GOVERNMENT RESPONSE TO FOLLOW-UP QUESTIONS ON THE DEFENCE COMMITTEE REPORT: THE ARMED FORCES COVENANT IN ACTION? PART 1: MILITARY CASUALTIES

Introduction

The Ministry of Defence (MOD), in consultation with the Department of Health (DH), has prepared this memorandum as the formal response on behalf of the Government to the House of Commons Defence Committee's follow up to their report on the Armed Forces Covenant in Action? Part 1: Military Casualties, the Seventh Report of Session 2010-12. The Government's formal response to its specific questions is set out below. Where appropriate, related recommendations have been grouped together and we have responded with a single narrative. The Committee's questions are in bold italics, with the Government's response in plain text. For ease of reference, section numbering follows that in the “Conclusions and Recommendations” section of the Committee’s annex of follow up questions.

Medical Treatment And Rehabilitation

2. The Government Response stated that “The establishment of the Transition Protocol and the Armed Forces Covenant have complemented the cross-Government partnership between MoD and DH alongside the Devolved Administrations to address the health care needs of the Service personnel, their families and veterans.” Can you tell us how the Transition Protocol is working and how many personnel have been helped by the Protocol?

The Transition Protocol was introduced in September 2010. A 6-month pilot of the Transition Protocol concluded in May 2011. The pilot scheme included wounded, injured and sick individuals with battle and non-battle injuries, and a variety of medical and social care requirements across the 3 Services. The pilot proved that the Protocol was fit for purpose, but also identified a number of lessons:

- The need for a single MOD Case Co-ordinator.
- The need to ensure the Patient Group is fully aware of who the Department of Health and MOD Co-ordinators are.
- Ensure all members of the Multi-Disciplinary Team (MDT) have a common understanding of the patient’s needs.
- Military abbreviations must be avoided in discussions with the Department of Health to prevent confusion.
- Early engagement with the MDT, at least 6 months prior to discharge.

These lessons have since been incorporated in the Transition Protocol and re-publicised across Defence.

It is not possible to say precisely how many personnel have been helped by the Transition Protocol in its first year. However, as a Defence-wide policy it applies to all wounded, injured or sick Service men and women who are medically discharged from Service. In 2011/12, 1,615 personnel were medically discharged, and most would have been helped to a greater or lesser extent by the Protocol.

We are also working on an overarching Defence Recovery Policy, which will incorporate all elements of the Transition Protocol. It will set out requirements for case conferences and the use of Defence Recovery Centres, to ensure that people will leave their Service only when it is the right time to do so, by answering 5 key questions:

- What is the individual’s permanent medical category?
- What is the individual’s employability in their Service?
- Has their treatment been optimised or reached a plateau?
- Has he/she completed all of their resettlement/ retraining?
- Is society ready to take on their support from the Armed Forces?
It is anticipated that the Defence Recovery Policy will be published by the end of 2012.

The Government Response also pointed to the creation of a Cabinet Sub-Committee to address Covenant issues. We understand that the Committee is chaired by Oliver Letwin with Steve Webb as his deputy. Who are the other members of the Sub-Committee? How often has it met? What has it discussed and what outcomes have there been?

The full membership of the Sub-Committee is as follows:

Minister of State – Cabinet Office (Chair) (The Rt Hon Oliver Letwin MP)
Minister of State – Department for Work and Pensions (Deputy Chair) (Steve Webb MP)
Minister of State – Ministry of Defence (Nick Harvey MP)
Minister of State – Department for Business, Innovation and Skills (John Hayes MP)
Minister of State – Department of Health (The Rt Hon Simon Burns MP)
Minister of State – Department for Education (Sarah Teather MP)
Minister of State – Department for Education (Nick Gibb MP)
Minister of State – Department for Communities and Local Government (The Rt Hon Grant Shapps MP)
Minister of State – Northern Ireland Office (The Rt Hon Hugo Swire MP)
Economic Secretary to the Treasury (Chloe Smith MP)
Parliamentary Under Secretary of State – Ministry of Justice (Crispin Blunt MP)
Parliamentary Under Secretary of State – Home Office (Lynne Featherstone MP)
Parliamentary Under Secretary of State – Ministry of Defence (The Rt Hon Andrew Robathan MP)
Parliamentary Under Secretary of State – Department for Transport (Mike Penning MP)
Parliamentary Under Secretary of State – Scotland Office (The Rt Hon David Mundell MP)
Parliamentary Under Secretary of State – Wales Office (David Jones MP)

The Committee has met four times so far – including two meetings attended by the Prime Minister – and has discussed a range of topics related to the Armed Forces Covenant. At its latest meeting, it finalised a set of priorities focused on four key areas of daily life: health; work; families and accommodation.

On health:

- Wounded and injured veterans will continue to receive priority access to NHS treatment for conditions related to their service, subject to the clinical needs of others. GPs have been asked to highlight the veteran status of patients when referring to secondary care.
- Replacement of prosthetic limbs to match the high quality of prosthetic limbs provided when they are initially fitted, subject to the clinical needs of the individual. This builds on the Government's announcement last Autumn to establish specialist prosthetic centres for veterans.
- Subject to clinical need, all personnel injured on operations abroad to be treated in a dedicated military ward on return to the UK.
- The provision of three rounds of IVF treatment for genitally wounded personnel.

On work:

- A review of the number of fully funded places at vocational training centres to ensure sufficient places are available.
- Better information at Jobcentre Plus to ensure that spouses of Service personnel who need to claim Jobseeker's Allowance after giving up their job to accompany their partner on Service postings are correctly assessed.
- Disregard of Armed Forces Compensation Award and War Pensions when calculating Universal Credit.

On families:
• Uninterrupted Special Educational Needs provision in England and Wales, including if a child is assessed with special needs while on a posting abroad.
• Funding for Service charities to provide respite care for 'significant others' looking after wounded and sick personnel.

The priority for the Autumn will be to tackle a number of issues concerning accommodation for serving personnel and their families.

3. Is the proposed Defence and National Rehabilitation Centre going to be established? If yes, how far advanced are the plans?

Ministers expect to be able to announce progress to the House on the establishment of the Defence and National Rehabilitation Centre (DNRC) towards the end of 2013 or early in 2014. If planning permission for the Stanford Hall estate (purchased by the Duke of Westminster for the DNRC purpose) is achieved and if sufficient capital has been acquired as a result of the fundraising campaign, which is being led by the Duke of Westminster and is well underway, a decision to proceed with the creation of a DNRC should be possible at that time. If the decision is to proceed the new Defence establishment (replacing the Defence Medical Rehabilitation Centre at Headley Court) could open in mid-2017.

The concept for the National elements of the Centre continues to be developed and the strategic case for a 70-patient vocational rehabilitation facility on the same site as the Defence establishment should be submitted to Ministers this September. Local consultation on the plans for the development of the site completed during early August. Support from the public seems to be favourable. Planning permission for both the Defence and National elements is due to be submitted to the relevant authorities in November.

In the meantime, investment in the DMRC at Headley Court will continue. A project to increase patient capacity and maintain the Centre’s infrastructure has completed to schedule with an official opening of the new complex due in September.

4. The Government Response stated that a joint UK/US Task Force had been set up to share best practice with four working groups on medical and rehabilitation issues and the support of personnel and their families. What have the outcomes of the working groups been so far? Can we see any reports?

The US-UK Task Force on the health of Service personnel, veterans and Service families was set up during 2011, under the co-chairmanship of a US Department of Defense 3* senior civil servant, and the Deputy Chief of the Defence Staff (Personnel) (DCDS(Pers)) and the Surgeon General as the UK 3* co-chairs. The Task Force has met via teleconference every 3 months, and comprises four working groups meeting separately by audio conference, each with a US and UK co-chair. The Working Groups deal with transition from military to civilian life; mental health, rehabilitation and support to Service families. The US Department of Defense and Veterans Administration is represented on the Task Force and all sub-groups, as are DCDS(Pers), the Surgeon General and the Departments of Health from the UK. The Working Groups function by exchanging information on relevant policies in order to highlight best practice that might be transferable between the two nations. Two working group UK co-chairs visited their opposite numbers in the US in May 2012, and progress in understanding mental health issues was furthered by attendance in June at the US Suicide Prevention Conference. In September 2012 UK representatives will attend the Canadian led tri-National conference in Washington. It has been agreed that a fifth working group should be established to study lessons learnt from collaboration on deployed medical support and it is expected that this will begin its activities in the Autumn.

The Task Force does not routinely produce formal reports. When they are produced, the distribution of any reports will need to take into account the views of other parties, including the US
Department of Defense. However, we will consider opportunities – and requests – to release information to the Committee in the future.

5. Has Professor Keith Willett established the regional networks for major trauma and trauma centres across England?

All of the 22 proposed major trauma centres and regional networks have been in place since April 2012. The centres and networks are modelled on local requirements, but benefit from national treatment principles as well as recent operational lessons from the Defence Medical Services. The establishment of the multi-speciality networks has also had wider implications for the NHS, as Strategic Health Authorities have used their introduction to better align other local services. Early evidence suggests that, as with the military investment at DMRC Headley Court, this new civilian investment is raising the profile and standard of post-trauma rehabilitation.

The Government Response also stated that “the Defence Medical Services (DMS) are also in partnership with the Royal British Legion and Imperial College to focus on new and emerging technologies to improve the fundamental understanding, mitigation, surgical management and recovery of injuries sustained by Military serving and ex-serving personnel as a result of blast”. What outcomes have there been to this work?

The RBL Centre for Blast Injury Studies is a collaboration between the Defence Medical Services, the Defence Science and Technology Laboratory (Dstl), the Royal British Legion and Imperial College, University of London. Early studies have looked at the musculo-skeletal effects of blast on the bony skeleton, and attempts to mitigate these, for example through better vehicle design; Dstl and Imperial College are looking more closely at this. A unique, custom-built, high energy blast rig has looked at bone damage, and a blast tube allows research into cellular damage. Research is also in progress and further design into effects of blast on lung and brain in collaboration with other UK university departments, although results are not yet available.

6. PTSD Screening tool When will the King’s College study report? Will there be any interim findings?

The screening study is ongoing and will report in around March 2015, although if necessary this deadline will be extended to ensure there is enough data. As data is being collected from three successive deployments, we do not expect to make interim reports as they may affect the consistency of the overall study.

Enhanced Mental Health Assessment Is the roll out of the EMHA complete? How many personnel have been assessed under the EMHA?

Roll-out is ongoing, with completion to be confirmed through audit. Following an initial pilot in 2011, the SMHA (Structured Mental Health Assessment, being the revised term for the EMHA) is being rolled out in two phases, in order to identify any practical challenges in the advance region prior to full roll-out (particularly in relation to information systems support). The first phase, in Army Primary Health Care Services (South) and the Royal Navy and Royal Air Force medical centres within that region, is complete. The second and final phase is now underway; SMHA is now rolling out to all regions and planned to be completed by the end of 2012. Initial guidance, informed by the pilot and experience in the advance region, has been published providing direction to all units, with a tri-Service policy to follow by the end of the year. Furthermore, the capability for recording SMHAs is now on the MOD DMICP computer system, again informed by experience from the advance region. Whereas compliance with the SMHA policy can be audited, evidence that this will lead to improved mental health of the whole population can however only be found if a study is conducted comparing populations that have this assessment used on them with populations who do not.
**NHS Veterans’ Mental Health Capability**  
Has the capability been rolled out within each Strategic Health Authority? What have been the initial outcomes? What is happening in the Devolved Administrations?

Further to Dr Murrison’s recommendation, the increased mental health capability is being rolled out across England. So far this has led to an additional 50 NHS professionals providing veteran focused mental health services. This is more than the 30 recommended by Dr Murrison MP in his report and it is expected that there will be more professionals in place during the course of the year.

We are not yet able to provide an update on the Devolved Administrations’ own response to Dr Murrison’s recommendation on increasing the number of mental health professionals. We will write to the Committee when this information is available.

**24 Hour Helpline**  
What are the latest statistics on usage of the helpline split between serving personnel, their families and veterans?

The latest statistics cover the period March to July 2012, in which time the helpline took 2,368 calls. These breakdown as below:

<table>
<thead>
<tr>
<th>Caller Type</th>
<th>Number</th>
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<tbody>
<tr>
<td>Army</td>
<td>1,080</td>
</tr>
<tr>
<td>Royal Navy</td>
<td>57</td>
</tr>
<tr>
<td>Air Force</td>
<td>85</td>
</tr>
<tr>
<td>Royal Marines</td>
<td>32</td>
</tr>
<tr>
<td>Merchant Navy</td>
<td>6</td>
</tr>
<tr>
<td>Reserve Forces</td>
<td>83</td>
</tr>
<tr>
<td>Armed Forces Unknown</td>
<td>249</td>
</tr>
<tr>
<td>Family, Friends, Carers</td>
<td>366</td>
</tr>
<tr>
<td>Professional</td>
<td>251</td>
</tr>
<tr>
<td>General Public</td>
<td>52</td>
</tr>
<tr>
<td>Widow/er</td>
<td>5</td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
</tr>
<tr>
<td>Unknown</td>
<td>88</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2,368</strong></td>
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</tbody>
</table>
**Big White Wall** What are the latest statistics on usage of the Wall split between serving personnel, their families and veterans?

To date, 2,518 members of the Armed Forces community have joined the Big White Wall. The latest usage statistics are:

<table>
<thead>
<tr>
<th></th>
<th>35%</th>
<th>65% Male</th>
<th>35% Female</th>
</tr>
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<tbody>
<tr>
<td>Serving Personnel</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Veterans</td>
<td>40%</td>
<td>84% Male</td>
<td>16% Female</td>
</tr>
<tr>
<td>Family</td>
<td>25%</td>
<td>12% Male</td>
<td>88% Female</td>
</tr>
</tbody>
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**RCGP on-line training** What has been the take-up of the e-learning package for the GP community?

The latest figures available are from August 2012. To date, the website has received 20,947 visits, and 717 users have registered for the e-learning.

There have been 301 attempts at the pre-course assessment, with users achieving an average score of 65%. 183 users have completed the post-course assessment, achieving an average score of 95%.

On average, users award the course 4 out of 5 points.

**Veterans’ Information Service** Did this service launch in April 2012? What has been the take-up of this service?

The Veterans’ Information Service has not yet been launched, but the intention remains to contact – after 12 months – all veterans who leave the Armed Forces from April 2012 onwards. Therefore we aim to have the Service in place by April 2013. Moreover, the Department of Health and the Service Personnel and Veterans Agency are in discussion with the Cabinet Office to evaluate the possibility of the Service being a pilot for the Government’s wider “Digital by Default” initiative.

**7. Has the research into the impact of physical injury on mental well-being been published? What changes is the MoD making in response to this research?**

The research into the impact of physical injury on mental well-being is about to be published. The Battle Injury Mental Health Monitoring pilot is ongoing and will report on its effectiveness after November 2012 by which time 24 months of data will have been gathered. Any changes to MOD policy will be governed by results of this pilot.

Further to Dr Murrison’s recommendation in “Fighting Fit”, we are also undertaking the post-operational screening study mentioned at section 6.

Finally, the King’s Centre for Military Health Research (KCMHR) intends to perform a third cohort study to extend the knowledge on mental health conditions in relation to deployments. The MOD is currently involved in negotiating the funding for this cohort.

**8. Is the SABRE research mentioned in the Government Response complete? What further research is the MoD now planning to commission?**

The SaBRE Future Reserves 2020 Employer research was completed and the report produced on 26 January 2012. The response was very positive and the results highlighted that 87% of employers would be supportive towards a mobilised employee and in response to the proposals to expand the Reserve Forces and extending their role under Future Reserves 2020 they would not fundamentally change their opinions or support. A public consultation will take place later in the year and will focus on Defence’s relationship with employers and how the mutual needs of the employer, Reservists employee and Defence can best be accommodated. The MOD will continue to engage and communicate fully and flexibly with employers to ensure a positive working
relationship. It recognises the importance of employers as an integral element of the Reserves proposition and remains committed to developing and maintaining the relationship through employer support.

9. The Government Response stated that it “is examining ways to further develop mental health support for the Armed Forces including ...”. What further ways is it examining to develop mental health support for the Armed Forces?

We are currently examining several further ideas. Options to improve access to mental healthcare include:

- Education of chaplains and allied health professionals
- Conducting a Self Referral pilot for referrals to Departments of Community Mental Health
- Anti-stigma campaigning

We are also examining specific actions to develop our provision of healthcare, including:

- Trial into Eye Movement Desensitisation & Reprocessing therapy, rapidly provided versus standard provision
- Trial into the effectiveness of Alcohol Education (see also section 11 below).
- Development of standard working practices of management of Alcohol Use Disorders in Armed Forces
- Development of guidance on Low Intensity Psychotherapy for mental health professionals
- Development of a distance-based mental health capability

Most of these ideas are longer-term options, which might be taken forward following further work. However, they build on some initiatives that are already in place, such as the Army’s anti-stigma campaign "Don’t Bottle It Up", and the mental health advice provided to non-operational locations over the telephone.

10. The Government Response stated that “we continue to explore further ways of improving the support for this important group” [the families of deployed personnel]. What have the results of this further exploration been?

The KCMHR study into the ‘Effects of home on the mental health of British forces serving in Iraq and Afghanistan’ concluded that ‘perceived home difficulties significantly influenced the mental health of deployed personnel’ and that whilst this may not indicate a causal effect (i.e. those with poorer pre-deployment mental health may be more likely to report a lack of support and continue to suffer from poorer mental health during deployment) we accept the report’s assertion that improving visibility of the ‘many support services to the partners and families of deployed personnel’ may have a positive impact on the mental health of those deployed. The challenge for us is to ensure that families know what is available and how to access it, particularly when trying to provide that support to families who do not live near the home base or in a garrison town. The report also made it clear that it is important that Service personnel know their families are being well supported whilst deployed. We are working with the single Service welfare organisations and the Families Federations to determine how best to meet this challenge.

Identifying those who need particular support is something that is done at a local Unit level. In order to enhance the welfare support for families of those deployed and provide local commanders with greater resources to enhance their welfare efforts and identify vulnerable families, the Families Welfare Grant was doubled in the April 2012 budget, to £4.40 per person per week deployed; this is estimated to provide an additional £2 million per year. The Families Welfare Grant (FWG) allows local commanders to enhance the direct support that they provide for families while their loved-ones are deployed. We have around 15,000 personnel deployed at any one time and so, given the deployment cycle throughout the year, the FWG benefits over 30,000 families per year. The Grant allows commanders to focus relatively small amounts of funds very effectively and directly on those that need it. This may be to help keep dispersed families better informed, to run activities to bring
families together, through coffee mornings, briefings or trips out, to encourage their mutual support for each other, both emotionally and practically. Such gatherings also help welfare staffs to uncover individual cases of need from families otherwise reluctant to come forwards.

The work under the Armed Forces Covenant to tackle areas of disadvantage is also having a positive effect on families and is removing some of the underlying stress placed on them as a result of the unique nature of Armed Forces life.

Separately, KCMHR are undertaking a study into the ‘Children of Military Fathers with PTSD’, this will not be published until the middle of 2013 and we await their findings with interest. Dr Nicola Fear of KCMHR has already briefed the MOD Children and Young People’s Trust Board on the KCMHR research, and Board members agreed to assist with seeking volunteers for the study. Dr Fear is invited to brief the Trust Board again on her findings once the study is concluded.

This update demonstrates how we continue to strive to improve the support provided to families within the resources available. One of the key challenges is how to ensure that families know of the support available and how to access it as families increasingly lead independent lives and often those most in need do not ask for it. In this regard, we seek to engender resilience in our personnel and their families and we remain of the view that we are keen to avoid an overly paternalistic approach to the support offered whilst ensuring that support is available and known about when it is needed.

**What was the annual expenditure from 2005-06 to 2011-12 on the Families Welfare Grant drawn by deployed personnel?**

The FWG is intended to provide additional support to the families of Service personnel deployed overseas. It is drawn by the commanding officer of deployed personnel to support activities at the home base that enhance communication or relieve hardships caused by the deployment.

As such, annual expenditure is managed by the three single Services and is not held centrally. Given the large number of units involved, the different sources of funding and the need to distinguish between this and other forms of welfare support, we have not been able to generate these costs to meet the Committee’s deadline. Therefore, we propose to write again when the costs are available and have been verified.

**11. Has the new policy on alcohol use been introduced yet? Can you describe the further measures to tackle alcohol misuse and encourage responsible drinking? What are you currently doing to review your policy on alcohol?**

Policy development of the new alcohol (and drugs) testing regime, which seeks to promote an alcohol free environment in safety-critical activities, was completed in Spring 2012 to allow Parliamentary scrutiny of Statutory Instruments in Autumn 2012. We still expect to implement this policy in late 2012/early 2013.

Policy and guidance on dealing with excessive alcohol consumption takes the form of both prescribed measures, incorporating administrative, disciplinary and healthcare procedures, as well as practical measures that a commanding officer can incorporate in their unit. These include the following:

- Ensuring the provision of education to encourage individual responsibility and to assist line managers in providing support.
- Annual Ship/unit/establishment health awareness days.
- Health and well-being road shows.
- Responsible drinking presentations in arrival briefings and annual training and as part of discussions on team work.
- Including the dangers of using alcohol as a remedy to deal with a traumatic experience during post-operational stress briefings.
• Reducing the link between alcohol and social activities.
• Restricting the number and opening times of alcoholic bars on military establishments.
• Preventing drinks promotions, two-for-one offers and the giving alcohol as prizes for competitions.
• Liaison with retailers to ensure a joined-up approach by a unit’s alcohol misuse prevention campaign, e.g. refusing to serve individuals who appear drunk.
• Running co-ordinated drink drive campaigns.
• Arranging no smoking campaigns (noting the link between smoking and drinking).
• Providing viable alcohol opt-out options at Service functions and ensuring food is provided at functions where alcohol is served.
• Greater provision of non-alcohol facilities, including relaxation areas for junior personnel.
• Ensuring unit alcohol preventative measures are factored into proactive, supportive and well structured unit committees, including welfare teams, flight safety, health and safety, road safety and health and wellbeing.

The current Armed Forces policy on alcohol abuse, misuse and testing was introduced across the Services in October 2009, while the new alcohol testing regime is scheduled to be introduced within the next six months. We expect further work from the KCMHR study period 2010-2013 will help us understand how effective our policy has been and what more can be done to promote responsible drinking.

Have you determined the research priorities for the next phase of King’s research? What are they?

The main objectives of the next phase of the KCMHR work will be to monitor the health, wellbeing and social functioning of currently serving UK military personnel and Service leavers; and to examine the role of the family in the wellbeing of Service personnel.

The main areas of investigation will be:

• health and wellbeing of serving and ex serving personnel;
• role of families and relationships among regulars and reserves;
• in-depth examination of specific clinical or high risk “groups”, and;
• the validation of questionnaires within a military population.

12. What are the results of the work to “understand the benefits of TRiM intervention by recording and outcome audits”.

Research carried out for the MOD by the Academic Centre for Defence Mental Health (ACDMH)\(^1\) has indicated that TRiM results in modest gains to occupational functioning and may offer greater benefits than are currently apparent. A number of single Service audits have been conducted and initial indications are that TRiM has resulted in some personnel being referred to medical support earlier than might otherwise have been the case. Because TRiM is a means of identifying those who may require mental health support, along with other longer standing methods, it is difficult to demonstrate that TRiM is having greater impact than those other techniques, without adoption of a control group implying the removal of one or other practice, which is not considered viable at this time. Since it is well received by individuals, and continues to identify those in need of support, often at an early stage, the MOD judges the scheme should continue. Additionally, anecdotal evidence also appears to indicate that TRiM has increased awareness of mental health issues and helped de-stigmatise discussion of mental health problems and self referral.

13. Have any particular problems arisen with demobilised medical reservists given that health professional often have a higher than average suicide rate?

\(^1\) In addition to the studies quoted in the previous response, see also, ‘A Cluster Randomized Controlled Trial to Determine the Efficacy of Trauma Risk Management (TRiM) in a Military Population’, Journal of Traumatic Stress, Vol 23, No 4, August 2010.
No. Research suggests that healthcare professionals – with no distinction between regulars and reserves – were at mildly higher risk compared to other military branches in the first KCMHR cohort study (Operation TELIC), but in the second cohort study (of both Operations TELIC and HERRICK) this risk disappeared.

Otherwise, it is MOD policy that the support required of reservists generally applies as much for healthcare professionals as everyone else.

14. Can the MoD explain what it is doing to “strive to learn from those experiencing injury and bereavement, to improve further the support we provide so that we meet the contemporary challenges faced by those who endure loss through service”? What is the take-up of SSAFA self help groups?

The issue of social care and carers’ respite breaks for the families of the wounded, injured and sick was discussed at the Covenant Cabinet Sub Committee on 26 June. Social care funding is devolved to Local Authorities and we are working with the Department of Health to raise awareness of the specific needs of the families of the injured. We will look to use the existing Armed Forces Networks to assist in improving this understanding by Local Authorities and the Community Covenant agreements will also prove valuable. The Care and Support White Paper, together with the draft Care and Support Bill, which the Government published on 11 July, sets out the Government’s plans for the biggest transformation of care and support since 1948. The draft Bill includes provision for a new duty on local authorities to meet carers’ eligible needs for support, putting them on the same footing as the people they care for. Additionally, under the Department of Health’s voluntary sector investment programme, that Department has asked Service charities to explore the possibilities offered by the Innovation Excellence and Service Development (IESD) grant fund.

Separately, we have been in discussion with the Families Federations, and we have agreed on the need to frame a study into the support of the families of those injured and of the bereaved and we are in the process of identifying funding for this; whilst we do not anticipate substantial progress in time for the first annual Covenant report, we hope to have initial findings for the 2013 report.

The outcome of the KCMHR study into the ‘Children of Military Fathers with PTSD’, discussed at section 10, will also help us to focus our efforts.

The MOD continues to fund a SSAFA Additional Needs and Disabilities Advisor post that oversees the SSAFA support groups. Through these means we are currently supporting over 800 people. The support groups are outlined below (with number of people supported in brackets):

**Support Group for the Families of Injured Service Personnel (FISP)**
This tri-Service group offers people the opportunity to meet and talk with others whose relatives have been injured while serving in the Armed Forces. It meets regularly offering mutual support and allowing families to share experiences, information and advice. (167)

**Support Group for Bereaved Families**
Set up by a group of bereaved families, this tri-Service group offers people the opportunity to meet and talk with others who have lost a loved one whilst serving in the Armed Forces. The group provides mutual support, information and advice and tries to resolve some of the difficulties faced after the death of a family member. (172)

**Support Group for Bereaved Siblings**
This group supports children and young people who have lost a brother or sister who was serving in the Armed Forces. It meets regularly and offers mutual support aiming to restore confidence through activities and giving young people the chance to talk about their feelings with others who have been through a similar situation. (68)
**Forces Additional Needs and Disability Forum**
The group was set up for Service families who have a family member who has an additional need or disability. It explores the existing support system and provides both families and service providers with an opportunity to discuss how to make sure they can access the best support available. (410)

Recent and upcoming support group events include:
- 21-23 September: Bereaved Siblings Support Group Event to be held in Prestatyn
- 12-14 October: Families of Injured Service Personnel Event to be held in Edinburgh.

Finally, we have recently secured additional funding from the Department for Education, Business Innovations and Skills and the Devolved Administrations to enable us to uplift the levels of the grants available under the Armed Forces Bereavement Scholarship Scheme in order to cover the increased tuition fees that came into force this year.

**Return to Military Service or Civilian Life**

16. The Government Response stated that the Army Recovery Capability (ARC) would not achieve the revised target capacity of 1,000 personnel by April 2012 but an earlier target of 750 with 1,000 being achieved by April 2013. When it reaches full capacity, the MoD stated that the ARC will be able to care for the most seriously wounded, injured and sick Army personnel. Has the ARC reached its target of supporting 750 personnel? When will it reach the target of 1,000 personnel? Has the MoD done an evaluation of the work of the ARC and the other Services’ recovery pathways- can the Committee see the results of such an evaluation?

The ARC has increased capacity to the point where it is able to provide support to 810 of our most seriously wounded, injured and sick personnel. It is still anticipated that the target of 1,000 will be achieved by April 2013.

The Army has also taken steps to ensure the benefits of the ARC are made available to those wounded, injured and sick personnel not under the direct command of a Personnel Recovery Unit, that is in addition to the 810/1000 figure.

The ARC’s performance is monitored through a number of governance structures reporting up to the Defence Recovery Steering Group, which includes key stakeholders from within Defence as well as our Charitable Partners. The Steering Group considers all aspects of the project development as well as current operations within the recovery pathway. A formal post project evaluation will be completed in Summer 2013, following the achievement of full operating capability.

19. Has the MoD completed its review of the Transition Protocol? What were the results of the review?

Progress on the Transition Protocol is discussed at section 2.

When will the Government’s report on the Armed Forces Covenant be published?

The annual report on the Armed Forces Covenant will be published towards the end of this year.

**Support For Former Service personnel**

20. The Government Response stated that the MoD is working with the Department of Health to identify the best way to ensure that Guaranteed Income Payments are not taken
into account in means tested social care. What is the latest position on the work of the MoD and the Department of Health on this issue?

The Department of Health is preparing regulations and guidance so that veterans will not have to use Guaranteed Income Payments, made under the Armed Forces Compensation Scheme, to pay for publicly arranged social care. The regulations and guidance are planned to come into force in October 2012.

23. The MoD provided the Committee with a timetable for the Veterans’ prosthetic services in the NHS. Are the MoD and the NHS on track to meet the deadlines in the timetable? The Committee would also like to see a more detailed project plan including the risk register for this project, in particular, in relation to staffing the service.

The programme of work is progressing in accordance with the earlier timetable provided to the Committee. Officials are working with the NHS Commissioning Board Authority to align the veterans' programme with the wider transition of prosthetics commissioning.

A more detailed project plan and risk register are under development and we will consider publication of these once the relevant stakeholders have been consulted.

24. Has the Cabinet Sub-Committee considered long term mobility issues, for example cars, housing and other aids and adaptations] and, if so, with what result?

To date, the Cabinet Sub-Committee has not considered the issue of other costs relating to long term mobility, and it is unlikely to feature in the near term.

25. The pilots of the transition protocols highlighted “particular challenges associated with the care of those with a serious brain injury and that the issue of long-term care needs to be addressed”. What were the different problems identified for those with serious brain injuries? What has been the outcome of further collaboration with the NHS and Devolved Administrations on this issue?

The seriously injured leavers’ protocol and continuing healthcare process that is already in place aims to ensure that the long term needs of individuals are identified and provided for. The costs of long term medical and social care for those with serious brain injuries (not just veterans) is known and fully understood – and is met for all of those who have been unfortunate enough to have received serious brain injuries (for example, as a result of traffic accidents or sporting injuries) as well as for those who have been injured as a result of their service.

As indicated elsewhere in the response, arrangements are in place to ensure that mental health needs of veterans are met by the NHS, and a disregard is to be put in place in relation to payment for provision of social care. The Department of Health is also working with service charities and the MOD to understand how personal budgets might be used by veterans to better facilitate their individual needs.

What are the emerging results of the clinical research into the effects of brain injury?

We are involved in various research collaborations into Traumatic Brain Injury (TBI) and Mild Traumatic Brain Injury (mTBI). It is important to distinguish between the two – the former being very apparent and the latter being more subtle and akin to “concussion”.

We are looking at markers of TBI in collaboration with Imperial College and also with Cambridge University. Dstl are also involved and have trans-Atlantic links with US researchers who have similar research with different markers. Similarly in a new research proposal, we intend to look longitudinally at mTBI in deployed troops using advanced scanning techniques in collaboration with Oxford and Birmingham universities. This is, if it gets scientific and ethical support, new and
potentially ground-breaking research but results are not expected for at least 18 months. Finally, neuro-endocrine effects are being researched with colleagues in Newcastle and Southampton.

It will be important in determining mTBI research results to filter out the effects of an operational tour from any pre-existing minor neuro-trauma such as boxing, falls, injury etc.

26. The MoD will “remain vigilant and continue to monitor those who served in Iraq and Afghanistan [for PTSD]”. What are the results of the monitoring of those who served in Iraq and Afghanistan?

It is not possible to predict the rates of mental health problems in the future, but up to the last data gathering point (2009) which includes periods of intense fighting, the rates of mental health problems have remained quite steady. MOD is actively negotiating a further cohort study to ensure there is good monitoring as we go forward.

Otherwise, Defence Analytical Services and Advice (DASA) continues to monitor and report quarterly the numbers presenting to Departments of Community Mental Health, and this information is available on their website http://www.dasa.mod.uk/. OMHNE (Operational Mental Health Needs Evaluation), the in-theatre assessment of mental health, has been conducted once in Iraq and twice in Afghanistan. And previous cohort research remains available from the KCMHR website.

Relationship With The Charitable Sector

27-29. The MoD acknowledged that there are instances when it “is not able to fund the provision of facilities and services, within the optimal time frame or to a higher standard”. It stated that it is entirely appropriate for generous support of charities to complement existing provision from public funds. What has been the level of charitable funding of the ARC to date? What is the total sum likely to be?

Over the next 10 years the MOD have a planned commitment amounting to £163M to the Army Recovery Capability. MOD is responsible for serving personnel from the point of wounding injury or sickness and is resourced to fund all core recovery events and activities on an individuals recovery plan to enable them to reach a successful outcome, be that a return to duty or a successful transition to civilian life. This includes calling on the Career Transition Partnership contract for those individuals who will be leaving the Army. Notwithstanding this high level of commitment, we fully acknowledge the vital support provided by our Charitable partners to this project.

Significant planned support has been committed by both our strategic partners Help for Heroes and The Royal British Legion as well as other service charities and organisations.

Help for Heroes has a planned commitment over twenty years of £153M for capital projects and operating costs, with a further £15m and £6m being committed to individual recovery plans and quick reaction funds respectively.

MOD has an established process to ensure offers of charitable assistance are considered for coherency with wider Defence priorities and that long-term affordability issues are addressed. Any acceptance must be appropriate and adhere with HM Treasury rules. It is accepted that this may result in MOD being slow to accept funding but this is to ensure that sustainability issues are considered and due diligence shown.

The Royal British Legion has a planned support amounting to c£50M over ten years.

Single service charitable support totalling c£17m has also been received.
The long-term affordability of MOD projects whether they are funded from the core Defence budget or by charities must be addressed before any commitments are made. Charities are independent of Government. Decisions about fund raising, the level of reserves, restricted and unrestricted funds held by charities are for charity trustees to make. They form an important part of the internal financial management of charities which are subject to regulation by the charity regulators.

31. Has the new portal described in the Government Response gone live? What level of activity has gone through the portal?

A new Charity Portal was launched on the www.veterans-uk.info website in January 2012 with details of Service charities. An easy-to-navigate alphabetical list with recognisable charity logos alongside can be accessed with a further click taking the user to a full page of useful information on the organisation. This includes background to the charity, what type of services are provided, who is eligible for help and how to contact the charity. The portal has continued to grow throughout 2012 with details of some 63 organisations now being listed. The MOD now has plans to move the Veterans-UK website content to the new www.gov.uk site where content will be accessed alongside all other Government information on a site that will be accessed by millions of people each year. We are also in discussion with the Royal British Legion regarding their concept for a single portal for all charitable services relating to the Armed Forces’ community.

29 August 2012