The instigation of a quinquennial review (QQR) process to ensure developments in medical treatments, technology and the understanding of physical and mental disabilities are considered and that the AFCS remains fit for purpose.

1.21 The Armed Forces Compensation Scheme Quinquennial Review 2016/17. The first QQR of the AFCS was published in 2017. At the time, emerging challenges impacting the AFCS included:

- New illnesses, such as Ebola and Zika, posing a particular risk to women on frontline operations.
- An increase in the number of women serving in front-line combat raising concerns specifically with:
  i. Gender differences in musculoskeletal injury, risk, and treatment course; and,
  ii. Discrepancies in pay awards between men and women potentially resulting in lower GIP's, for example, for women.
- An increase in claims for mental disorders which were considered more difficult to diagnose and treat than physical injuries.
- A lack of awareness of the Scheme and understanding of its administration.

1.22 Overall, the QQR team found that the AFCS remained fit for purpose whilst reiterating the continuing need for periodic reviews of the Scheme to ensure it continues to adapt to an inevitably changing environment. Additionally, recommendations were made to:

- Improve the clarity of descriptors for musculoskeletal conditions (as these conditions were found to be a dominant cause for medical downgrading) and brain injuries with complex functionally disabling effects.
- Task the IMEG with advising on approaches to mental disorders and understanding the long term impacts of non-freezing cold injury (NFCI) due to an increase in claims.
- ensure that Service Personnel do not experience a reduction in the value of their lump sum awards as a result of inflation, uprate lump sum awards on a prospective (annual) basis.
- Reactivate the Communications Working Group on a quarterly basis, to assess and improve the impact of communications on the AFCS. In addition, greater efforts were to be made to raise awareness among service leavers and other arms of the State (e.g., the National Health Service (NHS) and DWP) of the Scheme.
- Equality-proof the Scheme to ensure that no particular group are disadvantaged by the Scheme's provisions. As a result, the IMEG was tasked with investigating the perception that female claimants have a lower rate of award than male claimants.

1.23 One Year On, Armed Forces Compensation Scheme Quinquennial Review 2016/17. In 2018, the MoD published The Quinquennial Review of the Armed Forces Compensation Scheme One Year

On Report summarising the Secretary of State for Defence's response to, and progress made based on, the recommendations of the QQR 2016/17. Most significantly:

- The IMEG reviewed the wide range of infections exposed to Service Personnel and concluded that the Scheme's legislation, as it was, accommodated any service-acquired infection related disorder.
- The IMEG found that a decision on musculoskeletal conditions would depend on the individual case facts, and factors such as duration of service.
- A review of evidence on claims pertaining to mental disorders was conducted and the IMEG were content that recent evidence supported recommendations made in the 2011 and 2013 IMEG reports on the legislation and award values for mental disorders.
- The proposal to uprate lump sum awards annually by the Consumer Price Index (CPI) was rejected as it would contradict wider government policy.
- The Communications Working Group was re-established to advise on improving communications and influencing user behaviour.
- The use of digital channels such as Facebook and Twitter, an integral part of their communications strategy with a current reach of approximately 1.1 million, was considered the best way to continue disseminating information to potential claimants.
- New policies implemented within the Scheme are to be equality-proofed in accordance with the Equality Act 2010 and departmental policy. The IMEG found no anomalies between male and female awards in the Scheme, however they are to routinely assess final award outcomes for AFCS claims by women and review the issues relevant to female musculoskeletal physiology and injury, both short and long term.

Armed Forces Compensation Scheme Quinquennial Review 22/23

1.24 Within the context of the evolution of AFCS since 2005, in January 2022, an independent external reviewer was appointed to lead the AFCS QQR 2022/23. Although the 2010 Boyce Review recommends the instigation of a QQR process to ensure the AFCS remains fit for purpose, the scope of the 2022/23 QQR extends to a review of AFCS policy in recognition that it has been almost twenty years since the Scheme came into force (see Annex A for the Terms of Reference, agreed in July 2022).

Approach

1.25 The reviewer followed a three-phase process to completion:

- **Phase 1: Research**, establishing the background of the review and an understanding of the legislation and policy documents which guide the operationalisation of the AFCS. The reviewer, being independent and external to the Ministry of Defence (MoD), carried out extensive document analysis of the relevant policy and legal documents pertaining to the AFCS, including previous reviews.
- **Phase 2: Stakeholder Engagement,** with a factual understanding of the Scheme as represented in official documents, the reviewer engaged respondents to establish the most significant areas for concern, each of which constitute a chapter in Parts I and II of this report. Additionally, this phase enabled the reviewer to understand where areas for improvement had already been identified and what reforms were underway.

- **Phase 3: Drafting and Editing**, carried out in collaboration with all stakeholders to ensure concerns were accurately reflected in the final report and that recommendations are holistically beneficial and implementable.

1.26 The reviewer identified respondents using the 'snowball technique' whereby an initial cohort of respondents (identified through a stakeholder mapping exercise) recommended and directed the reviewer to other potential respondents based on their interests, experiences and/or knowledge. In total, the reviewer engaged with 105 respondents (a list of stakeholder organisations and groups, as well as the number of individuals representing each organisation and group, can be found at Annex B).

1.27 A large-scale public consultation was not conducted with claimants as was the case in the Boyce Review. Instead, the reviewer opted to speak with individuals with a deep understanding of one or more aspects of the AFCS to ensure that all contributions were based on knowledge and understanding. For example, the reviewer sought the views of representative organisations (e.g., charities) who have extensive engagement with, at least, dozens of individuals a year on the basis of providing support with AFCS applications. These organisations provided robust and comprehensive contributions. Additionally, those in the Armed Forces Compensation Scheme Recipient group (Annex B), were selected for their protracted engagement in the process, their in-depth knowledge of the working of the scheme through self-motivated enquiry, and efforts to engage with the MoD to improve the process as a result of their experiences and knowledge.

1.28 All respondents were engaged in in-depth, one-on-one interviews on the proviso that their anonymity would be safeguarded in the final report. It is for this reason that Annex B provides only the names of organisations and groups engaged and the number of individual contributors rather than listing or attributing individual responses. This approach was taken to maximise the likelihood that respondents would be candid in their contributions, especially where they are still in the employ of the Ministry of Defence as officials or in the Armed Forces.

1.29 For the purposes of corroboration, the reviewer was also invited to observe and/or join MoD events and review MoD internal survey data collected from AFCS claimants, to gain insight based on the contributions of participants. The reviewer's presence and objectives were made clear at each of these. Moreover, the reviewer undertook an analysis of open source internet sites, including blogs and social media sites. However, none of the participants in these events and surveys, nor those who had published their views on the internet are included in the list of contributors in Annex B as their comments were not made explicitly for the purpose of the QQR; all those listed in Annex B have been interviewed explicitly for the purpose of this review and consented to their views being represented in this report.

1.30 There are four individuals referred to in this report: Alex, Charlie, Nicky, and Sam. The first, Alex, is a fictional claimant, whereas Charlie, Nicky, and Sam's cases are based on the real cases of three respondents to this review. The reason for the fictionalising of the first, Alex, is that the reviewer determined that the degree of detail required to illustrate the necessary points throughout Part II of this report was too extensive and therefore would make it impossible to preserve the

individual's anonymity. Moreover, Alex's case is predominantly used to illustrate points of process rather than impact.

1.31 On the other hand, the cases of Charlie, Nicky, and Sam were selected as exemplars of specific adverse impacts of the AFCS on individuals' lives. It is important that their words and stories are heard to illustrate that these are real lived experiences, not just theoretical possibilities.

General Findings

1.32 The vast majority of the issues raised concern the handling of complex cases by the MoD. A case may be complex due to the personal circumstances of the claimant, the medical condition(s) of the claimant, or difficulties in attributing the injuries, illness, or disorder to the claimants' service. The AFCS, however, appears to work well where a claim is made for an acute injury or illness (i.e., an injury or illness from which the claimant recovers with little or no lasting effects), particularly where the claimant has already recovered at the time of claiming. Generally, therefore, it is those with injuries with longer term impacts, illnesses, and disorders for whom it appears the Scheme is least effective if not detrimental.

1.33 Additionally, with the exception of concerns regarding time limits, respondents did not raise claims pertaining to death attributable to service, neither in a positive nor negative context. Thus, these types of claims are rarely alluded to throughout the report.

1.34 Evidence gathered throughout the QQR process raised a number of areas for improvement in the policy and practice of the AFCS, each of which constitute a Chapter in Parts I and II of this report. The process of evidence-collection also uncovered a set of cross-cutting issues, each of which is perceived by most stakeholders (both officials and claimants and their representatives) as playing a role in their dissatisfaction with most, if not all, of the issues areas which form the chapters of this report. These are:

- **A perceived lack of empathy** on the part of the MoD, especially for those who are unable to engage in the claims process consistently or adequately (often due to the condition they are claiming for) or to meet the pre-set expectations (as drafted into some tariff descriptors)[3] on how well an individual should be able to recover from or cope with an injury, illness, or disorder.
- **Inefficiency** with regard to the effective but fair use of resources, often resulting from a lack of communication within the MoD, dissemination of inconsistent or incomplete information, and disparities in awareness of the AFCS among officials.
- **Inconsistency** within the Scheme, stemming from the inconsistent application of the underpinning principles and consequent difference in benefits and disadvantages to both parties to a claim (i.e., the MoD and claimants).
- **A lack of safeguarding of transparency and independence** in the policy and decision-making processes, as well as a lack of demonstrable willingness on the part of the MoD to be held accountable for its decisions.

[3] This is particularly the case for claims pertaining to Table 3—Mental Disorders as meeting the criteria of the descriptors is contingent on set periods of time passing. This issue is explored in Chapter 8.

- **A lack of resilience** as the Scheme does not provide the necessary discretion to decision-makers to make judgements which meet the needs of claimants in the context within which decisions on claims are being made (i.e., taking into account developments in medicine, technology and societal attitudes).

1.35 A note on terminology: the reviewer has opted to use the term 'empathy' in this report as opposed to 'compassion' as empathy requires that an individual act based on an awareness of, and an attempt at understanding, the emotional response their actions will elicit in others. On the other hand, compassion requires that individuals react to others *with* emotion based on empathy and/or sympathy. The reviewer holds that it is not incumbent on officials to deliver a service based on emotion but that a service inherently designed to improve the lives of those experiencing medical, if not emotional, difficulties should be delivered in such a way that it does not aggravate the emotional state of those accessing the service. Thus, the awareness and understanding of the emotional impact of the delivery of the Scheme is crucial to meeting the objectives of the Scheme.

1.36 Additionally, throughout this report, the reviewer does not refer to single, specific functions within the MoD but rather to the MoD as a whole, unless pertinent. This is a deliberate attempt to signal that implementation of these recommendations should be centrally coordinated in order to be successful.

Designing Recommendations

1.37 The recommendations contained in this report address issues across both the policy and practice of the AFCS to meeting the Schemes objectives. The reviewer recognises that the AFCS was partially designed to address the shortfalls of the WPS and reflect the operating context of the mid-2000's. However, considering the length of time that has passed since the implementation of the Scheme, the reviewer has revisited the WPS to re-evaluate the suitability of its various elements in the current context. Consequently, there are instances where provisions akin to the WPS have been determined as well-suited to addressing the challenges posed by the AFCS in its current incarnation.

1.38 Additionally, in formulating the recommendations, the reviewer has looked to comparative, international schemes, including those in Australia (Military Rehabilitation and Compensation, in force since 2004), Canada (Disability and Income Replacement Benefits, in force since 2006) and the United States (Veterans Disability Compensation and associated benefits, in force since 2008). Although the objectives of each Scheme are broadly consistent (i.e., to compensate members of the respective armed forces for injury and illness caused by service), the differences in methods for calculating compensation offer useful insights. The reviewer has not used these Schemes to assess amounts payable or what can be claimed for (e.g., medical expenses) as universal welfare provisions in each comparator country vary significantly and are therefore not comparable.

1.39 Each recommendation has been tested with relevant key stakeholders and it has been the reviewer's primary concern that stakeholders feel that they have been candidly and transparently engaged in their design. The reviewer has sought to flush out the challenges through extensive one-to-one engagement, distilling how these can feasibly be rectified considering demand on resources and competing priorities, openly recognising where there are some shortcomings that cannot be corrected without secondary adverse consequences. It is the hope of the reviewer that, by doing so,

those parties whose expectations are not met by the recommendations contained in this report will recognise that this is not a result of the delegitimization of their concerns but rather of the complexity of the challenge.

PART I: THE ARMED FORCES COMPENSATION SCHEME IN PRACTICE

PART I of this report explores the challenges posed by the assumptions and processes which guide the implementation of the Armed Forces Compensation Scheme (AFCS):

- **CHAPTER 2 GUIDING ASSUMPTIONS explores the differing assumptions made by key stakeholders and the implications of these on the expectations of the Scheme.**
- **CHAPTER 3 INFORMATION: AVAILABILITY AND ACCESSIBILITY focuses on the communication of information on the Scheme, particularly the nature, suitability and utility of the information for prospective and existing claimants.**
- **CHAPTER 4 MAKING A CLAIM tracks the experiences and challenges faced by claimants going through the AFCS claims process, particularly as concerns the nature of their interactions with the Ministry of Defence.**
- **CHAPTER 5 THE CASEWORKER seeks to understand the role of the caseworker in the claims process, the constraints placed on them by policy and process and how they can be supported to succeed in their role.**
- **CHAPTER 6 SUPPORTING GOOD DECISION-MAKING looks to the wider AFCS policy and operating environment to understand how it can be improved to better support policy and decision makers.**

2 Guiding Assumptions

2.1 The basic elements of the Armed Forces Compensation Scheme (AFCS), although clear as principles, remain open to interpretation. Consequently, individuals participating in the AFCS process draw on their own experiences and sources to interpret these elements, resulting in diverse expectations of what the Scheme is meant and able to achieve. In practice, this means that different parties are working to different objectives causing friction and resentment among some claimants as, being the party with the least agency in the decision-making process, it is their expectations that are least likely to be met.

2.2 Clarification of the basic tenets of the scheme can therefore:

- Provide certainty to all parties to a claim as to the objectives of the decision-making process.
- Provide decision-makers with clearer guidance.
- Confer upon claimants and their representatives the ability to hold the Ministry of Defence (MoD) accountable for decisions inconsistent with the objectives of the Scheme.

Compensation: For what and for whom?

2.3 Compensating veterans for injuries caused by service is a reflection of British political and societal values, stemming from a recognition of the unique nature of the risk individuals take on in joining the Armed Forces.

2.4 Prior to the AFCS, the War Pensions Scheme (WPS) governed how compensation for injury, illness, or disorder and death caused by service was administered. However, changes in demographics, medicine, technology, social values and economic health meant that the generous

parameters for compensation under the WPS no longer reflected the modern context and became unsustainable for the MoD. In essence, and over simplifying for illustrative purposes, an Armed Forces consisting primarily of young people expected to pursue a second career and assisted by significant technological and medical advancements in their recovery, should not require as much financial assistance as those who served, for example, in the first half of the twentieth century when medical advancements to assist with recovery from an injury, illness or disorder were limited and workplace adjustments could not be expected.

2.5 The determination not to dispose of the compensation scheme altogether indicates that the need for reform did not negate the governments recognition that individuals suffering an injury, illness or disorder or death as a result of service should be compensated. However, though it is not difficult to arrive at a consensus that compensation for injury, illness, a disorder and death in service should be provided to service personnel, agreement on the detail beyond the principle is complex.

2.6 The Armed Forces and Reserve Forces (Compensation Scheme) Order 2011 (The Order) and JSP 765 Armed Forces Compensation Scheme Statement of Policy (JSP 765), the primary documents governing the AFCS, simply refer to compensation for harm caused but do not provide detail as to what claimants are legitimately able to claim for. For many claimants, there is logic in extending the notion that the armed forces will 'take care' of any needs arising from an injury, illness, a disorder, or death in service as part of, for example, assisting their transition out of service. This is not an unfounded assumption as, per their terms of service (equivalent to an employment contract), almost all their needs— including medical, accommodation and education— are taken care of by the MoD whilst they serve. These experiences, therefore, set their expectations for their relationship with the MoD after leaving service.

2.7 This assumption is further reinforced by the AFCS itself as:

- the first underpinning principle of the AFCS states that '[t]he unique nature of military service is reflected by the nation's continuing commitment to those who have been injured, with an appropriate recognition for their sacrifice' (Para. 1.4, p.1, JSP 765); and,
- the Guaranteed Income Payments ensure that '[f]or more serious injuries, where the individual's capacity to earn in civilian life beyond their service career is detrimentally affected by their injury, an income stream is paid' (Para. 3.2, p.13, JSP 765).

2.8 Consequently, the experiences of many claimants that participated in this review are coloured by the MoD falling short of these expectations.

2.9 On the other hand, many officials administering the Scheme and engaged in this review considered that compensation is due for injuries of a specific nature that are, on the balance of probabilities, predominantly attributable to service. Moreover, compensation it is not intended to replace income. Respondents were often careful to highlight that there are many caveats in this explanation of the objective of the Scheme.

2.10 The basis of these assumptions is in the experiences of the officials' work culture and training, including that:

- Most, if not all, MoD respondents were acutely aware that the AFCS was designed and implemented to fix the unintended consequences of the WPS, limiting eligibility to claim for an injury, illness, disorder or death:
  i. caused or worsened *by* service, not simply suffered *in* service. WPS claimants need only prove that the cause occurred during their time serving. Under AFCS, it must be a result of activity undertaken in the course of service, placing a greater and more nuanced burden of proof on the claimant.
  ii. Where service is the *predominant cause not one of many* causes. Under the WPS, claimants are eligible for compensation where service was proven to be a cause, even if one of many. The AFCS, however, requires claimants to prove that service is the primary cause, even if not the only cause.
- the tariff tables, dictating which injuries, illnesses and disorders can be compensated and how much for (Annex D), seek to provide an objective, medical guide to decision-making, limiting the influence of the experiences of the claimant (and therefore, of impact of an injury, illness, or disorder) on the final decision.
- Public services providers, such as the National Health Service (NHS) and Department for Work and Pensions (DWP), are expected to provide for veterans to the same standard as they would for all other citizens. For example, injured veterans or serving personnel are expected to be treated by services provided to others by the NHS or Defence Medical Service (DMS) respectively, and compensation is not intended to cover private medical care.

2.11 These differing assumptions result in a difference in expectations regarding, on the behalf of claimants, the type of decision they can expect and, on the part of administrators, what they should and can base a decision on. Thus, in some cases, the decision is not one the claimant expected, agrees with, and can even understand how it was made. Ultimately, these claimants feel that the MoD is doing less than it has committed to (i.e., not 'taking care' of them) and officials feel that claimants do not understand the Scheme, resulting in an adversarial relationship between them. The fault lies in neither party but rather in the lack of clarity on the purpose of 'compensation' in the AFCS context.

RECOMMENDATION 1: A definition of compensation should be agreed that reflects the intent of the AFCS, to serve as the primary objective and measure of success in policy and decision-making, as well as provide clarity regarding what can be expected of the Scheme. The definition should include the following elements:

- **Recognition of damage and/or suffering predominantly caused or worsened by service; and,**
- **Where an individual is expected to experience a persistent disadvantage as a result of the damage and/or suffering caused by service, proportionate lifetime financial support to provide necessary stability and financial security is due.**

'No Fault'?

2.12 If eligibility for an award is based on harm suffered predominantly as a result of the claimant's service, parallels can be drawn between the AFCS budget and employers' liability insurance— both are unlimited funds to ensure employers are able to adequately compensate employees for suffering caused by their employment, no matter the worth of the claim. However, the key differentiating

factor is the 'no fault' element of the AFCS, the implications of which are fundamental to understanding the intent and purpose of the Scheme and therefore should not be left to inference.

2.13 In assessing a claim, the MoD is not determining whether to accept liability for an injury, illness, disorder or death, but whether it can be predominantly attributed to the claimant's service. Thus, acceptance of a claim is not acceptance of MoD liability, simply acceptance that the injury, illness, disorder, or death is a result of what has been asked of the claimant as part of their service, regardless of the legitimacy of the request that caused the harm.

2.14 The 'no fault' element is of great benefit to the MoD; in particular, it enables the MoD to pre-determine levels of compensation, precluding negotiations of amounts payable, without conceding grounds for a negligence claim. This is reasonable as the MoD cannot escape that harm to those serving is possible, if not probable, in many roles, not only in combat but also during training. This is not the case for other employers who must ensure every step is taken to prevent their employees from suffering harm; thus, harm would only be suffered for reasons not in the employer's control or as a result of negligence.

2.15 Thus, rather than seeking fault, the MoD are primarily concerned with ascertaining attributability and whether service is the predominant cause of the injury, illness, disorder, or death. A 2011 decision by the Upper Tribunal of the Administrative Appeals Chamber held that:

"the correct approach to the issues of cause and predominant cause under the AFCS is:

- First identify the potential process cause or causes (i.e., the events or processes operating on the body or mind that have caused the injury, illness, or disorder).
- Secondly, discount potential process causes that are too remote or uncertain to be regarded as a relevant process cause.
- Thirdly, categorise the relevant process cause or causes by deciding whether the circumstances in which each process cause operated were service or non-service causes. It is at this stage that a consideration of those circumstances comes into play and the old cases on the identification of a service cause applying the old attributability test provide guidance.
- Fourthly, if all of the relevant process causes are not categorised as service causes, apply the predominancy test." (Para. 118, JM v Secretary of State for Defence (AFCS) [2015] UKUT 332 (AAC) (JM v SSD))

2.16 The predominancy test requires that the decision-maker 'consider whether, without the "service cause", the injury [illness or disorder] would:

- have occurred at all, or
- have been less than half as serious.' (Para. 134, JM v SSD)

2.17 Per the decision, causation in the AFCS context does not consider fault a factor, as it is sufficient that the service itself be the predominant cause. For example, an AFCS claim for a stress-related mental disorder caused by bullying which had been repeatedly reported by the claimant but had not been investigated or no suitable action was taken as a result of an investigation that found in favour of the claimant, would attract the same amount of compensation under the AFCS as a claim for the same condition that was not caused by a failure to act on the part of the MoD . This is

because the amount payable is determined by the type of injury, illness, or disorder and contingent on attributability, regardless of whether the MoD is at fault. If negligence is a factor, the claimant is free to pursue a negligence case in the civil courts in addition to the AFCS claim.

2.18 However, the 'no fault' policy should apply equally to claimants and the MoD alike to ensure consistency and guarantee fair treatment of all parties as per the first underpinning principle of the Scheme (Para. 1.4). Therefore, in the case of the above example, the claim could not be dismissed based on evidence that an internal investigation had been conducted and found no evidence of bullying. The result of the investigation is not evidence that the stress was not caused by service, only that the MoD was not negligent nor permitted misconduct. It remains the case that the claimant experienced stress resulting in or worsening a mental disorder during their service and the fact of the investigation is contemporaneous evidence that the condition manifested during their service. Therefore, the finding of the investigation against the claimant does not preclude the attributability of the condition to Service.

2.19 In light of the cause and predominancy test described by the Upper Tribunal, Article 41 of The Order, by which '[t]he Secretary of State may withhold up to 40% of benefit… where the negligence or misconduct of a member or former member contributed to that person's injury or death', is unnecessary at best and inequitable at worst. If the cause and predominancy tests are applied equally to all parties to a claim, a claimant should be eligible to compensation where the injury, illness or disorder passes the cause and predominancy test regardless of whether there has been negligence or misconduct.

2.20 For example, if, in the course of training, a claimant's descent from a rope-climb results in significant friction burns, they are eligible under the AFCS even if they had received instructions on how to descend safely as the claimant was (i) ordered to carry out the exercise and (ii) in the process of learning during which mistakes are expected. Moreover, they would not have needed to descend, nor learn to descend, from the rope were it not for their Service. However, if the claimant climbed the rope inebriated and injured themselves jumping from the rope, the injury is not Service caused as the claimant had not been instructed to train on the rope and made a choice to misuse the equipment. In essence, the issues of negligence and misconduct are precluded by the cause and predominancy tests.

2.21 In this particular example, making a differentiation between 'mistake' and 'negligence' is imperative; a mistake is a misjudgement attributed to, for example, inexperience or incomplete information. Thus, in the course of service, it is expected that individuals will make mistakes, but they would not suffer injury, illness, a disorder, or death as a result of their mistakes were it not for service. Negligence, on the other hand, is the deliberate failure to act on information despite knowledge of the consequences, including choosing to ignore information. In the case of the latter, service cannot be the cause of injury as the individual has taken steps to act contrary to instruction or, as in the second example given above, has acted of their own volition entirely. Thus, it is the individual that has put themselves in the situation which has caused the injury, illness, disorder, or death, not their service.

2.22 Consequently, Article 41 only serves to provide the MoD with the option to reduce the compensation payable where an injury, illness, disorder or death is proven to be service caused by making an attribution of fault but does not provide the claimant with the ability to claim more compensation as a result of the MoD 's negligence without submitting to an independent court.

RECOMMENDATION 2: To ensure fair treatment of all parties to a claim and mitigate against perceptions of an adversarial relationship between the MoD and claimants, **the implications of a 'no fault' scheme for both the MoD and claimants in the AFCS context should be explicit in all documents pertaining to the AFCS, including those providing guidance to decision-makers and claimants; specifically, that:**

- **Evidence of blame is not relevant in deciding on a claim.**
- **The 'no fault' element of the Scheme does not preclude nor affect the claimants right to instigate a negligence claim against the MoD.**

RECOMMENDATION 3: Moreover, **Article 41 of the Order should be expired to ensure no right is conferred on the Secretary of State to reduce compensation payments by attributing fault to the claimant as concerns the cause of the injury, illness, disorder or death that is the subject of the claim where it is deemed attributable to service.**

2.23 Nevertheless, where the effect of or recovery from the injury, illness or disorder has been aggravated by the claimant (e.g., they have not attended rehabilitation or deliberately acted in ways which have hindered their recovery), this should be taken into account in considering the tariff descriptor that most accurately describes the injury(ies) and impact of the injury(ies) that is compensable**.**

Compensation or Benefit Under the Terms of Service?

2.24 A factor aggravating the perception of an adversarial relationship between the MoD and claimants under the AFCS is the use of misleading and inaccurate labels to represent the relationship between the two parties as they signal to claimants how they are to be treated by the MoD.

2.25 Considering the AFCS is part of every service-persons terms of service, the label 'compensation' is a misrepresentation of AFCS awards. Though the pure meaning of 'compensation' may be applicable (remuneration for loss suffered), the societal connotations of claiming compensation are not appropriate; that is to say, where an individual or organisation makes a claim against another for wrongdoing— this would be akin to the process of seeking compensation for negligence through the civil courts which remains an option available to AFCS claimants.

2.26 Instead, AFCS awards are better described as an employee benefit akin to the Industrial Injuries Disablement Benefit, included in the armed forces employment package alongside, for example, benefits such as subsidised accommodation and medical care. In fact, in listing the definitions of terms used throughout, Art. 2(1) of The Order governing the AFCS describes the amounts payable as benefits:

- '"benefit" means a benefit payable under this order',
- '"claimant" means a person who has claimed a benefit, a person to whom benefit has been paid and a person affected by any decision of the Secretary of State made under this Order',

- '"injury benefit" means a lump sum, a supplementary award and guaranteed income payment'.

2.27 Similarly, the use of the word 'customer' to label claimants and recipients of the AFCS connotes that there is an exchange of goods or services between parties. This is not the case. On first application, the applicant is making a claim that they meet the eligibility criteria that enables them to access a benefit under their terms of service. On acceptance of the claim, they are then recipients of the scheme. At no point in this relationship is there an exchange of goods or services between the parties.

2.28 This may appear an issue of semantics. However, for the purposes of guiding decision-making, the conceptualisation of the AFCS payment as a benefit as opposed to compensation necessitates a shift in the projected and expected approach to decision-making; namely, the interests of the MoD and the claimant are not in opposition, rather the claimant is simply accessing a benefit they are entitled to under their terms of service.

2.29 From the potential claimant's perspective, particularly those still serving, this shift in conceptualisation may serve to tackle concerns from those still in service who are reluctant to apply to the AFCS for fear that a claim amounts to an expression of dissatisfaction with the MoD and is therefore an antagonising act against their employer which may adversely impact their careers. This may not be written anywhere, or an idea perpetuated by officials administering the AFCS, but it is a concern raised by almost all respondents who were either recipients or claimants to the AFCS or representatives of such individuals. Some respondents were explicit they had either been told by their superiors to wait to apply until they had left Service or had made the decision themselves to avoid what they sensed might be a difficult situation by waiting.

RECOMMENDATION 4: Label changes are not often impactful, yet the labels in the AFCS context contribute to the negative perceptions of the AFCS and the MoD, thus:

- **the Scheme should be renamed to exclude the word 'compensation', for example, the Armed Forces Injury Scheme (AFIS).** This ensures a distinction between claims made *against* the MoD through the civil courts and entitlement to an award for injury based on the terms of service.
- **all communications, such as guidance to claimants, and training guides should make clear that awards under this Scheme are to be understood as an entitlement by virtue of the recipient's terms of service.**
- **the label 'customer' should be replaced by 'claimant' in the early stages and 'recipient' of the AFCS fund upon approval of a claim.**[4] The terms 'appellant' and 'respondent' should continue to be used in the appeals process.

2.30 The reviewer recognises that the term 'injury' in the suggested renaming of this Scheme may cause concerns as the term connotes physical injury alone and the Scheme also compensates for

[4] For consistency, 'customers' will be referred to as 'claimants' or 'recipients' and 'awards' interchangeably with 'benefits' throughout this report.

illnesses and disorders, and death attributable to service. However, the reviewer would contend that:

- One of the concerns repeatedly raised throughout this review process was that mental disorders are not treated as equal to physical injuries or disorders in the way the Scheme is administered, leading to inequities in how those with mental disorders are treated under the AFCS (see Chapter 8). Thus, the name should reflect that the Scheme treats all equally, regardless of whether mental or physical.
- Although it would be more accurate to include 'illness' and 'disorders' in the name, for the sake of simplicity and to avoid lengthening the acronym unnecessarily, the term 'injury' is here meant to include all forms of hurt, damage and loss sustained, an expansive definition that is not uncommon (e.g., moral injury).
- Death attributable to service is encompassed by the suggested name as it is the injuries attributable to service which cause the death of an individual.

Approaches to Claims Resolution

2.31 There are generally two ways of approaching policy and decision-making:

- *Defensive:* a focus on limitations to ensure that those seeking to abuse the scheme are unable to do so. It places a larger burden on the claimant to prove the legitimacy of the claim and places the decision-maker in the place of interrogator.
- *Permissive:* a general acceptance that some will abuse the scheme, but focus remains on ensuring that there are no unnecessary obstacles for those legitimate recipients. This inherently places less of a burden to prove the legitimacy of a claim on the claimant.

2.32 The AFCS was drafted in a climate in which the WPS was considered too generous and permissive for the modern context and to ensure the responsible management of public funds. Consequently, more defensive measures were built in to the AFCS. Although the reviewer considers defensive measures legitimate and necessary, overall, the AFCS places too much weight on these resulting in an undue burden being placed on the claimant in the claims process.

2.33 For example, the guiding assumption among decision-makers that part of their role as decision-makers under the AFCS is to take a defensive approach, results in a tendency to put effort into awarding the lowest possible tariff. This is illustrated by the general assumption among all MoD officials interviewed as part of the QQR process and familiar with decision-making on claims, that, upon receipt of a claim, the starting point for ascertaining an appropriate tariff descriptor is the descriptor with the lowest possible tariff level. The next steps are thus to justify why the injury, illness or disorder does not meet the criteria of the descriptor matched to the next tariff level up. This may seem innocuous but, as there are often not clear distinctions between descriptors, working the other way (i.e., starting from the highest tariff and justifying why the injury, illness or disorder should not be downgraded) can produce results more favourable to the claimant.

2.34 The implications of accepting that (i) the Scheme is a benefit under the Terms of Service where an injury, illness or disorder passes the cause and predominancy tests; and, (ii) service-people and veterans are entitled to this benefit regardless of where the fault lies for the injury, illness or disorder, are that the MoD need not prove it is not liable nor be concerned with reducing the number or size of payments.

2.35 The fast and efficient delivery of the scheme is a legitimate and necessary priority especially at a time at which public services are pressed for resources and working through the backlog caused by the Covid-19 pandemic. However, efficiency measures in the AFCS have often taken the form of standardising and streamlining procedures which restrict the ability of decision-makers to employ discretion, resulting in the depersonalisation of the process. An example is the standardisation of letters of acknowledgement and the use of a generic helpline as a point of contact for claimants. In delivering the AFCS, decision-makers can become focussed on these procedural limitations placed on them in administering the claim, deprioritising the experiences of the claimants (see Chapters 4 and 5).

2.36 The AFCS, though, ultimately exists to assist those injured in service, most of whom will be attempting to access the scheme at a vulnerable time in their life and for whom an award could be life changing. It follows that no part of the scheme should be detrimental and cause further suffering to the claimant; in essence, the assistance provided by the AFCS begins at the point of access, with the service provided during the claims process being a part of the assistance. Therefore, these efficiency measures and limitations are, and should always be, secondary to the objectives of the Scheme in guiding how decisions are made and should only be taken where they are not at the expense of the claimant's well-being and protect decision-makers from harm.

2.37 Nevertheless, respondents repeatedly asserted that, particularly for those suffering from mental disorders, the AFCS claims process leaves many claimants feeling unacknowledged and even rejected by its current or former employer (the MoD), often causing further harm to their mental health. For example, in the cases of Nicky, Charlie, Sam and Max (Case Studies in Annex E). This is further corroborated by posts and articles found through open source research on a variety of blogs, social media sites and podcasts[5] as well as by those attending events held by the MoD. Thus, many of the recommendations contained in this report seek to procedurally re-personalise the claims process whilst retaining stringent eligibility criteria concerning attributability to protect the Scheme from abuse.

[5] For example, Twitter (www.twitter.com), The Army Rumour Service (www.arrse.co.uk), AFCS Help (www.afcshelp.co.uk) and Veteran State of Mind (VSOM) podcast.

3 Information: Availability and Accessibility

3.1 Communications are central to ensuring that any policy is (a) transparent and (b) understood by those to whom it is most relevant. Thus, it is incumbent on the Ministry of Defence (MoD) to:

- ensure the details of the Armed Forces Compensation Scheme (AFCS) are publicly available.
- make reasonable efforts to ensure that the information is given to potential recipients.
- make the necessary efforts to ensure the information available is appropriately presented for the Scheme's primary recipients.

3.2 The first of these obligations is fulfilled as the legislation and Statement of Policy (JSP 765) are accessible by anyone on gov.uk. However, it is much harder to identify the efforts being made to fulfil the second and third obligations.

Targeting Communications

3.3 All serving or former serving personnel in the UK armed forces have a right to make an AFCS claim. Yet the Scheme is not as widely known as, for example, access to subsided accommodation or Defence Medical Services (DMS) are. In fact, claimant and recipient respondents to the review, as well as their representatives, asserted that the most common way that serving personnel find out about the AFCS is by word of mouth and not through MoD communications.

3.4 Demonstrable efforts must be made to ensure all serving personnel are aware of their right to apply to the AFCS and how to submit a claim. This is not only the responsibility of the AFCS delivery function but rather of the MoD as a whole.

RECOMMENDATION 5: The approach to communications should be a proactive one, with a view to changing the perception that it is a complaints process, including by:

- **Ensuring DMS and Defence Transition Services (DTS) are charged with making all potential claimants aware of their right to apply to the AFCS (particularly at the treatment and rehabilitation stage), including by providing links or hard copies of information on the Scheme and displaying posters regarding the AFCS in the relevant facilities.**
- **Ensuring communications regarding the AFCS are disseminated at every possible, relevant opportunity and that the messaging is centrally coordinated so it is consistent and coherent regardless of which part of the MoD the messaging emanates from.**
- **Establishing and sustaining a supportive AFCS community, ensuring specific third party organisations (including the Royal British Legion (RBL), Royal Marines Charity (RMA), Royal Air Forces Association (RAFA,) and the Veterans Advisory and Pensions Committees (VAPCs)), able to support claimants specifically in the AFCS claims process, are signposted, as well as additional resources for serving personnel (e.g., the chain of command and welfare officers).**

RECOMMENDATION 6: The MoD should periodically review all documents pertaining to the AFCS to ensure that the information presented in each is up-to-date, accurate and consistent.

User-Friendly Communications

3.5 The method by which most claimants (serving and formerly serving) attempt to understand the AFCS is independent internet research. On searching for the terms 'armed forces/ veteran/ army/RAF/navy injury/compensation', the first page of returns will contain one or more of the following www.gov.uk web pages *Armed Forces Compensation Scheme, Free help with compensation claims for injury in the armed forces,* and *Claim if you were injured while serving in the armed forces.*

3.6 However, none of these sites provide a comprehensive and digestible explanation of the Scheme and related processes; the reviewer repeatedly heard from respondents that it is very difficult to understand how the scheme works through open source research. Corroborating this, the reviewer, a former academic researcher whose sole job it has been to research the AFCS, found it impossible to understand the Scheme without extensive one-to-one engagement with a wide range of stakeholders who offered, in many cases, hours of their time to explain the nuances of the Scheme. It is unreasonable to expect that any claimant or claimant's representative have this access, thus improvement to the quality of information in MoD communications is imperative.

3.7 Respondents reported that, a consequence of the lack of information is that p,articularly for those with complex cases necessitating the submission of multiple forms of evidence (e.g., from service records as well as the NHS, describing years of different forms of treatment), the claimant is underprepared and overwhelmed by the process.

3.8 To ensure claimants are well informed, it is common practice that there be a set of documents that explain the Scheme in incrementally more detail. Figure 1 illustrates the explainers of the AFCS that are the MoD make available on the internet (April 2023), with the Summary at the top of the pyramid providing the least detail and the legislation at the bottom the most.

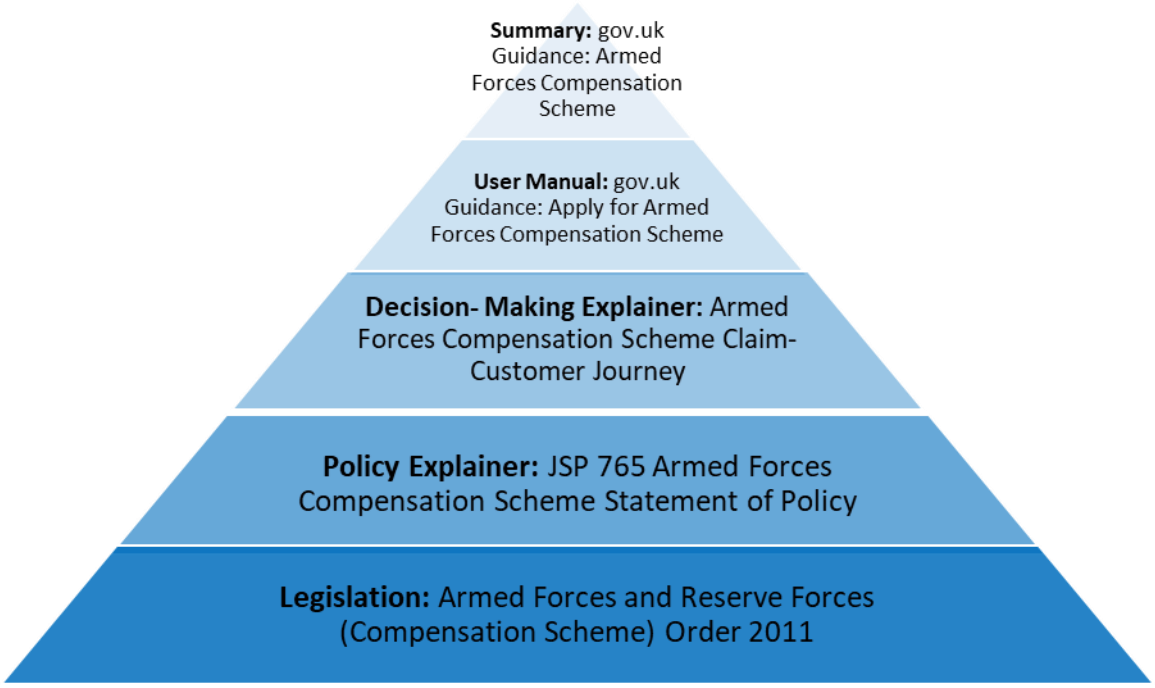

Figure 1: AFCS available explainers

3.9 The levels of explainer of particular concern are the user manual and decision-making explainer; The Order is generally, and acceptably, inaccessible to lay persons and the policy explainer should simply be a translation of the legislation into policy terms. The second and third documents in the pyramid, however, respectively, serve the purpose of:

- Setting out what is expected of the claimant, and
- Making transparent the parameters by which their claim will be decided on.

User Manual to the AFCS

3.10 The function of a user manual is currently being fulfilled by the *Apply for Armed Force Compensation Scheme Guidance* gov.uk page (Figure 2). However, the page does not give clarity to the claimant on how to navigate the process. Instead, it provides a list of things a claimant will need to register a claim in the 'Before you start' section, but the section of the application that requires the most effort and work is covered by a single line at the end: '[g]ather any details or documents you need in advance'. There is no indication as to what these documents might be and thus no:

- indication as to the time and effort burden the process will require on the part of the claimant.
- standard-setting as to what the MoD *can* ask of the claimant in the process.

3.11 Respondents reported that one of the most confusing aspects of the MoD communications is the tendency to over-simplify the process, depicting it as straightforward and bureaucratic, with the burden primarily falling on the MoD (lack of clarity on the burden of proof is further explored in Chapter 10). However, once the claim process begins, they are often overwhelmed, feel it is too late to seek out the necessary support or simply do not know where to ask for help.

Eligibility:

- you may be able to get a payment if you have an injury, illness or medical disorder caused or made worse by UK armed forces service
- claims can be made for both physical and mental health conditions
- if you want to claim for a condition related to exposure to asbestos, read the guidance on GOV.UK first
- only use this service to make a claim. If you want to ask for a review or appeal a previous decision, contact Veterans UK
- if you want to claim for bereavement or dependant's benefits, do not use this service. See our guidance on GOV.UK

Before you start

You'll be asked for:

- an email address if you want to claim online. If you do not have one, you should make a claim by post. Details of how to do this can be found further down this page
- details of anyone helping you make a claim, for example a charity or welfare adviser
- your own details, including your national insurance number
- your armed forces service, including dates you served, if you know them

- the illness or injury you're claiming for and why you think they are related to your armed forces service
- your doctor's details and, if you have them, details of any hospitals that have treated you for the medical conditions you're claiming for
- any other compensation or benefits you receive or have received for the conditions you're claiming for
- your bank account details

Gather any details or documents you need in advance - this will make it faster to answer the questions.

Figure 2: Apply for Armed Forces Compensation Scheme Guidance www.gov.uk

RECOMMENDATION 7: To ensure claimants are prepared for the AFCS claims process and have the necessary support in place prior to applying, **the Apply for Armed Forces Compensation Scheme Guidance webpage should be re-structured to focus on setting expectations, providing clarity on:**

- **What service the MoD will be providing throughout the claims process.**
- **The likely nature of their communications with the MoD during the claims process.**
- **The types of evidence they will be expected to gather, including what the MoD can legitimately request** (see Recommendation 9)**.**
- **Potential points at which and reasons why further information may be sought from the claimant.**
- **Potential points at which claimants may require support**
- **Links to where they might access support, including, for example, to charities that specifically offer AFCS support, the VAPC's and the Veterans Welfare Service (VWS);[6] and,**
- **Projected timelines.**

Decision-Making Explainer

3.12 Some claimants may only want to know exactly what will be expected of them during the AFCS claims process. However, others, particularly those with complex injuries, may want to understand how decisions are made. At this time, the 'Customer Journey' explainer, a step-by-step guide to the stages of the claims process (Figure 3), is the document closest to fulfilling this function.

3.13 This graphic, however, presents too much information, including acknowledgement of claims, the multiple outcomes at any given stage, and multiple options from Step 13 onwards. Rather than presenting as much information as possible, it is imperative that communications only present information that is useful to the reader considering the objective of the document. Thus, the information on timelines presented here is better suited to the user manual as per Recommendation 7.

[6] Reliant on the MoD ensuring that these bodies are well-informed and have the expertise to do so. See Recommendations 22, 30 and 34.

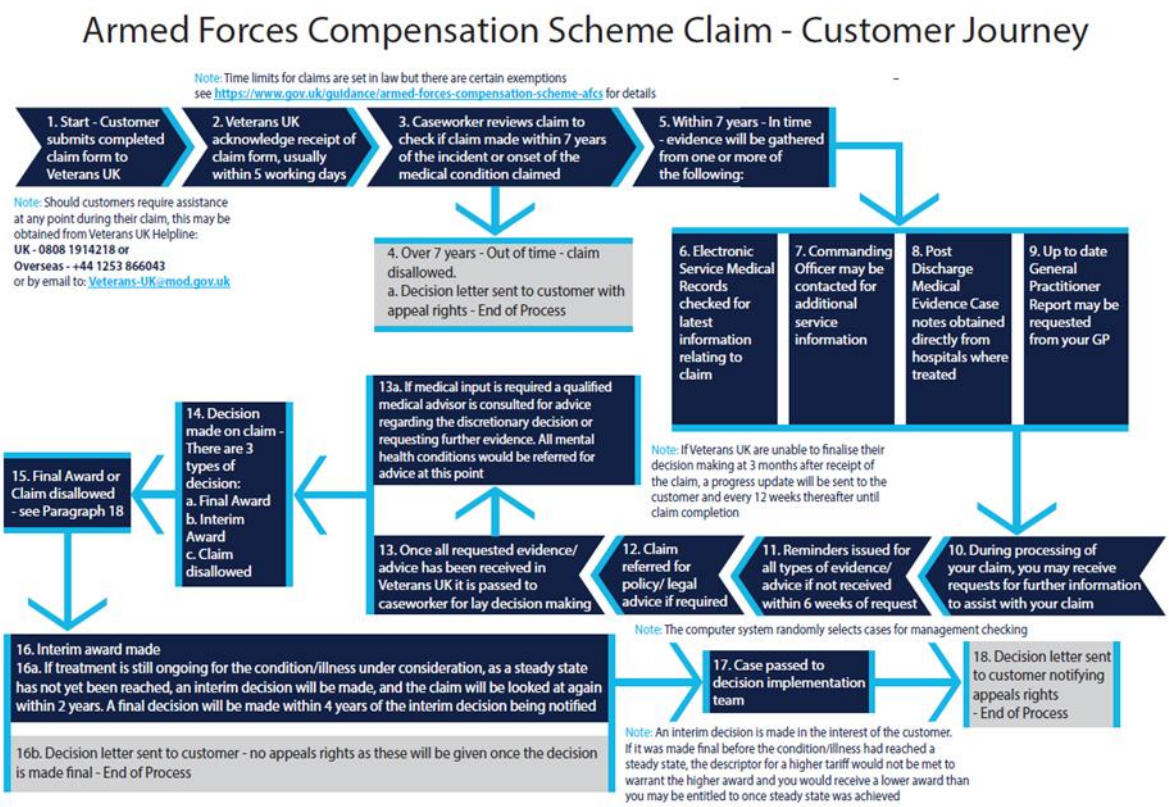

Figure 3: Armed Forces Compensation Scheme Claim- Customer Journey, www.gov.uk

RECOMMENDATION 8: The key to providing the decision-making explainer is not a step-by-step guide to decision making but rather transparency as to how decisions are made, thus **a document should be produced which focusses on how decisions are made, including:**

- **How attributability is determined (i.e., the cause and predominance test and the meaning of 'the balance of probabilities' in the AFCS context).**
- **The methods used to translate evidence of an injury, illness, or disorder into a tariff descriptor.**
- **The constraints and parameters to the medical, legal and policy advice regarding individual claims.**
- **The limitations on the use of interim awards and the instances in which they can be made.**

3.14 For example, the pertinent information in Figure 3 would be**:**

I. A check to ensure the claim meets the time limit requirements will be run (i.e., boxes 3-5).

II. If so, the MoD will seek evidence from (though not exclusively) the claimants Electronic Service Medical Records, Commanding Officer, Post Discharge Medical Evidence Case, up to date General Practitioner Records in collaboration with the claimant to ascertain whether the injury, illness or disorder is attributable to service according to the cause and predominance test (should include a lay-persons explanation of the test) (i.e., boxes 5-11);

III. If deemed attributable, further evidence from the same sources may be sought to ascertain whether and what award level corresponds to the claim (including an example).

IV. In complex cases, further advice may be sought from MoD medical advisors, legal and policy, (the parameters of what advice each of these actors can give should be made explicit) (i.e., boxes 12-13).

V. A decision can result in:
   - A final award, or
   - An interim award (an explanation of the limited uses of an interim award and examples of when one might be awarded should be provided).

VI. If insufficient evidence is found to support the claim at any stage, the claim will be disallowed. The claimant will be notified of the reasons why the claim is disallowed as well as of their right to request a reconsideration of and appeal the decision.

3.15 In addition to better informing claimants and providing them with agency in their claims process, transparency and accountability should have the effect of reducing the number of claimants who resort to solicitor's firms and pay for legal representation on a no win-no fee basis. Although the MoD is not able to prevent claimants from contracting paid representation, considering that the objective of the AFCS is to provide financial assistance and security to individuals suffering an injury, illness, disorder or death as a result of service, the MoD should be taking reasonable measures to ensure that recipients do not *need* to spend their compensation in order to get a fair hearing.

4 Making a Claim

4.1 The claims process is ostensibly simple: the claimant, perhaps with the help of a charity or superior, submits a claim for an injury, illness, or disorder with medical evidence to support both the claim that the injury exists and that it is predominantly attributable to service. However, in practice, the process is overly burdensome and even distressing for particularly vulnerable claimants.

4.2 Respondents raised the following broad issues areas regarding the claims process:

- *Unreasonable timeframes*. Between 1 April 2017 and 31 March 2022, initial injury, illness and disorder claims were cleared in an average of 61 working days, with the longest taking 2,841 working days. For claimants applying for a reconsideration or appeal during the same time period, on average, it took a further 124 and 391 working days and up to 2,279 and 4,294 working days respectively for a final decision to be made.[7]
- *Inaccessibility and a lack of transparency.* Claimants are unclear on how their claim is being processed or decided on and do not feel they have agency or even access to MoD support.
- *Lack of fairness and empathy.* As claimants feel they lack agency, they experience a lack of protection of their interests.

The Claimant

4.3 It is easy to conceptualise the 'claimant' as simply one factor of many in the process. However, improving and safeguarding their well-being is the objective of the Scheme. Thus, this section considers how the process is experienced and can impact a claimant to illustrate the issues identified by respondents to this review.

4.4 To better do so, the claims journey of a fictional claimant, Alex, is described. The reviewer has chosen the example as the degree of vulnerability experienced by the fictional claimant is not unusual, even if they are not in the majority. Most claims will be submitted for acute injuries, such as a broken leg, from which the sufferer will move on and continue in their life's trajectory as planned— these claims are often resolved with little contact between the claimant and the MoD. However, those with whom MoD officials will need to have the most interaction will be those with the most complex cases or more severe injuries and thus are the most vulnerable. This vulnerability is one of the defining characteristics of the population to which the MoD are providing its most important service under the Armed Forces Compensation Scheme (AFCS) (i.e., support in achieving financial stability and security, mitigating the negative impact of their injury, illness, or disorder on the well-being of the claimant), and should be a significantly influential factor in determining how the service is provided.

4.5 Alex is 36 and has multiple injuries caused by a single incident on operation nine months before submitting a claim under the AFCS. Alex has seven discrete diagnoses and, at the time of submitting his claim, is at various stages of treatment/ recovery for each:

- Hearing loss in one ear sufficiently severe that Alex cannot hear on the affected side.

[7] It should be noted that clearance times increased significantly in the years 2020/21 and 2021/22 due to COVID-19 restrictions which affected the MoD's ability to process claims at the same rate. However, it remains the case that these figures are an accurate reflection the experience of claimants and, if measures are not taken, will continue to be so due to the backlog in the system.

- A number of fractures to the facial bones which healed without treatment within six weeks of the incident.
- A wound to the face caused by shrapnel and which will leave permanent, severe scarring.
- First degree burns to the lower chest area which healed without treatment within the first few weeks after the incident.
- Injuries to the left lower leg leading to amputation below the knee. Recovery entails physio and rehabilitation to adapt to a prosthetic.
- A fractured right ankle, which left the joint misaligned, requiring surgery and for which recovery could take up to twelve months.
- A significant period of depression and anxiety which began when Alex started rehabilitation after being discharged from hospital. Alex is undergoing therapy.[8]

4.6 At this stage, Alex's facial wounds are healed, leaving a significant scar, as are the chest burns. Alex's right ankle still feels weak, and healing has been hindered by the loss of the left lower leg. In turn, it is taking longer for Alex to get through rehabilitation than might be expected. This is made even harder as Alex's depression negatively impacts their motivation. It is hard for Alex to hear on one side and so Alex doesn't always know everything that is happening in the moment. Nevertheless, Alex has not decided whether to wear a hearing aid. All these limitations mean that Alex cannot help around the house and with their two children especially as, most of the time, it is Alex that needs help, even if only until used to a new way of doing things. Alex cannot work and is essentially homebound. Alex is learning to manage their depression and anxiety attacks with therapy, but there are still bad days.

4.7 Feeling that, on the good days, it would be positive to do something productive, Alex decides to submit a claim under the AFCS. As with most claimants, and as discussed in Chapter 3, Alex hasn't gleaned much about what to expect from the process and feels that, given the circumstances and how much the Army has provided from the moment they joined, they should be able to manage the claims process without help.

Initial Decision-Making Process

4.8 The first decision on a claim is referred to here as the initial decision and the process to arrive at that decision, the initial decision-making process. Any reconsiderations or appeals of an initial decision are separate processes. In this section, the effectiveness of the initial decision-making process is considered.

Evidence

4.9 Alex is required to submit evidence to substantiate their claim. However, the claim form simply requests evidence of tests, diagnosis, and/or treatments rather than provides an indication of what form this evidence might take and who it should be from. This is not in itself problematic as it can be considered a recognition that not every case is the same, enabling claimants to make their own judgements on what evidence is pertinent to their claim.

[8] This combination of injuries has been taken from JSP 765 in which they are used to illustrate how decisions are made on multiple injury cases are decided on (Example 3, Annex D, JSP 765).

4.10 Alex is unsure as to what evidence to submit so describes the incident, subsequent medical interventions and provides a narrative regarding their suffering as a result of the injuries in addition to listing medical appointments and treatments. However, as many respondents to this review asserted is common, the MoD reply requesting further information regarding their mental disorder before a decision can be made, delaying the processing of Alex's claim.

4.11 Between 1 April 2017 and 31 March 2022, although the average initial claim clearance time for injury, illness and disorder claims was circa three months, the longest running claim cleared in that timeframe took almost twelve years. These statistics only include the time taken to reach the initial decision. The time taken to reach any subsequent decisions from reviews, reconsiderations or appeals have not been included.

4.12 Respondents to this review reported that, for claimants with complex claims in particular, where there are delays at the initial decision phase, it is commonly due to the MoD requesting further information months after the claim is submitted or closing the claim as the claimant does not yet have a diagnosis. Closing the claim on this basis has the effect of annulling the claim thus the claimant is free to reapply when they have a diagnosis. However, in both scenarios, claimants remain unclear as to how much evidence, or from whom, would ensure that their claim can be processed as there is no communication with caseworkers beyond a letter of information.

4.13 This scenario is particularly prevalent in mental disorder cases, where respondents report feeling that they can never submit sufficient evidence to satisfy the process and thus often end up having their claims rejected or being given an Interim Award. The latter can be extended (of those awarded since 1 April 2017, 56% of Interim Awards have been extended), and there is a perception that a final decision is only made when the MoD have a statutory obligation to do so (i.e., at the latest possible date). This particular concern will be considered in Chapter 8.

4.14 To fulfil the principles of fairness and transparency and mitigate against delays at the early stages, all parties to this process should know what is expected of them, further enabling all parties to be held accountable for their part in the process. This includes claimants themselves, who are responsible for providing proof when it is requested (see Chapter 10 on Burden of Proof provisions).

RECOMMENDATION 9: To mitigate against unnecessary delays at the early stages due to a lack of understanding of the process on the behalf of the claimant:

- By analysing previous claims and liaising with Medical Advisors, **a checklist of evidence that the claimant can expect the MoD to request should be published on the relevant gov.uk web pages and claim completion guidance.** A way of categorising types of claims for the purpose of compiling an evidence checklist will need to be found, for example, by tariff table.
- **The role of different forms of evidence in the decision-making process should be clarified, including what consideration will be given to medical notes, personal statements and discharge notes (including medical board statements where relevant) in determining the different elements necessary to decide on a claim (e.g., attributability and impact).** For example, in determining impact for the purposes of calculating the GIP (if Recommendation 37 and 38 are adopted), the personal statement will carry greater weight than in the process of allocating a descriptor for the purposes of awarding the lump sum.

- **The MoD should determine an 'ideal' window of time within which to make a claim for the purposes of guidance and adopt a policy of communicating this to claimants on first contact where it is clear from the claim submission that a decision cannot yet be made.** A differentiation will likely need to be made based on the condition for which a claim is being made, for example, between (i) common and acute conditions and (ii) uncommon, complex, persistent, and mental disorders.
- Especially in complex cases where the claimant has or is undergoing multiple treatments for multiple diagnoses, **before a decision is made, the caseworkers should seek the confirmation from the claimant that the evidence collected and on which the decision will subsequently be made is comprehensive**.

4.15 Recommendation 9 aligns with a 2009 decision of the Upper Tribunal whereby 'the Secretary of State should do everything possible to have up to date medical reports available… before making his own decision' (Para. 122, *Secretary of State for Defence v AD and another* (AFCS) [2009] UKUT 10 (AAC) (SSD v AD)).

4.16 Although a simple step, contacting claimants prior to finalising a decision to ensure MoD has all the pertinent evidence and context can make a significant difference to some claimants. For example, in Nicky's case (Figure 4), the claimant was not given the opportunity to clarify the significance of their slip on black ice nor offer further evidence or context to support their claim. And because of their personal circumstances, including mental health struggles, they now feel unable to contest the decision, despite the possibility of a different outcome.

Nicky was medically discharged in early 2021 due to osteoarthritis in both knees and carpal tunnel syndrome in both hands. Symptoms for the latter began presenting in 2017. In 2019, Nicky was diagnosed with Complex Regional Pain Syndrome. The surgery that Nicky had to their right hand in 2020 only made it worse. Today, Nicky is undergoing therapies to help manage the pain and live with the symptoms and effects of the injuries, including significantly disrupted sleep.

In April 2021, whilst at a Personnel Recovery Unit, an MoD official convinced Nicky to submit an AFCS claim for their injuries. The representative filled out the form on Nicky's behalf as they were unable to use their dominant hand due to the severity of their injuries. Soon after, Nicky received a request for evidence despite having sent it already. On enquiry, the MoD confirmed the evidence had been lost.

In August 2021, four months after submission, Nicky received a decision; the osteoarthritis in Nicky's knees predated 2005 and therefore was considered under the WPS. The claim for carpal tunnel syndrome in the hands was denied as the MoD did not consider the injury to attributable to service. In the decision letter, the MoD stated that, on the balance of probabilities, the injury was neither partly nor wholly caused by service, nor was it worsened by service, citing the legislation.

The MoD identified that the potential cause was a '[s]lip on black ice in the winter of 2016' for which '[t]here is no evidence that this was related to any aspects of service', despite the incident not being documented in Nicky's medical notes. The MA wrote that, the slip is unlikely to have been the cause, but, as per the synopsis

of causation, there is a strong association between Carpal Tunnel Syndrome and obesity, noting that Nicky's BMI was 39, concluding that, the 'claim is for rejection'.

Despite the difficulty the caseworker clearly had identifying the cause of the original injury, they did not call Nicky to ask if there was any other evidence or whether Nicky could provide more information. If they had, Nicky would have told them that the reason the slip on ice is not in their notes is because it had not been a notable event. It is only in the Medical Board (held in 2020) report because the Board asked whether there were any incidents Nicky thought, in hindsight, could have contributed. Nicky thought hard and mentioned the slip, but qualified it was only mentioned because they could think of nothing else.

Nicky has questions about why the elevated BMI is not considered a result of the osteoarthritis in the knees which presented in the late 2000's and was accepted for a WPS award. And why their osteoarthritis was not considered for an AFCS award. Nicky has decided against appealing or calling for clarification as they are too embarrassed by the comments on their weight. As Nicky struggles with their mental health, they prefer to avoid the situation all together, especially as Nicky just 'doesn't want to fight with anybody'.

Figure 4: Case Study I—Nicky

4.17 In SSD v AD, the Court of Appeal made clear the inevitable consequences of a Scheme in which there is not a prescribed timeframe at which a claimant can submit a claim, but rather it is left to the claimant to decide:

"Where the claim is made later – perhaps towards the end of the five years – rather than earlier, then almost inevitably the decision-maker will have much more concrete medical and other material available when assessing the trajectory of the injury than he will have where the decision is taken relatively soon after the injury occurred. It is therefore possible that two similarly placed individuals will receive different levels of compensation because one award is based on speculating what the trajectory is likely to be whilst the other is based on how it has in fact materialised." (Para. 55, *Secretary of State for Defence v Duncan Secretary of State for Defence v McWilliams* [2009] EWCA Civ 1043 (SSD v Duncan))

4.18 This is not necessarily problematic. However, it is a factor that may influence the decision of the claimant regarding when the claimant chooses to submit an application and one which they should be informed of.

RECOMMENDATION 10: In all communications regarding the submission of evidence, the MoD should make explicit the implications of submitting evidence at different stages and that any 'ideal window' set by the MoD is merely a guide. It should also be explicit that even where the claimant chooses for personal reasons to apply early and their condition deteriorates, there are opportunities for review at a later date (see Recommendation 60).

Explaining the Decision

4.19 The claimant is informed once a decision is made, with a brief explanation of the rationale or, if the claim has failed or an Interim Award has been made, a few sentences on why this is the case. For example, Nicky (Figure 4, Annex E) received notification that their claim was rejected but has had no opportunity to ask questions why. The brevity of the explanation in their award letter and references to their BMI means they do not understand the MoD's rationale. However, due to their

mental health, a factor that the MoD would be aware of had the department spoken to Nicky and attempted to identify what support they might need, Nicky is unable to face engaging with the MoD again at this stage.

RECOMMENDATION 11: Issues caused by claimants being unable to contact their caseworkers will be addressed by Recommendations 14, 15, 16 and 17, but, to provide reassurance that every aspect of their claim has been carefully considered, **all decision notifications should include a full explanation as to why the next tariff up has not been awarded, making reference to the evidence and how it has been interpreted by the caseworker, as well as, if relevant, why a temporary award has not been made.**

Post Initial Decision-Making

4.20 As per the legislation, claimants have recourse to two mechanisms if they are unhappy with their initial decision:

- *Reconsideration:* The Secretary of State for Defence is obliged to reconsider a decision based on a re-evaluation of the evidence and either reaffirm and substantiate the original decision or overturn it.
- *Appeal to the Tribunal:* The role of the Tribunal is to ascertain whether the initial decision is reasonable based on the evidence submitted by the claimant, including evidence potentially disregarded by the MoD, within the parameters of the AFCS.

4.21 From the claimant's perspective, the process is as follows:

- Claimant can request a reconsideration of the decision which the Secretary of State for Defence is obligated to carry out.
- Claimant can lodge an appeal with the Tribunal. If a reconsideration has not been carried out, the Tribunal will automatically request one from the MoD and notify the claimant. Where a reconsideration has already been carried out, the Tribunal will notify the MoD and set a hearing date.[9]

4.22 The reconsiderations and appeals process itself is heavily over-burdened with significant consequences:

- Obstacles to access to justice in a reasonable timeframe.
- Additional and unnecessary distress to the claimant; and, in turn,
- Difficulties for the Tribunal panel in deciding on appeals as the original injury, illness or disorder is not always the same in severity as at the initial claim submission. For example, the claimant's condition may have deteriorated as a consequence of the delays in, and burden placed on the claimant by, the process.

4.23 The reconsiderations process for injury, illness, and disorder and survivor claims concluded between 1 April 2017 and 31 March 2022, took an *average* of six and two months, but up to 8.75 years and one year, respectively.

[9] To note, the rules have only recently changed, and this process has been in force since 5 April 2023 only.

4.24 For claimants whose appeals of injury, illness and disorder and survivor claims concluded in the same time period, the process took an *average* of 20 and 27 months, but up to 16.5 and four years, respectively. Data is not collected on how much of the delays in the appeals process was due to the MoD preparing and registering the appeal or to a backlog in the Tribunal system.

4.25 Recognising it is a simplification and for illustrative purposes only, based on the data on average clearance times, for an injury/illness/disorder claimant who received a satisfactory appeal decision in the financial year 2021/22 and who had applied only once each for an initial decision, reconsideration and appeal, the process would have taken an average of just over two years. This reflects only the time the claimant was engaged in the process and not the time taken between steps to decide whether to take the next step (i.e., between receiving the initial decision and applying for a reconsideration or receiving the reconsideration decision and lodging an appeal) which will vary between claimants.

The reconsiderations process

4.26 Reconsiderations of injury, illness and disorder and survivor claims cleared in 2021/22 took an average of six and four months but up to three years and eleven months, respectively. This is partly due to resourcing but also to the fact that, contrary to the connotations of the term 'reconsideration', the MoD 'take a fresh look at the case in light of the comments and any evidence received' (Para. 8.24, p.45, JSP 765), including new evidence. Consequently, the MoD is not judging itself for a decision made on the information available at the time of the initial decision but rather with the benefit of new material it originally did not have access to. In essence, this constitutes a review based on new information rather than a reconsideration.

4.27 The nature of this post-initial decision stage:

- Unnecessarily lengthens the time it takes for a reconsideration to take place, adding to the overall time it takes for a claimant to receive a final decision as the reconsideration is not a one stage re-evaluation of the initial decision but rather a re-evaluation of the original case file in addition to an evaluation of new evidence.
- Means that the 25% of reconsiderations of illness, injury and disorder claims[10] since 1 April 2017 which resulted in the over-turning of a decision in favour of the claimant is not necessarily indicative of the quality of the initial decision-making of MoD officials. However, the statistic gives the impression that more initial decisions are 'wrong' than perhaps is the case.

RECOMMENDATION 12: The Order should be amended to ensure reconsiderations can only be of the material that the original decision was based on.

4.28 This will ensure that the time taken to carry out a recommendation is reduced, thus reducing the backlog of reconsiderations in the system, and that the number of decisions overturned at reconsideration are a fair reflection of the quality of MoD decisions at the initial decision-making stage. The latter is particularly important, not only to ensure the Department is not being

[10] There were no reconsiderations of survivor claims resulting in a favourable decision for the claimant in the same time period.

disadvantaged in an evaluation of its performance, but also to enable the Department to proactively identify areas of improvement by enabling the collection of accurate data (see Chapter 6).

4.29 The reviewer recognises that Recommendation 12 may result in a disadvantage to the claimant as, at this time, there is no mechanism for holding the MoD to account where, despite the availability of further evidence, the MoD has failed to attain it and has therefore made a decision based on incomplete information. It is for this reason that claimants are currently able to submit new evidence for consideration at any stage, including at reconsideration and appeal (see SSD v AD).

4.30 However, the mechanism for correcting a failure to collect available evidence should not be left to the reconsideration process; the reconsideration process should pertain only to the interpretation of evidence. The failure of the MoD to meet its obligation to collect knowable evidence should be mitigated against at the evidence collection stage by, for example, seeking assurance from the claimant that all the necessary evidence has been collected prior to a decision being made (see Recommendation 9) and by clarifying the burden of proof requirements (see Chapter 10).

4.31 It remains that, where the MoD has failed to meet its obligation regarding the collections of complete evidence despite having liaised with the claimant throughout the initial decisions process, the claimant can recourse to an Article 59 review whereby 'any decision of the Secretary of State may be reviewed at any time (including on the application of the claimant) if the Secretary of State is satisfied that the decision was given in ignorance of, or was based on, a mistake as to a material fact or of a mistake as to the law' where:

a) 'the material fact was knowable at the time the decision was made and was disclosed to the Secretary of State at that time';
b) 'if the ignorance or mistake was the ignorance or mistake of the Secretary of State';
c) 'where the ignorance or mistake relates to the diagnosis of an injury, where the correct diagnosis was knowable given the state of medical knowledge existing at the time the diagnosis was made.'

4.32 Moreover, if evidence of deterioration emerges after the finalisation of an accurate decision made on the basis of complete evidence, a review should be sought (see Chapter 9).

4.33 Although, on the part of the claimant, the reconsideration process has historically been lacking in transparency, recent developments to the process should greatly improve the claimant's experience. Prior to new Direct lodgement rules which came into effect in April 2023,[11] appeals were lodged with the MoD rather than the Tribunal. Where a reconsideration had not already been undertaken, the appeal was placed in a queue for reconsideration; a step which claimants were only made aware of upon receipt of the reconsideration decision.

[11] These changes apply to initial decisions made after 5 April 2023 only. All decisions made prior to this date will be subject to the previous process whereby appeals are lodged with the MoD.

4.34 However, as of April 2023, claimants lodge appeals with the Tribunal directly and, if one has not been undertaken, the claimant will be informed that a reconsideration will be completed first and that, upon receipt of that decision, they are free to lodge an appeal if they still wish to do so.

4.35 Although this adds an extra step to the claimant's process, it:

- enables the claimant to understand who is responsible for progress being made at what stage in their claim (i.e., it is the MoD caseworker not the Tribunal at the reconsideration stage), making the correct body clearly accountable to the claimant, and
- provide more accurate data on how long each stage is taking and whether it is MoD or the Tribunal that are not performing adequately when issues arise— an important factor in being able to efficiently and effectively respond to challenges in future (see Chapter 6).

The appeals process

4.36 An appeal can be lodged for a variety of reasons and addressing these is central to reducing the number of appeals. The primary reasons are:

- *The claimants' sense that the decision is too little to make up for the pain and suffering caused.* Providing the decision is made correctly within the parameters of the AFCS, there is little that can be done to mitigate against these appeals. It should not be the objective of policymakers to eliminate these types of appeal as it is integral to the concept of an appeals process to provide independent reassurance to all parties that a fair decision has been made.
- *A lack of understanding as to how the decision has been arrived at.* Recommendations 14 and 15 with regards to communications between claimants and caseworkers and Chapter 3 on the quality of communications should mitigate against this type of appeal.
- *Provisions made by the AFCS are insufficient or unjust, thus the decision may be correct as per the scheme but inequitable.* Recommendations made in Part II of this report address these issues.
- *The decision does not correspond to the evidence provided and is considered an erroneous application of the AFCS.* This is the type of appeal that the appeals process largely exists to tackle by providing quality assurance of decisions. However, if the initial decision making process is functioning well, these types of appeal should be few and far between.

4.37 Although the Department can, and should, put in place measures to reduce the number of appeals lodged in the first place, the department cannot prevent claimants lodging appeals as it is their right to do so. However, the Department should ensure that, where appeals are successful, proactive measures are taken where possible to improve the processes which led to, essentially, that incorrect decision.

4.38 30% of appeals concerning injury, illness and disorder claims were successful between 1 April 2017 and 31 March 2022. Broadly, the bases for these decisions to overturn the MoD's initial decisions included:

- A narrow focus on injury as opposed to impact, which the Tribunal disagreed with. This will form the focus of Chapter 7.
- the MoD disagreed with the medical evidence submitted. These occurrences should be minimised by Recommendation 9 and those in Chapter 8.

- Ignorance of evidence or a mistake in interpreting the evidence for the purposes of making a decision. This argument is largely employed successfully by solicitors with regards to Mental Disorder claims, indicating that decision-makers are selectively interpretating evidence in favour of the MoD. If so, claimants who trust the final decision and do not appeal or seek legal representation are potentially being disadvantaged. These occurrences should also be minimised by Recommendation 9 and those made in Chapter 8.

4.39 This section focuses on procedural measures that can be taken to reduce the time it takes to complete the appeals process.

4.40 The rules have recently been amended (taking effect in April 2023) so that there is direct lodgement; that is to say, where appellants used to lodge an appeal with the MoD, they now lodge their appeal directly with the Tribunal (as described in Para. 4.33). Providing a reconsideration has been completed, once the MoD receives notification from the Tribunal that an appeal has been lodged, the Department has 56 days to submit a response bundle to the Tribunal. These rule changes will reduce the time it takes for an appellant to be given a hearing date and thus reduce the overall time it takes for a claim to be finalised.[12]

4.41 These changes, however, do not tackle concerns raised by claimants and their representatives regarding a lack of preparation at hearings on behalf of the MoD and/or the MoD representatives' ability to make concessions during hearings, leading to adjournments and thus delays in the completion of individual appeal processes.

RECOMMENDATION 13: The MoD should ensure they are sufficiently resourced to enable a representative to attend every hearing, who is prepared to present arguments and empowered to make concessions at hearings.

4.42 This should be coupled with Recommendations 21, 22 and 23 on training and empowering caseworkers. It should not be particularly burdensome on resources as it is now widely accepted for parties to attend hearings remotely.

The Claimant- Caseworker Relationship

4.43 The MoD allocates a caseworker to every claimant once their claim is received—one at initial claim and another if a reconsideration or appeal is requested. The notions of 'caseworker' implies a collaborative and supportive working relationship between the claimant and their caseworker, especially in a system designed for injured, and therefore vulnerable, individuals. However, most claimant and claimant representative respondents to this review felt the relationship between claimants and their caseworkers was an adversarial one. Many stated that the MoD being charged with guiding claimants through the process amounts to a 'conflict of interest'.

4.44 The 'conflict of interest' terminology is illustrative of many claimants' perceptions that the process is *necessarily* adversarial. However, there should not be a conflict of interest in a 'no-fault' scheme; the acceptance of a claim to the AFCS is not tacit acceptance of culpability on the behalf of

[12] These are amendments made to the Tribunal rules in England & Wales only.

the MoD. Thus, it is the reasons why the process is *perceived* as adversarial that need addressing rather than a 'conflict of interest'. Some of this should be managed through improving communications and the presentation of information on the Scheme (see Chapter 3) but much of it can be managed through efforts to improve the claimant-caseworker relationship.

4.45 Recent changes to the process require that claimants be contacted by phone or email every 12 weeks with a progress update for as long as their case remains open. Many claimants will have no communication beyond these updates as most claims are straightforward. However, for those with more complex claims, typically, the first non-standard communication will be a request for further information to substantiate their claim, implicitly notifying the claimant of a delay.

4.46 This request is a seemingly straightforward request for more information. However, the only objective of the communication is to request further information and there are no opportunities provided to the claimant to ask any questions or seek assurance that, for example, their plan of action in response to the letter would fulfil the request. Claimants seeking more information or reassurances are provided only with a number for the general Veterans UK Helpline.

4.47 Claimants calling the Helpline are connected to an agent who deals with more than just AFCS claims, including queries regarding the WPS, pensions, Veterans Welfare Service (VWS) and other services. Between February 2022 and February 2023, the Helpline received 12,428 AFCS queries. However, agents are specifically trained to act as a barrier between claimants and their caseworkers and are directed to answer as many of the callers' queries as possible, including those that are case-specific. In accordance with the experiences of claimant respondents, in the case of Alex's letter requesting further information, for example, as agents do not have access to claimant files, the agent would likely simply ask Alex to read out the passage that is causing confusion and explain to Alex what it means. However, this explanation could only be marginally better than the letter itself the agent cannot give case-specific advice nor reassurance that the callers plan of action in response to the letter will resolve the matter.

4.48 Thus, most callers are no better informed by calling the Helpline with case-specific queries. In fact, respondents to this review reported these calls resulted in their being more concerned that they will not be able to get a fair result from the claims process as they are prevented from understanding how the decision is arrived at. Many respondents described the MoD as a 'black box', with officials purposefully preventing claimants from gaining further insight into the processing of their claims by ignoring their questions and simply repeated what was written in the letters.

4.49 However, Helpline agents are simply doing what their training directs them to; that is, that only in cases the agent judges as urgent can they request a call back from the caseworker. the MoD officials clarified that issues are generally only considered urgent if the caller has not received payment. Case-specific enquiries, estimated by officials to account for half of AFCS related calls, are not considered urgent.

4.50 There are clear and understandable reasons for the Helpline and keeping claimants at arms-length, including:

- Claimants can call too often tying up caseworkers' time.

- Caseworkers have received abusive calls from claimants (e.g., there are cases of caseworkers being found on social media receiving abusive messages).

4.51 However, this approach dismisses the inherent vulnerability of the claimant population which the MoD provide this service to, fostering a feeling among claimants, particularly those in the most difficult of circumstances, that the process lacks empathy and perhaps is actively working against their interests. The MoD must recognise that, for those who are having difficulty understanding the process or results of their claim, receiving generic letters filled with language only officials are accustomed to and calling a Helpline to speak to a different person each time who does not know their case and cannot speak to the rationale nor particulars of their case, is unsatisfactory, frustrating and, for some, anxiety-inducing.

4.52 As discussed in Chapter 2, ensuring the delivery of the Scheme does not further aggravate the suffering of the claimant is key to the objectives of the AFCS. Thus, a suitable hierarchy of priorities must be at the forefront of how the claimant-caseworker relationship is reimagined: efficiency measures must only be taken in so far as they do not negatively impact the ability of the MoD to protect the well-being of both claimants and caseworkers. Moreover, mitigating measures must be taken where measures to protect one conflict with the other. This is the subject of Chapter 5 The Caseworker.

5 The Caseworker

5.1 Caseworkers are expected to exercise significant judgement as their decisions must:

- 'aim to be consistent and equitable and properly reflect the extent of the injury or injuries which have been predominantly caused or made worse by service.' (Para. 2.11, p.4, JSP 765)
- 'use… evidence to decide whether or not the claimed causal link to service meets the balance of probabilities test and, if so, select a descriptor from the tariff, which reflects the nature and severity of the injury and its ongoing functional effects.' (Para. 2.38, p.11, JSP 765)
- 'take account of contemporary medical understanding on the causes and progress of disorders and each case is decided on its merits.' (Para. 2.45, p.12, JSP 765)

5.2 Making a fair and effective decision that provides, for example, Alex or Nicky (Figure 4; Case Study I, Annex E) the necessary financial certainty to ensure they are not disadvantaged, enabling them and, by extension, their family, to move on from their injuries, taking into account medical, social, and attitudinal progress, is a *significant* responsibility. In addition, caseworkers deal with vulnerable claimants which can be a significant emotional burden.

5.3 However, the role, as it is currently designed, limits caseworkers to act as collectors of evidence, based on the belief that the evidence alone will ultimately provide the caseworker with an objective answer; all caseworkers need to do is collect the evidence and allow The Order to present them with an objective outcome. This is reinforced by barriers that keep the claimant at arms-length throughout the process by preventing the claimant from participating in the process (described in Chapter 4).

5.4 This conceptualisation of the claims process as objective and formulaic obviates the true significance of the role of caseworker and results in their disempowerment. Caseworkers should be recognised and empowered to interpret the evidence and apply their discretion in complex and borderline cases, in recognition that they are charged with making a decision that meets the objectives of the Scheme and which, particularly for those who suffer long term consequences of their injuries, can be life-changing for the claimant. Thus, recommendations in this chapter are designed with a single objective in mind: to ensure caseworkers are recruited, trained and supported in a manner which enables the MoD to have full confidence in every caseworker's judgement on individual AFCS case.

Communication Between Caseworkers and Claimants

5.5 Caseworkers require structures that afford them the space and support to confidently exercise the necessary judgement to achieve the objectives of the Armed Forces Compensation Scheme (AFCS). An element of this, is recognition that there are complex cases which require the investment of more resources on the part of the caseworker than others to conclude effectively.

RECOMMENDATION 14: To this end, **the work of caseworkers should be restructured to ensure that, where a case is identified as complex upon first review, caseworkers are supported and enabled to take a proactive and more communicative approach to engaging with these claimants. This requires that caseworkers:**

- **Make initial contact over the phone with claimants upon receipt of the claim to explain what the caseworker's role is, why their claim has been flagged as complex, what the**

implications of this are, what the claimant can expect from them and what they might request from the claimant.

- **Keep notes on the personal circumstances and needs of the claimant so they can tailor communications and share these if the case is not resolved by the initial decision (i.e., share with the reconsideration and/or appeals caseworkers).**
- **Proactively contact claimants periodically to provide updates on their claim and full explanation as to what the different stages are and what the implications of different decisions are.**

5.6 A possible measure for initial identification of a complex case would be whether the impact of the injuries being claimed for will be persistent as opposed to claims for acute injuries which are likely to be more straightforward.

5.7 This has implications for the scope of the work of Veterans UK Helpline agents as concerns the AFCS (described in Paras. 4.47 to 4.49), in that there would be a more interactive working relationship between caseworkers and claimants with complex claims. Thus, Helpline agents should not obstruct interactions between the two parties.

5.8 However, in order to ensure equity and avoid discriminating those who were not initially flagged as in need of further support, the Helpline should not be asked to differentiate between claimants flagged to have complex cases and others.

RECOMMENDATION 15: Thus, **Helpline workers should be directed to answer generic questions only and automatically make a call-back request to the relevant caseworker for case-specific queries. To prevent caseworkers from being overwhelmed with these queries:**

- **Each caseworker should have an appropriate amount of 'clinic hours' a week during which they are able to take calls to answer case-specific queries directly from claimants or to respond to call-back requests put through from the Helpline.**
- **Clinic hours and their purpose for the relevant caseworker be clearly signposted in all communications with claimants.**

RECOMMENDATION 16: To provide caseworkers with an additional tool for communication where appropriate, **the MoD should explore options for communicating routinely with claimants/recipients via email and text message.**

5.9 Such methods of communication are appropriate in particular circumstance where a response is not required, including but not limited to, instances in which the claimant/recipient is being notified they been sent a communication by post, a reminder that they need to respond to a request for further evidence, or reminder to contact their caseworker.

5.10 Overall, these measures should ensure the Helpline remains a filter for persistent and abusive callers, whilst enabling claimants access to their caseworkers. Nevertheless, this will require that caseworkers are able to dedicate more time to particular claimants and therefore will need a smaller caseload. However, taking the number of Guaranteed Income Payments (GIP's) and survivor claims awarded at the initial claim stage between 1 April 2017 and 31 March 2022 as indicative of how

many claimants might require more personalised support,[13] it would have only been 592 claims (1.56% of all claims cleared), over a five year period (on average, 118 a year or ten a month).

RECOMMENDATION 17: In recognition of the additional labour required by recommendations made in this section, **caseworker caseloads should be capped, the unit of measurement and limit to be determined based on an audit of the resources expended on different case types to date, in consultation with caseworkers and in the course of a review of workforce requirements.**

5.11 For example, caseworkers may only take two cases categorised as complex and requiring additional hours of labour at any given time. Thus, the majority of cases, which are straightforward and require little liaison with the claimant, can continue to be assigned as they are now, but complex cases would be separated and assigned to caseworkers with capacity to take on these types of cases.

5.12 Options for creating two types of case worker—one general and the other specialised in complex cases—were explored. However, the reviewer feels that it is unreasonable to expect specific caseworkers to deal solely with complex cases due to the increased emotional labour this would require of a small cohort. Additionally, as there is no predictability regarding how many complex cases the MoD might receive within a certain period of time and (e.g., there may be surges of these in times of conflict), it is imperative that all caseworkers are trained and empowered to resolve such cases. This should also mitigate against a backlog of complex cases, and therefore extended waiting times for the most vulnerable, that might arise if the number of complex claims peaks unexpectedly.

The Role of Medical Advice in Decision-Making

5.13 Caseworkers independently collect and interpret evidence from various sources. The AFCS is purportedly designed to be operationalised by lay-people, reducing the over-reliance on in-house medical expertise as necessitated by the War Pensions Scheme (WPS). Thus, it can be inferred that the caseworker was envisioned as the ultimate decision-maker on behalf of the MoD.

5.14 Caseworkers seek medical evidence from treating physicians and advice from MoD Medical Advisors-Delivery (MA-D),[14] and each source of information should have a different purpose for the caseworker:

- The evidence submitted by treating physicians should be relied on to ascertain the nature of the injury and, where relevant, its impact.
- The advice from MA-Ds should pertain to how the medical evidence should be interpreted in light of The Order.

5.15 This requires that the right amount and level of medical evidence be requested from treating physicians to enable a lay caseworker to make a decision with reference to the advice of MA-Ds.

[13] This is based on the assumption that all claimants who were bereaved or suffered injuries with persistent, long-term effects which entitled them to a GIP, were vulnerable and in need of further support, and that all those with acute injuries were not. This figure does not include those who went on to request a reconsideration and/or appeal as these stages are managed by different caseworkers.

[14] MA-D will be used throughout this report to refer to Medical Advisors in the AFCS delivery function of the MoD, Armed Forces and Veterans Services. These medical advisors advise caseworkers on individual cases.

5.16 The role of MA-Ds should therefore be limited to supporting caseworkers in making decisions on whether, in accordance with the evidence submitted by the claimant, the injury can be attributed to service. However, evidence provided by respondents suggests that MA-Ds take an active role in interrogating and re-evaluating medical evidence in roughly 40% of cases, and, in the case of claims pertaining to mental disorders, are required to do so. In a decision letter provided to the reviewer by Charlie (Figure 5), for example, this extended to interrogating the evidence of MoD treating physicians, despite the latter's experience of dealing with injuries relating to service and legitimisation of their expertise by being employed by the same organisation.

Charlie was diagnosed in service with Complex Post Traumatic Stress Disorder (CPTSD) in May 2017 and was under the care of the Department of Community Mental Health (DCMH) (a DMS service) at the time of their initial AFCS award in early 2020: a Tariff 12 Interim Award indicating that the MoD determined Charlie's CPTSD 'has caused, or is expected to cause functional limitation or restriction at 2 years, from which the claimant has made, or is expected to make, a substantial recovery within 5 years', attracting a lump sum only of £10,300. A review was set for July 2022. At the time, Charlie had been receiving treatment for three years and was 18 months into a two-year graduated return to work programme.

In December 2020, consultants determined that Charlie should do no more than six hours of low stress work from home. They wrote that, although Charlie was dedicated to recovery and intensive treatment resulting in their learning techniques to manage the symptoms, they expect the symptoms are more than likely to persist. In March 2021, Charlie was discharged and transferred immediately into the care of the NHS Veteran's Mental Health Complex Treatment Service (CTS) via the Veteran's Mental Health Transition, Intervention and Liaison Services (TILS).

The impact of the CPTSD on Charlie's family, social and occupational life is extensive. Charlie must live by a strict routine, and to provide the best support possible, so do their spouse and four children. As Charlie struggles to cope with unexpected or increased pressure, they are unable to participate fully in childcare. Thus, Charlie's spouse only works during term time. Due to the wide-ranging impact of the CPTSD, Charlie's spouse has registered as their carer and two eldest children as Young Carers. Charlie found a civilian role that meets the requirements set by the graduated return to work programme but has frequently taken time off due to pressures exacerbating their condition.

In July 2022, MoD wrote that, on review, the Interim Award had been extended as the 'prognosis remains uncertain' since 'the letter [from the Consultant Psychiatrist] implies that [they] work' and 'progress' was being made with treatment, despite the 'progress' clearly referring to symptom management not recovery. Charlie's award was increased to a Tariff Level 10 interim award, attracting a GIP and lump sum, by which Charlie's CPTSD was expected to 'caus[e] functional limitation or restriction, which has continued, or is expected to continue for 5 years.' The award was to be reviewed in July 2024.

In addition to being unclear how the MoD arrived at this decision, the prolonged financial instability and uncertainty caused by the AFCS process, aggravated Charlie's symptoms. In Charlie's words: 'I have worked extremely hard to develop a way of life that allows me to manage my injuries and to live at home… [A] sustainable longer-term solution desperately requires an Armed Forces Compensation Scheme award that reflects the permanence and severity of my injuries, which will protect me and my family moving forwards, as soon as possible.'

At the time of the first Interim Award review, the information above was available to the MoD; five years of medical notes, the impact on family and social life, and determinations made by DMS and NHS regarding

occupational prospects and ongoing needs. In fact, in April 2021, the consultant confirmed that Charlie will be 'unable to be fully integrated into family life let alone secure and sustain meaningful employment'.

In August 2022, one month after the review decision and more than two years since initial application, having written to their MP and various officials querying their award decisions, Charlie received notification from MoD that, having received 'new information', they are making a final Tariff Level 6 award in recognition that Charlie has a '[p]ermanent mental disorder, causing severe functional limitation or restriction'. Charlie had not submitted any new evidence.

Figure 5: Case Study II Charlie

5.17 Thus, claimants and their representatives raised concerns that they must convince the MoD of their injury or its severity despite assertions made by treating physicians in medical notes. This is not the caseworker nor MA-Ds role; the legislation clearly lays out who is able to provide legitimate medical advice (e.g., in the case of mental disorders, consultant grade psychiatrists or psychologists at a minimum) and it is not within the remit of MoD officials to question whether a qualified medical expert is, essentially, good enough.

5.18 Moreover, there is evidence of caseworkers relying on medical advisors to make a decision for them. For example, in Charlie's case (Figure 5), the decision letter explicitly stated that the caseworker wrote to the medical advisor: '[p]lease could you review this case and determine whether it is appropriate to make a final award and at what tariff level', deferring to the medical advisor on the final decision.

RECOMMENDATION 18: Efforts should be made to explicitly tighten the scope of the medical advisor- delivery role in line with the original intent of the Scheme. Guidelines for both caseworkers and medical advisors should be published, providing clarity that:

- **the evidence submitted by the treating physician has primacy with regards to determining the nature of the injury, and reference should be made to other supporting medical evidence (e.g., Medical Board statements) submitted by the claimant where relevant.**
- **medical advisors are only to provide:**
  - **i) Advice concerning attributability.**
  - **ii) Assistance interpreting medical evidence provided by treating physicians into lay terminology.**
  - **iii) Advice on the interface between the medical evidence and the Scheme**. For example, where advise is sought on the application of a term such as 'permanent' in the context of The Order.
- **a lack of evidence regarding the condition of the claimant, adversely impacting the ability of the caseworker to make a decision, should result in caseworkers seeking clarification from treating physicians not from MoD medical advisors.**

5.19 The experiences of medical advisors should not be used to inform assumptions on the condition of the claimant or impact of their injuries. If there is insufficient evidence of these, further evidence should be procured, whether from the treating physician or from claimants themselves.

RECOMMENDATION 19: The definition of a 'treating physician' should be made clear in the guidance and legislation governing the AFCS as a licensed and registered physician who is primarily

responsible for the claimants' care in relation to the diagnosis and/or treatment that is the subject of the claim.

5.20 By taking these steps:

- Fewer aspects of the claim will need to be interrogated by the MoD (i.e., they need not interrogate the nature and severity of the injury beyond requesting sufficient and adequate medical evidence), reducing delays and the existing backlog caused by appeals based on the reinterpretation of evidence; and,
- the most adversarial element in the process from the claimant's perspective will be removed as they will be assured that their claim is being assessed based on the evidence submitted by a qualified individual that they have been personally assessed by.

5.21 The reviewer recognises that there are concerns that treating physicians often act as advocates for claimants and may frame evidence to ensure the best possible outcome for their patient whereas MoD medical advisors are more likely to be impartial. However, the reviewer does not consider this to be problematic as:

- *Securing the best possible outcome for the claimant is not incompatible with the principles of the AFCS.* Thus, the interests of the claimant, MoD and the treating physician are not in conflict. Even where a treating physician may frame evidence to advance the interests of their patient, it is extremely unlikely a qualified, registered physician will unrealistically exaggerate an injury. Those who are willing to do so, will do regardless of the restrictions in place and will always constitute a residual risk. At most, treating physicians are likely to provide a particularly favourable interpretation of existing injuries, illnesses, or disorders but one that is medically sound.
- Under The Order*, it is not within the scope of MoD officials to make a determination as to the competence of the treating physician nor their ability to make a sound, objective assessment of their patients' injury, illness or condition providing they are a qualified physician.* It is not the case that MA-Ds are more likely to be impartial than treating physicians, simply that the latter have singular access to specific information by virtue of having made a personal assessment of the claimants' condition (i.e., observations of the impact of the injury, illness or disorder on the claimant). On the other hand, MA-Ds are best place to make an assessment of whether the claimants' condition is attributable to service as they have access to the individuals entire medical and service records.

5.22 Concerns regarding the quality of the evidence provided by treating physicians are addressed in Chapter 6.

5.23 Finally, in the course of making a decision, caseworkers can also make reference to a series of publicly available Synopses of Causation. These are 'commissioned synopses of causation, covering a range of injuries and disorders likely to be seen in service personnel and veterans. Their focus is on what causes a disorder and its likely outcome… They were written by medical practitioners independent of MOD and its agencies and validated by external consultants within a relevant field.' (MOD compensation and occupational pension schemes: synopses of causation, www.gov.uk) However, these were written in 2008 and there have been significant developments in medicine and treatment since.

RECOMMENDATION 20: The MoD should instate a process whereby the Synopses of Causation are reviewed and updated regularly, for example, every three years, to ensure that caseworkers are making reference to up to date information when making decisions on individual claims.

Training and Development

5.24 In addition to the above, caseworkers must be supported with adequate training and professional development tools. The empowerment of caseworkers requires training on how to approach claimants, make decisions, deal with difficult interactions, and manage the consequences of emotional labour.

5.25 Many claimants, particularly those with complex claims and who are most likely to require a tailored approach, are vulnerable and suffering with mental disorders (even if not a discrete diagnoses) and these individuals form a core part of the group to whom the Scheme is directed. Just as would be the case in a clinic offering services to people with mental disorders, staff should be supported and trained to deal adequately with these interactions, both for the protection of the claimant as well as the staff.

RECOMMENDATION 21: Thus, **all claimant-facing staff, including caseworkers and helpline workers, should receive regular training and sessions regarding, but not limited to:**

- **The factors impacting the quality of life of claimants and recipients, ranging from changes to workplace adjustment requirements to the particularities of the impact of service on coping with illness, injuries, and disorders.**
- **Dealing with difficult situations, in particular when assisting those with mental disorders.** An example would be Trauma-Informed customer service training.

RECOMMENDATION 22: Additionally, **officials and volunteers working in related areas to the AFCS (such as VWS welfare managers and VAPC members) and third sector representatives that are active in advocating for and representing claimants in the claims process should be regularly engaged, including in joint MoD-led information and training sessions on AFCS policy and practice,** to ensure increased awareness of the issues faced by each of the stakeholders in the delivery of the AFCS and better join-up among the AFCS supporting community, led by the MoD.

5.26 Caseworkers should also have the routine opportunity to share information, especially where they have encountered difficulties, learn from and reach a consensus on how to handle difficult cases with their peers.

RECOMMENDATION 23: The MoD should ensure that caseworkers convene regular peer review workshops (e.g., monthly) to discuss difficult decisions and ensure that decisions are being made consistently across the board.

Caseworker Work Planning

5.27 Successful implementation of Recommendations 14 to 22 requires the redesigning of the caseworker workplan to ensure that each caseworker has adequate time and support to fulfil their responsibilities effectively.

RECOMMENDATION 24: In redesigning the caseworker workplan, the MoD should consider the additional:

- **Hours required to maintain clinic hours** (Recommendation 15).
- **Desk time required to procure and analyse the necessary evidence in complex cases.**
- **Emotional labour expended in dealing more closely with vulnerable claimants.**
- **On-going training to improve and maintain delivery standards** (Recommendation 22)**.**
- **Routine peer review workshops, including the time it takes to prepare for these workshops** (Recommendation 23).

5.28 The likely response to the recommendations in this Chapter will likely be that the MoD are already under-resourced. However, longer-term thinking is required to make lasting improvements to the operationalisation of the Scheme and the increased allocation of resources should be considered an investment to:

- Reduce the perception of an adversarial relationship with the MoD by including claimants in their own claims processes.
- Reduce the likelihood of reconsiderations and appeals as a short conversation with claimants about the evidence they have gathered before the claim is decided on would increase the chances that the correct evidence is gathered sooner.
- Reduce the overall time taken to conclude individual, complex cases, although it may increase the time taken to conclude an initial decision due to the increase in the number of interactions with the claimant and additional requirements for procuring evidence.

5.29 The latter regarding the overall time taken to conclude a claim is particularly important for some of the most vulnerable claimants; at this time, claims pertaining to mental disorders appear to be increasing in number. However, the data indicates that this is not the case. Instead, as these claims take significantly longer to process on average than claims pertaining to other tables, the proportion of a caseworker's caseload being for claims for mental disorders has increased over time. However, these are predominantly old claims that remain in the caseworker's caseload rather than new ones being added. Thus, if caseworkers are able to allocate more intense and longer stints of time to concentrate on these cases, they are more likely to resolve them in a shorter overall timeframe, reducing the waiting time for some of the most vulnerable claimants and reducing their caseloads quicker.

6 Supporting Good Decision-Making

6.1 Ensuring good decision-making requires robust policy-making and effective monitoring, evaluation and improvement of operational processes.

Independent and Transparent Policymaking

6.2 The quality of final Armed Forces Compensation Scheme (AFCS) decisions is reliant on the quality of the policies and processes which guide caseworkers in making their decisions. Thus, to ensure the quality of this guidance, the policy-making process must be robust, equitable, independent, and transparent.

The Independent Medical Expert Group (IMEG)

6.3 IMEG's role is to independently 'advise [the Minister for Defence People, Veterans and Service Families] Min(DPV) on medical and scientific aspects of the Armed Forces Compensation Scheme (AFCS) and related matters.' (Terms of Reference, Independent Medical Expert Group, www.gov.uk)

6.4 Although IMEG members are unpaid and should not have ever been employed by the Ministry of Defence (MoD) to safeguard the independence of the Group's advice, there is currently a close relationship between the IMEG and the MoD AFCS policy and Medical Advisory- Policy (MA-P) functions,[15] particularly evident in the latter's significant input in drafting IMEG reports which are commissioned to provide independent medical advice to inform AFCS policy.

6.5 Although the MA-P must assist in translating medical advice into policy and provide an assessment of whether it is justifiable under the policy intent of the AFCS to incorporate the IMEG's -advice, the active role of the MA-P and AFCS policy functions in producing the reports compromises the independence of the initial advice from the IMEG; IMEG reports are published on gov.uk for any interested party to read and, potentially, to hold the MoD to account for its policies.

RECOMMENDATION 25: Recognising that the drafting of these reports is a significant burden to place on unpaid volunteers (i.e., IMEG members), **an independent drafter, such as a medical PhD candidate or civil servant external to the MoD on secondment, should be recruited on a temporary basis to assist the IMEG in drafting its reports.**

6.6 This recommendation is likely to receive well-founded criticism, in that an independent drafter would still be employed by the MoD and would be an additional financial burden. Moreover, that the significant medical expertise is required to draft the IMEG reports. However, the reviewer would contend that:

- The independence of an external drafter would be greater than that of an existing employee of the MoD, especially as they would not have the same seniority nor relationship with the MoD as the current drafters do.
- A contracting arrangement by which an individual unaffiliated with the MoD can be contracted to carry out the drafting of IMEG reports in the run-up to their publication would

[15] MA-P is used throughout this report to refer to the Medical Advisory Armed Forces People Policy function which advises on medical matters pertaining to policy rather than individual cases. The latter is the remit of the MA-D function referred to in Chapter 5.

limit costs as it is not a continuous endeavour. Indeed, this would require an extra person to be paid at certain times, but it would also mitigate against the first critique by reducing the affiliation to the MoD to a financial one rather than using a permanent MoD civil servant.

- An understanding of medical jargon would indeed be necessary but not expertise as such, as the expertise sits, as it does now, with the experts who sit on the IMEG. Any drafter must therefore consult with the members to produce the report. A medical PhD student (likely to have well developed drafting skills and have handled countless medical journals for the purposes of review) or a civil servant with medical expertise, contracted to carry out the literature review, produce a first draft from notes from the members and then to liaise with the members to finalise the report is likely to have the competence to carry out this role.

6.7 A second concern pertains to safeguarding the representativeness of the IMEG. As the IMEG should represent an ever-changing and challenging medical field as relevant to the armed forces community, the list of expertise cannot, and should not, be entrenched in policy nor legislation and should remain flexible. However, it is far more likely that a predominantly practicing medical professional will be abreast of developments in medical practice and have a greater understanding of the challenges experienced by injured veterans. Thus, IMEG members predominantly practicing are likely to produce practical and contemporary advice for policymakers. Although this may already be a consideration in recruitment, it is not addressed in the Terms of Reference.

RECOMMENDATION 26: There should be a *requirement* in the terms and conditions of the IMEG membership that consultants are practicing and not solely academic.

6.8 Similarly, historically, there has been a distinct lack of geographic representation on the IMEG. Most members have worked in London or the Southeast of England. Medical practitioners working in different parts of the country will have experience working with patients in recovering in or adapting to different living conditions, including economic environments (impact, for example, the types of work available or standard of healthcare provided). Indeed, most veterans do not live in the Southeast and will be living and treated outside this area.

RECOMMENDATION 27: The reviewer recognises that, with the IMEG membership being voluntary, it is not easy to recruit. However, **measures should be taken to recruit on to the IMEG representatively and a system for monitoring and demonstrating these efforts are being made should be put in place.**

Safeguarding the Independence of Medical Advice in Decision-Making

6.9 Positive steps have recently been taken to provide further separation between the MA-P and MA-D functions, through the appointment of a Senior MA-D to oversee the team of MA-Ds. This function was carried out by the MA-P until 2022. This separation ensures that the MA-P does not act as a routine interpreter of the policy and law on individual cases but rather focusses on ensuring the policy and legislation provides a sufficiently clear guide to MA-Ds.

6.10 The MA-D function is thus able to advise caseworkers on that which is explicitly written into the law and policy as these form the basis of the claimants right to claim. Although MA-Ds are still able to seek clarification from the MA-P , it is ultimately their role to advise the caseworker on the

applicability of the law in medical matters. If clarification of the law is too often sought, the issue is not then with the MA-D function but rather with the drafting of the law and policy, which is within the scope of the MA-P.

6.11 To illustrate the differentiation, it is not acceptable to base decisions on individual cases on IMEG reports. IMEG reports constitute independent medical advice and are neither MoD policy nor law. They can be used as evidence to substantiate why a policy or legislative instrument exists, but they cannot be used as evidence that a decision is correct where the legislation is not found to support the decision.

6.12 The importance of the separation of the MA-P and MA-D functions is in the Rule of Law, whereby all laws should be clear, publicized, and stable and applied evenly. Thus, the legislation should be drafted with sufficient clarity to guide those who did not participate in drafting the policy and/or legislation, without reference to the material used to support their drafting. This is key to enabling claimants and other interested parties to hold the MoD to account for its decisions as they too should be able to interpret the law. If this does not occur, there is a greater risk that individual decisions are based on material that has not explicitly informed the legislation and policy and to which the claimant and public are not privy.

RECOMMENDATION 28: Recognising the recent separation of the roles, **the MoD should take the necessary steps to ensure that the policy medical advisory function and the delivery medical advisory function are well-defined and remain distinct**.

Improving Operational Processes

6.13 Monitoring, evaluation, and learning is crucial to ensuring the Scheme remains relevant and evolves to meet emerging challenges. Provision should thus be made to enable learning and the application of lessons learned.

Data Collection and Analysis

6.14 There have been many requests for data on the AFCS in the House of Commons since 2017. Oftentimes, however, the response is that the specific data requested is not held and the cost of gathering it outweighs the benefit of providing it. This raises questions as to how decisions are made on what data is collected and, most importantly, how data is used to improve the scheme.

6.15 The way in which the MoD collects and collates data is indicative of the reactive approach the Department takes to making changes to AFCS policy and delivery—reactive to inescapable changes (i.e., where a temporary award is made for which there is no appropriate descriptor), external complaints and requests for review voiced by, for example, charities advocating for claimants or Members of Parliament. In essence, although some information is gathered, there is not a proactive system in place that periodically and routinely ensures the information is analysed and presented to policy and decision makers. Instead, the MoD waits for requests to be made and tasks it's analysts to gather an analyse the information strictly necessary to respond to the request.

6.16 Part of the issue with data collection in the AFCS is the lack of digitalisation- a process which is in train. However, the primary focus of digitalisation is on usability, access, and ease of

administration. These are, of course, important objectives, but an additional benefit to digitalising current, future and past claims is, for example, the ability to identify trends. Expansion in the data collected and analysis as at Figure 6 would enable policy- and decision-makers to:

- Make evidence-driven changes proactively.
- Provide a record of the rationale behind decisions made and a basis on which to counter common and/or foreseeable complaints.
- Increase transparency enabling external stakeholders to identify how the MoD is working to mitigate against adverse claimant experiences.

6.17 There is already a user focussed survey in development which is set up to collect invaluable data (quantitative and qualitative) from the claimants' perspective during the claims process. However, there is insufficient join-up across the different functions of the MoD to ensure that existing tools and the data gathered in different parts of the MoD are effectively improved and utilised, as well as that new tools that are useful to multiple functions are developed.

RECOMMENDATION 29: Steps should be taken to:

- **Expand the quantitative and qualitative data collected,** as at Figure 6, **both from historical and future claims, using existing tools and new data collection mechanisms where necessary.**
- **Institute a routine process whereby analysts produce an analysis of trends periodically for use by the AFCS policy and delivery functions.**
- **Institute a process whereby MoD official across the functions, including policy-, decision-makers and analysts, routinely meet to discuss trends and take decisions on whether and how to act on these.**

Process	Data point
Initial Claims	What evidence is commonly requested and considered useful for determining the different claim types?
	How many initial claims are submitted with insufficient evidence and/or information and what are the common reasons for this?
	Categorisation of the different reasons for delay[16]
	Which Tables do the delayed claims correspond to and what claim type are they?
	The reasons why claims are rejected, including the Article used as justification.
Interim Awards	Categorisation of basis for Interim Awards.
	Categorisation of the basis for extending Interim Awards.
Reconsiderations	How many claims are in the reconsideration process?

[16] Delay being construed as in the system for longer than the average or than the key performance indicator for clearance times, whichever is shorter.

	Categorisation of the basis for request of reconsideration.
	How many reconsiderations are directly requested and how many are automatically carried out as a result of a request for appeal?
	How many reconsiderations are requested for each Tariff Table?
	How many claims for life-altering injuries/illnesses/disorders (e.g., attracting a GIP) and survivors claims are in the reconsideration system?
	How many reconsiderations result in the overturning of the original decision to the effect that the claimant is granted a tariff level 1-11 award where they were originally awarded a tariff level 12-15?
	How many reconsiderations result in the overturning of the decision and the award being raised by 1, 2, 3, etc, tariff levels?
	Outcomes of reconsiderations by Table and tariff level.
Appeals	How many claims are in the appeals stage?
	Categorisation of reason for request to appeal.
	How many appeals are requested for each Tariff Table?
	How many claims for life-altering injuries/illnesses/disorders (e.g., attracting a GIP) and survivors claims are in the appeals system?
	How many appeals result in the overturning of the original decision to the effect that the claimant is granted a tariff level 1-11 award where they were originally awarded a tariff level 12-15?
	How many appeals result in the overturning of the decision and the award being raised by 1, 2, 3, etc, tariff levels?
	Reasons for successful appeals.
	Outcomes of appeals by Table and tariff level.
General	How many claims are withdrawn and what stages?
	What are the reasons for claims being withdrawn?

Figure 6: Recommended additional data points to be collected by Defence Analysts

Operational Working Group

6.18 There is a distinct lack of a forum in which operations-specific issues can be raised and solutions sought. Instead, at this time, there are groups and commissions set up to deal with compensation more broadly, including a number of stakeholders with a variety of degrees of interest in distinct issues pertaining to both the War Pensions Scheme (WPS) and AFCS. Yet, throughout the review process, stakeholders to the AFCS, particularly veteran's charities, presented the reviewer with a plethora of solutions to various challenges faced by the MoD with regards to the Scheme. The

MoD should maximise the access it has to knowledgeable charities as they play a significant role in the AFCS process.

RECOMMENDATION 30: A small operations-specific working group should be convened routinely, including MoD officials (involved in the administration of the Scheme and supporting claimants, i.e., the Veteran's Welfare Service), the VAPC's and those charities that are significantly involved in representing and guiding claimants through the AFCS process, including the Royal British Legion, Combat Stress, the Royal Air Forces Association and the Royal Marines Charity, for example. **Efforts should be made to ensure that:**

- **the scope of the working groups discussion does not extend beyond AFCS-specific operational** issues (that is to say, it should not include issues concerning the WPS nor AFCS policy, unless it concerns spanning cases (see Chapter 12))**.**
- **the group's membership does not extend to groups that do not participate significantly in the AFCS process.**
- **relevant stakeholders are invited/ consulted on an ad hoc basis depending on the issues raised.** For example, Tribunal Members should be invited to discuss concerns raised about, or that become salient during, the appeals process.
- **the working groups activities are effectively utilised to improve operational policy and the training of caseworkers and medical advisors.**

Supporting Treating Physicians

6.19 To enable caseworkers to rely on the evidence on the nature and impact of an injury submitted by treating physicians (Recommendation 18), requires that treating physicians are provided guidance and support in understanding the objectives of the AFCS and, in turn, how to adequately submit evidence for the purposes of supporting a claim.

6.20 Requesting that treating physicians tailor the submission of evidence for AFCS claimants would be an increased burden on the health system. However, the AFCS claimant population is proportionately small and dispersed across the United Kingdom. As at 31 March 2022, there were a total of 46,731 individuals in receipt of an AFCS award. 3,556 (7.6%) of these are in receipt of a GIP, the greatest proportions of which are concentrated in the Southeast and Southwest of England, with 553 (15.6%) and 559 (15.7%) respectively. These figures represent the total number of recipients to whom a GIP award has been made over a seventeen year period.

6.21 Thus, based on the assumption that those in receipt of GIP's are most likely to require additional support in their claims process, the Local Authority with the greatest recorded concentration of AFCS GIP's (Rushmoor, Hampshire), would need to support only 41 recipients at this time (Location of Armed Forces Pension and Compensation Recipients 2022, www.gov.uk), each of which will have made the initial claim at a different point over a seventeen year period and are unlikely to all apply for a reconsideration, appeal or review at the same time. Based on recorded data from 275 Local Authorities, seventeen of which record none, there are an average of nine AFCS GIP recipients per Local Authority.[17]

[17] This is based on figures from 275 out of 333 Local Authorities in England.

6.22 Additionally, the health sector already provides similar support, and in much greater numbers, for the purposes of benefits claims; for example, General Practitioners compile evidence for Personal Independence Payment (PIP) applications.

RECOMMENDATION 31: Under the Armed Forces Covenant, **the MoD should procure the support of the health sector in supporting the AFCS community and to produce guidance for treating physicians on how to compile appropriate evidence packs to support claimants in the process.**

6.23 For example, the design of a standard form requesting specific types of evidence and prompting physicians to make an assessment using language consistent with the AFCS descriptors (e.g., tick boxes for whether the physician would consider the claimants condition to be moderate, severe, or very severe).

6.24 The reviewer recognises concerns that relying too much on treating physicians could jeopardise the physician's relationship with their patient (i.e., the claimant). However, all that should be requested is an assessment of the claimant's condition and at no point should the physician be asked to make an assessment as to whether or not the claimant should be entitled to an award. These efforts should be made in parallel with those outlined in Recommendations 9, 37 and 38.

Existing Resources

6.25 There already exist within the MoD functions which the delivery function of the AFCS can draw on to assist in the improvement of the administration of the Scheme.

Veterans Welfare Service

6.26 The Veterans Welfare Service (VWS), which sits within the MoD's Defence Business Service (DBS) alongside the delivery function of the AFCS, has a broad and varied remit, including to support individuals who require information and guidance in relation to the AFCS, such as to understand the process, timeframe and requisite supporting evidence. VWS staff also help clients with assisted online claims or hard copy paperwork. VWS's clients includes those who have been medically discharged in their transition out of the Services, who require transition or welfare support. VWS clients come to them via referrals from the single Services, or self-referrals, including those submitted via the Defence Transition Referral Protocol (DTRP), or third party- referrals (e.g., charities).

6.27 This is a clear example of where a lack of communication and join-up between MoD functions results in a missed opportunity to greatly improve the delivery of the Scheme as the VWS does not receive referrals from the AFCS delivery function. Although AFCS caseworkers currently have the option to make referrals to VWS, it rarely occurs if at all. However, considering the degree of vulnerability of some AFCS claimants, caseworkers should ensure they receive the support offered by the VWS.

RECOMMENDATION 32: The AFCS delivery function, upon identifying individuals with complex cases, should routinely refer these individuals to VWS to enable VWS to engage with the individual and discuss the support they might require throughout the AFCS claims, reconsideration or

appeals process. To enable welfare managers to provide the best possible support to the individual based on up to date and accurate information:

- **Welfare managers should be invited to all information and training sessions provided to AFCS caseworkers, for the purposes of disseminating information as well as creating and maintaining links between the functions.**
- **Where a claimant is being supported by the VWS, communications between the allocated AFCS caseworker and VWS welfare manager should be maintained throughout the course of the individuals AFCS claims, reconsideration, or appeals process.**
- **All written communications between the MoD and claimants/recipients concerning the AFCS should include contact details for and information on the service provided by VWS.**

6.28 The reviewer recognises, nevertheless, that the VWS has its own resourcing challenges. In light of the Independent Review of HMG Welfare Services for Veterans announced in March 2023, however, the reviewer considers this an opportune moment for the scope of the VWS as concerns the AFCS to be formalised and appropriately resourced.

Veterans Advisory and Pensions Committees

6.29 The Veterans Advisory and Pensions Committees (VAPC's) are a set of independent committees (i.e., a Non-Departmental Public Body (NDPB) sponsored by the MoD), organised into thirteen regions,[18] consisting of up to twenty volunteer members each. The VAPC's are charged by statute (The War Pensions Committees Regulations Statutory Instruments [2000] No. 3180, 2005 No. 3032, 2006 No. 3152 and 2017 No 1133) with advocating for and supporting veterans and their families in accessing welfare services.

6.30 Despite the function of the VAPC's being so tightly linked to the objectives of the AFCS, the reviewer did not find a single instance[19] illustrating that the VAPC's are actively engaged in understanding, evaluating, and improving the delivery of the AFCS, although a VAPC representative does sit on the Central Advisory Committee on Compensation (CAC) which predominantly considers policy issues. Thus, engagement with the VAPC, if it does occur, is entirely informal and personality driven, reliant on individual officials and VAPC members.

6.31 Some VAPC members, through their own initiative and contacts, already support individuals in their regions going through the AFCS claims, reconsideration, and appeals process, generally as advocates for claimants subject to particularly contentious claims processes. However, committees are only able to provide this support where they happen to have individual members keen to provide it and are reliant on those in need of support having knowledge of their existence and how to contact them. The latter is particularly problematic as they are not well-publicised, including by the MoD despite their being sponsored by the Department.

[18] Eastern England, London, East Midlands, West Midlands, Yorkshire and Humber, Northeast England, Northwest England, Southwest England, Southeast England, Northern Ireland, East Scotland, West Scotland and Wales.

[19] To note, the reviewer did not identify any instances of individual working relationships between VAPC members and MoD officials working on the AFCS, although this of course does not mean that they do not exist.

RECOMMENDATION 33: All written communications between the MoD and claimants/recipients concerning the AFCS should include contact details for, and information on the service provided by, the VAPC's to enable those requiring additional support throughout the process to access available resources.

RECOMMENDATION 34: The MoD should review its relationship with the VAPC's with a view to identifying potential opportunities for the VAPC's to assist claimants with complex AFCS claims, such as via a formal referral process for individuals in need of support as identified by AFCS caseworkers, particularly where the claimant expresses a preference for support from a body independent from the MoD.

6.32 The reviewer recognises that an Independent Review of the VAPC's has just concluded and that their role is within the scope of the aforementioned Independent Review of HMG Welfare Services for Veterans. Thus, this is an opportune moment to ensure that any reforms resulting from those reviews takes into account the potential for the VAPC's to provide greater support to AFCS claimants under new or revised terms of reference, acknowledging such an approach would necessarily require a review of the VAPCs' role as the AFCS Independent Complaints Panel.

PART II: POLICIES

PART II of this report is concerned with specific policies posing challenges to the achievement of the Armed Forces Compensation Scheme's objectives:

- **CHAPTER 7 CALCULATING AWARDS explores the system for calculating the worth of a claim, including whether it is the best way of achieving the aims of the Scheme, and whether elements of the process, such as the GIP factor and multiple injuries ranking method, are appropriate.**
- **CHAPTER 8 SEEKING PARITY considers whether different injuries, illnesses and disorders are treated equally under the Scheme, particularly mental disorders.**
- **CHAPTER 9 INEQUITABLE LIMITATIONS looks to the various limitations the Scheme places on claimants and recipients, including limits to eligibility, on financial assistance to support the application process and on review.**
- **CHAPTER 10 BURDEN OF PROOF considers the inequities of the burden of proof obligations placed on claimants when considered in light of the messaging on the role of the MoD in the evidence gathering process.**
- **CHAPTER 11 LUMP SUM UPRATING briefly considers the issue of formalising a process for uprating the lump sum awarded under the AFCS.**
- **CHAPTER 12 SPANNING looks to address whether there are steps that can be taken to tackle persistent issues regarding spanning cases.**

7 Calculating Awards

7.1 Under the Armed Forces Compensation Scheme (AFCS), the amount of compensation payable is determined by a series of tariff descriptors. Schedule 3 of the Order contains nine tariff tables each pertaining to different categories of injury and each table lists in order of severity the different injuries that are compensable under the relevant category (Annex D). Each of these descriptors is matched to a tariff level between 1 and 15. In turn, each tariff level corresponds to a pound sterling amount, with the highest amount corresponding to level 1 and lowest to level 15 (see Table 10, Annex D).

7.2 The tariff levels correspond to amounts payable in lump sum. However, where an injury corresponds to a tariff level 1 to 11, in addition to the lump sum, a Guaranteed Income Payment (GIP) is also payable once the claimant has left service. Different tariff levels attract different percentage amounts of GIP, increasing according to severity (see Figure 7).

Band	Tariff Levels	% GIP	Rationale
A	1-4	100	It is considered individuals with these tariff level awards are so seriously injured that they will be unable to work again, therefore all future salary and pension income is replaced.

B	5-6	75	It is considered individuals with these tariff level awards will be able to work but at a significantly reduced earnings capacity, therefore 75% of future salary and pension income is provided.
C	7-8	50	It is considered individuals with these tariff level awards will be able to work but that their earning capacity will be reduced by around half, so 50% of their future salary and pension income is provided.
D	9-11	30	It is considered individuals with these tariff level awards will be able to work but will experience a lower level of earnings due to their injury, so 30% of their future salary and pension income is provided.

Figure 7: GIP Bands (Para. 3.13, p.15, JSP 765)

7.3 100% GIP is different for each recipient. It is calculated by multiplying the recipient's salary at the time they leave service by their GIP factor—a number allocated in accordance with the age at their last birthday on leaving service (see Annex C for the current GIP factors table). Where an injury does not attract 100% of the GIP in accordance with the Bands, the allocated percentage of the total GIP is awarded.

7.4 For example, Alex is 36, the GIP factor for which is 1.014. Alex's wage upon being discharged from service was £35,000. Thus, Alex's total GIP is calculated as follows: 1.014 x 35000= 35,490. Figure 8 illustrates the process for deciding how much compensation each of Alex's injuries would attract individually.

Injury	Table	Tariff Descriptor	Tariff Level	Lump Sum £	GIP %	GIP £
Hearing loss in one ear so severe Alex cannot hear on one side.	7	'Blast injury to ears or acute acoustic trauma due to impulse noise with permanent sensorineural hearing loss in one ear of more than 75dB averaged over 1, 2 and 3kHz.'	10	27,810	30	10,647
A number of fractures to the facial bones which healed themselves within six weeks of the incident.	8	'Multiple fractures to face, or face and neck where treatment has led, or is expected to lead, to a good cosmetic and functional outcome.'	11	15,965	30	10,647
A wound to the face caused by shrapnel and which will leave permanent severe scarring.	2	'Severe scarring of face, or face and neck, or neck, scalp, torso or limb, where camouflage produces a good cosmetic result.'	12	10,300	0	
First degree burns to the lower chest area which healed without treatment within the first few weeks.	1	'Burns, with superficial burns affecting 1 to 4.4% of whole body surface area.'	15	1,236	0	
Injuries to Alex's left lower leg were so extensive, it was amputated below the knee. Recovery entails physio and rehab to learn to wear and use a prosthetic.	5	'Loss of one leg below knee (trans-tibial).'	6	144,200	75	26,617.50

A fractured right ankle which left the joint misaligned so required surgery for which recovery could take up to twelve months.	8	'Fracture or dislocation of one hip, knee, ankle, shoulder, elbow, or wrist, which has required, or is expected to require, arthrodesis, osteotomy or total joint replacement.'	9	41,200	30	10,647
A significant period of depression and anxiety which began when Alex started rehab after being discharged from hospital. Alex is undergoing therapy to learn management techniques and feels that it is helping.	3	'Mental disorder, which has caused, or is expected to cause, functional limitation or restriction at 26 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 2 years.'	13	6,180	0	

Figure 8: Illustration of initial award calculation

7.5 However, there are factors affecting whether the recipient receives the total compensation as determined by the above process:

- *They are in receipt of an Armed Forces pension.* The pension payments will be deducted from the GIP, so the recipient receives no more from the MoD than the GIP award total.
- *They are in receipt of compensation awarded by civil courts for the same injury.* This award amount will be deducted from the AFCS award, so the recipient is not compensated for the same injury twice as per convention.
- *Their lump sum award exceeds £650,000.* No more than the tariff level 1 lump sum of £650,000 can be paid for any single incident.
- *They suffer multiple injuries because of a single incident.* In these cases, an additional process enables the MoD to determine an amount payable for suffering resulting from the incident as a whole rather than for the different injuries.

7.6 As only one GIP can be paid, multiple injuries cases affect GIP awards in two ways:

- Where more than one injury attracts a GIP, only the highest Band injury will count towards determining the GIP payable (e.g., if a recipient has a Band B and a Band C injury, they will receive Band B 75% GIP).
- If there are two injuries attracting the same Band GIP, they will receive the GIP amount corresponding to the next Band up (for example, if a recipient has two injuries attracting a Band D GIP, they will be awarded Band C 50% GIP).

7.7 With regards to lump sum awards, multiple injury calculations are categorised into three types:

- *Category I: Those where the individual receives a Band A GIP* (i.e., 100% of the maximum available GIP). This applies where the recipient has either one tariff level 1-4 injury or two tariff level 5-6 injuries. In these cases, every injury will be compensated in full up to £650,000.
- *Category II: Those where at least two body zones have one or more injuries at tariff levels 1-11.* In these cases, the body is divided into five zones: A) head and neck, B) torso, C) limbs, D) senses and E) mental health. Then:

i) The injuries are allocated to the corresponding body zone and the lump sum awards for each zone added together.
ii) The body zones are then ranked in order of monetary value. If two body zones attract the same amount of compensation, one is treated as the higher and the other the lower.
iii) The injuries in the highest ranked body zone (i.e., with the highest monetary value) is paid at 100% of the total value of the lump sums. The injuries in the second ranked body zone are paid at 80% of the total value of the lump sums, 60% for the third, 40% for the fourth, and 20% for the fifth.

- *Category III: All other cases.* Each injury is ranked in order of monetary value. The highest ranked injury (i.e., the injury attracting the highest monetary value) is paid at 100%, the second highest ranked injury at 80%, the third at 60%, the fourth at 40% and the fifth and all remaining injuries at 20%.

7.8 Alex has a number of factors that will affect their final award payable. Four of Alex's injuries attract a GIP (see Figure 8) but, as all Alex's injuries are a result of a single incident, only the highest is payable. Thus, Alex is entitled to 75% of their GIP; that is £26,617.50 per year. However, Alex is also in receipt of an ill-health pension valued at £13,750 a year. As Armed Forces Pensions are deductible from the total award, Alex will receive £12,867.50 GIP per year.

7.9 Alex's case is a Category II multiple injury claim. Thus, Alex's final lump sum award is also affected as illustrated at Figure 9.

Injury	Body Zone	Tariff Level	Tariff Amount	% Payable	£ Payable
A fractured right ankle which left the joint misaligned so required surgery for which recovery could take up to twelve months.	C	9	41,200	100	41,200
Injuries to Alex's left lower leg were so extensive, it was amputated below the knee. Recovery entails physio and rehab to learn to wear and use a prosthetic.	C	6	144,200	100	144,200
Hearing loss in one ear so severe Alex cannot hear on one side.	D	10	27,810	80	22,248
A number of fractures to the facial bones which healed themselves within six weeks of the incident.	A	11	15,965	60	9,579
A wound to the face caused by shrapnel and which will leave permanent severe scarring.	A	12	10,300	60	6,180
A significant period of depression and anxiety which began when Alex started rehab after being discharged from hospital. Alex is undergoing therapy to learn management techniques and feels that it is helping.	E	13	6,180	40	2,472
First degree burns to the lower chest area which healed without treatment within the first few weeks.	B	15	1,236	20	247.20
				Total:	226,126.20

Figure 9: Illustration of Multiple Injury final award calculations

7.10 There are a number of additional mechanisms available to provide for particular and less common situations such as supplementary, temporary, and interim awards; the above only provides a basic understanding of how a relatively straightforward initial award decision is calculated.

7.11 As raised by many respondents to this review, there are a number of issues that negatively affect the transparency and fairness of the process:

- The complexity of the calculation means that most recipients are unable to understand exactly how their award is calculated and thus whether it is a fair outcome.
- The prescriptiveness of the tariff descriptors acts as a limiting factor on a caseworkers ability to exercise discretion in light of, for example, developments in treatment.
- The use of the GIP factor has a significant impact on the financial stability in the long term for the recipient.
- It is not clear why the multiple injuries ranking approach is fairer to recipients as claimed.

Injury vs. Impact

7.12 Currently, the tariff descriptors form the basis for calculation of both types of awards (i.e., the lump sum and GIP). Therefore, although most of the descriptors (primarily those pertaining to less serious tariff 12- 15 injuries) only focus on the injury itself and not the impact of the injury, to enable the MoD to make awards for injuries with lasting impacts, as the injuries in the descriptors become more serious, the descriptors begin to incorporate impact as per Art. 5(1) of the Order:

"[A] descriptor is to be construed as encompassing the expected effects of the primary injury and its appropriate clinical management, short of a discrete diagnosable disorder, including, but not limited to—

d) pain and suffering due to the primary injury.
e) the effect of operative intervention, including pain, discomfort, and scarring.
f) the effect of therapeutic drug treatment.
g) the use of appropriate aids and appliances.
h) associated psychological effects short of a discrete diagnosable disorder."

7.13 However, this approach has unhelpful consequences:

- it does not allow for caseworkers to increase the award amount in cases where the effect of a series of injuries in sum have a much greater impact than can be predicted if each injury is assessed in isolation. For example, an individual may learn to adapt to the amputation of their right leg, but it will be much harder if they also suffer a balance disorder resulting from hearing loss.
- it requires the MoD to go through the lengthy process of amending the legislation to add or change a descriptor each time a claim is submitted which clearly merits an award but there is no appropriate descriptor for or when developments in medicine, technology, and workplace adjustments, for example, affect the extent of the limitation the injury cases to the recipient.

7.14 The detrimental effects on transparency and flexibility of the complexity and prescriptiveness of the award calculation process can be addressed through a clear division between the purposes of the lump sum award versus that of the GIP.

RECOMMENDATION 35: It is recommended that lump sum awards be made solely on the basis of the nature of the injury, illness or disorder and the resulting mechanical limitation, not the impact on the recipient's day-to-day life.

7.15 How much is awarded in lump sum for an injury should, therefore, be a more objective process of matching an injury to a tariff descriptor. The tariff descriptors, however, currently incorporate a number of factors which allude to impact to varying degrees in each table.

RECOMMENDATION 36: Thus, to enable a shift to injury focussed descriptors, **the tariff descriptors should be drafted in reference to the following elements only:**

- **the injury (e.g., cervical spinal cord injury).**
- **Where relevant, recovery time (e.g., expected to recover within 26 weeks).**
- **Where relevant, the extent of medical intervention (e.g., operative treatment needed); and,**
- **where relevant, the functional, physical loss caused by the injury (e.g., tetra paresis).**

7.16 This approach ensures that descriptors and their corresponding tariff levels reflect the severity of the injury, illness or disorder but make no judgements regarding how a recipient should cope with the residual effects or recover. For example, Items 5, 17, 21A and 22 in *Table 6- Neurological disorders, including spinal, head or brain injuries* do not align with the above criteria thus would be amended as follows:

- Item 5: 'Brain injury resulting in major and permanent loss or limitation of responsiveness to the environment, including absence or severe impairment of language function, and a requirement for regular professional nursing care', to read:
  'Brain injury resulting in major and permanent loss or limitation of responsiveness to the environment, including absence or severe impairment of language function.'
- Item 17: 'Brain injury where the claimant has moderate and permanent motor or sensory problems and one or more permanent substantial cognitive, personality or behavioural problems, and that injury requires regular help or full-time supervision from others with activities of everyday living but does not require professional nursing care or regular help from other health professionals', to read:
  'Brain injury where the claimant has moderate and permanent motor or sensory problems and one or more permanent substantial cognitive, personality or behavioural problems.'
- Item 21A: 'Brain injury from which the claimant has made a substantial recovery, has no major cognitive personality or behavioural problems, but has substantial functionally disabling motor deficit in upper and or lower limbs, but is able to undertake some form of regular employment', to read:
  'Brain injury from which the claimant has made a substantial recovery, has no major cognitive personality or behavioural problems, but has substantial functionally disabling motor deficit in upper and or lower limbs.'
- Item 22: 'Brain injury from which the claimant has made a substantial recovery, has no major motor or sensory deficits, but does have one or more of a residual functionally disabling—
  (i) cognitive deficit,
  (ii) behavioural change, or
  (iii) change in personality,

but is able to undertake some form of regular employment', to read:
'Brain injury from which the claimant has made a substantial recovery, has no major motor or sensory deficits, but does have one or more of a residual functionally disabling—

(i) cognitive deficit,
(ii) behavioural change, or
(iii) change in personality'

7.17 Most tariff descriptors pertaining to injuries currently meet these criteria. However, Table 3- Mental Disorders and Table 4- Physical Disorders—illnesses and infectious diseases, require an adaptation to this approach to reflect that disorders can only be described by their symptoms. Recommendations for reframing the tariff descriptors in these tables to enable equitable calculation of lump sum awards are made in Chapter 8.

7.18 Differentiating the purpose for which lump sums are awarded from that of the GIP, requires that the tariff tables be employed as the basis for calculating lump sums alone and the process for calculating GIPs separated from the tariff tables entirely. This will ensure the provisions of the Scheme appropriately acknowledge 'the expected effect of the injury and treatment over the person's lifetime… to enable individuals to move forward with their lives following injury with financial security and to encourage individuals to take up the future', (Para. 3.3, p.13, JSP 765)

RECOMMENDATION 37: GIP awards should be based on the *sum impact* of the injuries on the recipients psychological, family, social and occupational life, irrespective of the nature or number of injuries they have suffered.

7.19 The tariff descriptors coupled with GIP Bands A- D (Figure 7) provide indications that these factors already play a part in assessing how much GIP a recipient receives. However, the Bands solely focus on occupational limitations and are prescriptively linked to specific tariff descriptors (by being prescriptively linked to tariff levels) amounting to a pre-emptive judgement as to how a recipient should react to an injury and subsequent treatment. This approach disregards that the same injuries and subsequent treatment can have very different impacts on two different people owing to, for example, pre-existing or environmental factors, and disempowers caseworkers from using their own judgement of an individual's situation (e.g., developments in treatment, technology, and workplace adaptations) to make the most appropriate decision for the claimant within the parameters of the Scheme.

RECOMMENDATION 38: GIP awards should be calculated independently from the lump sum tariff tables and with reference to a standalone table as at Figure 10**. Each claim should be assessed in its totality and a determination made as to whether the impact of the sum of the claimants' injuries and/ or disorders meet a GIP descriptor.**

7.20 Although it may appear that there is not a significant differentiation between Bands C and D, Band D pertains specifically to the recipient's mechanical function. For example, an individual who has their thumb amputated on their non-dominant may adapt well to their injury whilst suffer from a permanent functional limitation. However, another may have the same injury (an amputated thumb) in addition to a mental disorder which persistently limits their ability to participate in their

family and social life although they are able to continue working as they are qualified for a profession that enables them to work independently. The former would qualify for a Band D GIP and the latter a Band C GIP.

Band	GIP %	GIP Descriptor
A	100	**Injury or injuries, physical and/or mental disorder(s):** • **which continue OR are expected to continue to affect the claimant's function after undertaking adequate courses of best practice treatment, and** • **are judged by the treating physician to continue OR are expected to continue to affect the claimant's family and social life, and** • **are judged by the treating physician to remain incompatible with any paid employment until state pension age, and** • **are judged by the treating physician to require continued dependence on a caregiver for basic activities of daily living for the foreseeable future.**
B	75	**Injury or injuries, physical and/or mental disorder(s):** • **which continue OR are expected to continue to affect the claimant's function after undertaking adequate courses of best practice treatment, and** • **are judged by the treating physician to continue OR are expected to continue to affect the claimant's family and social life, and** • **are judged by the treating physician to remain incompatible with any paid employment until state pension age.**
C	50	**Injury or injuries, physical and/or mental disorder(s):** • **which continue OR are expected to continue to affect the claimant's function after undertaking adequate courses of best practice treatment, and** • **are judged by the treating physician to continue OR are expected to continue to affect the claimant's family and social life.**
D	30	**Injury or injuries, physical and/or mental disorder(s) which continue OR are expected to continue to affect the claimant's function after undertaking adequate courses of best practice treatment.**

Figure 10: Recommended GIP descriptors

7.21 This approach is similar to that taken in Australia, Canada, and the United States in calculating monthly payments to assist veterans injured in Service (Figure 11). To note, the United States' scheme increases payment for each dependent a claimant may have; the reviewer considers this to be incorporated into the impact on family life in the Recommendation 37.

7.22 Taking this approach, distinguishing between the purposes of lump sum and GIP awards, will:

- Provide clarity that acute injuries (i.e., those with short-term effects) attract a lump sum only and those with persistent effects attract a GIP in addition to a lump sum.
- Obviate the need to apply further processes to calculate GIP awards where there are, under the current system, two or more tariff 1- 11 injuries attracting multiple GIP's
- Ensure those experiencing persistent suffering as a result of, for example, multiple tariff 12-15 injuries and which affects their psychological, social, family, and occupational life are recognised.
- Ensure that GIP awards reflect where medical, technological, and social advancements reduce the lasting impact of an injury on an individual's psychological, family, social and occupational life.
- Increase transparency in GIP awards as the GIP descriptors are measurable and both caseworkers and recipients should be better able to relate the descriptors to the latter's lived experience.

Country	Method of Calculation
Australia	Four components of a veteran's life that may be affected by war-caused or defence-caused incapacity or impairment are assessed: • personal relationships. • mobility. • recreational and community activities. • employment and domestic activities. A table under each component sets out descriptions of the levels of effect of the injury on lifestyle. A rating is then allocated to each level. The ratings are added and divided by four to arrive at the overall lifestyle rating. A Lifestyle Rating form is requested. The claimant can: • self-assess (a Lifestyle Rating form, requesting selection of what the claimant believes to be the appropriate rating for their lifestyle effect, is issued). • complete a Lifestyle Questionnaire that asks questions about the effects of the incapacity on their lifestyle; or • the decision maker will allocate an average lifestyle rating based on the level of medical impairment. This alongside reports of the medical condition determines the lifestyle rating. Medical impairment is assessed by looking at physical loss or disturbance to body systems, and any loss of function suffered as a result. When a rating is selected from each appropriate table, the ratings are combined (not added arithmetically) to arrive at an impairment rating for all war-caused or defence-caused conditions. (DVA's Guides to Assess Compensation, www.vhc.org.au)
Canada	Pain and suffering compensation – a life-time monthly benefit or lump sum benefit (claimants' choice) is calculated using injury tables (similar to the Tariff tables) as well as completion of medical questionnaires which include a self-assessment of the severity of the impact of injury. There are a series of questionnaires relating to impacts of different conditions, the appropriate of which is selected by the decision maker and issued to the claimant on the initial assessment of a new claim. (www.veterans.gc.ca)
United States	The monthly payment is based on the disability rating and the details of the claimant's dependant family members. For example, "if you're a Veteran with a 70% disability rating, and you have a spouse, plus 3 dependent children under the age of 18, you would start with the basic rate of $1,907.06 (for a Veteran with a spouse and 1 child)."

This is calculated by the following steps:

- the disabilities are arranged in order of their severity, beginning with the most severe disability
- the degree of one disability is displayed in the left column, and the other in the top row
- the figures that appear in the space where this column and row intersect represents the combined value of the two
- this combined value is rounded to the nearest 10%
- if there are more than two disabilities, the combined value for the first two will be found as previously described
- the exact combined value is combined with the degree of the third disability
- this process is repeated for subsequent disabilities and the final figure is rounded to the nearest 10% (www.va.gov)

Figure 11: Comparator country calculation methods

7.23 This may appear to be a readoption of the War Pensions Scheme. However, the more stringent attributability criteria of the AFCS remains intact, ensuring that those suffering the effects of an injury, predominantly and on the balance of probability, attributable to service only are properly compensated. At the same time, it extracts the positive aspect of the WPS disablement assessment, whereby the Scheme provides sufficient discretion to the decision-maker to ensure improvements in medicine, technology, and adaptations, as well as the claimants individual circumstances, can be taken into account in each decision.

7.24 Moreover, reconfiguring GIPs in this way remains compatible with the mechanisms original intent under the AFCS; that is, to enhance or replace the income lost as a result of the injury, illness or disorder the individual claims for. Though it may appear to extend the purpose of GIPs to compensate for pain and suffering (the purpose of the lump sum), it is simply a recognition that a person's ability to carry out tasks directly relevant to their occupation are not the only factors that affect their ability to work, and therefore earn, in the long-term.

7.25 Instead, where an individual is unable to maintain a healthy psychological, family and social life, their occupational life is likely to, even if only eventually, suffer. For example:

- It is not unrealistic that a claimant who suffers significant depression caused by struggling to adapt to being wheelchair bound despite their being qualified to carry out a desk based job will experience just as much difficulty maintaining employment as someone with the same injury, who adapts well but is qualified for more physical occupations.
- A claimant who chooses to ensure their energy and treatment is geared towards enabling them to maintain their employment at the cost of their psychological, family and social well-being is likely to eventually feel the detrimental impacts of these choices and experience, for example, burn out, rendering them unable to continue employment in the same capacity.

7.26 Recognition of the interconnectedness of these factors is crucial as defining earning capacity solely by what the claimant is able to physically do when they are at their best means legitimising the expectation that an individual should sacrifice all other aspects of their life in order to earn. This is an outdated understanding of an individual's right to have a fulfilling life. Today, in Britain, it is recognised that it is an individual's right to have a fulfilling life overall; occupation is a part of this,

but one which can only be maintained where all other aspects of an individual's life (physical, psychological, family, social) also remain healthy.

GIP Factors

7.27 GIP factors are elemental in the calculation of a recipient's GIP as they determine how much an individual is projected to earn. They are, essentially, a base estimation of how much the injury has caused the individual to lose financially over their lifetime. For example, 100% GIP for a recipient who has been discharged due to injury at 20 and who, for arguments sake, was earning £20,000 at the time they left service, would currently be predicted to earn £23,640 on average until retirement at 60. Although it appears to assume a very modest increase in earnings, the GIP factors are based on an estimate of the average income for the remainder of an individual's lifetime, including their salaried working life and pension income. As the pension income is lower than the former, it brings down the average expected overall income, especially for those closer to retirement and who have more years ahead of them on a lower pension income than salaried working years.

7.28 The current system for calculating GIP's is based on the principle that recipients should not see a drop in their GIP at retirement, providing them with a predictable and stable income. Thus, an average income across the remaining expected lifetime is taken and used as a basis to calculate a consistent lifetime payment.

7.29 Although the principle is sound and, over a lifetime, means the recipient may receive a fair award, this method of calculating GIP's is increasingly disadvantageous the further from retirement the recipient is. This is owing to the way money is conventionally invested in the earlier years of employment to ensure financial security when in receipt of a lower income (i.e., pension) in retirement.

7.30 In their twenties and thirties, most people save their disposable income for a deposit on a home and only because of the income and salaried years left are they eligible for mortgages when ready to purchase a home. As time passes, their housing expenses decrease until their mortgage is paid off, whilst, most likely, their salary increases leaving them with increasingly more disposable income and capital in their home. In London and many parts of the Southeast of England, this scenario is generally only possible where there are two salaried individuals. This financial security enables individuals to spend any income they have in retirement on, for example, new needs (e.g., care), to provide security for their family or luxuries.

7.31 However, the payment structure of the GIP decreases an individual's opportunity to save and invest early to build capital. Even if the GIP is 100%, it is not only low, but also only paid to those who have significant care needs and therefore far higher expenditure on, for example, aids and adaptations and therefore little capacity to invest. Moreover, if they are in a partnership, it is likely their partner is not able to dedicate themselves to a highly paid career either, due to the recipient's care needs.

7.32 So, for the aforementioned 20-year-old, if they are in receipt of 50% GIP, they will be entitled to £11,820 GIP per year. As their pension will be deducted from their GIP this is the most they will receive. Consider that, 50% GIP is awarded to individuals with tariff level 7 or 8 injuries, as well as

potentially other tariff 9 and below injuries. For example, the recipient may have, at minimum, an injury ranging from a permanent disorder (mental or physical) with residual functional limitations whereby they are unable to continue a career and can only take lower-skilled, less demanding jobs (item 2, Tables 3 and 4, Annex D) to loss of both thumbs (item 22, Table 5, Annex D).

7.33 This 20-year-old will thus receive a maximum lump sum of £92,700 and a monthly income of £985. The former is likely sufficient for a deposit on a home. However, if this individual wishes to have a family and can only, for example, carry out low-paid work, the latter is insufficient to pay living expenses for a family and a mortgage if they are even approved for one. Additionally, if the disorder prevents the individual from participating in some aspects of family life (e.g., with childcare) or fully for periods of time, it is unlikely their partner will be able to maintain a well-paid job either.

7.34 Consequently, it is unlikely that they will be in a position to purchase a home to accrue capital and will always be paying rent. They will likely be facing a lifetime of making their GIP and any variable additional income stretch to meet ever increasing needs (whether because their family grows or because they are aging and have greater needs) in insecure accommodation. Thus, for this individual to be financially secure and maintain a good quality of life for themselves and a potential family, we are relying on their already having significant financial resources, whether through their family or partner. This is not the case for the vast majority of 20-year-olds in the Armed Forces.

7.35 For a 36-year-old, such as the fictional Alex described in Chapter 4, who already has a home and children and who has planned for their future based on their career trajectory and a minimum income (as we are socialised to do), the lifetime average income approach can also be disadvantageous. Alex's net income before being discharged was £2318, which was, let's assume for the sake of argument, supplemented by their partners part-time income of £1230. Their household real wage[20] was higher than a civilian equivalent household as those serving in the armed forces receive a number of financial benefits, including discounts.

7.36 However, upon being discharged from the Armed forces, Alex is unable to work even if they are expected to be able to return to work with substantially reduced earnings (Band B criteria) at some point in the future after undergoing treatment. Alex and their family are living off the £2,218 GIP per month alone; their partner has had to leave work as Alex is unable to participate in family life almost entirely whilst undergoing treatment and rehabilitation. Alex has decided to use some of their £226,126.20 lump sum award to make the necessary adaptations to their house and purchase the best aids to speed up their recovery, and the remainder has been paid into the mortgage. Alex lives in the Southeast, thus, although the monthly mortgage payments are greatly reduced, it has not been paid off entirely.

7.37 Alex's situation is now that they must cover their and their family's living expenses on 62% of their previous household income, even though they have greater needs and expenses than previously. Consequently, at potentially their most vulnerable time in life, Alex must re-evaluate

[20] Defined as 'the value of money earned by workers in an economy at a particular time, after taking into account the effect of inflation on what can be bought with that money' (https://dictionary.cambridge.org/dictionary/english/real-wages)

their life goals to be less ambitious than they had planned based on their employment in the Armed Forces. This might include selling their home within five years of being discharged, losing the investment they made in adapting their home to their needs.

7.38 If the goal of the AFCS is to ensure that recipients are not disadvantaged, the GIP factor is not contributing to fulfilling this aim. This is not simply a matter of the amount of money given to a recipient over a lifetime being insufficient, but the implications on financial planning of how the money is distributed over a lifetime.

RECOMMENDATION 39: To enable GIP recipients to financially plan as their peers would:

- **A second system of GIP factors should be devised that enables the distribution of the GIP over a lifetime to reflect the income distribution of the recipients fully employed equivalent more accurately (i.e., sees a higher income up to retirement after which the income reduces).** This second system should be as simple and easily understood by a layperson as possible; and,
- **a consultation should be carried out with recipients of an AFCS GIP, to explain the difference between the current system and the second system, with a focus on financial planning opportunities, and to gain an understanding as to which would be better received before moving forward with implementation.**

Multiple Injuries Ranking

7.39 As per JSP 765, the multiple injury ranking process was devised as '[t]he Scheme's underlying principle is to pay the highest awards to those most seriously injured.' (Para. 3.7, p. 13) The ranking system ensures that a recipient who has suffered injuries in one incident is awarded less than a recipient who suffers the same injuries over two or more incidents. However, none of the MoD 's communications explain why the former is considered to not be as seriously injured as the latter.

7.40 Officials explain that the reduction in payment is due to, as per convention in calculating compensation, a portion of the compensation amount of each tariff level being for pain and suffering. As the pain and suffering are experienced only once in the case of a single incident, this portion of the amount is only awarded for the most severe injury which is likely to have caused the most pain and suffering.

7.41 The reviewer considers that there is indeed merit to this argument. However, there are two problematic aspects to this approach:

- Although it is true that an individual who suffers injuries over two or more incidents experiences pain and suffering more times, it is not the case that the only pain and suffering experienced by the individual whose injuries are caused by a single incident will emanate from their most severe injury alone. For example, Alex's worst injury resulted in the amputation of their leg. However, the experience of pain and suffering resulting from all their other injuries in aggregate will have undoubtedly aggravated the pain they suffered overall. In essence, Alex's pain and suffering will not have been confined to the injury of their right leg.
- If pain and suffering is represented by a percentage of the calculated amount of compensation, it is unclear why pain and suffering increases in value the more injuries a person has suffered. For example, if pain and suffering accounts for 30% (figure for illustrative

purposes only) of the award calculation, why is it that, as per Figure 9, because they are suffered as a result of a single incident, the proportion of Alex's award for pain and suffering for their:

i) Blast injury is 20%,
ii) Fractured facial bones and shrapnel wound to the face 40%,
iii) Mental disorder 60%, and
iv) Burns 80%?

RECOMMENDATION 40: To ensure equity and transparency in calculating multiple injury awards:

- **A determination applicable to all claims should be made, substantiated, and explained in public communications as to what percentage of any award is considered to be for pain and suffering; and,**
- **The aggregate pain and suffering should be considered in calculating multiple injury awards, resulting in the consistent deduction of less than the full percentage awarded for pain and suffering for each injury, with the exception of the most severe (which should continue to attract 100% of the award).**

7.42 For example, if pain and suffering is determined to account for 30% of any award, rather than the full 30% being awarded for all injuries, 20% should be deducted from each of Alex's lump sum awards except those in Body Zone C where they have suffered the worst injuries, as at Figure 12. In essence, a third of the pain and suffering award is given in recognition of the aggregate pain and suffering caused by the multiple injuries.

Injury	Body Zone	Tariff Level	Tariff Amount	% Payable	£ Payable
A fractured right ankle which left the joint misaligned so required surgery for which recovery could take up to twelve months.	C	9	41,200	100	41,200
Injuries to Alex's left lower leg were so extensive, it was amputated below the knee. Recovery entails physio and rehab to learn to wear and use a prosthetic.	C	6	144,200	100	144,200
Hearing loss in one ear so severe Alex cannot hear on one side.	D	10	27,810	80	22,248
A number of fractures to the facial bones which healed themselves within six weeks of the incident.	A	11	15,965	80	12,772
A wound to the face caused by shrapnel and which will leave permanent severe scarring.	A	12	10,300	80	8,240
A significant period of depression and anxiety which began when Alex started rehabilitation after being discharged from hospital. Alex is undergoing therapy to learn management techniques and feels that it is helping.	E	13	6,180	80	4,944
First degree burns to the lower chest area which healed without treatment within the first few weeks after the incident.	B	15	1,236	80	988.80
				Total:	234,592.80

Figure 12: Example calculation of multiple injuries claim using recommended process

8 Seeking Parity

8.1 Seeking parity of treatment of different types of injuries, illnesses and disorders under the Armed Forces Compensation Scheme (AFCS) requires an assessment of, essentially, the comparative fairness of awards in accordance with the severity of an individual's experience of an injury, illness, or disorder. Therefore, to achieve parity, it is necessary to focus on outcome.

8.2 There are three particular issue areas concerning parity:

- Ensuring that awards for mental and physical disorders accurately reflect the severity of the claimants' experience and that they are treated with parity to other injury types.
- Historically, mental disorders have not been treated with parity to physical disorders, in both how they are described and how they are taken into consideration in calculating awards.
- Horizontal and vertical equity between and within the tariff tables, which requires parity of treatment between the injury/illness/disorder types represented by each table as well as fair financial awards in accordance with the severity of injuries and disorders.

Disorders and Injuries

8.3 The Table 3 and 4 tariff descriptors for mental and physical disorders as currently drafted do not achieve parity between the disorders they refer to and the injuries/illnesses the remaining tables capture, especially in the context of the recommendations to separate the purpose of lump sum from GIP awards. One way to achieve parity would be to seek as objective a description as possible for different degrees of impact. However, this is not possible without binding claimants to pre-set expectations of how a disorder should affect them. Thus, any assessment of impact must be inherently subjective and contextual.

8.4 The Table 3 and 4 descriptors as they are drafted, recognise this need for subjectivity and refer to moderate, severe and very severe functional limitation. However, the term 'functional limitation', as employed in these tables, is restricted to the ability to undertake paid work:

- Table 3- Mental disorders:
  - i) 'Functional limitation or restriction is very severe where the claimant's residual functional impairment after undertaking adequate courses of best practice treatment, including specialist tertiary interventions, is judged by the senior treating consultant psychiatrist to remain incompatible with any paid employment until state pension age.'
  - ii) 'Functional limitation or restriction is severe where the claimant is unable to undertake work appropriate to experience, qualifications and skills at the time of onset of the illness and over time able to work only in less demanding jobs.'
  - iii) 'Functional limitation or restriction is moderate where the claimant is unable to undertake work appropriate to experience, qualifications and skills at the time of onset of the illness but able to work regularly in a less demanding job.'
- Table 4- Physical disorders—illnesses and infectious diseases:

  i) 'Permanent functional limitation or restriction is very severe when the claimant is unable to undertake work appropriate to experience, qualifications and skills, following best practice treatment, and at best thereafter is able to undertake work only sporadically and in physically undemanding jobs.'

ii) 'Permanent functional limitation or restriction is severe where the claimant is unable to undertake work appropriate to experience, qualifications or skills at the time of onset of the disorder and over time able to work in only physically less demanding jobs.'

8.5 On the other hand, the severity of injuries in Tables 1, 2 and 5 to 9 is never assessed in accordance with the sufferer's ability to continue working but rather with the impairment on physical function resulting from the injury.

RECOMMENDATION 41: Thus, in order to achieve parity in outcome between the descriptor for injuries and disorders, **the definition of 'functional limitation' currently ascribed to Tables 3 and 4 should be redrafted to reflect the definition in Article 5(3) of The Order 2011:**

"The term "functional limitation or restriction" in relation to a descriptor means that, as a result of an impairment arising from the primary injury or its effects, a person

(a) has difficulty in executing a task or action; or

(b) is required to avoid a task or action because of the risk of recurrence, delayed recovery, or injury to self or others."

8.6 This definition is neutral on whether the task or action is for the purposes of, for example, work or family life. This is important as, for example, someone who has a disorder causing chronic fatigue but is able to undertake work appropriate to their skillset as a self-employed consultant project manager with flexible hours is no less injured for the purposes of receiving a lump sum than someone with the same disorder but who is unable to undertake work appropriate to their skillset as a physical trainer.

RECOMMENDATION 42: To represent an escalation of this definition of 'functional limitation', a judgement should be made by caseworkers as to the extent to which the recipient's life is limited because of the disorder, in both mental and physical disorder cases. Thus, making an overall assessment of the recipient's psychological, family, social and occupational life, prioritising none above the others and regardless of whether the limitation is all in one area or spread across multiple areas of their life, functional limitation as a result of their disorder is:

- **Moderate where 30% of their overall life is limited.**
- **Severe where 50% of their overall life is limited.**
- **Very severe 75% of their overall life is limited.**

RECOMMENDATION 43: Additionally, **the word 'permanent' should be removed from the relevant descriptors. Article 5(7) of The Order 2011 states that an injury or disorder is '"permanent" where following appropriate clinical management of adequate duration—**

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

ii) no further improvement is expected.'

Instead, where absolutely necessary, the word 'persistent' should be used to indicate that periods of improved capacity, for example, do not negate the severity of the disorder.

8.7 Clause (i) of Article 5(7) forces a caseworker to make an impossible determination that no developments could ever be made in the claimant's lifetime that would mitigate or eliminate the

impact of the disorder—a determination most medical professionals would not make. Nevertheless, there are instances in which treating physicians determine that the claimant is highly likely to experience symptoms persistently throughout their life. Yet, this does not necessarily meet the criteria set out in Article 5(7).

8.8 For example, in Charlies' case (Figure 5; Case Study II, Annex E), in April 2021 their consultant wrote that '[t]he unfortunate fact is that [they have] now had 2 significant doses of psychotherapy aimed at treating [their] PTSD and remain[s] on significant amounts of medication, and remain[s] quite disabled. This suggests that [their] disability will last several years at this level and is unlikely to completely ameliorate ever'; and, in May 2021, that they will be 'unable to be fully integrated into family life let alone secure and sustain meaningful employment'. Yet, in July 2022, the MoD determined that the 'prognosis remains uncertain' and awarded Charlie a Tariff Level 10 interim award, whereby it was expected that Charlie's CPTSD would 'caus[e] functional limitation or restriction… for 5 years.'

RECOMMENDATION 44: Furthermore, **there should be a presumption in favour of the claimant where there is no evidence to suggest the impact of their injury, illness, or disorder is not permanent.**

8.9 For example, where a claimant has undergone treatment with minimal effect, it is unlikely that the treating physician will assert that, even with ongoing treatment, the claimant's condition will not improve. However, if the recommended treatment has not had the projected effect, this should be sufficient to fulfil the criteria of persistent or permanent even where there is a chance continued treatment will see the claimants condition improve.

8.10 The reviewer recognises the degree of subjectivity built into the recommended assessment criteria. However, if caseworkers are trained and empowered to assess the claimant's life circumstances in the context of their condition (see Chapter 5), these descriptors should produce equitable results equivalent to those for observable injuries.

Mental Disorders and Other Injury, Illness and Disorder Types

8.11 There are a number of indications that mental disorders are not treated as equal in gravity and impact to physical injuries, illnesses, and disorders and that they are considered to be less verifiable for the purposes of the decision-making process. For example, they are the only descriptors that require a consultant's report to legitimise the claim. In this section, therefore recommendations are made to address disparities evident in Table 3 of Schedule 3 on Mental Disorders, the use of evidence in decision-making on Table 3 claims, and the use of Interim Awards in mental disorder claims.

Table 3- Mental Disorders

8.12 Although both Tables pertain to disorders, there are fewer Table 3- Mental Disorders descriptors and they are far briefer and less descriptive than their Table 4- Physical Disorders equivalents. This reflects the time at which the table was written in the early 2000's, when mental health was less understood and, to an extent, delegitimised. However, twenty years on, the impact of mental health is better understood and broadly accepted as being equal to that of physical health.

8.13 In particular, Table 3 recognises very few mental disorders that are less severe, equivalent to items 4 to 11 in Table 4, and which constitute an injury for the purposes of the AFCS.

RECOMMENDATION 45: Table 3- Mental Disorders should be expanded to recognise instances of less severe mental disorders or those which manifest for shorter periods of time. As mental disorders are described by temporal and severity measures, the number of descriptors should be expanded with reference to these same factors as per Figure 13.[21]

8.14 To note, the recommended descriptors do not include descriptors for mental disorders impacting the claimant for between two and five years, but instead include only descriptors for disorders impacting the claimant beyond two years but from which the claimant is expected to recover and descriptors for mental disorders that are expected to persist. This is because, the five year timeframe does not appear to have been drafted with any particular disorders or incidents in mind and therefore does not capture any particular type of claim. However, it does encourage the use of interim awards as these enable the MoD to get very close to five years' worth of evidence when extended, despite the ambition of the AFCS to make full and final awards as early as possible.

8.15 The recommended descriptors do not preclude the MoD from making an interim award where there is well founded doubt as to whether the claimant is likely to substantially recover and is not expected experience persistent functional limitations, for example.

	Moderate	Severe	Very Severe
Persistent	Mental disorder where symptoms and functional effects are well controlled by regular treatment.		
	Mental disorder expected to cause moderate functional limitation or restriction.	Mental disorder expected to cause severe functional limitation or restriction.	Mental disorder expected to cause very severe functional limitation or restriction
2 years+	One or more episodes of a mental disorder which has caused or is expected to cause, ongoing moderate functional limitation or restriction beyond 2 years but from which the claimant is expected to make a substantial recovery.	One or more episodes of a mental disorder which has caused or is expected to cause, ongoing severe functional limitation or restriction beyond 2 years but from which the claimant is expected to make a substantial recovery.	One or more episodes of a mental disorder which has caused or is expected to cause, ongoing very severe functional limitation or restriction beyond 2 years but from which the claimant is expected to make a substantial recovery.
26 weeks+	Mental disorder which has caused, or is expected to cause, moderate functional limitation or restriction at 26 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 2 years.	Mental disorder which has caused, or is expected to cause, very severe functional limitation or restriction at 26 weeks from which the claimant has made, or is expected to make, a substantial recovery within 2 years.	Mental disorder which has caused, or is expected to cause, very severe functional limitation or restriction at 26 weeks from which the claimant has made, or is expected to make, a substantial recovery within 2 years.
13 weeks+	Mental disorder which has caused, or is expected to cause,	Mental disorder which has caused, or is expected to cause,	Mental disorder which has caused, or is expected to cause,

[21] All references to 'functional limitation' are to be interpreted as per Recommendation 41.

	moderate functional limitation or restriction at 13 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.	severe functional limitation or restriction at 13 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.	very severe functional limitation or restriction at 13 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
6 weeks+	Mental disorder which has caused, or is expected to cause, moderate functional limitation or restriction at 6 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.	Mental disorder which has caused, or is expected to cause, severe functional limitation or restriction at 6 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.	Mental disorder which has caused, or is expected to cause, very severe functional limitation or restriction at 6 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.

Figure 13: Recommended Table 3- Mental Disorders descriptors

8.16 The reviewer has not made recommendations regarding the Tariff Level each descriptor should correspond to as the process for their allocation is unclear (see Recommendation 53). Nevertheless, it is not the intention that the most severe descriptors are in the top row of Figure 13. Instead, the grid has been used to clearly present the number of gradations in severity and duration that should be contained in Table 3 to ensure there is a clear distinction between descriptors. Medical expert advice will be required to allocate each descriptor to a tariff level to achieve vertical equity in the table and horizontal equity between Table 3 and other Tables.

8.17 An additional concern regarding the Table 3 descriptors pertains to the definition of 'substantial recovery'. It is unclear whether the point at which recovery is substantial is the same no matter what the severity of the disorder is at its worst or if it is proportionate to the severity of the disorder.

RECOMMENDATION 46: The term 'substantial recovery' as employed in Table 3 should be more clearly defined as recovery to the extent that the disorder no longer affects the claimant's function (i.e., does not meet the criteria for a GIP Band D as per Recommendation 38). **A substantial recovery should entail achievement of a fixed degree of recovery, and it should not be proportionate to the severity of the disorder.**

Evidence and Mental Disorders

8.18 Equally important is parity in how mental disorders are evaluated in the claim's calculation process in comparison with physical disorders. At this time, evidence suggests that the tariff descriptors pertaining to mental disorders are interpreted as reading 'has caused' alone and the 'or expected to cause' is often disregarded (see Table 3, Annex D). That is to say, MoD officials avoid making a final decision on a mental disorder claim where the time prescribed in the tariff descriptor has not passed.

8.19 For example, item 4 (Table 3, Annex D) prescribes that the disorder should cause or be expected to cause functional limitation at two years. Respondents working within the MoD as well as claimants and their representatives, made clear that it is common practice to request two years' worth of evidence to determine whether the disorder has indeed caused two years of functional

limitation, ignoring the provision that it is enough that it is 'expected to cause' functional limitation for two years. If the claimant is not able to gather two years' worth of evidence, for example, they are given an Interim Award, resulting in a disproportionate number of Interim Awards being awarded to recipients with a mental disorder.

8.20 As per Article 52(1), '[a]n interim award may be made where the Secretary of State is satisfied that a person is entitled to injury benefit but—

a) the prognosis for the injury in that particular case is uncertain; and
b) it is not possible to determine which descriptor is applicable to it.'

8.21 However, mental disorders are, as indicated by the MoD's approach to decision-making, considered generally harder to verify and the tariff descriptors are interpreted as requiring the indicated time to lapse before the disorder can be considered to have met the requirements of a descriptor. Invariably, therefore, for those with mental disorders persistent for a period longer than two years but less than five years, and who have applied to the AFCS prior to the two-year point, for example, their claim will automatically meet the requirements of Article 52(1) and an Interim Award will be made.

8.22 Moreover, for those whose conditions are persistent beyond the five-year point, the MoD will continue to wait for confirmation that the mental disorder will affect the recipient for a minimum 5 year period, making use of Articles 52(6) and 52(7) which make provision for extending an Interim Award for a further two years in cases where:

- 'the prognosis remains uncertain at the end of the initial 2 year period; and
- the Secretary of State considers the extension just and equitable having regard to all the circumstances of the case.'

8.23 This general underpinning assumption that mental disorders are less verifiable means that 44% of interim awards were made for claims pertaining to Table 3 mental disorders, between 1 April 2017 and 31 March 2022, with 98% of these being a tariff levels 10 to 13, by which it should be sufficient that the claimant is 'expected' to recover between two and five years after their diagnosis.

8.24 Most concerning, the common use of interim awards for mental disorders is more likely to be detrimental to recipients of a Table 3 award than others without a mental disorder diagnosis. In devising the AFCS, the MoD made early full and final awards a priority, mitigating against the recognised detrimental effects of uncertainty on ill-health and recovery. These effects are particularly pronounced and aggravating for those with mental disorders, yet it is those recipients who are likely to experience prolonged uncertainty—interim awards in mental disorder claims can take anywhere between a year and five years to finalise.

8.25 In some cases, this delay and the instability it causes the claimant, perversely results in the worsening of the recipient's condition and therefore the prolonging of the Interim Award period as their disorder deteriorates to meet the conditions of the next tariff descriptor up in the table. Charlie's case (Figure 5; Case Study II, Annex E), is one such example. In February 2022, Charlie wrote of their experience:

'the Armed Force Compensation Scheme process, caused me considerable anxiety, making my PTSD more challenging to manage and life at home more volatile… [It] alienates and degrades those with serious psychological wounds. It leaves us loathing life, fearing the future, feeling like we are a terrible burden on those we love, and believing that it would have been far easier if we had either died or lost our limbs.'

8.26 Another case is that of Sam (Figure 14): despite evidence submitted by their consultant psychiatrist regarding the gravity of their condition, the MoD made an interim award, demonstrating their reluctance to make an award for a Table 3 condition based on the consultants' expectations. This led to the significant deterioration of Sam's mental health, to the extent that they were at risk of suicide.

In November 2016, following their first experience of suicidal ideation, Sam was diagnosed with PTSD attributed to multiple instances of combat-related trauma. At the time Sam submitted their AFCS claim in 2018, they had been signed off work for over a year and had a discharge date set for March 2019; the Medical Board had determined that, due to their PTSD, there was 'no likelihood of a return to work within a military capacity'. Moreover, Sam described not being able to maintain relationships with friends and family as a result of trying to manage their symptoms, resulting in increasing isolation.

Based on the evidence, the MoD determined that it was fair to award Sam a Table 3 Tariff Level 12 Interim Award, to be reviewed within two years, whereby the PTSD 'has caused, or is expected to cause functional limitation or restriction at 2 years, from which the claimant has made, or is expected to make, a substantial recovery within 5 years.' (Table 3, Annex D) That is a lump sum only of £10,300.

In providing a statement regarding the financial impacts of the decision, Sam described that they are unable to support their children, including making child maintenance payments, nor make the necessary mortgage payments which may result in the sale of their home. Moreover, the process had aggravated their co-morbid depression, exacerbating the PTSD symptoms, as the lack of recognition of their condition made Sam feel worthless and ashamed of even applying to the AFCS. The MoD had signalled that, despite being unable to continue to serve or to undertake any paid work, Sam's condition was not bad enough to warrant meaningful compensation or a guaranteed income payment. At their worst moments, Sam felt this way too and that their life was not worth living.

Sam was told by their consultant that the AFCS process itself and the financial uncertainty it caused amounted to a form of secondary trauma, which had prompted further instances of suicidal ideation. In other words, Sam felt badly let down by the organisation that should have been there to support them at their most challenging time. By the end of 2018, much of Sam's energy was going into managing their symptoms, including those aggravated by the AFCS process, leaving little space for trying to build and maintain a healthy family and social life and they became increasingly isolated. Sam remained unable to undertake any form of paid work throughout this process.

Being of a higher rank than most AFCS claimants, thus having a network of senior contacts in the MoD and experience of dealing with its bureaucratic processes, Sam was able to raise his case with officials. His arguments were based on a comprehensive analysis of where the intent of the legislation and the policy were not being carried through in their implementation. Thus, in 2019, Sam's Interim Award was reviewed, and they received their final award of a Table 3 Tariff 6 award, whereby the PTSD was deemed a 'Permanent mental disorder, causing severe functional limitation or restriction'. This level of award attracted a Guaranteed

Income Payment and Armed Forces Independence Payment, both of which proved vital to Sam, who has been unable to undertake any form of paid work since.

Figure 14: Case Study III—Sam

RECOMMENDATION 47: Every measure possible should be taken, e.g., through training, to ensure that caseworkers and other decision-makers do not disadvantage claimants with mental disorders by placing a greater evidence burden on them than for those with physical disorders or than is required by legislation. Guidelines should make clear that:

- **Where the claimant has submitted a claim whilst their disorder is ongoing, caseworkers must make a decision based on the treating physicians' expectations of how long the disorder will persist as is clearly provided for by the tariff descriptors.** Guidance and information on the reasons for this request should be provided to treating physicians submitting evidence to explain why this information is needed as many are reluctant to provide it.
- **Interim awards are only to be made in exceptional circumstances as they negate one of the AFCS's primary objectives: to provide the recipient with financial certainty and enable them to move on. If the treating physician has made a determination of their expectations of the duration of the mental disorder, the evidence does not meet the requirements of Articles 52(1), 52(6) and 52(7) on making and extending Interim Awards.**

RECOMMENDATION 48: To support the objective of making a full and final award as early as possible, Article 52 should be amended to shorten the time for which Interim awards can be in place from 24 to 12 months, ensuring they are reviewed after 12 months and, in very rare cases after an extension of another 12 months, ensuring all Interim Awards are reviewed annually at worst.

8.27 Further aggravating the uncertainty of the circumstances of those subject to Interim Awards, they do not have recourse to appeal, removing their agency in the process and binding them to the ability and/or willingness of the MoD to review their case before the expiry of the Interim Award. This is inequitable and foments the perception that the MoD lack empathy in their decision-making.

RECOMMENDATION 49: Interim Awards should be subject to appeal. However, the right to appeal should be limited to the strength of the evidence that a final award cannot be made at that time and not to the tariff level the interim award is made on.

8.28 In addition, and of crucial importance to recipients of an Interim Award, although the date of review presented by the MoD in an Interim Award letter is not set in stone and therefore a review can be conducted before the review date, claimants are not informed of this. For example, in Charlie's case (Figure 5; Case Study II, Annex E), although their graduated return to work programme was due to conclude and they were discharged within eight months of their initial interim award, they were not informed of their right to request an early review. Had Charlie been informed, they could have requested a review much sooner, reducing the unnecessary period of uncertainty.

RECOMMENDTION 50: All Interim Award decision letters should notify recipients that:

- **The award review date indicates the date by which the Interim Award must be reviewed. However, if the recipient receives any significant new evidence relevant to their AFCS claim, they have the right to request an early review.**
- If Recommendation 49 is adopted, **recipients have the right to appeal the interim award decision on the basis that there is sufficient evidence to make a final award but not on the basis that they should be awarded an interim award at a different tariff level.**

8.29 Lastly, particularly indicative of the assumption that mental disorders are less verifiable, claimants with mental disorders must prove their disorder with a report from a specialist consultant. This requirement means that claimants with mental disorders overall face greater obstacles, and are therefore disadvantaged, in the claims process than those with other injuries, illnesses and disorders. Moreover, for those who have left service and are being treated by the NHS:

- waiting lists for referrals to consultants can be unreasonably long, prolonging the period of uncertainty for the claimant.
- Consultants, as non-treating physicians, are likely to provide briefer reports as they are unlikely to be familiar with the claimant's particulars.
- Those claimants with lesser means are further disadvantaged in comparison to those who are able to pay to obtain a report from a private consultant.

RECOMMENDATION 51: As is the case with all other claims, it should be a requirement that claims pertaining to Table 3- Mental disorders be substantiated by a report from the lead treating physician, regardless of whether it be a consultant or not. The strength of the evidence should be sought in the detail the treating physician is able to provide through their familiarity with the claimant.

8.30 The form this evidence can be presented in should be detailed in the requirements from the outset as per recommendations made in Chapter 6.

Horizontal and Vertical Equity

8.31 Each tariff Level 1 to 15 represents different degrees of severity of injury, illness, or disorder, hence the different amounts payable attached to each level. The commonality between each of the tariff descriptors from different tables allocated to a single level is thus the degree of severity. To achieve horizontal and vertical equity between the tables, ensuring recipients receive the same amount as those recipients with different but similarly severe injuries/illnesses/disorders, there must be consistency in how severity is determined and, in turn, a clear rationale underpinning the tariff level to which each descriptor is allocated.

8.32 There are currently no guidelines for how decisions are made on allocating descriptors to tariff levels. At this time, where there are new descriptors or descriptors are amended potentially affecting their tariff level, decisions are made by consensus between medical, policy and operational officials. These decisions are based on the different areas of expertise, memory of prior discussions and in the context of developments in medicine, technology and social attitudes.

8.33 This approach to decision-making does not necessarily result in inaccuracies, but it does not provide proof of how decisions are made and the rationale that led to the decision for those wishing to question a decision, resulting in a lack of transparency. For example, though there may be a clear and justifiable reason why permanent loss of function in one leg attracts a different tariff level to amputation of one leg, there is no audit trail for this decision or guidelines that the MoD can point to and provide the answer.

8.34 Additionally, the lack of written, explicit guidance on decision-making and definitions puts at risk:

- the consistency between current and future decisions made by those not privy to current and past discussions.
- Progress or determinations made on a variety of considerations that may be pertinent in future leading to, at the very least, duplication and inefficiency and, at worst, mistake.

8.35 Moreover, without a guide to understand the MoD's rationale, it has been difficult for the reviewer to fairly assess the horizontal and vertical equity of the tariff tables, especially in making recommendations pertaining to amendments to Table 3—Mental Disorders (Recommendation 45).

RECOMMENDATION 52: An exercise to produce guidelines and definitions for each Tariff Level should be carried out followed by an assessment of each tariff descriptor to ensure that each has been matched to the correct tariff level. These guidelines should be published, periodically reviewed, and provide the basis for any future decisions on allocating descriptors to tariff levels.

RECOMMENDATION 53: In light of the results of the exercise described in Recommendation 52**, a specific reconsideration of how the severity of Table 3 Mental Disorders descriptors is measured and determined should be carried out with a view to ensuring they are each allocated equitable Tariff Levels.**

9 Inequitable Limitations

9.1 The Armed Forces Compensation Scheme (AFCS) sets out a series of limitations on claimants and recipients which result in inconsistencies within the Scheme. In particular:

- Arbitrary time limits for submission of a claim.
- Inequitable ineligibility of claims based on certain types of injury.
- Refusal to reimburse medical expenses, even where these are inevitable due to evidence requirements.
- Arbitrary limitations on applications for review of award.

Time Limits

9.2 There are a variety of time limits for different elements of the application process. However, the basis for these time limits is often unsatisfactory and appears arbitrary if not counter to the objectives of the Scheme.

General Time Limits

9.3 Article 47(1) of The Order provides that 'the time specified for making a claim for injury benefit is 7 years beginning with whichever is the earlier of the following days—

i. the day on which the injury occurs;
ii. the day an injury which is not caused by service is made worse by service;
iii. the day on which the member's service ends;
iv. the day a member first seeks medical advice in relation to an illness.'

9.4 "The above time limits do not apply in cases where the illness (including mental health disorder) is medically considered a late-onset illness. In these cases, the time limit is three years from the date of diagnosis, whenever that diagnosis takes place. This provision applies to post-service claims only (i.e., it could be some decades after service has ended)." (Para. 5.7, p.34, JSP 765)

9.5 In JSP 765, the rationale given for these time limits is that it is:

"sufficient time for an individual to make a claim. If a relatively minor injury is sustained as a result of service, it might be that the individual wants to make the claim immediately and move on. However, if the injuries are of a more serious nature and continued medical treatment is required, they may wish to delay their claim until their injuries are more settled and they have established their rehabilitative process… Deferring claims until the ongoing disablement caused by an injury is clearer can, in many cases, be helpful by allowing awards to be made final with appeal rights; however, interim awards may be made". (Para. 5.5, p.34)

9.6 This rationale is focussed entirely on an assumption of the administrative burden of making a claim and providing sufficient time for claimants to gather the evidence to submit a claim. However, the administrative burden on an individual who is suffering an injury cannot be compared to that on a healthy, less vulnerable individual. Particularly in the cases of individuals with mental disorders, embarking on an administrative task of any kind can be daunting, causing them to delay completion of the task. This is not only relevant to those with discrete mental disorders, but also applies to those suffering with mental disorders as a consequence of other injuries, illnesses and disorders.

9.7 These time limits are therefore another manifestation of the MoD's pre-determined judgement of how long it should take someone to recover sufficiently from even the most significant traumas and be able to fulfil the task of applying to the AFCS. These expectations obviate the impact of their individual circumstances on their recovery.

Worsening of an Injury

9.8 Additionally, this seven-year time limit has perverse consequences on those who have valid worsening claims whereby:

"benefit is payable to or in respect of a former member of the forces by reason of an injury made worse by service if the injury—

a) was sustained before the member entered service and was recorded in the report of the medical examination when the member entered service,

b) was sustained before the member entered service but without the member's knowledge and the injury was not found at that examination, or

c) arose during service but was not caused by service,

and in each case service on or after 6th April 2005 was the predominant cause of the worsening of the injury." (Article 9(1), The Order)

9.9 However, as per Article 9(2) of The Order, worsening claims can only be made once the claimant has left service. Therefore, claimants are only eligible to be compensated for conditions worsened by service if they leave service within seven years of the diagnosis of the worsening of their condition. Consequently, those individuals who suffer the worsening of their injury as a result of service but chose to dedicate more of their career to the Armed Forces, exceeding the seven year time limit, are penalised.

9.10 Claims are only accepted for instances of Article 9(1)(a) and (b) worsening cases if the worsening happened between six months and five years after entering services (Article 9(3)(a), 9(3)(b) and (4)) and, in Article 9(1)(c) cases, if the worsening resulted in the claimant being downgraded within five years of sustaining the injury and remained downgraded until leaving service (Article 9(5)(a)).

9.11 The rationale offered in JSP 765 for invalidating claims made for worsening occurring within the first six months of service is that 'an individual who has an existing injury on joining service is given a reasonable period to assess whether service is compatible with that injury' (Para. 2.17, p.6) and for those occurring after five years of entering service or of sustaining the injury, that 'it is considered medically reasonable that if there is no further injury and clinically the injury does not worsen within five years of starting service, then any subsequent worsening cannot be predominantly considered to be caused by service.' (Para. 2.18, p.6)

9.12 However, the robustness of these arguments is questionable. On the matter of six months being determined as a reasonable period to assess compatibility, if the injury was not hidden from the MoD by the claimant, and both the MoD and the claimant knew of the injury or neither knew upon the offer of employment being made and accepted, was the claimant not at that moment

deemed compatible with service? This is particularly relevant as passing medical and fitness assessments are significant in being admitted to the Armed Forces, to the extent that they are tailored as much as necessary to the types of roles. Therefore, if the MoD has carried out its due diligence and affirmed that the claimant was considered fit and well to enter service, why is all the risk of the worsening of the injury placed on the claimant for the first six months of service? It is the opinion of the reviewer, that, in requiring an applicant to the armed forces to carry out a series of medical and fitness assessments, the measure of success in which is determined by the MoD, the offer of employment is tacit acceptance of any risks associated with the applicant's health.

9.13 Additionally, both the six-month lower limit and five-year upper limit for worsening of injury claims seem arbitrary; why would a claimant who suffered the worsening at five months and twenty days or five years and four days have any less valid a claim to an AFCS award than someone who suffered the worsening at six months and two days or four years and eleven months? Essentially, it is unclear why at six months the MoD accept responsibility as it is not medically unreasonable that an injury may be worsened by service after five years.

9.14 The only rationale can therefore be that it has been determined that there must be a limit for administrative purposes. However, although the MoD cannot of course be responsible for all injuries that are merely linked to service, the justifiable and equitable limits are in the attributability test as the time limits only reduce the number of possible claims rather than protect the MoD from taking on excess, inequitable responsibility. If worsening of an injury occurs seven years after the injury was sustained and there is medical evidence that it is service caused, the claim should not be invalidated by an arbitrary time limit. Equally, as is already the case, if a claim is made to the effect that an injury was worsened within two years but there is insufficient evidence of attributability, the MoD is within its rights to reject the claim.

Death attributable to service

9.15 An AFCS award can be made for a death attributable to service where:

a) 'the death was caused (wholly or partly) by service;
b) the cause of the death occurred on or after 6th April 2005; and
c) one of the conditions specified in paragraph (3) is satisfied.' (Article 10(1), The Order)

9.16 Article 10(3), as referred to in Article 10(1)(c), sets out the conditions as:

a) 'occurred in service;
b) occurred within the period of 7 years beginning with the day on which service ends and was caused by—
    i) an injury which was caused by service; or
    ii) the worsening by service of an injury which existed before or arose during service and which was not caused by service; or
c) occurred more than 7 years after the day on which service ends and—
    i) the death is caused by a late onset illness which was caused by service'

9.17 Similar to the other time limit provisions discussed in this Chapter, it is unclear why seven years is a legitimate point of time at which the eligibility criteria for making a claim for death caused by service tightens. Why would a claim that, at seven years and three months, an injury caused by

service caused the death of a veteran be less valid than the same claim made at six years and eleven months?

9.18 As per the above discussions on general and worsening of injury time limits, evidence of attributability should be the only limitation to the legitimacy of a claim as there is no equitable argument to be made that the passage of time reduces the responsibility of the MoD towards individuals suffering as a result of service. The imposition of time limits is a disproportionately defensive measure (see Chapter 2) considering the number of individuals who may have otherwise valid claims and could receive life-changing benefits under the Scheme were there no time limits in comparison to the resulting additional administrative burden to the MoD.[22]

RECOMMENDATION 54: All general time limits (Article 47) to submitting a claim as well as those associated with claims for worsening of an injury (Articles 9(3)(a), 9(3)(b), 9(4) and 9(5)(a)) and death attributable to service (Articles 10(3)(b) and 10(3)(c)(i)) should be removed and eligibility of a claim should be based solely on the strength of the evidence of attributability.

9.19 Abolishing time limits should not mean that individuals with tenuous claims for conditions that have arisen or been aggravated over time due to reasons unconnected to service will be able to legitimately claim under the AFCS. The attributability test and balance of probabilities elements of the AFCS are sufficiently stringent to ensure that any post-service intervening factors (e.g., accidents or conditions caused by aging) are taken into consideration in the processing of claims.

Injury Type

9.20 Although the tariff tables (Annex D), make clear which injuries, illnesses and disorders a claim can be submitted for, and there is an attributability test to ensure the incident is predominantly caused by service, there are further exclusions in the legislation which limit the eligibility of claims in accordance with how the injury, illness or disorder occurred and when it was recognised.

Death attributable to service

9.21 Article 10(3)(c)(ii) of The Order states that a claim can be made for death attributable to Service after the seven year time limit where 'the predominant cause of the death is an injury for which an award of injury benefit has been made which gave rise to an entitlement within tariff levels 1 to 9 (inclusive)'. However, aside from the administrative argument outlined above, it is unclear why receipt of a tariff level 1 to 9 award is one of the only two validating criteria[23] for receipt of an award after the seven year time limit.

9.22 If a veteran had not made a claim for the original injury due to unawareness or ill-health, for example, but the evidence supported the claim that they suffered an attributable tariff 1 to 9 injury for which an award would have been made, their dependents should still be able to submit a claim to the MoD to be assessed on its merits.

[22] As described in Chapter 1, there were only 570,000 individuals as at December 2022 eligible to apply for the AFCS by virtue of their currently being in service or having served in the Armed Forces.
[23] Article 10(3)(c)(i) validates late onset illness as a result of service.

RECOMMENDATION 55: Article 10(3)(c)(ii) should be expired to enable dependents of those not in receipt of a tariff level 1 to 9 award to submit an application for assessment under the AFCS.

Slips, Trips and Falls

9.23 Articles 11(4) and (5) of The Order provide that 'benefit is not payable to or in respect of a person by reason of an injury sustained by a member, the worsening of an injury, or death which is caused (wholly or partly) by that member slipping, tripping or falling' unless it occurs whilst the claimant is:

- participating, in the pursuance of a service obligation, in a hazardous activity.
- carrying out activity, in the pursuance of a service obligation, in a hazardous environment.
- training to improve or maintain the effectiveness of the forces.
- targeted in an act of terrorism as a result of their being a member of the armed forces.
- Travelling to or from an emergency called out to in pursuance of a service obligation.

9.24 If read carefully, the exceptions to Articles 11(4) and (5) essentially mean that claims arising from slips, trip or falls occurring, for example, on a flight of stairs whilst carrying out clerical duties, will not be accepted. However, there are many terms in this Article which are left undefined:

- Emergency: does this include in the course of civil contingencies work, for example, a fall down a flight of stairs whilst covering for Border Force during a strike?
- Hazardous activity and hazardous environment: if there is an accidental fire resulting from a gas explosion in a clerical building is that a hazardous environment in the pursuance of service even if not deliberate?
- Slip, trip, and fall: If someone close to the explosion falls down the stairs as a result of the explosion did they fall or were they propelled by it?

9.25 Overall, Articles 11(4) and (5) significantly complicate the eligibility criteria for claims as the terms contained within it are so open to interpretation, making it difficult for claimants to dispute the rejection of claims on the basis of these Article 11 provisions. Furthermore, fundamentally, Articles 11(4) and (5) are superfluous as the attributability test and tariff tables already dictate the parameters of a valid claim. That is to say, if the injury sustained can be proved to predominantly be caused by service and it meets the criteria of Tariff Level 15 at a minimum (even if a descriptor does not exist as a temporary award can be made), the claimant should be eligible for an award.

RECOMMENDATION 56: Articles 11(4) and (5) should be expired and the criteria for eligible injuries, illnesses and disorders limited to attributability and whether the injury meets a Tariff Level irrelevant of whether the injury was caused by a slip, trip or fall.

Excluded Conditions

9.26 Article 12(1)(f) states that '[b]enefit is not payable to or in respect of a person by reason of an injury sustained by a member, the worsening of an injury, or death which is caused (wholly or predominantly) by… an illness which is—

i. caused by a single gene defect or is predominantly hereditary in origin; [or]
ii. a personality disorder'.

9.27 However, this provision disadvantages those with no prior knowledge of a hereditary tendency or personality disorder, whose conditions are triggered by service and therefore may not have suffered as a consequence of these pre-existing conditions, from claiming benefits under the AFCS. In doing so, it places the burden of the consequences of service on the potential claimant even where they had no prior knowledge of the pre-existing condition. This approach absolves the MoD of responsibility for individuals who have been medically approved for service and who have accepted the terms of service in good faith.

RECOMMENDATION 57: Therefore, **Articles 12(1)(f)(i) and (ii) should be expired to ensure that pre-existing conditions and personality disorders are not considered prejudicing factors in claims where, on the balance of probabilities, it is likely that the claimant would not have suffered the injury, illness or disorder, or the worsening of their condition, had it not been for service.**

Financial Assistance

9.28 Article 15(1)(e) of The Order provides that '[b]enefits payable for injury are… medical expenses'. Article 47(5) goes on to limit the scope of this provision in stating that '[a] claim for medical expenses must be made prior to the expenses being incurred except in circumstances where the Secretary of State is satisfied that prior approval was not reasonably practicable due to a medical emergency'. In practice, and as per JSP 765, medical expenses are only approved for reimbursement where the claimant lives abroad, and their residential status and history meet certain criteria.

9.29 Although there are no explicit required expenses, the evidence requirements place a *de facto* financial burden on claimants and therefore disadvantages those with lesser financial means. This is particularly egregious as it is precisely these individuals whom this Scheme is designed for.

9.30 The MoD requires a certain amount of medical evidence to even consider an application. Although many applicants will have service medical records which are easily accessible by the MoD's, there are many others who have at least some aspects of their injury, illness or condition that manifested post-service and who have been or are being treated under the NHS and for which they are financially unable to seek treatment privately.

9.31 Considering the well-known and increasing pressures on the NHS at this time, resulting in individuals waiting for non-emergency treatment for months, if not years, claimants who are no longer under the care of Defence Medical Services (DMS) or whose injuries are not so extensive that they do not fall under an NHS priority scheme for injured veterans, are disadvantaged in their ability to produce the correct evidence within a reasonable time frame. Some of this can be addressed through recommendations made in Chapter 6, but more should be done to assist financially where paying for private treatment or consultations would ensure those with lesser financial means are not disadvantaged.

9.32 This is particularly important as regards mental disorder claims as NHS mental health services are significantly over-burdened, leading to delays in any sort of treatment and therefore the exacerbation of the disorder. Yet, the current evidence requirements for such a claim require the claimant to submit evidence from a consultant grade physician specifically, despite it being very difficult to access these individuals let alone be treated consistently by one. This means that some

claimants may be left with no income for many years whilst they await access to treatment, undergo the treatment, request a report from a consultant and, only then, go through the claims process.

9.33 Some of this can be addressed by changing the evidence requirements so that it is the treating physician that is required to submit the evidence (as per Recommendation 51) and are supported in doing so (Recommendation 31). Additionally, however, claimants should be supported financially where the only option for seeking treatment within a reasonable timeframe is privately and, more broadly, where administrative costs are required to even gather the evidence (e.g., some GP surgeries require a payment for a supporting letter to be written for a patient).

RECOMMENDATION 58: To ensure those with lesser financial means are not disadvantaged by AFCS evidence requirements, the MoD should ensure that:

- **Any administrative costs necessarily incurred by the claimant in the evidence gathering process (e.g., paying GP surgeries for letters) be reimbursed automatically, including where a report from a non-treating physician is required (e.g., a consultant grade for Mental Disorder claims).** This is in recognition that the treatment they will be receiving is likely the only one they will have been offered by the NHS. This should not apply to claimants who have opted at the outset to be treated privately.
- **Efforts are made to liaise with the health sector under the Armed Forces Covenant to ensure that claimants requesting support with AFCS applications do not incur charges.**

9.34 Particularly with regards to claimants with mental disorders, reducing the administrative burden on the claimant can assist in ensuring the claims process does not aggravate the claimant's condition.

9.35 There remains the concern that applicants might resort to private healthcare unnecessarily at the outset, incurring expenses the MoD would be obligated to reimburse under Recommendation 58. However, a separate pre-approval process, based on evidence of unreasonable timeframes for access to NHS care, can be put in place to ensure that these applicants receive confirmation that they will be reimbursed for private healthcare in the period up until they are able to access NHS care.

RECOMMENDATION 59: A pre-approval process for accessing private healthcare (beyond the request of a consultant grade report as per requirements) should be implemented, for those able to prove that timeframes for accessing NHS care are unreasonable. The pre-approval process should include the requirement of evidence that NHS treatment has been sought (e.g., appointment letters which indicate that a consultation has been booked for a year later, for example, or confirmation that the patient is on a waiting list)**.**

9.36 Private medical expenses should only be approved for reimbursement up until the time at which the patient is able to access treatment under the NHS. Where claimants have opted to be treated privately despite the availability of NHS treatment, they need not be reimbursed.

Review

9.37 As per The Order, recipients of an AFCS award have a right to a review of their award. Between 1 April 2017 and 31 March 2022, 2,345 reviews of injury, illness, and disorder claims were registered, of which:

- *510 (22%) were on service termination*. Article 55 of The Order provides that, where an award has been made whilst the recipient remained in service and the injury, illness or disorder has worsened or caused another condition by the time the recipient leaves service, a review can be requested provided that the severity of the injury, illness or disorder meets a higher tariff level at that time.
- *885 (38%) met the criteria for an exceptional circumstances review within ten years of the award decision.* Article 56 of The Order provides that, where a condition has unexpectedly and exceptionally worsened or caused a further injury to develop and the recipients condition meets a higher tariff level, an exceptional review can be requested up to ten years after the initial decision was issued.
- *60 (2%) met the criteria for a final review any time after ten years of the award decision being made.* Article 57 of The Order provides that, where the Secretary of State for Defence 'considers that it would be manifestly unjust to maintain the effect of the decision' and more than ten years has passed since the award decision was issued, an award can be revised where a condition has unexpectedly and exceptionally worsened or caused a further injury to develop and the recipients condition meets a higher tariff level.
- *895 (38%) were based on the Ignorance or Mistake provision.* Article 59 of The Order provides that a review may be requested where the MoD makes a decision based on ignorance of evidence knowable at the time of the decision or a mistaken interpretation of the evidence.

9.38 In this section of the report only the right to a review under Articles 55, 56 and 57 is discussed (constituting 62% of the reviews registered between 1 April 2017 and 31 March 2022), as a differentiation is made between these and the right to a review under Article 59 of The Order. The first three types of review occur only where the initial decision on the claim under review was accepted. The latter, on the other hand, is only requested where the MoD's decision on the claim is not accepted by the claimant and is therefore akin to a request for reconsideration or appeal. The right to request a review under Article 59 is discussed in Chapters 4 and 10.

9.39 The right to review is significantly limited and complex, as there are very specific circumstances in which a recipient can request a review. Additionally, the criteria for eligibility changes depending on how long it has been since the initial decision was issued by the MoD:

- Each of these reviews must be applied for within one year of service termination or of a diagnosis of worsening of the recipient's condition or of a further injury, illness or disorder caused by that for which the original award was made.
- The Order provides that recipients are only entitled to one of each of these reviews, regardless of whether the outcome was in their favour.

9.40 The primary concern with this system of reviews is that it is complex, the reasons for which are not entirely clear, effective or just. Firstly, JSP 765 justifies the time limits for application as:

- In the case of service termination reviews, '[b]y the date of service termination, the majority of injured personnel will have reached the point at which their condition has been treated and stabilised or at least prognosis and future recovery path will be clear'. (Para. 8.13, p.43)
- In the case of exceptional reviews, 'this is enough time to contact DBS to let them know that the award should be looked at again'. (Para. 8.16, p.43)
- In the case of the ten-year time limit for exceptional reviews, it 'allows a reasonable period of time for any departure from the expected course of recovery to become evident' (Para. 8.15, p.43)
- In the case of final reviews, no justification is given for the one-year time limit.

9.41 The above justifications are based on simple assumptions regarding recovery and stabilisation timeframes. However, there may be instances where, due to NHS waiting times, for example, confirming a diagnosis, accessing treatment or making the link between the new injury, illness or disorder and the original takes longer than a year, the recipient initially receives a misdiagnosis or where, due to deteriorating mental health, the recipient is unable to submit a claim. These individuals should not be penalised for factors that are out of their control.

9.42 Limiting the number of reviews a recipient can apply for under each article to once has a clear and legitimate benefit to the MoD in reducing the administrative burden as there will likely be a proportion of review applications that are based on insufficient evidence. However, this system is disproportionately detrimental to younger recipients. For example, a recipient who was awarded a 50% GIP at 23 only has one chance to request a review due to deterioration from the age of 33 until their death, regardless of the belated effects of their injury.

9.43 This approach, progressively limiting the right to review over time, is a defensive one—i.e., protecting the MoD from taking on an administrative burden based on an informed assumption of expected recovery. However, it also precludes those who do not conform to the implicit assumptions in their recovery or through-life management from being provided for.

RECOMMENDATION 60: The review system should be simplified. Articles 55, 56 and 57 of The Order should be replaced by a single Article providing for an application to review at any time after the initial decision is issued or diagnosis of worsening or secondary condition(s) based on evidence that the injury has significantly deteriorated, or a secondary injury is predominantly attributable to the initial injury for which an award was made.

9.44 The reviewer recognises, however, that an unlimited right to review may result in the submission of requests for review 'just in case', disproportionately adding to the MoD's administrative burden.

RECOMMENDATION 61: The right to review should be limited to once every five years for each claim irrespective of the outcome rather than, in effect, three through-life. Claimants should, however, be able to request the first review as of twelve months after the initial decision (i.e., the claimant does not have to wait five years after the decision to request a review)**.**

9.45 This will ensure that younger recipients are not disproportionately disadvantaged whilst dissuading requests for review on tenuous evidence. It also enables those whose conditions are complex and have not stabilised at the time of the initial claim to request a review once they are advised their condition has stabilised whilst ensuring that they are receiving some form of income in the meantime.

9.46 It is imperative that, particularly those in receipt of a GIP, be made aware, and reminded, of their right to request a review.

RECOMMENDATION 62: Article 51(1)(c) should be amended to place an obligation on the Secretary of State to inform the claimant of their right to review in addition to their right to reconsideration and appeal. All communications should make the differentiation between each of these processes clear.

9.47 Additionally, at this time, there is no specific provision that enables the Secretary of State for Defence to review a decision where the claimant has been found to be in receipt of an AFCS award based on fraudulent evidence.

RECOMMENDATION 63: Article 59(2) of The Order should be amended to confer the right upon the Secretary of State to review an award where evidence of fraud has been found.

10 Burden of Proof

10.1 In accordance with Article 60 of The Order, 'the burden of proving any issue is on the claimant'. However, there are a number of elements of the Armed Forces Compensation Scheme (AFCS) that obfuscate this very clear assertion.

10.2 JSP 765 states that '[w]hile the responsibility to show that the injury is caused by service rests with the individual, the process itself is designed not to be onerous. The process of determining a claim is inquisitorial and not adversarial, with DBS undertaking the majority of evidence gathering on the individual's behalf (Para. 2.2, p.3), and '[i]n making a decision on a claim, the decision-maker will ensure that any subsequent scrutiny of the decision will clearly show that all available and relevant evidence was obtained and considered at the time of the initial claim.' (Para. 8.4, p.41)

10.3 Additionally, Article 59 of The Order provides that 'any decision of the Secretary of State may be reviewed at any time (including on the application of the claimant) if the Secretary of State is satisfied that the decision was given in ignorance of, or was based on, a mistake as to a material fact or of a mistake as to the law',

a) 'if the material fact was knowable at the time the decision was made and was disclosed to the Secretary of State at that time;
b) if the ignorance or mistake was the ignorance or mistake of the Secretary of State;
c) where the ignorance or mistake relates to the diagnosis of an injury, where the correct diagnosis was knowable given the state of medical knowledge existing at the time the diagnosis was made.'

10.4 Thus, although The Order states the burden of proof for any issue is on the claimant, JSP 765 and Article 59 place the burden of collecting the evidence of the injury and it's attributability on the MoD and Article 59 provides the claimant with recourse to challenge the MoD where it has failed to collect the available evidence, resulting in an erroneous decision. This was reinforced in the conclusions of the Lord Boyce Review, 2010, wherein it was determined that the work of collecting evidence to substantiate a claim *should* fall to the MoD and not the claimant who is suffering from an injury, illness, or disorder.

10.5 Although it can be argued that the legislation and policy explainer are not in conflict, it is a complex and nuanced differentiation to make for a lay person, between the burden of proving attributability and an administrative burden to collect the evidence.

10.6 From the claimant's perspective, aside from providing a narrative of their injuries and treatments with any evidence they might have to hand on application, JSP 765 provides the impression that the claimant need not participate in the claims process at all. This is reinforced by the fact that claimants are not even provided with a list of evidentiary requirements to ensure their claim submission is considered complete (see Chapter 4). For example, JSP 765 states that '[i]t is not helpful if evidence should come to light at a later stage that could have been considered at the outset and may have had an impact on the original award, so the Scheme is designed to minimise the likelihood of this happening' (Para. 8.2, p.41)— presumably through the MoD's inquisitorial practices as there are no further instructions for claimants.

10.7 Nevertheless, 38% (895) of reviews registered between 1 April 2017 and 31 March 2022 were Article 59 Ignorance or Mistake reviews, indicating that MoD officials do not consider their obligation to gather comprehensive evidence to substantiate a claim to be greater than the burden of proof on the claimant (Article 60, The Order). Anecdotally, the reviewer also heard from a multiplicity of respondents that, where solicitors are retained by appellants, Article 59 is commonly employed by legal professionals to succeed. The MoD, however, does not hold statistics on the basis for successful appeals thus the reviewer was unable to substantiate this.

10.8 Nevertheless, there are no penalties for the MoD for failing to fulfil these obligations. In contrast, where the claimant is considered to have failed in their obligation to provide proof, and, more so, within a specific time period, they are penalised. Article 63 of The Order states that a claim file be closed and treated as never initiated 'where a claim has been made, and the claimant "C" has been requested in writing—

a) to provide further information which is reasonably required for the determination of the claim and—
    i) that information is not given or sent to the Secretary of State within 3 months of the date on which the request is sent; and
    ii) C does not provide a satisfactory explanation for that failure; or
b) to attend a medical examination—
    i) at a time and place specified in a notice given or sent to C, not less than 10 days before the date of the examination; and
    ii) C fails to attend without providing, within 3 months of the date of the examination to which the request related, a satisfactory explanation for that failure.'

10.9 The cases of Nicky, Charlie, and Sam (Case Studies, Annex E) all illustrate the disproportionately detrimental impact the MoD's failure to collect the necessary evidence can have, particularly on the most vulnerable, as it unnecessarily prolongs the claims process and thus period of instability for claimants.

10.10 The MoD's evasion of its responsibilities, as stated in JSP 765, is only possible because the legislation does not make provisions for mechanisms for penalising the Department for its failure to collect the necessary available material to make a well-evidenced decision on individual claims.

RECOMMENDATION 64: Article 60 should be amended to reflect the recommendations in The Boyce Review and obligations the MoD purports to take on in JSP 765, including that:

- **The burden on the claimant is to provide evidence when requested by the MoD and be available to assist the MoD in efforts to collect evidence to substantiate the claimants claim.**
- **The burden of collecting all knowable evidence to substantiate a claim is on the Secretary of State, although it remains the obligation of the claimant to assist the MoD when requested.**

10.11 Placing a legislative obligation on the Department should provide a greater incentive to ensure initial decisions are made based on all the evidence knowable at the time of the decision and reduce the number of successful Article 59 reviews. Significantly, this should also reduce the number of claimants adversely affected by the prolonged instability cause by protracted claims processes.

10.12 Recommendations 9, 14 and 15 on maintaining communications with claimants provide practical solutions for ensuring the fulfilment of the obligation described in Recommendation 64.

10.13 Moreover, despite the possibility that the claimant is undergoing treatment, in transition or simply finding it difficult to carry out administrative tasks, the application of Article 63 for failing to provide further information within three months, means that potentially vulnerable claimants have to restart the process once more. This is particularly inequitable as the MoD provide no assurances on how long a claim may take to process, expecting claimants to wait for as long as is necessary, yet place a legislative obligation on claimants to respond within three months when they are contacted.

RECOMMENDATION 65: A file should not be closed without reasonable efforts being made by the MoD to contact the claimant. A warning must first be issued in writing that a file will be closed, stating the reasons why, and providing a further three months for the claimant to contest the closure of the file.

11 Lump-Sum Uprating

11.1 Article 72 of The Order provides that '[t]he annual amount of guaranteed income payment, survivor's guaranteed income payment or child's payment is to increase as if these payments were pensions eligible to be increased under the Pensions (Increase) Act 1971'. However, the lump sum amounts in Table 10 of Schedule 3 of The Order (Annex D), which allocate an amount payable to each tariff level, have not been uprated since 2018. This last uprating resulted from specific recommendations made in the Armed Forces Compensation Scheme (AFCS) Quinquennial Review (QQR) 16/17.

11.2 Despite the AFCS QQR 16/17 recommending that the lump sum awards be up rated annually in accordance with the Consumer Price Index (CPI), the MoD, in the one-year on report, stated that it would not adopt this recommendation. Nevertheless, the Department reported that the lump sums would be uprated periodically, in alignment with AFCS policy. Yet, as at April 2023, there is no process for the periodic uprating of lump sum awards nor has the MoD undergone an ad hoc uprating process.

11.3 It remains the case that lump sum awards should offer a real term benefit to recipients and thus should reflect the cost-of-living at the time at which they are awarded. In Canada, for example, payments are adjusted every January 1st in accordance with the percentage increase to the CPI to ensure monthly payments reflect the cost-of-living. (www.veterans.gc.ca)

RECOMMENDATION 66: A process for uprating lump sum awards to take into account inflation and other cost-of-living factors every five years should be put in place to ensure that the lump sum amounts offer the intended appropriate benefit to recipients in real terms. This process should not be contingent on the QQR process but rather be an automatic process triggered independently of the QQR.

11.4 This will ensure that lump sums are up rated, regardless of delays in completing and publishing the QQR, although, if deemed necessary by a reviewer, a review of the lump sum awards should still be within scope of the QQR.

12 Spanning

12.1 Spanning is a particular issue which affects those who served (whether as a Regular or Reservist) both before the Armed Forces Compensation Scheme (AFCS) came into effect on 6 April 2005 and after, as the AFCS is only applicable to injuries, illnesses and disorders suffered after 6 April 2005. During the period 1 April 2017 to 31 March 2022, 951 spanning cases were registered.

12.2 In spanning cases, it is not immediately clear whether the injury, illness, or disorder is attributable to Service prior to the date the AFCS came into force or after, as the injury, illness, or disorder has developed and/or deteriorated over time. This is most common with conditions such as hearing loss, musculoskeletal disorders, and mental disorders. In these cases, it is difficult to determine a point in time of the origin of the injury, illness, or disorder.

12.3 Therefore, it is not clear whether the injury, illness or disorder should be compensated under the rules of the War Pensions Scheme (WPS) or AFCS. Yet, to abide by the convention of preventing double compensation for the same injury, the MoD must determine which Scheme the claim falls under at the time of receipt.

12.4 Claimant and claimant representative respondents felt that there was not always a clear rationale to why the MoD had opted to process the claim under, for example, the AFCS and not the WPS, leading them to believe that the predominant and deciding factor is the generosity of the Scheme (i.e. that the MoD are likely to choose to process a claim under the Scheme which enables them to pay out the least in compensation). However, officials who participated in this review confirmed that the parameters for deciding on these cases are not clear and are decided on a case-by-case basis, but it is not the case that the deciding factor is how much each scheme would award the claimant.

12.5 It is inescapable that spanning cases are, and will remain, difficult to decide on due, firstly, to the sometimes-conflicting rules of the WPS and AFCS and, secondly, to the medical complexity of these cases . Nevertheless, efforts need to be made to tackle the perception that saving money in spanning cases is a motivating factor. This requires that the parameters on deciding on spanning cases be clear for caseworkers and claimants and that there be consistency in how spanning cases are decided on.

RECOMMENDATION 67: A guide to decision-making in spanning cases should be produced and published, to guide caseworkers and inform claimants. To do so, an audit of how decisions have been made in spanning cases to date should be conducted, with a focus on the rationale and results.

13 CONCLUDING REMARKS

13.1 This report contains recommendations addressing issues ranging from the intangible notion of cultural change (Recommendations 1 and 2) to the very specific issues such as work plans and guidelines (Recommendations 14, 15, 17 and 24). This is because fundamental and significant change does not result from addressing only one aspect of a process. For example, changing how much agency a caseworker is willing to give a claimant during the claims process is dependent on how they have been trained to interact with claimants, how much the discourse in their workplace legitimises (or not) the claimants own narrative and knowledge and, quite frankly, how much time they can afford to give a claimant if they are going to meet their performance objectives and get that promotion. Thus, we cannot simply say 'listen to claimants,' we have to make adjustments at every stage, sometimes only micro adjustments, to create an environment which supports these objectives.

13.2 However, not everything is within the Ministry of Defence's (MoD) gift. For example, the MoD cannot declare that the National Health Service (NHS) must demand of its staff that they set aside time to liaise with claimants to work on AFCS claims within a certain timeframe. This is within the remit of the Department of Health and Social Care and the NHS, and the MoD can only make attempts to influence policy in this area.

13.3 On the other hand, there are many changes that the MoD can make, and it is these that this report focuses on. However, making positive changes to improve the AFCS is the responsibility of the department as a whole, not individual functions. If there is no oversight from the centre of the department, then where does the responsibility lie for ensuring that, for example, MoD central communications are putting out up to date and suitable comms regarding the work of the AFCS delivery function? Each function has their own sphere of responsibility and cannot extend to oversee the work of other functions. That is the purpose of the centre; to coordinate across the department.

13.4 Looking back to Chapter 1 of this report, the reviewer identified that the objectives of the Scheme were not being met because there is:

- **A perceived lack of empathy** on the part of the MoD in making decisions.
- **Inefficiency** with regard to the effective but fair use of resources.
- **Inconsistency (therefore, unfairness)** within the Scheme.
- **A lack of effort to ensure and safeguard transparency and independence** in both the policy and decision-making processes.
- **A lack of resilience** as the Scheme is insufficiently flexible in its ability to incorporate developments.

13.5 These concerns, individually and in sum, are having a detrimental effect on some of the most vulnerable claimants to the Scheme. Thus, the reviewer has sought to make recommendations focussing on four key objectives, and it is the recommendations that work most explicitly towards these that are likely to have the most beneficial effects on the Scheme.

KEY OBJECTIVE 1: FAIRNESS

13.6 The vast majority of the recommendations in this report are focussed on a single, crucial objective: ensuring the overall fairness of the policies and operational processes associated with the Scheme. As discussed in Chapter 2, as the MoD are the administrators of the Scheme, where there are imbalances and biases, these tend to favour the MoD and work against the claimant, especially those who are most vulnerable. The result is most egregious in the case of claimants suffering from Mental Disorders and whose conditions are aggravated by unfairness in particular aspects of the Scheme, such as in the assessment of mental disorder claims (Chapter 7), in the limitations placed on claimants (Chapter 9) and a lack of clarity in the burden of proof provisions (Chapter 10).

13.7 The knock-on effect of a fairer scheme is a more empathetic one as an emphasis on fairness requires recognition of the adverse impacts of policies and processes that are beneficial only to the MoD. For this reason, empathy as an objective is primarily wrapped up in Key Objective 1: Fairness.

13.8 Guaranteed Income Payments (Recommendations 37, 38 and 39). As discussed in Chapter 7, the current conceptualisation and method of calculation of GIP's is too narrow and inflexible to account for the inevitable differences in how an injury or injuries might affect an individual's function. Simply put, factors such as pre-existing conditions (which may be attributable to service), professional qualifications, family circumstances and developments in medicine, technology and social attitudes (e.g., legitimisation of workplace adjustments), cannot be taken into account in a fixed set of tariff descriptors. Thus, Recommendations 37 and 38 on a standalone method for calculating GIP's by assessing the psychological, family, social and occupational impact on the claimant, are essential to enabling the MoD to ensure decisions on individual cases reflect the lived circumstances of the claimant and meet the objectives of the GIP as a policy and tool.

13.9 Additionally, the calculation of GIP's can be disadvantageous for younger claimants and therefore, as per Recommendation 39, restructuring the administration of payments so it reflects the income over a lifetime of individuals of a similar age who have not been injured would not require MoD to increase amounts payable but would provide younger recipients of a GIP the opportunity for financial stability later in life.

13.10 Defining 'Functional Limitation' (Recommendations 41, 42, 43 and 44). As discussed in Chapter 8, there is a disparity in how disorders and injuries are treated under the AFCS, especially with regards to Mental Disorders. To support decision-makers to treat all injuries, illness and disorders equally, the report makes a recommendation that the definition of 'functional limitation' should not be different for the purposes of assessing mental and physical disorders but should rather consistently be that described in Article 5(3) of The Order (Recommendation 41).

13.11 Recommendations 42 is designed to enable decision-makers to make an assessment based on the impact of the injury(ies) on the claimants psychological, family, social and occupational life, in recognition that the first three of these are likely to have an impact on their occupational life over a longer period of time and, therefore, on the claimants capacity to earn in the future. Recommendations 43 and 44 on removing the requirement of 'permanence' from the relevant descriptors in favour of 'persistence' where necessary, and how to apply the criteria, enable a fairer and more flexible conceptualisation of the ways in which the impacts of an injury(ies) can fluctuate

over time but be no less limiting on the claimants function than an injury with a consistent impact (e.g., amputation of a limb).

13.12 Mental Disorder Descriptors (Recommendations 45, 46 and 53). It is clear from a cursory reading of Tariff Table 3—Mental Disorders (Annex D) that it was drafted at a time in which Mental Disorders were not well understood nor considered an injury in the same way as physical injuries, illnesses and disorders (Chapter 8). However, understanding and recognition of the impacts of mental disorders has progressed since, and the varying degrees and ways in which mental disorders can impact a claimant must be recognised by the Table 3—Mental Disorders tariff descriptors. Thus Recommendations 45, 46 and 53 are designed to enhance Table 3 by (i) adding descriptors for mental disorders with less severe impacts in particular; (ii) redefining one of the most problematic terms within the descriptors to provide a guide to what it means to have 'substantially recovered' from a mental disorder for the purposes of the Scheme; and, (iii) ensuring that each descriptor is allocated to an appropriate tariff level in accordance with a modern understanding of the severity of mental disorders.

13.13 Interim Awards and Evidence Requirements in Mental Disorder Claims (Recommendations 47, 48, 49, 50 and 51). In the course of conducting this review, one of the issues that appeared to cause disproportionately disadvantageous outcomes for recipients, was the use of Interim Awards, particularly for those claiming for PTSD. The two main reasons were that:

- Interim Awards are being made where there appears to be enough evidence to make a final award because the evidence burden in Mental Disorder cases is greater in practice than for other injuries, illnesses and disorders. Specifically, this is because evidence of the 'expected' impacts are not being taken into account, causing prolonged uncertainty for the most vulnerable (i.e., those with mental disorders with impacts lasting beyond two year); and,
- the interim award review date tends to be set at the latest possible moment (i.e., two years) despite the fact that there are often indicators in the initial claim submission that, in the intervening period, there will likely be developments to evidence a final award before the review date. Combined with a failure to inform recipients of their right to request an early review, this practice also unnecessarily prolongs the period of uncertainty.

13.14 Thus, Recommendations 47, 48, 49 and 50 — aimed at reducing the instances in which Interim Awards can be made, lowering the maximum review period to twelve months, opening Interim Awards to appeal and requiring recipients to be made aware that they can request a review at any time before the review date—implemented together, should encourage decision-makers to treat mental disorder claims in a manner comparable to physical injuries, illnesses and disorders and provide those in receipt of an interim award with reassurance that they will not be kept in a state of uncertainty for longer than necessary.

13.15 Recommendation 51 is designed to provide reassurance to claimants that medical evidence from individuals familiar with their case is treated with primacy by the MoD when considering the nature of their condition. This is imperative to ensuring that the true extent of the claimant's injury is considered and is not reinterpreted in the decision-making process, making it harder for claimants to hold the MoD to account for its decisions.

13.16 Clarifying Obligations (Recommendations 9, 14, 15 and 64). A consistent concern raised by respondents external to the MoD is that it is exceedingly difficult to hold the MoD to account for failures to fulfil their purported obligations. The MoD, however, is able to penalise claimants for, for example, not responding to communications quickly enough or not providing all the necessary evidence by closing a claim, delaying a decision or making an interim award.

13.17 To rebalance and address these concerns, Recommendations 9, 14 and 15 provide mechanisms ensuring that decisions are made collaboratively, providing claimants with agency in their own claims process. Moreover, Recommendation 64 is designed to clarify the obligations of both the MoD and claimants under the burden of proof provisions to enable each party to hold the other to account for failing to fulfil them.

KEY OBJECTIVE 2: SIMPLICITY

13.18 Simplicity should be a key objective in the design and administration of any service or scheme as it is central to transparency and, therefore, essential for accountability. Many of the recommendations in this report are thus aimed simply at ensuring all aspects of the Scheme support the two key actors—the claimant/recipient and the caseworker—and focus on the key elements for deciding on a claim—the injury, illness or disorder and attributability.

13.19 Simplification by focussing on the two key elements of a claim (i.e., the injury, illness or disorders and attributability) to enable accountability can be achieved by removing needless limitations to eligibility and the right to request a review of an award. Recommendations pertaining to supporting the key actors fall under Key Objective 3: Empowerment.

13.20 Limitations on Eligibility (Recommendations 54, 55, 56 and 57). As described in Chapter 9, there are a myriad of time limits and prejudicing factors which adversely affect claimants who may otherwise have an injury sufficiently severe and predominantly attributable to service on the balance of probability. The reviewer found no reason beyond reducing the administrative burden for this. Nevertheless, considering that the potential AFCS claimant population is not particularly large and those affected by these limits even smaller, the increased administrative burden created by removing these limits is likely to be minimal in the long term.

13.21 However, for individuals who have a legitimate claim but fall foul of these time limits, the impact can be devastating. It can mean the difference between someone with CPTSD spiralling because they missed the time limit after having struggled to come to terms with accepting treatment for their condition, for example, and being provided with the financial certainty to be able to focus on their treatment.

13.22 In short, the benefits of the complex system of limitations to eligibility do not outweigh the benefits of simplification; namely, ensuring those who are entitled to an award to receive one. Thus, Recommendations 54, 55, 56 and 57 remove the time limits in favour of limitations to eligibility based on proving the injury, illness or disorder is predominantly attributable to service.

13.23 Criteria for Eligibility to Request a Review (Recommendations 60, 61 and 62). Also discussed in Chapter 11, the existing criteria for eligibility to request a review can have the same detrimental

effects described above. However, in addition, it disproportionately impacts younger claimants. Thus, Recommendations 60, 61 and 62 are designed to simplify the criteria for requesting a review by focussing on the deterioration of the injury, illness or disorder whilst putting in place safeguards to prevent recipients from requesting reviews 'just in case', unnecessarily adding to the administrative burden of the MoD.

KEY OBJECTIVE 3: EMPOWERMENT

13.24 Key to improving the delivery of the AFCS is the empowerment of the two key actors in the claims process; claimants must be empowered to have agency in their claims process and caseworkers to confidently use their judgement in making the correct decision within the parameters of the Scheme. The most important recommendations in this report are designed to empower these actors and, ultimately, to improve the quality of decisions by providing opportunities for claimants and caseworkers to collaborate and jointly take ownership of the outcome.

13.25 Giving Claimants and Recipients Agency (Recommendations 2, 7, 8, 9, 10, 11, 14, 15, 24, 52 and 62). As referenced throughout this report, the simplest way to empower claimants and recipients in the AFCS process is to arm them with as much information as they need to navigate the system. This includes information regarding the principles of the Scheme (Recommendations 2), the process prior to application (Recommendations 7, 8 and 9), the initial application stage (Recommendations 10 and 11), and post the initial decision process (Recommendations 14, 52 and 62). This information will enable claimants and recipients to actively engage in the process and hold the MoD to account where it is not fulfilling its obligations at any stage.

13.26 The claims process must afford claimants and recipients the agency to act on the information provided as opposed to placing obstacles to prevent them from doing so. Thus, Recommendations 15 and 24 provide claimants with opportunities to engage.

13.27 Reinvigorating the Role of Caseworker (Recommendations 18, 21, 22, 23, 24, 37, 38, 41, 42 and 46). The significant responsibility placed on caseworkers must be recognised through their work planning (Recommendation 24) and training (Recommendation 21, 22 and 23). Moreover, the MoD must demonstrate its trust in its caseworker's ability to exercise judgement in making these potentially life-changing decisions by providing guidance, training and clarity regarding their role in contrast to that of, for example, medical advisors (Recommendation 18).

13.28 Empathy will likely arise naturally from an expectation that caseworkers give greater weight to the claimants lived circumstances (i.e., Recommendations 37, 38, 41, 42 and 46) and interact more with individuals with complex claims.

KEY IMPROVEMENT OBJECTIVE 4: LEARNING

13.29 There are very few processes in place for monitoring, evaluating and learning proactively in AFCS policy and delivery. As explored in Chapter 6, changes tend to occur reactively. However, forecasting and proactively identifying issues can limit the adverse impacts on claimants and ensure that the AFCS is evolving along with the policy and social environment.

13.30 Collecting Information (Recommendations 29 and 30). It is imperative that processes are put in place to ensure that policy makers and decision makers are able to routinely access sources of information to assess whether improvements to the Scheme are necessary. This entails setting up routine data collection and analyses processes (Recommendation 29) as well as forums to discuss concerns with, and learn from, key stakeholders (Recommendation 30).

13.31 Auditing and Assessing (Recommendations 52 and 67). Existing policies and guidelines should be routinely audited and assessed to ensure they are fit for purpose given the political, societal and technological environment, including whether the Tariff Level allocations remain adequate (Recommendation 52) and whether difficult cases, such as spanning cases, are being decided on consistently across the organisation (Recommendation 67).

Increased Investment

13.32 Implementation of recommendations made in this report will inevitably require further investment across the MoD. In particular, in:

- The caseworker cohort, with regards to increasing capacity and up-skilling.
- Improving communications and maintaining the standard and coherence of information.
- Building the capacity to capture and analyse data proactively from various sources.

13.33 This investment is essential, however, to repairing the relationship between the MoD and AFCS claimants and ensuring the delivery of a quality service by increasing the independence, transparency and responsiveness of the AFCS. Additionally, investment in the initial stages of the claims process is likely to mitigate the risk of reconsiderations and appeals, and thus mitigate the risk of further expenditure later in the post-initial decision-making stage of the process in the long-term.

The War Pensions Scheme (WPS) and the AFCS QQR 2022/23 Recommendations

13.34 A final note concerning Recommendations 37 and 38 on GIPs; 54, 55 and 56 on time limits; and 60, 61 and 62 on requests for review. It is clear that the recommended assessment for GIP awards, expiration of time limits and removal of a number of limitations to the right to request a review more closely resemble the provisions of the WPS and, if implemented, may appear to be a return to the legacy Scheme. Indeed, as indicated in Chapter 1, the reviewer sought to learn from the provisions of the WPS, alongside equivalent Schemes in Australia, Canada and the United States, to make recommendations to improve the AFCS.

13.35 However, although the three areas (GIPs, time limits, and right to request review) are, essentially, 'big ticket items', there are a multiplicity of limitations to eligibility and differences in the assessment process in the AFCS that are unaffected by recommendations in this review and ensure the AFCS remains significantly distinct from the WPS. These include:

- The limitations on attributability under the AFCS remain unaffected in that causation of the injury, illness, or disorder being claimed for must be *predominantly* attributable to service. Under the WPS, the injury, illness, or disorder need only be *partly* attributable to service. (Para. 2.1, p.60, JSP 765)
- As a result, in effect, the burden of proof for causation under the WPS is much lower and it is only where the claimant applies after seven years of leaving service that 'reliable evidence' is

necessary to prove that the injury, illness, or disorder was at least partly caused by service where there is reasonable doubt. (Para. 2.6, p.60, JSP 765)

- To receive an award under the WPS, the claimant's condition(s) must be medically certified by an MoD medical advisor. Particularly for complex cases, this is a significant resource burden on the MoD.

13.36 The first two factors in particular, ensure that there are fewer claims that are likely to meet the eligibility criteria for an award under the AFCS than under the WPS. Thus, the recommended amendments to GIP calculations, time limits and the right to request a review will benefit a limited cohort of claimants that meet the more stringent eligibility and burden of proof criteria under the AFCS. In addition, the recommendations made regarding GIPs and the right to request a review, although adopting some of the elements of the WPS, retain key differences.

13.37 GIP Calculations. Although Recommendation 37 requires that caseworkers assess the sum impact of the claimant's injury in determining what percentage GIP the claimant is entitled to, akin to the WPS disablement assessment, Recommendation 38, which redefines the GIP Band, adds a secondary set of criteria for entitlement to a GIP. Consequently, caseworkers must assess:

- the overall sum impact of the injury, illness, disorder on the claimant's functional limitation, similar to the WPS; and,
- the result of the functional limitations on different aspects of the claimant's life as, in order to be eligible for a Band A or B GIP, the functional limitation must affect the claimant's capacity to earn.

13.38 The second layer is unique to the AFCS as, under the WPS, earning capacity is not considered in assessing the disablement of the claimant. (Para. 2.13, p.61, JSP 765)

13.39 Right to Request a Review. Recommendation 60 enables recipients the opportunity to request a review where their condition has significantly deteriorated, or they have a diagnosis of a second injury, illness or disorder caused by a condition they are in receipt of an award for. However, Recommendations 61 places a limitation on how often a review can be requested to every five years—a limit which is unaffected if by the outcome. This is to ensure recipients only apply if they have the evidence to substantiate their request for a review.

13.40 This constitutes a significantly more limited right to request a review than that provided for under the WPS, whereby the reasons a recipient can request a review are extensive and the number of times unlimited. (Paras. 6.3- 6.7, pp.74- 75, JSP 765)

SUMMARY OF RECOMMENDATIONS

PART I: THE ARMED FORCES COMPENSATION SCHEME IN PRACTICE
CHAPTER 2 GUIDING ASSUMPTIONS—
Compensation: For what and for whom?
RECOMMENDATION 1: A definition of compensation should be agreed that reflects the intent of the AFCS, to serve as the primary objective and measure of success in policy and decision-making, as well as provide clarity regarding what can be expected of the Scheme. The definition should include the following elements:

- Recognition of damage and/or suffering predominantly caused or worsened by service; and,
- Where an individual is expected to experience a persistent disadvantage as a result of the damage and/or suffering caused by service, proportionate lifetime financial support to provide necessary stability and financial security is due.

'No Fault'?
RECOMMENDATION 2: The implications of a 'no fault' scheme for both the MoD and claimants in the AFCS context should be explicit in all documents pertaining to the AFCS, including those providing guidance to decision-makers and claimants; specifically, that:

- Evidence of blame is not relevant in deciding on a claim.
- The 'no fault' element of the Scheme does not preclude nor affect the claimants right to instigate a negligence claim against the MoD.

RECOMMENDATION 3: Article 41 of the Order should be expired to ensure no right is conferred on the Secretary of State to reduce compensation payments by attributing fault to the claimant as concerns the cause of the injury, illness, disorder or death that is the subject of the claim where it is deemed attributable to service.

Compensation or Benefit Under the Terms of Service?
RECOMMENDATION 4: Labels in the AFCS context contribute to the negative perceptions of the AFCS and the MoD, thus:

- the Scheme should be renamed to exclude the word 'compensation', for example, the Armed Forces Injury Scheme (AFIS).
- all communications, such as guidance to claimants, and training guides should make clear that awards under this Scheme are to be understood as an entitlement by virtue of the recipient's terms of service.
- the label 'customer' should be replaced by 'claimant' in the early stages and 'recipient' of the AFCS fund upon approval of a claim.

CHAPTER 3 INFORMATION: AVAILABILITY AND ACCESSIBILITY—
Targeting Communications
RECOMMENDATION 5: The approach to communications should be a proactive one, with a view to changing the perception that it is a complaints process, including by:

- Ensuring DMS and Defence Transition Services (DTS) are charged with making all potential claimants aware of their right to apply to the AFCS (particularly at the treatment and

rehabilitation stage), including by providing links or hard copies of information on the Scheme and displaying posters regarding the AFCS in the relevant facilities.

- Ensuring communications regarding the AFCS are disseminated at every possible, relevant opportunity and that the messaging is centrally coordinated so it is consistent and coherent regardless of which part of the MoD the messaging emanates from.
- Establishing and sustaining a supportive AFCS community, ensuring specific third party organisations (including the Royal British Legion (RBL), Royal Marines Charity (RMA), Royal Air Forces Association (RAFA,) and the Veterans Advisory and Pensions Committees (VAPCs)), able to support claimants specifically in the AFCS claims process, are signposted, as well as additional resources for serving personnel (e.g. the chain of command and welfare officers).

RECOMMENDATION 6: The MoD should periodically review all documents pertaining to the AFCS to ensure that the information presented in each is up-to-date, accurate and consistent.

User- Friendly Communications

RECOMMENDATION 7: The Apply for Armed Forces Compensation Scheme Guidance webpage should be re-structured to focus on setting expectations, providing clarity on:

- What service the MoD will be providing throughout the claims process.
- The likely nature of their communications with the MoD during the claims process.
- The types of evidence they will be expected to gather, including what the MoD can legitimately request.
- Potential points at which and reasons why further information may be sought from the claimant.
- Potential points at which claimants may require support
- Links to where they might access support, including, for example, to charities that specifically offer AFCS support, the VAPC's and the Veterans Welfare Service (VWS); and,
- Projected timelines.

RECOMMENDATION 8: A document should be produced which focusses on how decisions are made, including:

- How attributability is determined (i.e., the cause and predominance test and the meaning of 'the balance of probabilities' in the AFCS context).
- The methods used to translate evidence of an injury, illness, or disorder into a tariff descriptor.
- The constraints and parameters to the medical, legal and policy advice regarding individual claims.
- The limitations on the use of interim awards and the instances in which they can be made.

CHAPTER 4 MAKING A CLAIM—

Initial Decision-Making Process

RECOMMENDATION 9: To mitigate against unnecessary delays at the early stages due to a lack of understanding of the process on the behalf of the claimant:

- A checklist of evidence that the claimant can expect the MoD to request should be published on the relevant gov.uk web pages and claim completion guidance

- The role of different forms of evidence in the decision-making process should be clarified, including what consideration will be given to medical notes, personal statements and discharge notes (including medical board statements where relevant) in determining the different elements necessary to decide on a claim (e.g., attributability and impact).
- The MoD should determine an 'ideal' window of time within which to make a claim for the purposes of guidance and adopt a policy of communicating this to claimants on first contact where it is clear from the claim submission that a decision cannot yet be made.
- Before a decision is made, the caseworkers should seek the confirmation from the claimant that the evidence collected and on which the decision will subsequently be made is comprehensive.

RECOMMENDATION 10: In all communications regarding the submission of evidence, the MoD should make explicit the implications of submitting evidence at different stages and that any 'ideal window' set by the MoD is merely a guide. It should also be explicit that even where the claimant chooses for personal reasons to apply early and their condition deteriorates, there are opportunities for review at a later date.

RECOMMENDATION 11: All decision notifications should include a full explanation as to why the next tariff up has not been awarded, making reference to the evidence and how it has been interpreted by the caseworker, as well as, if relevant, why a temporary award has not been made.

Post Initial Decision-Making

RECOMMENDATION 12: The Order should be amended to ensure reconsiderations can only be of the material that the original decision was based on.

RECOMMENDATION 13: The MoD should ensure they are sufficiently resourced to enable a representative to attend every hearing, who is prepared to present arguments and empowered to make concessions at hearings.

CHAPTER 5 THE CASEWORKER—

Communication Between Caseworkers and Claimants

RECOMMENDATION 14: The work of caseworkers should be restructured to ensure that, where a case is identified as complex upon first review, caseworkers are supported and enabled to take a proactive and more communicative approach to engaging with these claimants. This requires that caseworkers:

- Make initial contact over the phone with claimants upon receipt of the claim to explain what the caseworker's role is, why their claim has been flagged as complex, what the implications of this are, what the claimant can expect from them and what they might request from the claimant.
- Keep notes on the personal circumstances and needs of the claimant so they can tailor communications and share these if the case is not resolved by the initial decision (i.e., share with the reconsideration and/or appeals caseworkers).
- Proactively contact claimants periodically to provide updates on their claim and full explanation as to what the different stages are and what the implications of different decisions are.

RECOMMENDATION 15: Helpline workers should be directed to answer generic questions only and automatically make a call-back request to the relevant caseworker for case-specific queries. To prevent caseworkers from being overwhelmed with these queries:

- Each caseworker should have an appropriate amount of 'clinic hours' a week during which they are able to take calls to answer case-specific queries directly from claimants or to respond to call-back requests put through from the Helpline.
- Clinic hours and their purpose for the relevant caseworker be clearly signposted in all communications with claimants.

RECOMMENDATION 16: The MoD should explore options for communicating routinely with claimants/recipients via email and text message.

RECOMMENDATION 17: Caseworker caseloads should be capped, the unit of measurement and limit to be determined based on an audit of the resources expended on different case types to date, in consultation with caseworkers and in the course of a review of workforce requirements.

The Role of Medical Advice in Decision-Making

RECOMMENDATION 18: Efforts should be made to explicitly tighten the scope of the medical advisor-delivery role in line with the original intent of the Scheme. Guidelines for both caseworkers and medical advisors should be published, providing clarity that:

- the evidence submitted by the treating physician has primacy with regards to determining the nature of the injury, and reference should be made to other supporting medical evidence (e.g., Medical Board statements) submitted by the claimant where relevant.
- medical advisors are only to provide:
  iv) Advice concerning attributability.
  v) Assistance interpreting medical evidence provided by treating physicians into lay terminology.
  vi) Advice on the interface between the medical evidence and the Scheme.
- a lack of evidence regarding the condition of the claimant, adversely impacting the ability of the caseworker to make a decision, should result in caseworkers seeking clarification from treating physicians not from MoD medical advisors.

RECOMMENDATION 19: The definition of a 'treating physician' should be made clear in the guidance and legislation governing the AFCS as a licensed and registered physician who is primarily responsible for the claimants' care in relation to the diagnosis and/or treatment that is the subject of the claim.

RECOMMENDATION 20: The MoD should instate a process whereby the Synopses of Causation are reviewed and updated regularly, for example, every three years, to ensure that caseworkers are making reference to up to date information when making decisions on individual claims.

Training and Development

RECOMMENDATION 21: All claimant-facing staff, including caseworkers and helpline workers, should receive regular training and sessions regarding, but not limited to:

- The factors impacting the quality of life of claimants and recipients, ranging from changes to workplace adjustment requirements to the particularities of the impact of service on coping with illness, injuries, and disorders.
- Dealing with difficult situations, in particular when assisting those with mental disorders.

RECOMMENDATION 22: Officials and volunteers working in related areas to the AFCS (such as VWS welfare managers and VAPC members) and third sector representatives that are active in advocating for and representing claimants in the claims process should be regularly engaged, including in joint MoD-led information and training sessions on AFCS policy and practice.

RECOMMENDATION 23: The MoD should ensure that caseworkers convene regular peer review workshops (e.g., monthly) to discuss difficult decisions and ensure that decisions are being made consistently across the board.

Caseworker Work Planning

RECOMMENDATION 24: In redesigning the caseworker workplan, the MoD should consider the additional:

- Hours required to maintain clinic hours.
- Desk time required to procure and analyse the necessary evidence in complex cases.
- Emotional labour expended in dealing more closely with vulnerable claimants.
- On-going training to improve and maintain delivery standards.
- Routine peer review workshops, including the time it takes to prepare for these workshops**.**

CHAPTER 6 SUPPORTING GOOD DECISION-MAKING—

Independent and Transparent Policymaking

RECOMMENDATION 25: An independent drafter, such as a medical PhD candidate or civil servant external to the MoD on secondment, should be recruited on a temporary basis to assist the IMEG in drafting its reports.

RECOMMENDATION 26: There should be a *requirement* in the terms and conditions of the IMEG membership that consultants are practicing and not solely academic.

RECOMMENDATION 27: Measures should be taken to recruit on to the IMEG representatively and a system for monitoring and demonstrating these efforts are being made should be put in place.

RECOMMENDATION 28: The MoD should take the necessary steps to ensure that the policy medical advisory function and the delivery medical advisory function are well-defined and remain distinct.

Improving Operational Processes

RECOMMENDATION 29: Steps should be taken to:

- Expand the quantitative and qualitative data collected, both from historical and future claims, using existing tools and new data collection mechanisms where necessary.
- Institute a routine process whereby analysts produce an analysis of trends periodically for use by the AFCS policy and delivery functions.

- Institute a process whereby MoD official across the functions, including policy-, decision-makers and analysts, routinely meet to discuss trends and take decisions on whether and how to act on these.

RECOMMENDATION 30: A small operations-specific working group should be convened routinely, including MoD officials (involved in the administration of the Scheme and supporting claimants, i.e., the Veteran's Welfare Service), the VAPC's and those charities that are significantly involved in representing and guiding claimants through the AFCS process. Efforts should be made to ensure that:

- the scope of the working groups discussion does not extend beyond AFCS-specific operational
- the group's membership does not extend to groups that do not participate significantly in the AFCS process.
- relevant stakeholders are invited/ consulted on an ad hoc basis depending on the issues raised.
- the working groups activities are effectively utilised to improve operational policy and the training of caseworkers and medical advisors.

RECOMMENDATION 31: The MoD should procure the support of the health sector in supporting the AFCS community and to produce guidance for treating physicians on how to compile appropriate evidence packs to support claimants in the process.

Existing Resources

RECOMMENDATION 32: The AFCS delivery function, upon identifying individuals with complex cases, should routinely refer these individuals to VWS to enable VWS to engage with the individual and discuss the support they might require throughout the AFCS claims, reconsideration or appeals process. To enable welfare managers to provide the best possible support to the individual based on up to date and accurate information:

- Welfare managers should be invited to all information and training sessions provided to AFCS caseworkers, for the purposes of disseminating information as well as creating and maintaining links between the functions.
- Where a claimant is being supported by the VWS, communications between the allocated AFCS caseworker and VWS welfare manager should be maintained throughout the course of the individuals AFCS claims, reconsideration, or appeals process.
- All written communications between the MoD and claimants/recipients concerning the AFCS should include contact details for and information on the service provided by VWS.

RECOMMENDATION 33: All written communications between the MoD and claimants/recipients concerning the AFCS should include contact details for, and information on the service provided by, the VAPC's to enable those requiring additional support throughout the process to access available resources.

RECOMMENDATION 34: The MoD should review its relationship with the VAPC's with a view to identifying potential opportunities for the VAPC's to assist claimants with complex AFCS claims, such as via a formal referral process for individuals in need of support as identified by AFCS caseworkers,

particularly where the claimant expresses a preference for support from a body independent from the MoD.

PART II POLICIES
CHAPTER 7 CALCULATING AWARDS—
Injury vs. Impact
RECOMMENDATION 35: It is recommended that lump sum awards be made solely on the basis of the nature of the injury, illness or disorder and the resulting mechanical limitation, not the impact on the recipient's day-to-day life.

RECOMMENDATION 36: The tariff descriptors should be drafted in reference to the following elements only:

- the injury (e.g., cervical spinal cord injury).
- Where relevant, recovery time (e.g., expected to recover within 26 weeks).
- Where relevant, the extent of medical intervention (e.g., operative treatment needed); and,
- where relevant, the functional, physical loss caused by the injury (e.g., tetra paresis).

RECOMMENDATION 37: GIP awards should be based on the *sum impact* of the injuries on the recipients psychological, family, social and occupational life, irrespective of the nature or number of injuries they have suffered.

RECOMMENDATION 38: GIP awards should be calculated independently from the lump sum tariff tables and with reference to a standalone table. Each claim should be assessed in its totality and a determination made as to whether the impact of the sum of the claimants' injuries and/ or disorders meet a GIP descriptor.

GIP Factors
RECOMMENDATION 39: To enable GIP recipients to financially plan as their peers would:

- A second system of GIP factors should be devised that enables the distribution of the GIP over a lifetime to reflect the income distribution of the recipients fully employed equivalent more accurately (i.e., sees a higher income up to retirement after which the income reduces).
- a consultation should be carried out with recipients of an AFCS GIP, to explain the difference between the current system and the second system, with a focus on financial planning opportunities, and to gain an understanding as to which would be better received before moving forward with implementation.

Multiple Injuries Ranking
RECOMMENDATION 40: To ensure equity and transparency in calculating multiple injury awards:

- A determination applicable to all claims should be made, substantiated, and explained in public communications as to what percentage of any award is considered to be for pain and suffering; and,
- The aggregate pain and suffering should be considered in calculating multiple injury awards, resulting in the consistent deduction of less than the full percentage awarded for pain and suffering for each injury, with the exception of the most severe (which should continue to attract 100% of the award).

CHAPTER 8 SEEKING PARITY—

Disorders and Injuries

RECOMMENDATION 41: The definition of 'functional limitation' currently ascribed to Tables 3 and 4 should be redrafted to reflect the definition in Article 5(3) of The Order 2011:

"The term "functional limitation or restriction" in relation to a descriptor means that, as a result of an impairment arising from the primary injury or its effects, a person

(a) has difficulty in executing a task or action; or

(b) is required to avoid a task or action because of the risk of recurrence, delayed recovery, or injury to self or others."

RECOMMENDATION 42: To represent an escalation of this definition of 'functional limitation', a judgement should be made by caseworkers as to the extent to which the recipient's life is limited because of the disorder, in both mental and physical disorder cases. Thus, making an overall assessment of the recipient's psychological, family, social and occupational life, prioritising none above the others and regardless of whether the limitation is all in one area or spread across multiple areas of their life, functional limitation as a result of their disorder is:

- Moderate where 30% of their overall life is limited.
- Severe where 50% of their overall life is limited.
- Very severe 75% of their overall life is limited.

RECOMMENDATION 43: The word 'permanent' should be removed from the relevant descriptors. Article 5(7) of The Order 2011 states that an injury or disorder is '"permanent" where following appropriate clinical management of adequate duration—

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

ii) no further improvement is expected.'

Instead, where absolutely necessary, the word 'persistent' should be used to indicate that periods of improved capacity, for example, do not negate the severity of the disorder.

RECOMMENDATION 44: There should be a presumption in favour of the claimant where there is no evidence to suggest the impact of their injury, illness, or disorder is not permanent.

Mental Disorders and Other Injury, Illness and Disorder Types

RECOMMENDATION 45: Table 3- Mental Disorders should be expanded to recognise instances of less severe mental disorders or those which manifest for shorter periods of time. As mental disorders are described by temporal and severity measures, the number of descriptors should be expanded with reference to these same factors.

RECOMMENDATION 46: The term 'substantial recovery' as employed in Table 3 should be more clearly defined as recovery to the extent that the disorder no longer affects the claimant's function. A substantial recovery should entail achievement of a fixed degree of recovery, and it should not be proportionate to the severity of the disorder.

RECOMMENDATION 47: Every measure possible should be taken, e.g., through training, to ensure that caseworkers and other decision-makers do not disadvantage claimants with mental disorders by

placing a greater evidence burden on them than for those with physical disorders or than is required by legislation. Guidelines should make clear that:

- Where the claimant has submitted a claim whilst their disorder is ongoing, caseworkers must make a decision based on the treating physicians' expectations of how long the disorder will persist as is clearly provided for by the tariff descriptors.
- Interim awards are only to be made in exceptional circumstances as they negate one of the AFCS's primary objectives: to provide the recipient with financial certainty and enable them to move on. If the treating physician has made a determination of their expectations of the duration of the mental disorder, the evidence does not meet the requirements of Articles 52(1), 52(6) and 52(7) on making and extending Interim Awards.

RECOMMENDATION 48: To support the objective of making a full and final award as early as possible, Article 52 should be amended to shorten the time for which Interim awards can be in place from 24 to 12 months, ensuring they are reviewed after 12 months and, in very rare cases after an extension of another 12 months, ensuring all Interim Awards are reviewed annually at worst.

RECOMMENDATION 49: Interim Awards should be subject to appeal. However, the right to appeal should be limited to the strength of the evidence that a final award cannot be made at that time and not to the tariff level the interim award is made on.

RECOMMENDTION 50: All Interim Award decision letters should notify recipients that:

- The award review date indicates the date by which the Interim Award must be reviewed. However, if the recipient receives any significant new evidence relevant to their AFCS claim, they have the right to request an early review.
- Recipients have the right to appeal the interim award decision on the basis that there is sufficient evidence to make a final award but not on the basis that they should be awarded an interim award at a different tariff level.

RECOMMENDATION 51: As is the case with all other claims, it should be a requirement that claims pertaining to Table 3- Mental disorders be substantiated by a report from the lead treating physician, regardless of whether it be a consultant or not.

Horizontal and Vertical Equity

RECOMMENDATION 52: An exercise to produce guidelines and definitions for each Tariff Level should be carried out followed by an assessment of each tariff descriptor to ensure that each has been matched to the correct tariff level. These guidelines should be published, periodically reviewed, and provide the basis for any future decisions on allocating descriptors to tariff levels.

RECOMMENDATION 53: A specific reconsideration of how the severity of Table 3 Mental Disorders descriptors is measured and determined should be carried out with a view to ensuring they are each allocated equitable Tariff Levels.

CHAPTER 9 INEQUITABLE LIMITATIONS—

Time Limits

RECOMMENDATION 54: All general time limits (Article 47) to submitting a claim as well as those associated with claims for worsening of an injury (Articles 9(3)(a), 9(3)(b), 9(4) and 9(5)(a)) and death attributable to service (Articles 10(3)(b) and 10(3)(c)(i)) should be removed and eligibility of a claim should be based solely on the strength of the evidence of attributability.

Injury Type

RECOMMENDATION 55: Article 10(3)(c)(ii) should be expired to enable dependents of those not in receipt of a tariff level 1 to 9 award to submit an application for assessment under the AFCS.

RECOMMENDATION 56: Articles 11(4) and (5) should be expired and the criteria for eligible injuries, illnesses and disorders limited to attributability and whether the injury meets a Tariff Level irrelevant of whether the injury was caused by a slip, trip or fall.

RECOMMENDATION 57: Articles 12(1)(f)(i) and (ii) should be expired to ensure that pre-existing conditions and personality disorders are not considered prejudicing factors in claims where, on the balance of probabilities, it is likely that the claimant would not have suffered the injury, illness or disorder, or the worsening of their condition, had it not been for service.

Financial Assistance

RECOMMENDATION 58: To ensure those with lesser financial means are not disadvantaged by AFCS evidence requirements, the MoD should ensure that:

- Any administrative costs necessarily incurred by the claimant in the evidence gathering process (e.g., paying GP surgeries for letters) be reimbursed automatically, including where a report from a non-treating physician is required (e.g., a consultant grade for Mental Disorder claims).
- Efforts are made to liaise with the health sector under the Armed Forces Covenant to ensure that claimants requesting support with AFCS applications do not incur charges.

RECOMMENDATION 59: A pre-approval process for accessing private healthcare (beyond the request of a consultant grade report as per requirements) should be implemented, for those able to prove that timeframes for accessing NHS care are unreasonable. The pre-approval process should include the requirement of evidence that NHS treatment has been.

Review

RECOMMENDATION 60: The review system should be simplified. Articles 55, 56 and 57 of The Order should be replaced by a single Article providing for an application to review at any time after the initial decision is issued or diagnosis of worsening or secondary condition(s) based on evidence that the injury has significantly deteriorated, or a secondary injury is predominantly attributable to the initial injury for which an award was made.

RECOMMENDATION 61: The right to review should be limited to once every five years for each claim irrespective of the outcome rather than, in effect, three through-life. Claimants should, however, be able to request the first review as of twelve months after the initial.

RECOMMENDATION 62: Article 51(1)(c) should be amended to place an obligation on the Secretary of State to inform the claimant of their right to review in addition to their right to reconsideration and appeal. All communications should make the differentiation between each of these processes clear.

RECOMMENDATION 63: Article 59(2) of The Order should be amended to confer the right upon the Secretary of State to review an award where evidence of fraud has been found.

CHAPTER 10 BURDEN OF PROOF—

RECOMMENDATION 64: Article 60 should be amended to reflect the recommendations in The Boyce Review and obligations the MoD purports to take on in JSP 765, including that:

- The burden on the claimant is to provide evidence when requested by the MoD and be available to assist the MoD in efforts to collect evidence to substantiate the claimants claim.
- The burden of collecting all knowable evidence to substantiate a claim is on the Secretary of State, although it remains the obligation of the claimant to assist the MoD when requested.

RECOMMENDATION 65: A file should not be closed without reasonable efforts being made by the MoD to contact the claimant. A warning must first be issued in writing that a file will be closed, stating the reasons why, and providing a further three months for the claimant to contest the closure of the file.

CHAPTER 12 LUMP SUM UP-RATING—

RECOMMENDATION 66: A process for uprating lump sum awards to take into account inflation and other cost-of-living factors every five years should be put in place to ensure that the lump sum amounts offer the intended appropriate benefit to recipients in real terms. This process should not be contingent on the QQR process but rather be an automatic process triggered independently of the QQR.

CHAPTER 13 SPANNING—

RECOMMENDATION 67: A guide to decision-making in spanning cases should be produced and published, to guide caseworkers and inform claimants. To do so, an audit of how decisions have been made in spanning cases to date should be conducted, with a focus on the rationale and results.

ACRONYMS & ABBREVIATIONS

AFCS	Armed Forces Compensation Scheme
BG	Bereavement Grant
BMI	Body Mass Index
Boyce Review, The	First Review of the Armed Forces Compensation Scheme. Led by The Lord Admiral Boyce in 2010
CAC	Central Advisory Committee on Compensation
CBT	Cognitive Behavioural Therapy
CDP MA	Chief of Defence People Medical Advisor
CP	Child Payment
CPI	Consumer Price Index
CPTSD	Complex Post-Traumatic Stress Disorder
CTS	Veterans Mental Health Complex Trauma Service
DCMH	Department of Community Mental Health
DMS	Defence Medical Services
DTS	Defence Transition Services
DWP	Department for Work and Pensions
GIP	Guaranteed Income Payment
GIP Band	Bands determining the percentage payable of the Guaranteed Income Payment
GIP Descriptor	Recommended definitions of the Guaranteed Income Payment Bands
GIP Factor	The factor attributable to each recipient based on their age to enable determination of their individual Guaranteed Income Payment
HMCTS	His Majesty's Courts and Tribunal Service
Helpline, The	The Veteran's UK Helpline
IMEG	Independent Medical Expert Group
Interim Award	An award made when it is deemed there is insufficient evidence to confidently make a final award

Lump sum	Single payment made to all successful claimants
MA-D	Medical Advisor, Armed Forces and Veterans Services, Ministry of Defence
MA-P	Medical Advisor, Armed Forces People Policy, Ministry of Defence
MoD	Ministry of Defence
MoJ	Ministry of Justice
MinDPV	Minister for Defence People, Veterans and Service Families
NFCI	Non-Freezing Cold Injury
NHS	National Health Service
ONS	Office for National Statistics
PTSD	Post-Traumatic Stress Disorder
QQR	Quinquennial Review
SGIP	Survivors Guaranteed Income Payment
Scheme, The	Armed Forces Compensation Scheme
Service	Employment in the Armed Forces
TILS	Veteran's Mental Health Transition, Intervention and Liaison Services
Tariff Descriptor	Descriptions of injury linked to a Tariff Level
Tariff Level	Levels representing the increasing severity of the injuries each tariff level is linked to
Tariff Table	Contain all the tariff descriptors by category of injury and links each to a tariff level
Tribunal, The	First-tier Tribunal (War Pensions and Armed Forces Compensation Chamber)
Upper Tribunal	Upper Tribunal (Administrative Appeals)
VAPC's	Veteran's Advisory Pensions Committees
VWS	Veterans Welfare Service
WPS	War Pensions Scheme

TABLE OF FIGURES

BIBLIOGRAPHY

Case Law

- *JM v Secretary of State for Defence* (AFCS) [2015] UKUT 332 (AAC)
- *Secretary of State for Defence v AD and another (AFCS)* [2009] UKUT 10 (AAC)
- *Secretary of State for Defence v Duncan Secretary of State for Defence v McWilliams* [2009] EWCA Civ 1043

Legislation

- *The Armed Forces and Reserve Forces (Compensation Scheme) Order* 2011
- *The War Pensions Committees Regulations Statutory Instruments* [2000] No. 3180, 2005 No. 3032, 2006 No. 3152 and 2017 No 1133

Government Publications

- JSP 765 Armed Forces Compensation Scheme Statement of Policy (2022)
- Location of Armed Forces Pension and Compensation Recipients 2022, www.gov.uk
- MOD compensation and occupational pension schemes: synopses of causation, www.gov.uk
- Terms of Reference, Independent Medical Expert Group, www.gov.uk
- The Quinquennial Review of the Armed Forces Compensation Scheme 'One Year On' Report (April 2018)
- The Review of the Armed Forces Compensation Scheme, Cm7798 (February 2010)

Websites

- AFCS Help, www.afcshelp.co.uk
- Armed Forces Compensation Scheme (AFCS), https://www.gov.uk/guidance/armed-forces-compensation-scheme-afcs
- Cambridge Dictionary, www.dictionary.cambridge.org
- Claim if you were injured while serving in the armed forces, https://www.gov.uk/claim-for-injury-received-while-serving/how-to-claim
- Free help with compensation claims for injury in the armed forces, https://www.gov.uk/government/collections/free-help-with-compensation-claims-for-injury-in-the-armed-forces
- The Army Rumour Service, www.arrse.couk
- Twitter, www.twitter.com
- Veteran State of Mind Podcast, www.vsompodcast.com

ANNEX A: Terms of Reference, Armed Forces Compensation Scheme Quinquennial Review 22/23

Purpose

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

Previous Reviews

The AFCS was first reviewed in 2009-10 and independently chaired by Admiral the Lord Boyce. Whilst finding the Scheme fundamentally sound, recommendations were made to significantly improve the AFCS, all of which were implemented. Lord Boyce subsequently concluded that, whilst future reviews of particular aspects of the Scheme could not be ruled out, a re-design of the Scheme should not be required. Consequently, a process to review the policy aspects of the Scheme on a quinquennial basis, as is common among government, academic, occupational and legislative authorities, was initiated. These are internal Ministry of Defence (MoD) reviews with external validation through consultation with the Central Advisory Committee (on Compensation).

The first QQR of the AFCS was published in 2017. The QQR team found that the AFCS remained broadly on track and that the aims of the Scheme were being met overall, making 43 recommendations for improvement whilst reiterating the continuing need for periodic reviews of the AFCS to ensure it continues to adapt to an inevitably changing environment. In 2018, the MoD released a report summarising the progress made based on the recommendations of the 2017 QQR one year on.

Scope of Current Review

Taking into consideration developments since the last QQR (published in February 2017), including improvements to the scheme and its administration and recommendations from the Independent Medical Expert Group (IMEG), the scope of the review will consider but not be limited to the following areas identified by the Ministry of Defence and external stakeholders:

1. **Horizontal and vertical equity and the treatment of complex and/or emerging conditions** for the purpose of making an award under the AFCS, including but not limited to back injuries, Mesothelioma, Mild Traumatic Brain Injury (mTBI), Musculoskeletal (MSK) Disorders, and so-called 'Long-Covid'.

2. **Treatment of mental health conditions**, including Post-Traumatic Stress Disorder (PTSD), for the purpose of making an award under the AFCS, particularly with regards to whether and how these conditions are treated with parity to physical conditions.

3. **Effectiveness of use of Interim Awards** particularly in the case of mental health-based claims.

4. **Effectiveness of the AFCS's administration in processing and assessing claims**, including efficiency and digitalisation, independence and use of Medical Advisors, transparency and the appeals process.

5. **Collection and monitoring of data** pertaining to the AFCS, including what data is held and how it is used for the purposes of improving the identification of trends in, for example, how many claims are withdrawn and why and changes in conditions being claimed for.

6. **Effectiveness and adequacy of communications** pertaining to the AFCS, particularly:

a) Principles of the AFCS;

b) Access to information for potential claimants;

c) Availability of data regarding the AFCS; and,

d) Differentiation between the AFCS and related but distinct schemes such as the War Pensions Scheme (WPS).

7. **Interaction of the AFCS with other public and private sector services** (such as financial or welfare services) which may result in unintentionally detrimental outcomes for those in receipt of compensation.

Although not specifically addressed above, the impact of the Covid-19 pandemic will be considered in each of the above areas where relevant.

In addition, the review will provide an overview of developments since the 2017 QQR, including those resulting from the QQR's recommendations.

Limitations

As per the above stated purpose of the QQR, whether or not the scheme remains fit for purpose and recommendations for improvements to its administration and implementation are in scope of this review. However, the following remain out of scope:

1. **Purpose** of the AFCS;

2. **Fundamental design** of the AFCS; and,

3. **Medical determinations** unrelated to policy and which fall under the remit of the IMEG.

Implementation

The review is due to commence in 2022 and complete in Spring 2023. Recommendations arising from the review will be evidence-based, costed, sustainable, simple to administer and seek to enable the continued provision of compensation transparently and without undue burden or delay.

Resources and Funding

The Sponsor for the review will be the Head of Armed Forces People Support. The review will be constituted for a maximum of one year and conducted by the Lead Reviewer, who has been appointed externally to ensure independence from a policy perspective. The review lead will provide a report detailing costed, implementable and sustainable recommendations for the Director of Armed Forces People Policy and Head of Armed Forces People Support within one year of the review's commencement.

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

The review lead will engage with internal and external stakeholders in order to provide clear, evidence-based conclusions which are implementable by DBS.

The primary stakeholders providing support for the review will be:

- Armed Forces People Support, Ministry of Defence

- Chief of Defence People Medical Adviser
- Central Legal Services
- Defence Statistics
- Reserve Forces and Cadets
- Defence Resources
- Single Service Pay Colonels
- DBS
- Department for Work and Pensions
- Ministry of Justice
- Office for Veteran Affairs, Cabinet Office
- Advisory Committee on Compensation, Ministry of Defence[24]
- Third Sector, including but not limited to Royal British Legion, Combat Stress and SSAFA

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

Milestones, Deliverables and Timelines

The review lead will be responsible for developing a detailed programme plan. Regular progress reports will be provided to the Head of Armed Forces People Support. A draft report, detailing findings with initial recommendations, is to be provided to the Head of Armed Forces People Support no later than nine months after commencement; this will be discussed with Central Advisory Committee on Compensation (CAC) members to ensure agreement with direction the review is taking. A final report detailing recommendations that MOD should implement to ensure the AFCS is fit for purpose is to be produced no later than twelve months after the review's commencement. The report will be published on the www.gov.uk website, following submission to the Minister for Defence Personnel and Veterans.

[24] Internal Members: Head – Armed Forces People Support, AFP Support Compensation and Insurance Policy Team Leader, Head of Vets UK, Deputy Head Vets UK, Army Pay Colonel, RAF Pay Colonel and RN Pay Colonel. External Members: Chair Independent Medical Expert Group, War Widows' Association, Royal British Legion, RAF Families Federation, Naval Families Federation, Army Families Federation, SSAFA – The Armed Forces Charity, Combat Stress, British Limbless Ex-Service Men's Association, Veterans Advisory Pension Committee (VAPC)

ANNEX B: Armed Forces Compensation Scheme Quinquennial Review 22/23 Respondents

	Organisation	# Participating Representatives
1	Armed Forces Compensation Scheme Recipients	8
3	Blesma	1
4	COBSEO: The Confederation of Service Charities	2
5	Combat Stress	1
6	Department of Health and Social Care	1
7	Department for Work and Pensions	6
8	Government Actuary Department	1
9	Independent Medical Expert Group	2
10	Mission Motorsport	1
11	Ministry of Defence: Armed Forces People Support	5
12	Ministry of Defence: Defence Business Services	17
13	Ministry of Defence: Defence Medical Services	1
14	Ministry of Defence: Defence Statistics	3
15	Ministry of Defence: Legal Advisors	1
16	Ministry of Justice	3
17	National Health Service	4
18	Navy Families Federation[25]	1
19	Office for Veterans Affairs	4
20	Pensions Appeal Tribunal Northern Ireland	1
21	Pensions Appeal Tribunal Scotland	1

[25] Acting as representative of all three families' federations in their capacity of member of the Compensation Advisory Committee

22	Royal Air Forces Association	2
23	Royal British Legion	2
24	Royal Marines Charity	6
25	Veterans Advisory Board, Cabinet Office	8
26	Veterans Advisory Pension Committees	16
27	Veteran's Review Board, Australia	1
28	War Pensions and Armed Forces Compensation Chamber	6
	TOTAL	105

ANNEX C: Schedule 4 Table of Factors, The Armed Forces and Reserve Forces (Compensation Scheme) Order 2011

Table of Guaranteed Income Payment Factors

Column (a) Age at last birthday	*Column (b) GIP Factor*	*Column (a) Age at last birthday*	*Column (b) GIP Factor*
16	1.205	37	1.000
17	1.202	38	0.986
18	1.199	39	0.972
19	1.196	40	0.957
20	1.192	41	0.943
21	1.189	42	0.928
22	1.185	43	0.913
23	1.182	44	0.897
24	1.170	45	0.882
25	1.157	46	0.866
26	1.145	47	0.849
27	1.132	48	0.833
28	1.120	49	0.816
29	1.107	50	0.799
30	1.094	51	0.781
31	1.081	52	0.763
32	1.068	53	0.744
33	1.055	54	0.724
34	1.041	55	0.705
35	1.028	Over 55	0.705
36	1.014		

ANNEX D: Part 1, Schedule 3, The Tariff and Supplementary Awards, The Armed Forces and Reserve Forces (Compensation Scheme) Order 2011

Table 1 - Burns(*)

Item	*Column (a)*	*Column (b)*
	Level	***Description of injury and its effects ("descriptor")***
1	4	Burns, with partial, deep or full thickness burns affecting 70% or more of whole body surface area.
2	5	Burns, with partial, deep or full thickness burns affecting 50 to 69.9% of whole body surface area.
3	5	Burns, with partial, deep or full thickness burns to the face or face and neck including one or more of the following: loss of or very severe damage to chin, ear, lip or nose, resulting in or expected to result in residual scarring and poor cosmetic result despite treatment and camouflage.
4	6	Burns, with partial, deep or full thickness burns affecting 15 to 49.9% of whole body surface area.
5	7	Burns, with partial, deep or full thickness burns to the face or face and neck resulting in, or expected to result in, residual scarring and poor cosmetic result despite treatment and camouflage.
6	8	Burns, with partial, deep or full thickness burns affecting 9 to 14.9% of whole body surface area.
7	9	Burns, with partial, deep or full thickness burns to face or face and neck resulting in, or expected to result in, residual scarring and satisfactory cosmetic result with camouflage.
8	11	Burns, with partial, deep or full thickness burns affecting 4.5 to 8.9% of whole body surface area.
9	12	Burns, with partial, deep or full thickness burns affecting less than 4.5 % of whole body surface area.
10	12	Burns, with superficial burns affecting more than 15% of whole body surface area.
11	13	Burns, with superficial burns to the face or face and neck.
12	14	Burns, with superficial burns affecting 4.5 to 15% of whole body surface area.
13	15	Burns, with superficial burns affecting 1 to 4.4% of whole body surface area.

- (*) Awards for all burns include compensation for any residual scarring or pigmentation and take into account any skin grafting.
- (*) Awards for partial, deep or full thickness burns include compensation for actual or expected metabolic or cardiovascular consequences.

Table 2 - Injury, Wounds and Scarring(*)

(*) A non-freezing cold injury under item 22A must be diagnosed by a non-treating consultant neurologist.

(*) A descriptor for a freezing cold injury or a non-freezing cold injury refers to either unilateral or bilateral damage to the upper or lower extremities.

Item	*Column (a)*	*Column (b)*
	Level	*Description of injury and its effects ("descriptor")*
A1	2	Bilateral complex injury to both upper limbs including hand on only one side and only from above elbow on the other, causing permanent total or virtually total functional limitation or restriction.
1	5	Complex injury covering all or most of the area from thigh to ankle or shoulder to wrist, with complications, causing permanent significant functional limitation or restriction.
2	5	Loss of both kidneys or chronic renal failure.
3	6	Complex injury covering all or most of the area from thigh to knee, knee to ankle, shoulder to elbow or elbow to wrist, with complications, causing permanent significant functional limitation or restriction.
4	6	Injury covering all or most of the area from thigh to ankle or shoulder to wrist, with complications, causing permanent significant functional limitation or restriction.
5	6	Complex injury to chest, with complications, causing permanent significant functional limitation or restriction.
6	7	Complex injury covering all or most of the area from thigh to ankle or shoulder to wrist, causing permanent significant functional limitation or restriction.
7	7	Injury covering all or most of the area from thigh to knee, knee to ankle, shoulder to elbow or elbow to wrist, with complications, causing permanent significant functional limitation or restriction.
8	7	Injury to chest, with complications, causing permanent significant functional limitation or restriction.
9	7	Complex injury to chest causing permanent significant functional limitation or restriction.
10	7	Complex injury to abdomen, including pelvis or perineum, or both, with complications, causing permanent significant functional limitation or restriction.
11	6	Severe facial lacerations including one or more of the following: loss of or very severe damage to chin, ear, lip or nose, which have required, or are expected to require, operative treatment, but with poor cosmetic result despite camouflage.
12	7	High energy transfer gunshot wound, deeply penetrating missile fragmentation or other penetrating injury (or all or any combination of these) with clinically significant damage to bone, soft tissue structures and vascular or neurological structures of the head and neck, torso or limb, with complications, which have required, or are expected to require, operative treatment with residual permanent significant functional limitation or restriction.
13	8	Injury covering all or most of the area from thigh to ankle or shoulder to wrist, causing permanent significant functional limitation or restriction.
14	8	Complex injury covering all or most of the area from thigh to knee, knee to ankle, shoulder to elbow or elbow to wrist, causing permanent significant functional limitation or restriction.
15	7	Severe facial lacerations which have required, or are expected to require, operative treatment, but with poor cosmetic result despite camouflage.

16	8	Injury to abdomen, including pelvis or perineum, or both, with complications, causing permanent significant functional limitation or restriction.
17	8	Complex injury to abdomen, including pelvis or perineum, or both, causing permanent significant functional limitation or restriction.
18	8	Injury to chest, causing permanent significant functional limitation or restriction.
19	9	Injury to abdomen, including pelvis or perineum, or both, causing permanent significant functional limitation or restriction.
20	9	Injury covering all or most of the area from thigh to knee, knee to ankle, shoulder to elbow or elbow to wrist, causing permanent significant functional limitation or restriction.
21	9	Complex injury covering all or most of the hand, with complications, causing permanent significant functional limitation or restriction.
22	9	High energy transfer gunshot wound, deeply penetrating missile fragmentation or other penetrating injury (or all or any combination of these) with clinically significant damage to soft tissue structures and vascular or neurological structures of the head and neck, torso or limb, which have required, or are expected to require, operative treatment with residual permanent significant functional limitation or restriction.
22A	9	Non-freezing cold injury in the feet, hands or both, with small fibre neuropathy diagnosed clinically and by appropriate tests with continuing neuropathic pain and severely compromised mobility or dexterity beyond 26 weeks.
23	10	Severe facial lacerations which have required, or are expected to require, operative treatment with a good cosmetic result with camouflage.
24	10	Complex injury covering all or most of the area from thigh to ankle or shoulder to wrist, with complications, which has caused, or is expected to cause, significant functional limitation or restriction at 26 weeks, with substantial recovery beyond that date.
25	10	Complex injury to chest, with complications, which has caused, or is expected to cause, significant functional limitation or restriction at 26 weeks, with substantial recovery beyond that date.
26	10	Complex injury covering all or most of the foot, with complications, causing permanent significant functional limitation or restriction.
28	11	Complex injury covering all or most of the area from thigh to ankle or shoulder to wrist, which has caused, or is expected to cause, significant functional limitation or restriction at 26 weeks, with substantial recovery beyond that date.
29	11	Traumatic damage to spleen which has required splenectomy and where there is, or where there is a high risk of, overwhelming post-splenectomy infection.
30	10	Severe facial scarring which produces a poor cosmetic result despite camouflage.
31	11	High energy transfer gunshot wound, deeply penetrating missile fragmentation or other penetrating injury (or all or any combination of these) with clinically significant damage to soft tissue structures of the head and neck, torso or limb, which have required, or are expected to require, operative treatment with residual permanent significant functional limitation or restriction.
32	11	Complex injury covering all or most of the area from thigh to knee, knee to ankle, shoulder to elbow or elbow to wrist, with complications, which has caused, or is expected to cause, significant functional limitation or restriction at 26 weeks, with substantial recovery beyond that date.
33	11	Injury covering all or most of the area from thigh to ankle or shoulder to wrist, with complications, which has caused, or is expected to cause, significant functional limitation or restriction at 26 weeks, with substantial recovery beyond that date.

34	11	Complex injury to chest, which has caused or is expected to cause, significant functional limitation or restriction at 26 weeks, with substantial recovery beyond that date.
35	11	Complex injury to abdomen, including pelvis or perineum, or both, with complications, which has caused, or is expected to cause, significant functional limitation or restriction at 26 weeks, with substantial recovery beyond that date.
36	11	Complex injury covering all or most of the hand, with complications, which has caused or is expected to cause significant functional limitation or restriction at 26 weeks, with substantial recovery beyond that date.
37	12	Complex injury covering all or most of the area from thigh to knee, knee to ankle, shoulder to elbow or elbow to wrist, which has caused, or is expected to cause, significant functional limitation or restriction at 26 weeks, with substantial recovery beyond that date.
38	12	Severe scarring of face, or face and neck, or neck, scalp, torso or limb, where camouflage produces a good cosmetic result.
39	12	Injury to chest, with complications, which has caused or is expected to cause, significant functional limitation or restriction at 26 weeks, with substantial recovery beyond that date.
40	12	Injury covering all or most of the area from thigh to ankle or shoulder to wrist, which has caused or is expected to cause, significant functional limitation or restriction at 26 weeks, with substantial recovery beyond that date.
41	12	High energy transfer gunshot wound, deeply penetrating missile fragmentation or other penetrating injury (or all or any combination of these) to the head and neck, torso or limb which have required, or are expected to require, operative treatment with substantial functional recovery.
42	12	Traumatic injury to external genitalia requiring treatment resulting in severe permanent damage or loss.
43	12	Injury covering all or most of the area from thigh to knee, knee to ankle, shoulder to elbow or elbow to wrist, with complications, which has caused, or is expected to cause significant functional limitation or restriction at 26 weeks, with substantial recovery beyond that date.
44	12	Complex injury to abdomen, including pelvis or perineum, or both, which has caused or is expected to cause significant functional limitation or restriction at 26 weeks, with substantial recovery beyond that date.
45	12	Complex injury covering all or most of the foot, with complications, which has caused, or is expected to cause, significant functional limitation or restriction at 26 weeks, with substantial recovery beyond that date.
46	13	Injury to abdomen, including pelvis or perineum, or both, with complications, which has caused, or is expected to cause, significant functional limitation or restriction at 26 weeks, with substantial recovery beyond that date.
47	13	Injury to all or most of the area from thigh to knee, knee to ankle, shoulder to elbow or elbow to wrist, which has caused, or is expected to cause, significant functional limitation or restriction at 26 weeks, with substantial recovery beyond that date.
48	13	Injury to chest, which has caused, or is expected to cause, significant functional limitation or restriction at 26 weeks, with a substantial recovery beyond that date.
49	13	Moderate facial scarring where camouflage produces a good cosmetic result.
50	13	Lung damage due to toxic fumes, smoke inhalation or blast, where symptoms have continued, or are expected to continue beyond 6 weeks and where the claimant has made or is expected to make a substantial recovery within 26 weeks.
51	13	Traumatic tension or open pneumothorax.

52	13	Superficial shrapnel fragmentation or one or more puncture wounds (or both such injuries) to head and neck, torso or limb which have required, or are expected to require, operative treatment.
53	13	Fractured tooth which has required, or is expected to require, root resection.
54	13	Loss of two or more front teeth.
55	13	Non-freezing cold injury which has caused neuropathic pain in the feet, hands or both, with significant functional limitation or restriction at 26 weeks and substantial recovery beyond that time. Continuing cold sensitivity may be present beyond 26 weeks.[1]
55B	13	Blunt trauma resulting in soft tissue injury to head and neck, torso or limb, which has required, or is expected to require, operative treatment.
55A	13	Freezing cold injury including skin, nail and soft tissue damage, which has caused, or is expected to cause, significant functional limitation or restriction at 26 weeks, with substantial resolution of symptoms beyond that date.
56	14	Injury to abdomen including pelvis or perineum, or both, which has caused, or is expected to cause, significant functional limitation or restriction at 26 weeks, with substantial recovery beyond that date.
57	14	Moderate scarring of scalp, neck, torso or limbs where camouflage produces a good cosmetic result.
58	14	Minor facial scarring.
59	14	Flesh wound which has required, or is expected to require, operative treatment.
60	14	Traumatic injury to external genitalia requiring treatment resulting in moderate permanent damage.
61	14	Damage to one front tooth which has required, or is expected to require, a crown or root canal surgery.
62	14	Damage to two or more teeth other than front which have required, or are expected to require, crowns or root canal surgery.
63	14	Loss of one front tooth.
64	14	Loss of two or more teeth other than front.
65	14	Non-freezing cold injury which has caused pain in the feet, hands or both, with functional limitation or restriction at 6 weeks and substantial recovery by 12 weeks. Continuing cold sensitivity may be present beyond 12 weeks.[a]
65A	14	Freezing cold injury including skin, nail and soft tissue damage, which has caused, or is expected to cause, significant functional limitation or restriction at 6 weeks, with substantial resolution of symptoms beyond that date.
66	15	Minor scarring of scalp, neck, torso or limbs.
67	15	Injury to abdomen, including pelvis, or both, which has caused, or is expected to cause significant functional limitation or restriction at 13 weeks, with substantial recovery within 26 weeks.
68	15	Shrapnel fragmentation or one or more puncture wounds (or both such injuries) to head and neck, torso or limb not requiring operative treatment.

(*) When applied to a limb injury the expression “complex injury” means that the injury affects all or most of the following structures: skin, subcutaneous tissues, muscle, bone, blood vessels and nerves.

(*) When applied to a limb injury the expression “with complications” means that the injury is complicated by at least one of septicaemia, osteomyelitis, clinically significant vascular or neurological injury, avascular necrosis, gross shortening of

the limb, mal-united or non-united fracture, or the fact that the claimant has required, or is expected to require, a bone graft.

(*) When applied to a limb injury, the expression “injury covering all or most of the area” means external injury causing direct damage to contiguous areas of the limb circumference. In the case of a lower limb this may include direct damage to the buttocks.

(*) When applied to an injury to the torso the expression “complex injury” means that there is clinically significant damage to vital structures and organs including two or more of the following: trachea, lungs, heart, gastrointestinal tract, great vessels, major nerves, diaphragm, chest or abdominal wall, pelvic floor, liver, pancreas, kidneys, bladder, spleen or ovaries.

(*) When applied to an injury to the torso the expression “with complications” means that management of the injury has required two or more of the following: resuscitation, ventilation, thoracic or abdominal drainage, a laparotomy with repair and/or removal of organs and structures.

(*) When applied to an injury in this Table, the term “torso” means any part of the chest, back or abdomen including pelvis and perineum.

(*) When applied to any injury, the expression “vital structures” includes major nerve or blood vessels.

(*) An award for injury to a limb or the torso includes compensation for related scarring and damage to, or removal of structures (including skin, subcutaneous tissue, muscle, bone, tendons, ligaments, blood vessels, lymphatics and nerves).

(*) Neuropathic pain is pain initiated or caused by a primary lesion or disorder of the nervous system.

Table 3 - Mental disorders(*)

(aa) Functional limitation or restriction is very severe where the claimant’s residual functional impairment after undertaking adequate courses of best practice treatment, including specialist tertiary interventions, is judged by the senior treating consultant psychiatrist to remain incompatible with any paid employment until state pension age.

(a) Functional limitation or restriction is severe where the claimant is unable to undertake work appropriate to experience, qualifications and skills at the time of onset of the illness and over time able to work only in less demanding jobs.

(b) Functional limitation or restriction is moderate where the claimant is unable to undertake work appropriate to experience, qualifications and skills at the time of onset of the illness but able to work regularly in a less demanding job.

Item	*Column (a)*	*Column (b)*
	Level	*Description of injury and its effects (“descriptor”)*
A1	4	Permanent mental disorder causing very severe functional limitation or restriction(aa)
1	6	Permanent mental disorder, causing severe functional limitation or restriction.(a)
2	8	Permanent mental disorder, causing moderate functional limitation or restriction.(b)
3	10	Mental disorder, causing functional limitation or restriction, which has continued, or is expected to continue for 5 years.
4	12	Mental disorder, which has caused, or is expected to cause functional limitation or restriction at 2 years, from which the claimant has made, or is expected to make, a substantial recovery within 5 years.
5	13	Mental disorder, which has caused, or is expected to cause, functional limitation or restriction at 26 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 2 years.

6	14	Mental disorder, which has caused or is expected to cause, functional limitation or restriction at 6 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.

(*) In assessing functional limitation or restriction in accordance with article 5(6) account is to be taken of the claimant's psychological, social and occupational function.

(*) Mental disorders must be diagnosed by a clinical psychologist or psychiatrist at consultant grade.

Table 4 - Physical disorders – illnesses and infectious diseases(*)

Item	*Column (a)*	*Column (b)*
	Level	*Description of physical disorder and its effects ("descriptor")*
1	6	Physical disorder causing severe functional limitation or restriction where life expectancy is less than 5 years.
1A	6	Physical disorder causing permanent very severe functional limitation or restriction.
2	7	Physical disorder causing severe functional limitation or restriction where life expectancy is reduced, but is more than 5 years.
3	8	Physical disorder causing permanent severe functional limitation or restriction.
4	11	Physical disorder which has caused, or is expected to cause, severe functional limitation or restriction at 26 weeks from which the claimant has made, or is expected to make, a substantial recovery beyond that date.
5	11	Physical disorder causing permanent moderate functional limitation or restriction.
6	12	Permanent physical disorder where symptoms and functional effects are well controlled by regular medication.
7	13	Physical disorder which has caused, or is expected to cause, severe functional limitation or restriction at 6 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
8	13	Physical disorder which has caused, or is expected to cause, moderate functional limitation or restriction at 26 weeks, from which the claimant has made, or is expected to make, a substantial recovery beyond that date.
9	14	Physical disorder which has caused, or is expected to cause, severe functional limitation or restriction at 6 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 13 weeks.
10	14	Physical disorder which has caused, or is expected to cause, moderate functional limitation or restriction at 13 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
11	15	Physical disorder which has caused, or is expected to cause, moderate functional limitation or restriction at 6 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 13 weeks.

(*) This Table relates to diseases and related physical health problems included in the World Health Organisation International Classification of Diseases and Related Health Problems. Mental and behavioural disorders and traumatic and accidental physical injuries are excluded.

(*) Permanent functional limitation or restriction is very severe when the claimant is unable to undertake work appropriate to experience, qualifications and skills, following best practice treatment, and at best thereafter is able to undertake work only sporadically and in physically undemanding jobs.

(*) Permanent functional limitation or restriction is severe where the claimant is unable to undertake work appropriate to experience, qualifications or skills at the time of onset of the disorder and over time able to work in only physically less demanding jobs.

Table 5 - Amputations(*)

[1] These descriptors also apply to circumstances where stump length or condition precludes satisfactory fitting of prosthesis.

[2] "Total loss of use of another limb" means the total loss of the physical capacity or power to carry out its expected functions as compared with a normal healthy person of the same age and sex.

Item	*Column (a)*	*Column (b)*
	Level	*Description of injury and its effects ("descriptor")*
1	1	Loss of both legs (above or below knee) and both arms (above or below elbow).
2	1	Loss of both eyes or sight in both eyes and loss of either both legs (above or below knee), or both arms (above or below elbow).
3	1	Total deafness and loss of either both legs (above or below knee) or both arms (above or below elbow).
4	1	Loss of both arms where one loss is a shoulder disarticulation or forequarter loss, and the loss of the other arm is at any level.[1]
5	1	Loss of both arms above or below elbow (not shoulder disarticulation or forequarter) and one leg (above or below knee).
6	1	Loss of one arm, above or below elbow, and one leg, above or below knee, with total loss of use of another limb due to traumatic injury involving vital structures.[2]
7	2	Loss of both arms where one loss is at or above elbow (trans-humeral or elbow disarticulation) and the loss of the other arm is at, above or below elbow.
8	2	Loss of one arm above elbow (shoulder disarticulation or forequarter).[1]
9	2	Loss of both legs where one loss is at hip disarticulation or hindquarter loss, and the loss of the other leg is at any level.[1]
10	2	Loss of both legs above or below knee (not hip disarticulation or hemipelvectomy) and one arm (above or below elbow).
11	3	Loss of both arms below elbow (trans-radial).
12	3	Loss of both legs where one loss is at or above knee (trans-femoral or knee disarticulation) and the loss of the other is at any level.
13	3	Loss of one leg above knee (hip disarticulation or hemipelvectomy).[1]
14	4	Loss of one arm at or above elbow (trans-humeral or elbow disarticulation).
15	4	Loss of both legs below knee (trans-tibial).
16	4	Loss of both hands (wrist disarticulation) or where amputation distal to that site has led to permanent total loss of use of both hands.
17	5	Loss of one arm below elbow (trans-radial).

18	5	Loss of one leg at or above knee (trans-femoral or knee disarticulation).
19	5	Loss of both feet at ankle distal to the calcaneum.
20	6	Loss of one leg below knee (trans-tibial).
21	6	Loss of one hand (wrist disarticulation) or where amputation distal to that site has led to permanent total loss of use of one hand.
22	7	Loss of both thumbs.
23	8	Loss of one foot at ankle distal to the calcaneum.
24	10	Loss of both great toes.
25	10	Loss of thumb.
26	10	Loss of both index fingers.
27	10	Loss of two or more fingers, other than thumb or index finger, from each hand.
28	10	Partial loss of thumb and index finger from each hand.
29	11	Loss of two or more fingers, other than thumb or index finger, from one hand.
30	12	Loss of great toe.
31	12	Loss of two or more toes, other than great toe, from each foot.
32	12	Loss of index finger from one hand.
33	12	Partial loss of thumb and index finger from one hand.
34	12	Partial loss of two or more fingers, other than thumb or index finger, from each hand.
35	12	Loss of one finger, other than thumb or index finger, from each hand.
36	12	Partial loss of thumb or index finger from each hand.
37	12	Persistent phantom limb pain.
38	12	Stump neuroma with trigger point stump pain.
39	13	Loss of two or more toes, other than great toe, from one foot.
40	13	Partial loss of each great toe.
41	13	Partial loss of one finger, other than thumb or index finger, from each hand.
42	13	Loss of one finger, other than thumb or index finger, from one hand.
43	13	Partial loss of two or more fingers, other than thumb or index finger, from one hand.
44	13	Partial loss of thumb or index finger from one hand.
45	14	Partial loss of great toe from one foot.
46	14	Loss of one toe, other than great toe, from each foot.
47	14	Partial loss of one finger, other than thumb or index finger, from one hand.
48	14	Partial loss of two or more toes, other than great toe, from one foot.

49	15	Loss of one toe, other than great toe, from one foot.

(*) Loss of one or both legs below knee includes loss of foot with loss of all or part of calcaneum (heel).

(*) Loss of a finger or thumb means that amputation has taken place at the metacarpophalangeal joint.

(*) Loss of a toe means that amputation has taken place at the metatarsophalangeal joint.

Table 6 - Neurological disorders, including spinal, head or brain injuries(*)

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

(b) Labyrinthine causes of audiovestibular symptoms must be excluded by detailed specialist audiovestibular assessment.

Item	***Column (a)***	***Column (b)***
	Level	***Description of injury and its effects ("descriptor")***
1	1	Cervical spinal cord injury where the claimant requires ventilatory support and there is complete tetraparesis.
2	1	Cervical spinal cord injury with minimal upper limb function and complete or near complete paraparesis.
3	1	Complete brachial plexus injury with avulsion of the roots from the spinal cord, resulting in complete flaccid paralysis and sensory loss, with persistent severe central pain.
4	1	Brain injury with persistent vegetative state.
5	1	Brain injury resulting in major and permanent loss or limitation of responsiveness to the environment, including absence or severe impairment of language function, and a requirement for regular professional nursing care.
6	2	Cervical spinal cord injury with some useful upper limb function and complete or near complete paraparesis.
7	2	Thoracic spinal cord injury with complete paraparesis.
8	2	Injury to conus medullaris or cauda equina giving rise to complete paraparesis.
9	2	Complete brachial plexus injury with avulsion of the roots from the spinal cord, resulting in complete flaccid paralysis and sensory loss, without persistent severe central pain.
10	2	Partial brachial plexus injury in which spontaneous recovery or operative treatment has led to some restoration of useful function in the arm at the shoulder and elbow, but with no restoration of useful function in the hand.
11	2	Brain injury where the claimant has some permanent limitation of response to the environment together with substantial motor and sensory problems and one or more substantial cognitive, personality or behavioural problems, and that injury requires some professional nursing care and is likely to require considerable regular support from other health professionals.
12	3	Injury to conus medullaris or cauda equina giving rise to partial paraparesis or severe monoparesis.
13	3	Thoracic spinal cord injury with partial paraparesis.
14	4	Injury to conus medullaris or cauda equina giving rise to partial asymmetric paraparesis.
15	4	Uncontrolled post head injury epilepsy.

16	4	Traumatic spinal injury with partial spinal cord, conus or cauda equina damage causing paraparesis of upper or lower limbs, or both, with some recovery and restoration of upper limb motor and sensory function, but no useful manual dexterity or ability to walk.
17	4	Brain injury where the claimant has moderate and permanent motor or sensory problems and one or more permanent substantial cognitive, personality or behavioural problems, and that injury requires regular help or full-time supervision from others with activities of everyday living but does not require professional nursing care or regular help from other health professionals.
18	5	Partial brachial plexus injury in which spontaneous improvement or operative treatment has led to restoration of some useful function in the arm and hand.
19	5	Hemiplegia.
20	6	Injury to conus medullaris or cauda equina giving rise to partial monoparesis.
21	7	Traumatic spinal injury resulting in partial paresis of lower or upper limbs, or both, with substantial recovery, restoration of lower and upper limb motor and sensory function, including a useful ability to walk.
21A	7	Brain injury from which the claimant has made a substantial recovery, has no major cognitive personality or behavioural problems, but has substantial functionally disabling motor deficit in upper and or lower limbs, but is able to undertake some form of regular employment[(a)].
22	7	Brain injury from which the claimant has made a substantial recovery, has no major motor or sensory deficits, but does have one or more of a residual functionally disabling— (i) cognitive deficit, (ii) behavioural change, or (iii) change in personality, but is able to undertake some form of regular employment[(a)].
23	8	Mild brachial plexus injury with substantial recovery of arm and hand function resulting in good restoration of manual dexterity.
24	9	Permanent isolated damage to one cranial nerve.
25	10	Permanent foot or wrist drop.
26	11	Mild traumatic brain injury which has caused or is expected to cause either or both functionally limiting or restricting central nervous system symptoms or functionally limiting or restricting audiovestibular symptoms of peripheral labyrinthine origin[(b)] (including permanent sensorineural hearing loss of less than 50 dB averaged over 1, 2 and 3 kHz) for more than 52 weeks.
27	11	Brain or traumatic head injury with persistent balance symptoms and other functionally limiting neurological damage including permanent sensorineural hearing loss of less than 50dB averaged over 1, 2 and 3kHz.
27A	11	Intra-cerebral haematoma requiring or expected to require decompressive surgery and interval cranioplasty but with poor cosmetic result.
28	12	Cerebral infarction due to vascular injury in the neck, resulting in persisting impairment of function and restriction of activities.
29	12	Controlled post head injury epilepsy.
30	12	Permanent substantial peripheral motor sensory or autonomic nerve damage.
31	12	Entrapment neuropathy which has not responded to treatment.
32	13	Permanent facial numbness including lip.
33	13	Entrapment neuropathy which has responded, or is expected to respond, to treatment.

34	13	Mild traumatic brain injury or head injury which has caused or is expected to cause either or both functionally limiting or restricting central nervous system symptoms or functionally limiting or restricting audiovestibular symptoms of peripheral labyrinthine origin[(b)] for more than 6 weeks with substantial recovery thereafter.
35	14	Permanent facial numbness which does not include the lip.
36	15	Permanent minor peripheral sensory nerve damage.

(*) An award for brain injury in levels 1, 2 or 4 includes compensation for associated sexual dysfunction, incontinence of the bowel and bladder, and epilepsy.

(*) An award for a spinal injury including a spinal cord, conus medullaris or cauda equina injury, complete or partial, at any tariff level, includes compensation for associated sexual dysfunction and incontinence of the bowel and bladder.

(*) The descriptors for a brachial plexus injury are for a unilateral injury.

Table 7 - Senses(*)

[1] These descriptors apply to bilateral hearing loss caused otherwise than by blast injury or acute acoustic trauma due to impulse noise.

Item	*Column (a)*	*Column (b)*
	Level	*Description of injury and its effects ("descriptor")*
1	1	Total deafness and loss of both eyes, or total deafness and total blindness in both eyes, or total deafness and loss of one eye and total blindness in the other eye.
2	2	Loss of eyes.
3	2	Total blindness in both eyes.
4	2	Loss of one eye and total blindness in the other eye.
5	2	Total deafness in both ears.
6	5	Loss of one eye and permanent damage to the other eye, where visual acuity is correctable to 6/36.
7	5	Blast injury to ears or acute acoustic trauma due to impulse noise with permanent bilateral sensorineural hearing loss of more than 75dB averaged over 1, 2 and 3kHz.
8	6	Severe binocular visual field loss.
9	6	Blast injury to ears or acute acoustic trauma due to impulse noise with permanent sensorineural hearing loss of 50-75dB averaged over 1, 2 and 3kHz in one ear and more than 75dB loss averaged over 1, 2 and 3kHz in the other.
10	6	Bilateral permanent hearing loss of more than 75dB averaged over 1, 2 and 3kHz.[1]
11	7	Blast injury to ears or acute acoustic trauma due to impulse noise with permanent bilateral sensorineural hearing loss of 50-75dB averaged over 1, 2 and 3kHz.
12	8	Total deafness in one ear.
13	8	Bilateral permanent hearing loss of 50-75dB averaged over 1, 2 and 3kHz.[1]
14	8	Loss of one eye or total blindness in one eye.
15	9	Partial loss of vision where visual acuity is correctable to 6/60.
16	9	Permanent and inoperable cataracts in both eyes.

17	10	Partial loss of vision where visual acuity is correctable to better than 6/60 and at least 6/36.
18	10	Detached retina in both eyes.
19	10	Blast injury to ears or acute acoustic trauma due to impulse noise with permanent sensorineural hearing loss in one ear of more than 75dB averaged over 1, 2 and 3kHz.
20	10	Acute physical trauma to ear causing conductive or permanent sensorineural hearing loss in one ear of more than 75dB averaged over 1, 2 and 3kHz.
21	11	Partial loss of vision where visual acuity is correctable to better than 6/36 and at least 6/18.
22	11	Blast injury to ears or acute acoustic trauma due to impulse noise with permanent sensorineural hearing loss in one ear of 50-75dB averaged over 1, 2 and 3kHz.
23	11	Acute physical trauma to ear causing conductive or permanent sensorineural hearing loss in one ear of 50-75dB averaged over 1, 2 and 3kHz.
24	12	Partial loss of vision where visual acuity is correctable to better than 6/18 and at least 6/12.
25	12	Permanent and inoperable cataract in one eye.
26	12	Operable cataracts in both eyes.
27	12	Moderate binocular visual field loss.
28	12	Detached retina in one eye.
29	12	Secondary glaucoma.
29A	12	Traumatic uveitis.
29B	12	Post head injury hyposmia or anosmia.
30	13	Significant penetrating, or blunt injury, to both eyes.
31	13	Retinal damage (not detached) to both eyes.
32	13	Partial loss of vision where visual acuity is correctable to better than 6/12.
33	13	Dislocation of lens in one eye.
34	13	Degeneration of optic nerve in both eyes.
35	13	Permanent diplopia.
36	13	Blast injury to ears or acute acoustic trauma due to impulse noise.
37	13	Acute physical trauma to ear causing conductive or permanent sensorineural hearing loss in one ear.
38	14	Diplopia which is present, or is expected to be present, at 13 weeks, from which the claimant has made, or is expected to make, a substantial recovery beyond that date.
39	14	Operable cataract in one eye.
40	14	Corneal abrasions in both eyes.
41	14	Hyphaema in both eyes which has required, or is expected to require, operative treatment.
42	14	Retinal damage (not detached) in one eye.

43	14	Significant penetrating, or blunt, injury in one eye.
44	14	Degeneration of optic nerve in one eye.
45	14	Slight binocular visual field loss.
46	14	Traumatic mydriasis.
47	15	Diplopia which is present, or is expected to be present, at 6 weeks, from which the claimant has made, or is expected to make, a substantial recovery beyond that date.
48	15	Corneal abrasions in one eye.
49	15	Hyphaema in one eye which has required, or is expected to require, operative treatment.

(*) For the purposes of this table the following definitions apply:—

"Total blindness in both eyes" means that the claimant must have been diagnosed as being blind by an accredited medical specialist;

"Total blindness in one eye" means that the claimant must have been diagnosed by an accredited medical specialist as having visual acuity of 3/60 or worse in the affected eye;

"Total deafness" means that the claimant's bilateral average hearing threshold level is 90dB or more, averaged over 1, 2 and 3kHz, as measured by appropriately calibrated equipment meeting British Standards, operated by trained staff, and using quality assured pure tone audiometry;

"Total deafness in one ear" means that the average hearing threshold is 90dB or more averaged over 1, 2 and 3kHz as measured by appropriately calibrated equipment meeting British Standards, operated by trained staff, and using quality assured pure tone audiometry.

(*) All awards for hearing loss, including blast injury to ears and acute acoustic trauma, include compensation for associated tinnitus, and no separate award is payable for tinnitus alone.

(*) Degree of visual field loss must be assessed by reference to an accredited specialist physician report which includes reasons.

Table 8 - Fractures and dislocations(*)

Item	*Column (a)*	*Column (b)*
	Level	*Description of injury and its effects ("descriptor")*
1	9	Fracture of one femur, tibia, humerus, radius or ulna, with complications, causing permanent significant functional limitation or restriction.
2	9	Fracture or dislocation of one hip, knee, ankle, shoulder, elbow, or wrist, which has required, or is expected to require, arthrodesis, osteotomy or total joint replacement.
3	10	Fractured heels of both feet causing permanent significant functional limitation or restriction.
4	10	Fractures or dislocations of both hips, both knees, both ankles, both shoulders, both elbows or both wrists causing permanent significant functional limitation or restriction.
5	10	Multiple face fractures causing permanent significant cosmetic effect and functional limitation or restriction despite treatment.
6	11	Fractures or dislocations of both hips, both knees, both ankles, both shoulders, both elbows or both wrists which have caused, or are expected to cause, significant functional limitation or restriction beyond 26 weeks.
7	11	Fractured heel of one foot causing permanent significant functional limitation or restriction.

8	11	Fractured heel of both feet which has caused, or is expected to cause, significant functional limitation or restriction beyond 26 weeks.
9	11	Fracture of pelvis which has caused, or is expected to cause, significant functional limitation or restriction beyond 26 weeks.
10	11	Fracture or dislocation of great toe of both feet, which has caused, or is expected to cause, significant functional limitation or restriction beyond 26 weeks.
11	11	Fractured tarsal bones of both feet which have caused, or are expected to cause, significant functional limitation or restriction beyond 26 weeks.
12	11	Fractures of both femurs, both tibiae, both humeri, both radii or both ulnae which have caused, or are expected to cause, significant functional limitation or restriction beyond 26 weeks.
13	11	Fracture of one femur, tibia, humerus, radius or ulna causing permanent significant functional limitation or restriction.
14	11	Fracture of one femur, tibia, humerus, radius or ulna, with complications, which has caused, or is expected to cause, significant functional limitation or restriction beyond 52 weeks.
15	11	Multiple fractures to face, or face and neck where treatment has led, or is expected to lead, to a good cosmetic and functional outcome.
16	11	Fracture or dislocation of one hip, knee, ankle, shoulder, elbow or wrist causing permanent significant functional limitation or restriction.
17	11	Shoulder joint instability which has required or is expected to require operative treatment with permanent significant functional limitation or restriction.
17A	12	Shoulder joint instability which has required or is expected to require operative treatment with substantial recovery.
18	12	Fracture of one femur, tibia, humerus, radius or ulna, which has caused, or is expected to cause, significant functional limitation or restriction beyond 26 weeks.
19	12	Fracture of mandible or maxilla, which has required, or is expected to require, operative treatment and which has caused, or is expected to cause, significant functional limitation or restriction beyond 26 weeks.
20	12	Fracture of both hands which has caused, or is expected to cause, significant functional limitation or restriction beyond 26 weeks.
21	12	Fractures of both clavicles, or both scapulae, which have caused, or are expected to cause, significant functional limitation or restriction beyond 26 weeks.
22	12	Fracture of the skull with sub-dural or extra-dural haematoma which has required evacuation, from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
23	12	Fracture or dislocation of thumb of both hands which has caused, or is expected to cause, significant functional limitation or restriction beyond 26 weeks.
24	12	Fracture or dislocation of one hip, knee, ankle, shoulder, elbow or wrist, which has caused, or is expected to cause, significant functional limitation or restriction beyond 26 weeks.
25	12	Fracture or dislocation of index finger on both hands which has caused, or is expected to cause, significant functional limitation or restriction beyond 26 weeks.
26	12	Fracture or dislocation of great toe or associated structures of one foot which has caused, or is expected to cause, significant functional limitation or restriction beyond 26 weeks.

27	12	Fractured tarsal bones on one foot which have caused, or are expected to cause, significant functional limitation or restriction beyond 26 weeks.
28	12	Fractured heel of one foot which has caused, or is expected to cause, significant functional limitation or restriction beyond 26 weeks.
29	12	Fractured heel of both feet from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
30	12	Fractured or dislocated patella on both knees which has caused, or is expected to cause, significant functional limitation or restriction beyond 26 weeks.
31	12	Fractured metatarsal bones on both feet which have caused, or are expected to cause, significant functional limitation or restriction beyond 26 weeks.
32	12	Fractures of both femurs, both tibiae, both humeri, both radii or both ulnae, from which the claimant has made, or is expected to make a substantial recovery within 26 weeks.
33	12	Depressed skull fracture requiring operative treatment.
34	13	Fractured tarsal or metatarsal bones on both feet from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
35	13	Fracture or dislocation of metatarsal bones on one foot which has caused, or is expected to cause, significant functional limitation or restriction beyond 26 weeks.
36	13	Fracture or dislocation of great toe of both feet from which the claimant has made or is expected to make a substantial recovery within 26 weeks.
37	13	Fracture of one femur, tibia, humerus, radius or ulna from which the claimant has made, or is expected to make a substantial recovery within 26 weeks.
38	13	Fracture of skull with intracranial, extracerebral haematoma that has not required evacuation.
39	13	Fracture of ethmoid which has required or is expected to require operative treatment.
40	13	Fracture of zygoma which has caused, or is expected to cause, significant functional limitation or restriction beyond 26 weeks.
41	13	Fracture or dislocation of one hip, knee, ankle, shoulder, elbow or wrist from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
42	13	Fracture of one hand which has caused, or is expected to cause, significant functional limitation or restriction beyond 26 weeks.
43	13	Fractured heel of one foot, from which the claimant has made, or is expected to make a substantial recovery within 26 weeks.
44	13	Fracture of both hands from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
45	13	Blow-out, or other, fracture of orbit which has required, or is expected to require, operative treatment.
46	13	Dislocated jaw which has caused, or is expected to cause, significant functional limitation or restriction beyond 26 weeks.
47	13	Fracture of one scapula or one clavicle which has caused, or is expected to cause, significant functional limitation or restriction beyond 26 weeks.
48	13	Fracture of both clavicles or both scapulae from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.

49	13	Fracture of pelvis from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
50	13	Fracture of sternum which has, or is expected to have, symptoms continuing beyond 26 weeks.
51	13	Subluxed dislocated acromio or sterno-clavicular joint, which has caused, or is expected to cause, significant functional limitation or restriction beyond 26 weeks.
52	13	Fractures or dislocations of two or more toes, other than great, of both feet which have caused, or are expected to cause, significant functional limitation or restriction beyond 26 weeks.
53	13	Fracture or dislocation of thumb on one hand which has caused, or is expected to cause, significant functional limitation or restriction beyond 26 weeks.
54	13	Fracture or dislocation of thumb of both hands which has caused, or is expected to cause, significant functional limitation or restriction at 13 weeks from which the claimant has made, or is expected to make a substantial recovery within 26 weeks.
55	13	Fractures or dislocations of index finger on both hands, which have caused, or are expected to cause, significant functional limitation or restriction at 13 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
56	13	Fractures or dislocations of two or more fingers, other than index, on both hands, which have caused, or are expected to cause, significant functional limitation or restriction beyond 26 weeks.
57	13	Fracture or dislocation of index finger on one hand which has caused, or is expected to cause, significant functional limitation or restriction beyond 26 weeks.
58	13	Fractured or dislocated patella of one knee which has caused, or is expected to cause significant functional limitation beyond 26 weeks.
59	13	Shoulder joint instability not requiring operative treatment.
60	14	Dislocated jaw from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
61	14	Fractured zygoma from which the claimant has made, or is expected to make a substantial recovery within 26 weeks.
62	14	Fractured ethmoid which has not, or is not expected to require, operative treatment.
63	14	Fracture of mandible or maxilla from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
64	14	Fracture of one hand from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
65	14	Deviated nasal septum requiring corrective surgery.
66	14	Displaced fracture of nasal bones.
67	14	Simple skull fracture.
68	14	Fractured fibula which has caused, or is expected to cause, significant functional limitation or restriction beyond 26 weeks.
69	14	Fracture or dislocation of thumb on one hand which has caused, or is expected to cause, significant functional limitation or restriction at 13 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.

70	14	Fracture or dislocation of index finger, on one hand, which has caused, or is expected to cause, significant functional limitation or restriction at 13 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
71	14	Fracture or dislocation of one finger, other than index, on both hands, which has caused, or is expected to cause, significant functional limitation or restriction beyond 26 weeks.
72	14	Fractures or dislocations of two or more fingers, other than index, on one hand, which have caused, or are expected to cause significant functional limitation or restriction beyond 26 weeks.
73	14	Fractures or dislocations of two or more fingers, other than index, on both hands which have caused, or are expected to cause, significant functional limitation or restriction beyond 13 weeks from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
74	14	Fractures or dislocations of two or more toes, other than great toe, on one foot, which have caused, or are expected to cause, significant functional limitation or restriction beyond 26 weeks.
75	14	Fractures or dislocations of one toe other than great toe, on both feet, which have caused, or are expected to cause, significant functional limitation or restriction beyond 26 weeks.
76	14	Fractures or dislocations of two or more toes, other than great toe, on both feet, from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
77	14	Fracture or dislocation of great toe on one foot from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
78	14	Fracture or dislocation of index finger on both hands, from which the claimant has made, or is expected to make, a substantial recovery within 13 weeks.
79	14	Fracture or dislocation of thumb on both hands, from which the claimant has made, or is expected to make, a substantial recovery within 13 weeks.
80	14	Subluxed dislocated acromio or sterno-clavicular joint from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
81	14	Fracture of coccyx from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
82	14	Fracture of clavicle or scapula from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
83	14	Fracture of sternum from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
84	14	Fractured tarsal or metatarsal bones on one foot which have caused, or are expected to cause, significant functional limitation or restriction at 13 weeks from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
85	14	Fractured or dislocated patella of both knees which has caused, or is expected to cause, significant functional limitation or restriction at 6 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
86	14	Stress fracture where symptoms have lasted, or are expected to last, for more than 6 weeks.
87	15	Fracture of mastoid.
88	15	Undisplaced fracture of nasal bones.
89	15	Deviated nasal septum which has not required, or is not expected to require, operative treatment.

90	15	Fractured or dislocated patella of one knee which has caused, or is expected to cause, significant functional limitation or restriction at 6 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
91	15	Fracture of three or more ribs.
92	15	Fractures or dislocations of two or more toes, on one foot, which have caused, or are expected to cause significant functional limitation or restriction at 13 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
93	15	Fractures or dislocations of one toe, other than great toe, on both feet, which have caused, or are expected to cause significant functional limitation or restriction at 13 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
94	15	Fracture or dislocation of thumb on one hand from which the claimant has made, or is expected to make, a substantial recovery within 13 weeks.
95	15	Fractured tarsal or metatarsal bone on one foot, which has caused, or is expected to cause, significant functional limitation or restriction at 6 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 13 weeks.
96	15	Fracture or dislocation of two or more fingers, other than index, on one hand which have caused, or are expected to cause, significant functional limitation or restriction at 13 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
97	15	Fracture or dislocation of two or more fingers, other than index, on both hands, from which the claimant has made, or is expected to make, a substantial recovery within 13 weeks.
98	15	Fracture or dislocation of one finger, other than index, on both hands, which has caused, or is expected to cause, significant functional limitation or restriction at 13 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
99	15	Fracture or dislocation of index finger on one hand, from which the claimant has made, or is expected to make, a substantial recovery within 13 weeks.
100	15	Fracture or dislocation of one finger, other than index, on one hand, which has caused or is expected to cause significant functional limitation or restriction beyond 26 weeks.
101	15	Fractured fibula from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
102	15	Fracture of three vertebral transverse or spinous processes.

(*) In this table, shoulder includes acromio-clavicular and sterno-clavicular joints.

(*) An award for an injury in this table includes compensation for any expected consequential osteoarthritis.

(*) An award for dislocation includes ligament and other soft tissue damage not requiring operative treatment.

(*) Where a fracture results in a dislocation only one award is payable.

Table 9 - Musculoskeletal disorders(*)

Item	*Column (a)*	*Column (b)*
	Level	*Description of injury and its effects ("descriptor")*
1	9	Permanent severely impaired grip in both hands.
2	9	Septic arthritis or other pathology requiring arthrodesis ,osteotomy or partial or total joint replacement.

2A	9	2A 9 Traumatic back injury resulting in vertebral or intervertebral disc damage and medically verified neurological signs, which has required, or is expected to require, operative treatment and which is expected to result in permanent significant functional limitation or restriction.
2B	9	Septic, rheumatoid or post traumatic arthritis requiring arthrodesis, osteotomy or total joint replacement.
3	10	Ligament injury which has resulted in full thickness rupture, affecting both knees, ankles, shoulders, elbows or wrists, causing permanent significant functional limitation or restriction.
4	11	Ligament injury which has resulted in full thickness rupture, affecting one hip, knee, ankle, foot, shoulder, elbow or wrist, causing permanent significant functional limitation or restriction.
5A	11	Full thickness muscle or tendon unit rupture causing permanent significant functional limitation or restriction.
5	11	Ligament injury which has resulted in full thickness rupture, affecting both knees, ankles, shoulders, elbows, wrists which has caused, or is expected to cause, significant functional limitation or restriction at 26 weeks, from which the claimant is expected to make a substantial recovery beyond that date.
6	11	Traumatic back injury (with medically verified neurological signs and vertebral damage) extending over several levels of vertebrae, which has required, or is expected to require, operative treatment and which has caused, or is expected to cause, significant functional limitation or restriction beyond 13 weeks.
7	11	Radiologically confirmed juxta-articular aseptic necrosis of hip or shoulder.
8	11	Ligament injury short of full thickness rupture, to both knees, ankles, shoulders, elbows or wrists, causing permanent significant functional limitation or restriction.
9	11	Permanent severely impaired grip in one hand.
10	11	Radiologically confirmed osteoarthritis of both hips, both knees, both ankles, both shoulders, both elbows or both wrists (caused by a repetitive or attrition injury), causing permanent significant functional limitation or restriction.
11	12	Two frozen shoulders, or other shoulder pathology, which have caused, or are expected to cause, significant functional limitation or restriction beyond 26 weeks.
12	12	Ligament injury short of full thickness rupture, to both knees, ankles, shoulders, elbows or wrists, which has caused, or is expected to cause, significant functional limitation or restriction at 26 weeks, from which the claimant has made or is expected to make a substantial recovery beyond that date.
13	12	Ligament injury, short of full thickness rupture, to one knee, ankle, foot, shoulder, elbow or wrist causing permanent significant functional limitation or restriction.
14	12	Ligament injury, which has resulted in full thickness rupture, affecting one knee, ankle, foot, shoulder, elbow or wrist which has caused, or is expected to cause, significant functional limitation or restriction at 26 weeks from which the claimant has made, or is expected to make, a substantial recovery beyond that date.
15	12	Full thickness muscle or tendon unit rupture which has caused, or is expected to cause, significant functional limitation or restriction beyond 26 weeks.
16	12	Traumatic back injury (with medically verified neurological signs and vertebral damage), extending over several levels of vertebrae which has caused, or is expected to cause, significant functional limitation or restriction beyond 13 weeks.

16A	12	Traumatic back injury with one or more intervertebral disc prolapses or vertebral body or facet joint fractures which has required, or is expected to require, operative treatment and which has caused, or is expected to cause, significant functional limitation or restriction beyond 13 weeks.
16B	12	Radiologically confirmed tarsal or metatarsal avascular necrosis requiring operative intervention.
16C	12	Recurrent subluxation of patella.
16D	12	Hip, pelvis, knee, ankle, shoulder, elbow or wrist strain, sprain or overuse injury with confirmed significant osteochondral defect, and which has required or is expected to require operative treatment.
17	13	Frozen shoulder, or other shoulder pathology, which has caused, or is expected to cause, significant functional limitation or restriction beyond 26 weeks.
18	13	Two frozen shoulders, or other shoulder pathology, which have caused or are expected to cause significant functional limitation at 6 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
19	13	Ligament injury short of full thickness rupture, to both knees, ankles, shoulders, elbows or wrists from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
20	13	Muscle or tendon unit injury short of full thickness rupture, which has caused, or is expected to cause, significant functional limitation or restriction beyond 26 weeks.
21	13	Two muscle or tendon unit injuries, short of full thickness rupture, from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
22	13	Full thickness muscle or tendon unit rupture, from which the claimant has made, or is expected to make a substantial recovery within 26 weeks.
23	13	Ligament injury short of full thickness rupture, to one knee, shoulder, ankle, elbow or wrist which has caused, or is expected to cause, significant functional limitation or restriction at 26 weeks with substantial recovery beyond that date.
24	13	Traumatic back injury with one or more intervertebral disc prolapses or vertebral body or facet joint fractures which has caused or is expected to cause, significant functional limitation or restriction beyond 13 weeks.
25	13	Radiologically confirmed osteoarthritis of hip, knee, ankle, back, shoulder, elbow or wrist (caused by repetitive or attrition injury) causing permanent significant functional limitation or restriction.
26	13	Overuse injury of lower limb requiring, or expected to require, operative treatment.
27	13	Hip, pelvis, knee, ankle, shoulder, elbow or wrist strain, sprain or overuse injury, which has required, or is expected to require, operative treatment.
27A	13	Ligament injury which has resulted in full thickness rupture affecting one knee, ankle, shoulder, elbow or wrist from which the claimant has made or is expected to make a substantial recovery within 26 weeks.
28	14	Frozen shoulder, or other shoulder pathology, which has caused, or is expected to cause, significant functional limitation or restriction at 6 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
29	14	Ligament injury short of full thickness rupture to one knee, ankle, shoulder, elbow or wrist, which has caused or is expected to cause, significant functional limitation or restriction at 13 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
30	14	Muscle or tendon unit injury short of full thickness rupture, which has caused or is expected to cause significant functional limitation or restriction at 13 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.

31	14	Tendon or ligament rupture of finger, thumb or toe which has required, or is expected to require, operative treatment.
32	14	Back sprain or strain, with one or more intervertebral disc prolapses which has caused, or is expected to cause significant functional limitation or restriction beyond 13 weeks.
33	14	Low back or neck pain syndrome.
34	14	Anterior knee pain syndrome in both knees which has caused, or is expected to cause, significant functional limitation or restriction at 6 weeks, from which the claimant has made, or is expected to make, a substantial recovery beyond that date.
35	14	Overuse injury of foot or heel, which has required or is expected to require operative treatment.
35A	15	Overuse injury of foot or heel which has not required operative treatment.
36	15	Knee meniscus injury which has caused, or is expected to cause, significant functional limitation or restriction at 6 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 26 weeks.
37	15	Anterior knee pain syndrome in one knee which has caused, or is expected to cause, significant functional limitation or restriction at 6 weeks, from which the claimant has made, or is expected to make, a substantial recovery beyond that date.
38	15	hernia which has required operative treatment.
39	15	Frozen shoulder which has caused, or is expected to cause, significant functional limitation or restriction at 6 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 13 weeks.
40	15	Ligament injury short of full thickness rupture, to one knee, ankle, shoulder, elbow or wrist which has caused, or is expected to cause, significant functional limitation or restriction at 6 weeks, from which the claimant has made, or is expected to make, a substantial recovery within 13 weeks.

(*) Post traumatic arthritis is arthritis which is secondary to a significant traumatic injury which was documented in the medical records at the time it occurred

(*) An award for an injury in this table includes compensation for any expected consequential osteoarthritis.

(*) An award for dislocation includes ligament and other soft tissue damage not requiring operative treatment.

(*) References to back in this table include cervical, thoracic, lumbar and sacral vertebral segments or coccyx.

Table 10 - Tariff amounts

Column (a) Level	Column (b) Amount
1	£650,000
2	£484,100
3	£391,400
4	£298,700
5	£180,250
6	£144,200
7	£92,700

Column (a) Level	Column (b) Amount
8	£61,800
9	£41,200
10	£27,810
11	£15,965
12	£10,300
13	£6,180
14	£3,090
15	£1,236

ANNEX E: Case Studies

CASE STUDY I—NICKY

Nicky was medically discharged in early 2021 due to osteoarthritis in both knees and carpal tunnel syndrome in both hands. Symptoms for the latter began presenting in 2017. In 2019, Nicky was diagnosed with Complex Regional Pain Syndrome. The surgery that Nicky had to their right hand in 2020 only made it worse. Today, Nicky is undergoing therapies to help manage the pain and live with the symptoms and effects of the injuries, including significantly disrupted sleep.

In April 2021, whilst at a Personnel Recovery Unit, an MoD official convinced Nicky to submit an AFCS claim for their injuries. The representative filled out the form on Nicky's behalf as they were unable to use their dominant hand due to the severity of their injuries. Soon after, Nicky received a request for evidence despite having sent it already. On enquiry, the MoD confirmed the evidence had been lost.

In August 2021, four months after submission, Nicky received a decision; the osteoarthritis in Nicky's knees predated 2005 and therefore was considered under the WPS. The claim for carpal tunnel syndrome in the hands was denied as the MoD did not consider the injury to attributable to service. In the decision letter, the MoD stated that, on the balance of probabilities, the injury was neither partly nor wholly caused by service, nor was it worsened by service, citing the legislation.

The MoD identified that the potential cause was a '[s]lip on black ice in the winter of 2016' for which '[t]here is no evidence that this was related to any aspects of service', despite the incident not being documented in Nicky's medical notes. The MA wrote that, the slip is unlikely to have been the cause, but, as per the synopsis of causation, there is a strong association between Carpal Tunnel Syndrome and obesity, noting that Nicky's BMI was 39, concluding that, the 'claim is for rejection'.

Despite the difficulty the caseworker clearly had identifying the cause of the original injury, they did not call Nicky to ask if there was any other evidence or whether Nicky could provide more information. If they had, Nicky would have told them that the reason the slip on ice is not in their notes is because it had not been a notable event. It is only in the Medical Board (held in 2020) report because the Board asked whether there were any incidents Nicky thought, in hindsight, could have contributed. Nicky thought hard and mentioned the slip, but qualified it was only mentioned because they could think of nothing else.

Nicky has questions about why the elevated BMI is not considered a result of the osteoarthritis in the knees which presented in the late 2000's and was accepted for a WPS award. And why their osteoarthritis was not considered for an AFCS award. Nicky has decided against appealing or calling for clarification as they are too embarrassed by the comments on their weight. As Nicky struggles with their mental health, they prefer to avoid the situation all together, especially as Nicky just 'doesn't want to fight with anybody'.

CASE STUDY II—CHARLIE

Charlie was diagnosed in service with Complex Post Traumatic Stress Disorder (CPTSD) in May 2017 and was under the care of the Department of Community Mental Health (DCMH) (a DMS service) at the time of their initial AFCS award in early 2020: a Tariff 12 Interim Award indicating that the MoD determined Charlie's CPTSD 'has caused, or is expected to cause functional limitation or restriction at 2 years, from which the claimant has made, or is expected to make, a substantial recovery within 5 years', attracting a lump sum only of £10,300. A review was set for July 2022. At the time, Charlie had been receiving treatment for three years and was 18 months into a two-year graduated return to work programme.

In December 2020, consultants determined that Charlie should do no more than six hours of low stress work from home. They wrote that, although Charlie was dedicated to recovery and intensive treatment resulting in their learning techniques to manage the symptoms, they expect the symptoms are more than likely to persist. In March 2021, Charlie was discharged and transferred immediately into the care of the NHS Veteran's Mental Health Complex Treatment Service (CTS) via the Veteran's Mental Health Transition, Intervention and Liaison Services (TILS).

The impact of the CPTSD on Charlie's family, social and occupational life is extensive. Charlie must live by a strict routine, and to provide the best support possible, so do their spouse and four children. As Charlie struggles to cope with unexpected or increased pressure, they are unable to participate fully in childcare. Thus, Charlie's spouse only works during term time. Due to the wide-ranging impact of the CPTSD, Charlie's spouse has registered as their carer and two eldest children as Young Carers. Charlie found a civilian role that meets the requirements set by the graduated return to work programme but has frequently taken time off due to pressures exacerbating their condition.

In July 2022, MoD wrote that, on review, the Interim Award had been extended as the 'prognosis remains uncertain' since 'the letter [from the Consultant Psychiatrist] implies that [they] work' and 'progress' was being made with treatment, despite the 'progress' clearly referring to symptom management not recovery. Charlie's award was increased to a Tariff Level 10 interim award, attracting a GIP and lump sum, by which Charlie's CPTSD was expected to 'caus[e] functional limitation or restriction, which has continued, or is expected to continue for 5 years.' The award was to be reviewed in July 2024.

In addition to being unclear how the MoD arrived at this decision, the prolonged financial instability and uncertainty caused by the AFCS process, aggravated Charlie's symptoms. In Charlie's words: 'I have worked extremely hard to develop a way of life that allows me to manage my injuries and to live at home… [A] sustainable longer-term solution desperately requires an Armed Forces Compensation Scheme award that reflects the permanence and severity of my injuries, which will protect me and my family moving forwards, as soon as possible.'

At the time of the first Interim Award review, the information above was available to the MoD; five years of medical notes, the impact on family and social life, and determinations made by DMS and NHS regarding occupational prospects and ongoing needs. In fact, in April 2021, the consultant confirmed that Charlie will be 'unable to be fully integrated into family life let alone secure and sustain meaningful employment'.

In August 2022, one month after the review decision and more than two years since initial application, having written to their MP and various officials querying their award decisions, Charlie received notification from MoD that, having received 'new information', they are making a final Tariff Level 6 award in recognition that Charlie has a '[p]ermanent mental disorder, causing severe functional limitation or restriction'. Charlie had not submitted any new evidence.

CASE STUDY III—SAM

In November 2016, following their first experience of suicidal ideation, Sam was diagnosed with PTSD attributed to multiple instances of combat-related trauma. At the time Sam submitted their AFCS claim in 2018, they had been signed off work for over a year and had a discharge date set for March 2019; the Medical Board had determined that, due to their PTSD, there was 'no likelihood of a return to work within a military capacity'. Moreover, Sam described not being able to maintain relationships with friends and family as a result of trying to manage their symptoms, resulting in increasing isolation.

Based on the evidence, the MoD determined that it was fair to award Sam a Table 3 Tariff Level 12 Interim Award, to be reviewed within two years, whereby the PTSD 'has caused, or is expected to cause functional limitation or restriction at 2 years, from which the claimant has made, or is expected to make, a substantial recovery within 5 years.' (Table 3, Annex D) That is a lump sum only of £10,300.

In providing a statement regarding the financial impacts of the decision, Sam described that they are unable to support their children, including making child maintenance payments, nor make the necessary mortgage payments which may result in the sale of their home. Moreover, the process had aggravated their co-morbid depression, exacerbating the PTSD symptoms, as the lack of recognition of their condition made Sam feel worthless and ashamed of even applying to the AFCS. The MoD had signalled that, despite being unable to continue to serve or to undertake any paid work, Sam's condition was not bad enough to warrant meaningful compensation or a guaranteed income payment. At their worst moments, Sam felt this way too and that their life was not worth living.

Sam was told by their consultant that the AFCS process itself and the financial uncertainty it caused amounted to a form of secondary trauma, which had prompted further instances of suicidal ideation. In other words, Sam felt badly let down by the organisation that should have been there to support them at their most challenging time. By the end of 2018, much of Sam's energy was going into managing their symptoms, including those aggravated by the AFCS process, leaving little space for trying to build and maintain a healthy family and social life and they became increasingly isolated. Sam remained unable to undertake any form of paid work throughout this process.

Being of a higher rank than most AFCS claimants, thus having a network of senior contacts in the MoD and experience of dealing with its bureaucratic processes, Sam was able to raise his case with officials. His arguments were based on a comprehensive analysis of where the intent of the legislation and the policy were not being carried through in their implementation. Thus, in 2019, Sam's Interim Award was reviewed, and they received their final award of a Table 3 Tariff 6 award, whereby the PTSD was deemed a 'Permanent mental disorder, causing severe functional limitation or restriction'. This level of award attracted a Guaranteed Income Payment and Armed Forces Independence Payment, both of which proved vital to Sam, who has been unable to undertake any form of paid work since.