THE GOVERNMENT RESPONSE TO THE QUINQUENNIAL REVIEW OF THE ARMED FORCES COMPENSATION SCHEME 2022/23

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Ministerial foreword

Foreword by the Minister for Defence People and Families

Every day our Armed Forces work with courage and dedication to ensure our security, support our national interests and safeguard our prosperity. They, in turn, must have assurance that as a Nation and as a Government, we will support them if they are injured or become ill due to their service. They must be confident that they will receive fair and just compensation as part of that support.

The Armed Forces Compensation Scheme (AFCS) provides compensation for injury or illness caused or made worse by service; or where death is caused by service in the UK Armed Forces on or after 6 April 2005. The Scheme applies equally to Regular and Reserve forces. It was developed through wide-ranging, detailed consultation and consideration over several years before its introduction in 2005. Awards have been designed to sit alongside civilian state benefits for which AFCS recipients may apply. The provisions of the Scheme reflect principles underlying modern clinical management of injuries, and medical and scientific aspects are kept under regular review with advice from the Independent Medical Expert Group. All of this makes the AFCS a world-leading compensation scheme. And, in addition to financial support provided under the AFCS, service personnel and veterans have access to specialist health services and priority NHS treatment for conditions related to service, subject to the clinical needs of others.

Additional scrutiny of the Scheme is provided through the Quinquennial Review (QQR) process, under which arrangements are independently reviewed every five years to ensure they remain fit for purpose. The latest QQR of the AFCS, which this Government response addresses, commenced in early 2022 and its Report was published in July 2023.

I am grateful for the work of the Reviewer in undertaking a thorough assessment of the AFCS and how it works in practice. Officials from many disciplines across the

Ministry of Defence have carefully considered the findings. I am pleased to report that the Department accepts the important changes proposed to the presentation of information about the AFCS and the claims process, as well the need for improving communication with claimants throughout their claim journey. Steps will also be taken to empower caseworkers so that they are equipped to successfully fulfil their role. I am confident that these changes will significantly improve awareness of the AFCS and the experience of those who make a claim under the Scheme.

There are some recommendations, which after careful analysis, the Department will not be taking forward as they do not align with the key underlying principles of the AFCS. For example, proposals to change the way in which AFCS awards are calculated introduce elements which will not deliver consistent and equitable outcomes; and removing time limits for making a claim goes against the principles to enable claimants to look forward in their lives through the provision of financial support and security.

This report sets out our assessment against each recommendation. A number of these have already been implemented and our aim is that all those which have been accepted will be actioned on a rolling basis over the next 18-24 months.

Dr Andrew Murrison MP

Minister for Defence People and Families

Introduction and executive summary

In January 2022, an independent external reviewer was appointed to lead the AFCS QQR 2022/23. The overarching purpose of the Review was to ensure that the AFCS remains fit for purpose. Its recommendations address issues across both the policy and practice of the AFCS in meeting Scheme objectives. This Executive Summary provides an overview of the Government's response to key areas of focus identified in the report and is aligned with the headings used there. It is not exhaustive and detailed responses to each recommendation can be found in the body of this report.

Information: Availability and Accessibility; Making a Claim

A number of recommendations focus on the availability and accessibility of information about the AFCS, including around the process of making a claim. The Department accepts that it is vital that claimants are provided with information about the AFCS, making a claim and what to expect during the process, at all relevant points. The information should be consistent and coherent, and available through multiple appropriate channels. It should be kept under regular review to make sure it is up-to-date and accurate. The work flowing from these recommendations will be overseen by a Communications and Training Working Group which will be established in early 2024.

The Caseworker

The Review included a number of recommendations about how caseworkers carry out their responsibilities and the training provided, and some link directly to initiatives that are already in the process of being adopted by Defence Business Services (DBS). Others propose changes to the way in which caseworkers plan and manage their work. The Department believes that once caseworkers are empowered with the resources to undertake their roles, they should have reasonable autonomy to plan their work. Further restrictions are not helpful to caseworkers or to the claimants they are helping, and so recommendations to redesign the caseworker workplan are not being taken forward.

Supporting Good Decision-Making

The Review rightly identifies that to enable good decision-making by caseworkers, the AFCS has to be underpinned by a robust, equitable, independent and transparent policy-making process. The Independent Medical Expert Group (IMEG) plays a key role in this, advising on the medical and scientific aspects of the AFCS,

and the Department has already implemented the recommendation to recruit to IMEG representatively. Furthermore, a small operations-specific working group of Departmental officials involved in the administration of the AFCS, and charities involved in guiding claimants, is already in place. We will continue to engage through this forum to consider ways to improve operational policy and support the training of caseworkers and medical advisors.

Some QQR recommendations refer to the Veterans Welfare Service (VWS), Defence Transition Services (DTS) and the Veterans Advisory and Pensions Committees (VAPCs). These bodies came under the scope of the Independent Review of UK Government Welfare Services for Veterans. The delivery model of DTS and VWS will transform following the Veterans Welfare Review – this does not affect the implementation of the recommendations in this review, and for the purposes of clarity, they are referred to throughout by their current name. As noted in the response to the Veterans Welfare Review, the Government will work to clarify the future role and structure of the VAPCs and related QQR recommendations will be considered once that work is complete.

Calculating Awards

Several recommendations propose changes to the ways in which awards are calculated. This includes separating the lump sum and the Guaranteed Income Payment (GIP), so that the latter focuses solely on the injury while the former considers impact which would extend to psychological, family and social life as well as financial factors over a lifetime. We carefully considered these recommendations to determine whether the significant changes proposed would bring about positive benefits to claimants whilst also being proportionate. We have concluded that the proposals change the original intent of the Scheme which is to provide compensation for pain and suffering, and in the most serious cases, an income stream for life. Awards have been designed to sit alongside the full range of other State care and support available. The recommended changes would, to varying degrees, go against each of the important principles on which the Scheme is based and increase the risk of inequitable outcomes for claimants. Furthermore, rather than simplifying the method for calculating awards, the changes would introduce increased complexity into the Scheme, making it less transparent and more difficult for claimants to understand. For all these important reasons, they are not being taken forward.

Seeking Parity

A number of recommendations are aimed at achieving parity between disorders and injuries; between mental health and other injury types; and, between and within AFCS tariff tables. We will commission IMEG to consider the recommendations

which are about medical aspects of the Scheme in their 8th report; work on this is due to start during 2024.

The Department does not, however, accept the proposal to reduce the time for which interim awards can be in place from 24 to 12 months. This is because our operational experience shows that reducing the 24-month interim award period is unlikely to be beneficial to claimants. Many would struggle to obtain the necessary medical treatment to give an accurate picture of their injury in that period, and there will be cases (mostly mental health) where finalising in 2 years will be impossible, as the prognosis cannot be reliably predicted. This is likely to disadvantage the claimant with a lower award than they would have received at 4 years. Instead, as with other aspects of AFCS, there is a case for better communication as to why interim awards are made, to manage claimant expectations and to show that this is in their best interests.

Inequitable limitations

The QQR discusses the limitations around time limits for claims and the circumstances of reviewing an award. These provisions are in place to provide certainty to claimants and to help meet the principles of the Scheme. The AFCS is designed so awards cover the expected effects of the injury and treatment over the person's lifetime. Time limits for making a claim were introduced in the legislation to support this, by providing a full and final award to give the injured person certainty and the chance to focus on their future. On a practical level, time limits facilitate effective evidence gathering for claims. The Scheme already includes provisions where time limits may be extended. Time limits are also features of other no-fault schemes, where a substantially more restrictive limit of 3 years is normal. By comparison, under the AFCS a claim has to be made no later than 7 years after the illness/injury (unless the claim is for a late onset illness) - a not insignificant period of additional time.

Awards also take due account of the medically expected progress and prognosis of the injury including, where appropriate, expected deterioration as the person ages. This, by definition, means that reviews of awards should only be available in certain limited circumstances, and these are already provided for within the Scheme. The Department will, however, explore ways in which better communication can help claimants understand the current system and the reasons for certain provisions.

Burden of Proof; Lump-sum Uprating; Spanning

The QQR recommends changing the AFCS legislation surrounding responsibility for proving any issue related to a claim. As part of the wider communications work about the AFCS, the MOD will improve information provided to the claimant about the evidence needed to support a claim.

The Department has previously agreed that AFCS lump sums should be reviewed and uprated on a periodic basis, in consultation with key internal and external stakeholders. We accept that it would be timely to do this during 2024/25, while also considering a standard process and time period for this to happen in future years as advocated for in the QQR.

Finally, the Department will work on guidance for decision-making in spanning cases, where attributable service spans both the AFCS and its predecessor scheme, the War Pension Scheme.

1. Guiding Assumptions

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.

Response to recommendation 1:

The MOD accepts the importance of common understanding of the meaning and purpose of 'compensation' within the context of the AFCS, as a taxpayer-funded scheme. This would provide clarity to claimants about the Scheme and could be used as a way of measuring success in policy and decision-making, alongside the underpinning principles of the AFCS. We believe this can be best achieved by explaining the different elements of the AFCS compensation package (e.g., lump sum, Guaranteed Income Payment - GIP), and how they operate alongside other benefits provided by the MOD and by the State. While some of this information can already be found in various documents, we will seek to improve it and develop standard wording which will be used in all internal and external guidance, and literature. Our intention is to complete this work alongside the annual review of JSP765 (Armed Forces Compensation Scheme Statement of Policy) due to be completed by the end of 2024 at the latest.

The AFCS does not provide the level of lifetime financial support that the Reviewer refers to in the second bullet. Such support would be akin to awards in Personal Injury cases, which are determined by considering more wider-ranging factors than those used in the AFCS. This aspect will not, therefore, be taken forward.

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.

Response to recommendation 2:

The Department accepts this recommendation. This issue is already touched on in JSP765, and we will consider how to make this clearer as part of a planned refresh of the documentation relating to the scheme, to be completed by the end of 2024.

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.

Response to recommendation 3:

The AFCS pays compensation for injury, illness or death which is predominantly caused by service, and this key aspect is not disputed by the Department or in the QQR. Article 41 relates to cases where the egregious negligence or misconduct by the service person contributed to the injury or death (for example, where an injury happened while driving without a seatbelt or during negligent discharge of a weapon), and in these circumstances up to 40% of the benefit may be withheld.

Our experience shows that this provision is very rarely used (since 2012, there have been 44 cases, averaging at 4 per year). The Department does not make a decision under Article 41 unless there is compelling evidence of negligence or misconduct, and even then, only after careful consideration. There is a close link to Recommendation 2, which the MOD has accepted.

Against that backdrop, we believe that, in the context of a taxpayer-funded scheme, Article 41 remains an important provision which recognises the obligations on the service person to comply with instructions and follow guidance and rules. This recommendation is, therefore, rejected.

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. The terms ‘appellant’ and ‘respondent’ should continue to be used in the appeals process.

Response to recommendation 4:

Service personnel are not entitled to awards under the AFCS by virtue of their terms and conditions of service. The AFCS is a statutory scheme, made by the Secretary of State for the benefit of certain members of the Armed Forces who meet the eligibility criteria set out in statute. The scheme exists independently of the service person’s Terms and Conditions of Service (TACOS), which are set by their Service.

The scheme is made under s1(2) of the Armed Forces (Pensions and Compensation) Act 2004, which defines it in law as a compensation scheme, and this is reinforced by the provisions of Article 7(1) which specify that it is a compensation scheme to be known as the Armed Forces and Reserve Forces Compensation Scheme 2011. Article 40 of the Scheme provides that where damages are awarded by the civil courts against MOD in relation to an injury or death for which AFCS benefit is payable, this is set off against benefits under the AFCS, and specifically that such benefits may be withheld or reduced. The first two bullets in this recommendation are therefore rejected.

The suggestion at bullet 3 is accepted and we will work to ensure consistent application of the words ‘claimant’, ‘recipient’, ‘appellant’ and ‘respondent’ as part of the work already agreed to take place by the end of 2024 for Recommendations 1 to 3.

2. Information: availability and accessibility

Recommendations 5,6,7,8

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.

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); and,
- Projected timelines.

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.

Response to recommendations 5,6,7,8:

We accept Recommendations 5,6,7, and 8 about the availability and accessibility of information. It is vital that claimants are provided with information about the AFCS, making a claim and what to expect during the process (including an explainer on how decisions may be made), at all relevant points. The information should be consistent and coherent, and available through multiple appropriate channels. It should be kept under regular review to make sure it is up-to-date and accurate.

The Department meets with the organisations like the Royal British Legion (RBL), Royal Marines Charity (RMA), Royal Air Forces Association (RAFA) mentioned in recommendation 5, through the Customer Advisory Group. We will continue to engage though this forum, and others, to consider ways to signpost claimants to resources which will help them through the AFCS claims process. To tie in with other recommendations in this report, we will also consider whether the Customer Advisory Group should be renamed the Claimant Advisory Group.

As we work through the recommendations in this report, our intention is to define all associated QQR communications requirements to develop an overarching campaign that not only covers this review, but also coheres with other activity in this area. We will use the established OASIS model to do so – this is the Government Communication Service recommended approach and captures the following elements:

O – Objectives (what we are trying to deliver - the benefits for the claimant).

A – Audience (who we are aiming to communicate with - both primary and secondary audiences including key stakeholders).

S – Strategy (how we are going to communicate in a strategic and methodical way).

I – Implementation (delivery of planned communications in a strategic way using tactical methods like channels use – could be leaflets, posters, information on the gov.uk webpage).

S – Scoring (conduct evaluation to assess effectiveness of the communications and gather insight for future communications development).

The recommendations focussing on communications will be overseen by a Communications and Training Working Group which we will establish in early 2024. Our aim is that these recommendations are implemented during the course of the following 12 months.

3. Making a claim

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.

Response to recommendation 9:

The Department accepts the recommendation to compile a checklist of the sort of evidence that may be requested during the course of the claim although it would be a non-exhaustive checklist. We are committed to enhancing our communication efforts by providing comprehensive information on our webpages. We will develop an evidence checklist to include the role of different forms of evidence and how they will be used in the consideration process. This will be completed within the next 12 months. This work will be overseen by the Communications and Training Working Group.

After careful consideration, the Department has decided not to proceed with the suggestion to identify an ideal window of time to make a claim. The time limit for

making a claim is, in most cases, 7 years. There are instances when this time limit can be extended and JSP765 provides some guidance around timing of claims. We believe that the benefits of any further prescription would be outweighed by the potentially adverse consequences for claimants. The ideal window for each case will depend very much on individual circumstances. It would be difficult and impractical to try to define this and the Department wants to avoid providing any information which could inadvertently have an adverse impact on a claim.

Instead, we will continue to provide claimants with information and support throughout the claims process ensuring that they have the necessary resources to make an informed decision based on their specific circumstances.

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).

Response to recommendation 10:

The Department rejects this recommendation. AFCS processes are designed to assess claims based on the available evidence and to make fair and informed decisions within the parameters of the Scheme rules. Claimants are encouraged to send in their evidence with, or soon after, their application.

The Reviewer's comments about any 'ideal window' being a guide only are noted, and the Department's position on this issue is already covered in the response to Recommendation 9. The Scheme is designed to provide a full and final award considering the expected effects of the injury and its treatment through life. In cases where an injury unexpectedly deteriorates, the Scheme already provides avenues for a review. There are no plans to revisit these provisions within the policy.

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.

Response to recommendation 11:

The Department agrees with the intention behind this recommendation.

We will consider the approach taken when providing decision letters so that they include information about the basis on which the decision as to the tariff descriptor has been taken, and where relevant, why a temporary award has not been made. We will take a proportionate approach, on the basis that in many cases it will be clear why the next tariff up was not awarded (for example where the tariff descriptors are based on loss of limbs). However, in cases involving a degree of judgement (such as cases involving descriptors in Tables 3 and 4) then the decision letter will also explain why the next tariff up has not been awarded. This change will be in place by the end of June 2024.

Recommendation 12:

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

Response to recommendation 12:

In principle this recommendation is welcomed and the intent behind it is clear, and the MOD will assess the legislative changes required during 2024. We will also consult with all parties with an interest across Government, including the Ministry of Justice, to ensure any changes are supported and can be properly implemented.

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.

Response to recommendation 13:

The Department supports this recommendation. Since 2019 the number of hearings has grown significantly, and the Department continues to improve attendance by increasing the number of courts attended virtually. Virtual attendance offers several

advantages over traditional in-person attendance. Firstly, it eliminates the need for officials to travel long distances, saving valuable time and resources. This allows for increased productivity and efficiency in managing multiple cases simultaneously. Additionally, virtual attendance enables representatives to participate in tribunals regardless of their geographical location.

The Department does recognise that there will still be instances where in-person attendance remains appropriate. This may be on request by the presiding Judge and in cases where there is a case management hearing. We will continue to prioritise such cases for in-person attendance.

4. The caseworker

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.

Response to recommendation 14:

We recognise the need to ensure that claimants are kept informed and operational teams have already commenced an initiative to review and improve communication with claimants. Each claimant is contacted once every 12 weeks as a minimum to provide an update on the claim, and usually more often as the case demands.

As set out in the response to recommendation 15, first contact with claimants will remain with the Helpline staff who are specifically trained in this area. The detail at bullet 2 is already in place as caseworkers make file notes about tailoring communications to meet the needs of that particular claimant.

Currently, cases are processed upon receipt without a defined procedure to identify potentially complex cases. We will establish criteria to determine if a case is complex and implement a modified process accordingly. This process will be put in place by the end of June 2024.

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.

Response to recommendation 15:

Our Helpline workers play a crucial role in providing support and assistance to claimants, including addressing both generic and specific queries when they work collaboratively with caseworkers. They are specifically trained to deal with first contact and are skilled in handling a wide range of enquiries. Over the last 12 months, 91% of calls have been satisfactorily answered at first point of contact, which supports our view that it would be counter-productive to limit Helpline staff to answering generic questions only.

The suggestion of 'clinic hours' for caseworkers to take calls from claimants would also be regressive. Caseworkers support multiple claimants at any one time, and to ensure readiness for a call, it is essential for caseworkers to adequately prepare by familiarising themselves with the case details beforehand, as not to do so would severely limit any possible help the caseworker can provide. Therefore, a significant amount of time could be spent just in preparation for 'clinic hours'. In addition, opening a small window of opportunity to call your caseworker will likely add to the frustration of most claimants as calls are often lengthy, limiting the amount of calls a caseworker can reasonably accommodate during that period.

For these reasons, the Department does not intend to take forward recommendation 15.

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.

Response to recommendation 16:

The Department accepts this recommendation. We have already implemented the use of email to contact claimants and we are piloting the use of text messaging. These communications are delivered within our existing service standards, and claimants are not disadvantaged no matter which method they use to contact us.

The Department is also currently engaged in a transformation project aimed at delivering a self-service portal, including for AFCS claimants. The programme will be delivered during 2024 and 2025. The portal will deliver a number of benefits for the claimant, including being able to see real time updates on their claim; the ability to scan in evidence; direct messaging between claimant and caseworker. Claimants will be able to access the portal from any device (mobile phone, laptop), at any time and from anywhere in the world.

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.

Response to recommendation 17:

The Department already has an established process in place to ensure that caseworker caseloads are manageable and do not become overly burdensome. The Department also acknowledges that as other QQR recommendations are taken forward, they may have an impact on caseworker workload and this will be taken into account in resourcing decisions.

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.

Response to recommendation 18:

Under the AFCS, the DBS medical advisors are trained in medico-legal determination within Scheme rules with the aim of supporting consistent, equitable decision-making across the spectrum of injuries and disorders claimed. This is in line with the duties specified in the second bullet of this recommendation.

The Department accepts that evidence, in the form of factual reports from the treating physician is essential in determining a claim. It is, however, important to note that the claimant’s medical team are representatives for the claimant with a professional need to maintain the trust and confidence of their patient. They cannot (and probably should not) take an objective view of the situation in these circumstances. Furthermore, there are other issues: some claimants may have multiple treating physicians, who do not all have the same opinion; in other instances, a treating physician hasn’t seen the in-service medical records which may demonstrate an entirely different incident to the history given by the claimant to their treating physician. For all these reasons, rather than giving primacy to evidence from the treating physician, a holistic approach is taken in considering claims.

Caseworkers do contact administrative staff to request primary care reports and hospital case notes from treating physicians. However, they do not directly ask specific questions of the treating physician about the claimant’s condition/s. This raises issues around the impartiality of the treating physician, the equity of decisions, a lack of knowledge of the AFCS and of disability assessment experience, and the potential to affect the doctor/patient relationship.

There are also time implications in the treating physician responding to requests as suggested in bullet 3, with delays impacting the claimant.

In conclusion, bullets 1 and 3 of this recommendation are rejected for the reasons given above. Bullet 2 sets out the role of the medical advisor-delivery and this is already in line with current practice.

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.

Response to recommendation 19:

The Department accepts that the definition of a 'treating physician', especially where the tariff requires diagnosis by a particular type of medical practitioner/health professional, should be made clear in AFCS guidance. It is important that the definition takes into account that in many cases, claimants often have multiple clinicians looking after their needs such as physiotherapists, social workers, mental health therapists, and any/all of them could be regarded as the 'treating clinician' at different stages of the claimant's journey.

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.

Response to recommendation 20:

The Department acknowledges the intent behind this recommendation, and during 2024/25 will agree the process through which we prioritise and review synopses of causation. It is crucial to understand that changes in medical understanding of causation do not occur frequently or rapidly, and it typically takes several years to develop a body of quality evidence that supports new ways of thinking. The commissioning of synopses is challenging to undertake, and they require validation by senior expert clinicians in the respective field. IMEG reports have increasingly focused their evidence-based discussions on difficult and contentious aspects of an injury or disorder. For example, their ongoing 7th report will include comments on lower limb injuries and disorders, as well as subsequent osteoarthritis, fitness for work, mental health, anxiety, PTSD treatment resistance and hearing loss.

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.

Response to recommendation 21:

We accept this recommendation as part of our ongoing activity to ensure our staff are equipped to carry out their roles effectively.

Training is continually provided to claimant-facing staff including caseworkers and helpline staff. Where gaps in knowledge or skills are identified or where it is felt that specific learning and development could enhance service delivery, customised training is designed and delivered. For example, there has been recent discussion about the need for a trauma-informed approach and training options are currently being scoped.

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.

Response to recommendation 22:

The Department supports this recommendation; as mentioned at Recommendation 5, the Customer Advisory Group (CAG) is already in place and is attended by all the stakeholders that have been identified in this recommendation. The group meets twice a year currently and will be engaged in information and awareness sessions on AFCS policy and practice. Feedback from these sessions will also be shared with caseworkers.

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.

Response to recommendation 23:

The Department accepts this recommendation and has already started the process of having regular case-based discussions for caseworkers. They are providing an important opportunity for benchmarking and to improve consistency across teams.

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).

Response to recommendation 24:

Recommendation 24 is not accepted. The Department acknowledges the importance of having structure to the working day of caseworkers, and we feel that once caseworkers are empowered with the resources to undertake their roles, they should have reasonable autonomy to plan their work. Furthermore, recommendation 15 (bullet 1) has been rejected for the reasons outlined in that response, and the proposals in recommendations 22 and 23 (bullets 4 and 5) are already happening, all of which negate the need for redesigning the workplan.

In relation to bullets 2 and 3, workloads are regularly kept under review to account for the desk time required on complex cases, and the emotional labour in dealing more closely with vulnerable claimants. With the latter, training is also provided as set out in response to recommendation 21.

5. Supporting good decision-making

Recommendations 25, 26, 27

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.

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.

Response to recommendations 25, 26, 27:

The drafting of IMEG reports is a complex process and writing topic reports involves an extensive literature review and discussion with military and civilian experts, which goes hand in hand with setting them in a military context while addressing the relevant issues. It is a gradual, iterative process undertaken over time. There is frequent critical review and revision by the appropriate medical expert on IMEG, in close liaison with the IMEG Chair and the Defence People Medical Advisor, as well as input from other members and, where needed, independent external advice. With these factors in mind, our view is that it would not be feasible for the drafting of IMEG reports to be undertaken by a medical PhD candidate or civil servant external to the MOD, and this recommendation is therefore rejected.

We accept the importance of having IMEG members who are practising and not solely academic, and indeed, all past and present medical expert members of IMEG with academic appointments are primarily clinicians and widely regarded as leaders in their specialities. Any further mandating of the terms and conditions of IMEG recruitment is not necessary. The current recruitment process also allows us to sufficiently specify the requirements for membership that IMEG needs at any

particular time: for example, in the summer of 2023, we commenced recruitment activity for the position of a medical epidemiologist for which a medical qualification is not necessary, but whose expertise is vital to IMEG's work. The intentions behind recommendation 26 are therefore already met under existing arrangements.

We accept the need for representative IMEG recruitment, and with the most recent campaign mentioned above, we have adopted a new approach to advertising through different social media channels as well as the more traditional methods used previously. This will help to ensure that IMEG recruitment remains representative, and we will continue to monitor and report the impact of these efforts as required by the Cabinet Office and the Government's Governance Code.

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.

Response to recommendation 28:

The Department agrees that the roles of the policy medical advisor function and the delivery medical advisor function should be well-defined and remain distinct. The terms of reference for both roles were reviewed during 2022 and 2023, so this recommendation has already been implemented.

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-, decisionmakers and analysts, routinely meet to discuss trends and take decisions on whether and how to act on these.

Response to recommendation 29:

MOD accepts the importance of the collection of data about historical and future claims and its regular analysis by policy, operational delivery and analytical teams. The current data collected, which feeds into the Annual Statistics release, is regularly used in reviewing AFCS policies.

The move to a new IT system for compensation claims during 2024 and 2025 provides the opportunity and capability for this recommendation to be fully implemented, so that the analysis of data, including trends, can routinely feed directly into policy and operational decision-making.

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 issues.
- 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.

Response to recommendation 30:

The working group proposed in this recommendation is already in place – the Department meets with some of the organisations mentioned through the Customer Advisory Group. Membership is drawn from those who guide claimants through the AFCS process. We will continue to engage though this forum, and others, to consider ways to improve operational policy and support the training of caseworkers and medical advisors.

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.

Response to recommendation 31:

Under the Armed Forces Covenant, the health sector already strives to reduce disadvantage faced by Armed Forces personnel and their families in their access to

healthcare as compared to other citizens, with special consideration for those most seriously disabled due to service. The NHS commissions bespoke services that vary across jurisdictions. In England there are a suite of services to treat veterans, these include Op RESTORE – The Veterans' Physical Health and Wellbeing Service supporting veterans with physical health injuries and related medical problems attributed to their time in service, and Op COURAGE – The Veterans' Mental Health and Wellbeing Service which supports veterans with their mental health.
The remit of the Covenant does not extend to procuring the support of the health sector in this way or producing the guidance as suggested in this recommendation. It may be possible for the Department to produce guidance about evidence packs to support claims, but questions remain about the practicalities of disseminating such information and whether it would be used. However, the Department undertakes to consider this matter through the Communications and Training Working Group to see how best we can work with the health sector, and agreed actions will be implemented over the next 12 months.

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.

Response to recommendation 32:

The Department accepts that individuals with complex cases may need specific support through the AFCS claims, reconsideration and appeals processes, and that this could be provided by the Veterans Welfare Service (VWS). Referrals by AFCS caseworkers to the VWS are currently made on a case-by-case basis. However, as the Reviewer has identified in the QQR report, if complex cases are to be routinely referred to the VWS and the specific actions in bullets 1, 2 and 3 undertaken, then this needs to be formalised and appropriately resourced.

This recommendation will therefore be considered alongside the implementation of recommendations concerning the VWS in the Independent Review of UK Government Welfare Services for Veterans.

Recommendations 33, 34

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.

Response to recommendations 33, 34:

The Department is separately working to clarify the future role and structure of the VAPCs, and these recommendations will be considered once that work is complete.

6. Calculating awards

Recommendations 35, 36, 37, 38

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.

Response to recommendations 35, 36, 37, 38:

Recommendations 35 to 38 propose that the calculation of the lump and the Guaranteed Income Payment (GIP) should be separated so that:

- The lump sum provides compensation for the nature of the injury and resulting mechanical limitation.

- The GIP provides compensation based on the sum impact on the recipient's psychological, family, social and occupational life.

The AFCS was introduced in 2005, following extensive consultation and development over several years. The Scheme has been designed to enable a holistic approach to assessing compensation claims from service personnel and veterans who have been injured or suffer illness due to their service. The focus is the claimed injury or disorder, associated severity, pain and suffering and impact on daily living including post-service employability. Descriptors and awards for all injuries and disorders take account of mental health symptoms short of a discrete diagnosable disorder. Lump sums compensate for pain and suffering and are analogous to pain/suffering in personal injury claims. Where descriptors and tariffs are not working or are contentious, they are brought to IMEG's attention for consideration and possible revision, supported by relevant case facts. Importantly, awards have been designed to sit alongside the full range of other State care and support available.

Following a detailed assessment of these QQR recommendations, there are a number of important reasons why the MOD believes that they will not result in an improved system which benefits the very people the Scheme is designed to support. Our analysis shows that the proposals carry a high risk of inconsistency and inequity in awards because some of the judgments proposed will, by their very nature, be subjective. Trying to address these risks is likely to result in a more complex system. This will in turn lead to further evidence requirements and increased timescales in assessing claims. It is important for claimants to have award decisions made in a fair, efficient and timely manner, and the Department does not believe that the risks and delays associated with these proposals will be in claimants' interests. Instead, these recommendations are likely to result in a system which is counter to the core principles on which the AFCS has been designed: fairness, simplicity, modernity, security, employability, human rights and affordability.

The MOD therefore believes that no changes should be made to current arrangements for calculating awards for AFCS claims, which align with the principles of the scheme and are as fair as possible.

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 equivalents 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.

Response to recommendation 39:

Where an individual has a lasting injury received as a result of service which has an ongoing impact on the amount they are able to earn over their lifetime in terms of both salary and pension, financial stability is provided through a lifelong, tax-free, inflation-proof income known as a Guaranteed Income Payment (GIP). This is an income replacement stream which is calculated and put into payment when the individual leaves service.

The GIP is therefore based on the individual's age at last birthday, their basic salary (minus allowances) at the time they leave service, and the severity of the injury/illness. The calculation of GIP uses this data, along with a series of assumption factors, to determine the lifelong loss of earnings the individual is likely to face in terms of both salary and pension because of their service-caused injury or injuries.

The current calculation of the GIP factor includes two component factors:

- Flat payment factors - Reflects the reduction in payment required so that the flat payment until death is equivalent in value to receiving full salary until retirement and then 50% of salary until death.
- Lost promotions factors – Reflects the increase in salary required to counteract the effect of lost promotions over the course of the claimant's career.

These factors are then multiplied to produce the GIP factor. Recommendation 39 proposes that a second set of GIP factors is introduced which would enable the distribution of the GIP over a lifetime, in the same way that the income of a fully employed equivalent person would be distributed. The aim would be that rather than having the GIP 'smoothed' over the lifetime as in the current system, there is a higher income up to retirement after which it would reduce.

The simplest approach if we were to implement this recommendation would be to remove the flat payment factor, leaving just the lost promotions factor. This would allow for a fixed GIP increasing with CPI until the assumed retirement age, at which point it would reduce depending on how much the individual was receiving in retirement pension.

Overall, GIP recipients would receive the same value from their payments under the current flat structure as under the proposed variable structure. However, the proposed system would be more complex to administer and to explain to claimants. While it may allow claimants to plan their future life more effectively through additional upfront funds, there is a risk that the income fall in retirement would result in financial hardship later in life.

We note that the Reviewer recommends a consultation before implementation. Such a consultation would first require detailed work to develop the new system, and as initial assessments do not suggest its benefits would outweigh the current approach, we do not feel the resource required could be justified. The Department therefore rejects this recommendation. Instead, we believe that there is further work to be done to communicate the total value of compensation under the AFCS and the benefits this affords, and this will be taken forward as part of the wider communications work arising from the QQR.

The Department also undertakes to review the GIP factors during 2024/25, and to update them as necessary.

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).

Response to recommendation 40:

The current system for multiple injuries ranking is designed to ensure equity in line with the Scheme's overriding principles, so that:

- 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.
- Where appropriate, each injury sustained receives some compensation.

The proposed system would instead compensate all injuries other than the most severe, at a fixed rate. Given that the current system is a fair approach and aligns to AFCS principles, which are not in dispute, this recommendation is rejected.

7. Seeking parity

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."

Response to recommendation 41:

The Department will review the policy intent behind the tariffs in Tables 3 and 4 and how these are applied in practice during 2024 and consider whether any changes are needed to the legislation.

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.

Response to recommendation 42:

Calculation of degrees of limitation is a highly specialised area that requires expertise from consultant medical rehabilitation specialists, physiotherapists, and occupational therapists. These professionals collaborate closely, taking into account family input to assess the individual's abilities. The Department believes that it is right for this to remain a professionally driven process with suitably skilled people carrying out assessments of functional limitation. It would not be appropriate for a caseworker, as a lay person, to undertake these tasks. The MOD does not, therefore, accept this recommendation.

There is also a link to recommendation 37. This proposes that GIP awards should be based on the sum impact of the injuries on the recipient's psychological, family, social and occupational life, irrespective of the nature or number of injuries they have suffered, which after careful consideration, the MOD is not accepting.

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.

Response to recommendation 43:

Making determinations that an injury or illness is 'permanent' is not straightforward and the alternatives may also raise issues. Further work is needed to fully consider alternatives to the word 'permanent'; IMEG has looked at this issue as part of their 7th Report, due to be published in 2024, and MOD will consider their findings before a decision is made.

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.

Response to recommendation 44:

In the AFCS the individual must show that, on the balance of probabilities, the injury or illness was caused wholly or partly by service and if partly, predominantly by service. This means they must show that they are suffering from a particular injury, and that it is more likely than not that that injury arose because of their service in the UK Armed Forces. Moving away from evidence-based decision making has implications for maintaining the robustness of the Scheme as well as being counter to best practice in civilian benefit schemes. For example, the Department for Work

and Pensions moved away from subjective assessment when Disability Living Allowance was changed to Personal Independence Payment to allow for a more robust, objective assessment of a claim and to reduce the potential for fraud.

The Department believes that clinician-determined, evidence-based decision making must remain a fundamental aspect of the AFCS and does not therefore accept the change proposed in this recommendation.

Recommendations 45, 46

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.

Response to recommendations 45, 46:

The Department’s initial assessment on expanding Table 3 – Mental Disorders is that all current descriptors in every category take account of less severe mental health disorders. Operationally, expanding the Table as suggested is likely to increase the number of interim awards which goes against the principles of the Scheme and does not benefit the claimant.

However, we consider it would be appropriate that both recommendations should be referred to IMEG for consideration as part of their 8th Report.

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.

Response to recommendation 47:

The Department acknowledges the intent of this recommendation, it is supported by the acceptance at Recommendation 8 to producing a document that will provide caseworkers with guidance in decision making.

The Department also acknowledges the concerns raised regarding the decision-making process based on the anticipated duration of an ongoing mental health disorder. It is recognised that there can be multiple treating physicians involved, each with their own perspectives and opinions on prognosis. Our experience is that treating physicians are often hesitant to provide a definitive prognosis regarding the duration of a mental health condition.

We will continue to review and define our processes to ensure that all relevant medical evidence is thoroughly considered, allowing for a fair and comprehensive evaluation of each claimant's condition. This will be reinforced by the work we have committed to complete under Recommendations 7 and 9.

Previous IMEG reports have addressed the consideration of interim awards within the scheme, particularly in mental health claims, and this will be covered again in their upcoming 7th Report scheduled for release in 2024.

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.

Response to recommendation 48:

Our initial assessment, drawing on our operational experience, is that reducing the 2-year interim award period is unlikely to be beneficial to claimants. Many would not have had the necessary treatment in that period, and there will be cases (mostly mental health) where finalising in 2 years will be impossible, as the prognosis cannot be reliably predicted. This is likely to disadvantage the claimant with a lower award than they would have received at 4 years. Instead, there is a case for better communication as to why interim awards are made, to manage claimant expectations and to show that this is in their best interests.

Reviewing annually is not appropriate as a fixed timeline, as a medical adviser will decide the interim review period based on evidence of the severity of the condition, phase of treatment and frequency of sessions condition, and therefore the likely timeline in which a permanent award can be made.

Issues relating to mental health claims are currently being reviewed by IMEG and will form a topic chapter in their 7th Report, expected in 2024. We will review their findings before making a final decision on this recommendation.

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.

Response to recommendation 49:

An interim award is made in cases where an injury is caused by service but has not reached steady state because treatment is incomplete, or where the ongoing disabling effects are uncertain. At the date of decision, the most appropriate descriptor is selected and the period for which the interim award applies is specified.

A final award will should be made within two years, starting with the date on which the interim award was made, but can be extended for a maximum of four years. This situation may arise if claims are made very early after injury, where treatment has not begun or is in very early stages, in cases of multiple injuries (where some injuries are settled but others not) and sometimes in mental health disorders where an adequate course of appropriate best practice treatment has not been received.

Interim awards are therefore made with the best interests of the claimant at heart, and opening these award decisions to appeal will entail much administration and resource that would not necessarily benefit the claimant. The Department will not therefore take forward this recommendation, but we accept that there is a case for

better communication as to why interim awards are made, to manage claimant expectations, and to show that this is in their interests.

Recommendation 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.

Response to recommendation 50:

The Department agrees that interim award decision letters should inform recipients of the date by which the award must be reviewed, and of their right to request an early review where they receive any significant new evidence. Examples of what the significant new evidence could be will also be provided. This work should be completed by the end of June 2024.

Recommendation 49 that interim awards should be subject to appeal is rejected, for the reasons previously explained, and the Department will not therefore take forward the second bullet of recommendation 50.

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.

Response to recommendation 51:

Following review and recommendation from the 2010 Boyce Review of the AFCS, the Armed Forces Compensation Scheme Statement of Policy (JSP765), includes circumstances when caseworkers will routinely seek medical advice when assessing a claim, and this includes all cases involving mental health problems. The inclusion of factual reports from the treating physician plays a key role in ensuring a comprehensive and equitable assessment of mental health claims. These reports establish the validity and severity of the condition and enable decision-makers to make well-founded decisions regarding compensation. Given the difficulties in accessing NHS consultant psychiatrists and psychologists, the proposed change

could be welcome. It would still be necessary to define who could be a lead treating physician to give a robust diagnosis.

The issue of the need for consultant level diagnosis for mental health disorders is currently being explored by IMEG as part of their consideration of mental health awards in the 7th IMEG Report, due in 2024. The Department will fully consider this recommendation once their findings have been published.

Recommendations 52, 53

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.

Response to recommendations 52,53:

These recommendations focus on the principles against which tariff descriptors and the corresponding tariff levels have been set. When the AFCS was designed, benchmarking was done against other compensation and benefit schemes to ensure that each tariff descriptor was matched to the correct tariff level. These were considered again in the Boyce Review of the AFCS in 2010.

Tariff descriptors and awards levels in each table are now regularly reviewed by IMEG to ensure that they remain appropriate. At the same time, consideration of vertical and horizontal equity both in general across the spectrum of injury categories, and specifically for mental health compared with physical disorders, also takes place. Mental health awards were extensively audited in the 6th IMEG report (July 2022), and it is worth noting that this found no evidence of a lack of parity or esteem of mental health disorders in comparison to physical disorders. Mental health awards are also being considered as part of the 7th IMEG report, due to publish in

2024. To date, all IMEG findings and recommendations have been accepted by ministers, and subsequent legislative amendments have taken place.

JSP765 read in conjunction with the tariff tables and descriptors provides useful information and examples to demonstrate how awards are calculated.

The Department therefore believes that the existing process by which IMEG thoroughly and regularly reviews tariff descriptors and levels, and the information that is already publicly available about them meets the proposals in these recommendations.

8. Inequitable limitations

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.

Response to recommendation 54:

The AFCS is designed so awards take into account the expected effects of the injury and treatment over the person's lifetime. Time limits were introduced in the legislation to support this, by providing a full and final award to give the injured person certainty over a lifetime, and the chance to focus on their future. On a practical level, time limits facilitate effective evidence gathering for claims.

The Boyce Review re-examined all these provisions, taking on board independent expert advice, and made some adjustments but concluded that overall, they remained fit for purpose. The Scheme already includes provisions where time limits may be extended. Time limits are also features of other no-fault schemes, where a time limit of 3 years is normal as compared to 7 years under the AFCS.

Removing time limits would be a backward step towards the type of rules found in legacy schemes, like the War Pension Scheme. This is likely to add delays to the process as evidence to support claims may not be readily available. Ultimately, this would cause an unhelpful distraction to the benefits of having a full and final award and prove detrimental to claimants being able to move forward in their lives. It is also worth noting that most claims under the AFCS are made while the claimant is in service, soon after the injury/illness occurs, and removing time limits would serve no useful purpose. The Department therefore rejects this recommendation and instead, as part of the wider communications work proposed in the QQR, improved and accessible guidance around when and how to submit a claim, will be included.

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.

Response to recommendation 55:

The Reviewer questions why, where the death occurred after the 7-year time limit, only dependents of veterans with tariff level 1 to 9 awards can apply for death benefit. These benefits are the Survivors' Guaranteed Income Payment, Child Payments and the Bereavement Grant. An example is given of a veteran who, for whatever reason, did not make a claim for the original injury but who would have been awarded compensation had they done so. The Reviewer asserts that dependents should be able to make an application for injury benefit after the 7-year time limit, irrespective of the original level of award made to the veteran.

The reasoning behind this provision is that it is generally an award which also results in a GIP being payable, that is likely to be a material factor in the person's death following this time interval from service termination. This applies whether the award was made at service termination or on subsequent review because of unexpected worsening. During the 2024/25 legislative cycle, the Department will review the current tariff levels at which death benefits are payable to decide whether they should be expanded.

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.

Response to recommendation 56:

(The Department believes the Reviewer refers to Article 11(3) and 11(4) of the AFCS legislation.)

As with other compensation schemes, the AFCS has a threshold for claims consideration. Slips, trips and falls can happen anywhere and are not generally unique to service. Attributability is more than just something that happened while on duty, the injury must occur because of something that is unique to service and not civilian life. Articles 11(3) and (4) provisions cover these points, and ultimately enable the focus of the AFCS to be on the more serious injuries and disorders. However, paragraphs 4 and 9 of Article 11 do allow for exemptions, for example, where a slip, trip or fall was caused by undertaking activities in pursuance of a service obligation (including activity of a hazardous nature, in a hazardous environment, and training to improve or maintain the effectiveness of the forces), or where injury was caused by reason of acts of terrorism or other warlike activities, or during an emergency situation.

As the provisions in Article 11 (3) and (4) are therefore considered to be fair and proportionate and support the underlying principles of the Scheme, the Department does not accept this recommendation.

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.

Response to recommendation 57:

In putting forward this recommendation, the Reviewer seeks to specifically remove any disadvantage caused to those with no prior knowledge of a hereditary tendency or personality disorder, and whose condition is triggered by service.

By way of background, when medical checks are carried out prior to being accepted for service, previous or existing injuries and disorders will be considered and, in many cases, single Service and Defence Medical Services policy will not prevent enlistment. Nor, dependent on case facts, will it necessarily prevent a later claim for worsening including in cases where the claimant had no prior knowledge of the condition, which is the focus of this proposed change. Therefore, the existing rules do not disadvantage those with no prior knowledge.

Instead, our assessment is that removing this provision would involve transferring risk currently held by individuals to MOD when accepting them for service. This could potentially necessitate a subsequent tightening in recruitment policy to address these risks, thereby disproportionately reducing the MOD's ability to recruit effectively.

The Department therefore rejects this recommendation but will reflect on the impact of non-disclosure of previous injury in pre-acceptance medical checks when the individual makes a claim under the AFCS.

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.

Response to recommendation 58:

In terms of evidence requirements, if the claimant is still in service, evidence is obtained from electronic service medical records and therefore the claimant incurs no cost. If they have left service, they should be able to obtain evidence from their GP/primary care practice by way of a Subject Access Request at no cost. If further evidence or information is needed, the Department is responsible for requesting this from the relevant medical professional and paying for it. There should therefore be no circumstances under which a claimant, whatever their financial means, is disadvantaged by having to pay for AFCS evidence requirements. As part of the wider communications work highlighted elsewhere in this report, we will include information about the types of evidence that may support a claim and advise claimants how to make a Subject Access Request.

Additionally, as explained in the response to recommendation 51, the need for consultant level diagnosis for mental health disorders is currently being re-examined by IMEG as part of their consideration of mental health awards in the 7th IMEG Report, due in 2024.

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).

Response to recommendation 59:

Much progress has already been made and work continues, under the Armed Forces Covenant, to ensure that armed forces personnel and their families face no disadvantage in their access to healthcare as compared to other citizens.

The NHS commissions bespoke services that vary across jurisdictions. In England there are a suite of services to treat veterans, these include Op RESTORE – The Veterans' Physical Health and Wellbeing Service supporting veterans with physical

health injuries and related medical problems attributed to their time in service, and Op COURAGE – The Veterans' Mental Health and Wellbeing Service which supports veterans with their mental health. The Department believes that these existing arrangements meet the intent of this recommendation and will consider how to raise awareness of the available support as part of the wider communications work arising from the QQR.

It is also worth noting that the role of the private sector in treating service-attributable injuries and disorders was carefully considered by the Boyce Review in 2010. It concluded that private provision for the types of injury suffered in service was not always appropriate, and a mix of private and NHS care carried a high risk of poor communication between both providers to the detriment of the claimant. The same issues are relevant today.

Recommendations 60, 61

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 decision (i.e., the claimant does not have to wait five years after the decision to request a review).

Response to recommendations 60, 61:

The AFCS makes full and final awards at the outset and aims to take due account of the medically expected progress and prognosis of the injury including, where appropriate, expected deterioration as the person ages. The intention is that the resultant award provides a degree of financial certainty and allows the person to move forward and focus on their future. This, by design, means that reviews should only be available in certain limited circumstances; these are outlined in detail in the legislation but include on service termination, in exceptional circumstances where an injury or illness unexpectedly deteriorates or consequential problems develop

beyond those anticipated, a review due to ignorance or mistake of fact or law, and a final review where more than 10 years have passed since the latest AFCS decision.

The review provisions and associated time frames were set following careful consideration, and were subsequently re-examined by the Boyce Review, which also took on board independent expert advice. That Review made some adjustments but concluded that overall, the provisions remained fit for purpose. In the absence of evidence to suggest otherwise, we believe that this continues to be the case.

Moving back to a War Pension Scheme style system would effectively go against the principles of the AFCS and erode its intended benefits. For all these reasons, the Department believes that rather than changing the current provisions, there is a need for better communication to help claimants understand the review system.

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.

Response to recommendation 62:

We accept that claimants should be informed of their ability to have their award decision reviewed, and that this should be made clear in all relevant communications. This work will be taken forward as part of the wider review of communications, which is mentioned elsewhere in this paper. The MOD does not agree that a change in legislation is therefore required for this purpose.

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.

Response to recommendation 63:

The Reviewer has rightly identified that the current AFCS provisions are not adequate for cases in which fraud is detected, after an award is in payment. Article 59(2) refers to a ‘mistake’ and it can be problematic to extend that to cases of fraud.

The Department accepts the intent behind this recommendation and will consider how to take it forward in legislation during 2024/2025.

9. 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.

Response to recommendation 64:

The MOD believes that current practice is compliant with Article 60 as it stands, and legislative change is not needed. While the responsibility to show that an injury is caused by service rests with the claimant, the process for doing so is designed to be as easy to navigate as possible. The process is not intended to be adversarial, but inquisitorial, with DBS undertaking most of the evidence gathering on the individual's behalf.

The MOD, including the single Services and Defence Medical Services have a duty to provide relevant service evidence where available. This can include the individual's service history, medical records and details of any incident(s), as well as evidence from the Chain of Command, medical officers and others. Claimants can of course provide any additional evidence they wish.

The MOD accepts a responsibility to provide information to the claimant about the evidence needed to support a claim. However, changing the legislation as suggested risks placing an undue burden on the MOD, for example, in cases where the claimant may not be fully co-operative in evidence gathering, or in practically determining and collecting all 'knowable evidence'.

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.

Response to recommendation 65:

The Department accepts this recommendation. Activity is currently taking place to review and improve the process for file closure, and this is due to be completed by June 2024. As part of this, we will include steps for writing to claimants prior to file closure, with an appropriate timeline for contesting such a decision.

10. Lump-sum uprating

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.

Response to recommendation 66:

The AFCS provides a tax-free lump sum for pain and suffering caused by injury or illness.

The awards were last uprated in 2018, when the top-level award was increased to £650,000 and the others were uprated in line with the Consumer Prices Index (CPI). At the time, the proposal to uprate lump sum awards annually by CPI was not accepted as it would be a departure from wider government policy for compensation lump sums. It was agreed though that lump sums would be reviewed and uprated on a periodic basis, in consultation with HM Treasury and key internal and external stakeholders. The Department accepts that it would be timely to consider this during 2024/25, while also considering a standard process and time period for this to happen in future years, as advocated for in this recommendation.

11. 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.

Response to recommendation 67:

The Department accepts this recommendation. We have already committed to producing a decision explainer document in response to Recommendation 8 and will include information about spanning cases within that.

IMEG has conducted an audit of cases and their findings will be covered in their forthcoming 7th Report, although it should be noted that almost 20 years since the introduction of the AFCS, the numbers of such cases is small and continues to fall.