

Health Service Guidance covering Arrangements between the Ministry of Defence and the NHS for:

- A. The Use of Defence Medical Services (DMS) Personnel in NHS Trusts**
- B. The Treatment of Service Personnel in NHS hospitals**
- C. Continuing Medical Care of Service Personnel on Retirement or Discharge from the Armed Forces**

Chapter 1: Summary of Guidance

Introduction

1. This Guidance comes into effect from April 2005, and replaces both **HSC 1999/112** (Financial Arrangements for Ministry of Defence Hospital Units (MDHUs) and **HSG(97)29** (Arrangements between Ministry of Defence (MOD) and the NHS for the treatment of Service personnel in NHS hospitals). The Guidance makes reference to NHS Trusts which should be taken as also referring to NHS Foundation Trusts. The Guidance will be subject to regular review and, where appropriate, updated to reflect NHS and/or MOD changes that impact on the Guidance.

Principles

2. The underpinning principles of this Guidance are that:
 - The treatment of Service personnel should, as far as is appropriate, align with NHS arrangements for the treatment of civilians;
 - MOD is able to secure higher levels of access where required for operational purposes from any NHS Trust or other provider as appropriate, in return for enhanced payments as negotiated by MOD Central Budgets (Commercial) Medical with the NHS Trust or other provider;
 - The provision of healthcare to Service personnel, and hence operational effectiveness, should benefit from improved performance within the NHS;
 - Defence Medical Services (DMS) personnel working at MDHUs or other NHS Trusts should be fully integrated into the host NHS Trust; and,
 - Host NHS Trusts should not be financially disadvantaged as a result of hosting, employment of DMS personnel or of provision of treatment.

The use of Defence Medical Services (DMS) Personnel in NHS Trusts

3. **NHS Trusts hosting Ministry of Defence Hospital Units (MDHUs).** MDHUs were set up following Defence Cost Study 15 (1994), which led to the closure of the military hospitals, and were established and integrated within host NHS Trusts. They contribute to the NHS clinical capacity and enable DMS personnel to maintain their clinical expertise while maintaining their military skills and ability to deploy quickly to areas of conflict in support of frontline forces. **Revised principles for hosting MDHUs are set out in Chapter 2**
4. **DMS Personnel in NHS Trusts other than those hosting MDHUs.** When DMS personnel are appointed to an NHS Trust that does not host an MDHU, the MOD will enter into a Singleton Contract with the Trust concerned. **The principles governing such appointments are in Chapter 3**
5. **The funding arrangements for the placement of Military Junior Doctors in NHS Trusts are in Chapter 4**

6. A formal Business Arrangement should be agreed between the MOD and any NHS Trust hosting DMS personnel. **The principles governing such arrangements are in Chapter 5**
7. On those occasions where major military deployments result in additional costs being incurred by either the host Trusts or other NHS Agencies, these will be reimbursed by the MOD. **Details are in Chapter 6**

The Treatment of Service Personnel in NHS Hospitals

8. Members of the UK Armed Forces are entitled to full use of NHS hospitals on the same basis as civilians. NATO forces are entitled to full use of NHS hospitals on the same basis as UK civilians if appropriate military provision is not available. Personnel of foreign and Commonwealth Forces that are not part of NATO, and who are serving in the UK attached to Foreign Embassies, High Commissions, the UK Armed Forces or other NATO forces serving here, are also entitled to full use of NHS hospitals on the same basis as UK civilians if appropriate military provision is not available. **Policy and administrative procedures are described in Chapter 7**

The Continuing Medical Care of Service Personnel on Retirement or Discharge from the Armed Forces

9. The NHS is responsible for the medical care of Service personnel on leaving the Armed Forces provided the individual is entitled to residency in the UK. A small group of Service personnel have a significant and debilitating illness at the time of medical discharge. For these individuals, it is essential that the MOD is able to engage as soon as possible with the Primary Care Trusts (PCT) of future residence to ensure that there is a seamless transfer of care between that managed by the MOD and the future care that will be provided and/or commissioned by the PCT. **This issue is covered in Chapter 8.**

Glossary of Terms and Abbreviations

10. **A glossary of the terms and abbreviations used within this Guidance is in Chapter 9.**
11. Summary of Chapters

Chapter 1 Summary of Guidance

Chapter 2 Principles for Hosting Ministry of Defence Hospital Units (MDHUs)

Chapter 3: DMS personnel in NHS Trusts not hosting MDHUs (Singleton Placements)

Chapter 4: Junior Doctors/Training Places

Chapter 5: Business Arrangements

Chapter 6: Arrangements to be adopted in the event of major MOD deployment(s).

Chapter 7: Treatment of Service Personnel in NHS Hospitals.

Appendix 1 – MDHUs

Appendix 2 – NATO Countries

Appendix 3 – Service Administration Contacts

Appendix 4 – Military Administrative Officers (Civilian Hospitals)

Chapter 8 Continuing Medical Care of Service Personnel on retirement or discharge from the Armed Forces

Chapter 9: Glossary of Terms

Chapter 2:

PRINCIPLES FOR HOSTING OF MINISTRY OF DEFENCE HOSPITAL UNITS(MDHUs) BY NHS TRUSTS

Introduction

1. This sets out the principles for the hosting of MDHUs by NHS Trusts.

Process and Principles

2. Within each NHS Trust hosting an MDHU, DMS personnel will be integrated with NHS staff to provide medical, nursing and other clinical treatment to NHS and military patients. The clinical input provided by DMS personnel is designated 'Trust Protected Time' (TPT) and the time that MOD requires DMS personnel to spend on military duties is 'Military Protected Time' (MPT). The framework that underpins the integration of DMS personnel, the agreement of TPT/MPT and the provision of treatment to military patients will be set out in local Business Arrangements which will be agreed between MOD and each NHS Trust (See Chapter 5).
3. As an integral part of the Business Arrangement, MOD and a NHS Trust may agree that a DMS person shall participate in Outreach Clinics held in military establishments within the Trust's catchment area, where they will see Service Patients. Service Patients seen in these Outreach Clinics will be included in the treatment requirement (see Chapter 5), and the time will be part of TPT. Outreach Clinics undertaken outside the catchment area will normally be part of MPT unless specific arrangements have been made.

Hosting an MDHU

4. DMS personnel appointed to an NHS Trust will be fully integrated into the fabric of that Trust and employed in a way that will:
 - Ensure clinical competency for their military operational role;
 - Maintain and enhance their clinical skills;
 - Include access to all appropriate Trust facilities;
 - Within TPT be equivalent, in terms of standard hours worked and rotas attended, to their NHS colleagues. Consultants Planned Activities (PA) either in Trust or Military Protected Time will not exceed 12 per week.
5. DMS personnel will be appointed on the basis that either:
 - a. The DMS person or persons can be grouped in a Squad with others of like qualifications/clinical roles. MOD and the Trust will agree the Whole Time Equivalent¹ (WTE) to be provided; or
 - b. The post is a Standalone Post, which, by virtue of the appointment, qualifications and experience required, cannot readily be filled effectively by utilising a squad. MOD and the Trust will agree a Job Plan² upon which TPT will be based.
6. Thereafter, three months before the start of each year³, MOD will negotiate with the Trust its proposals for the forthcoming year, identifying:

¹ 'Whole Time Equivalent': the clinical effort, expressed in terms of posts, that the Trust would have had if they had employed NHS personnel

² A Job Plan will reflect (1) the annual output required by the Trust of the appointment to be filled and (2) the number of programmed activities to be undertaken by the DMS person in contributing to that output and the periodicity with which they are to be undertaken.

³ "Year" means the period 1 April to 31 March.

- a. The WTE number within each Squad; and
- b. Changes to the Standalone Posts.

Where the MOD proposes to reduce its clinical input on a permanent basis, either by size of squad or number of stand-alones, it should give the Trust sufficient time to recruit replacement NHS staff.

WTE Personnel

7. A clear baseline is required in respect of what MOD is offering Trusts in terms of WTE personnel. This should, as far as possible, align with NHS arrangements, but agreement must be reached between MOD and the Trust about the basis upon which WTE will be calculated.
8. When exceptional levels of operational deployment render the MOD unable to provide 100% of the WTE agreed with the Trust, the financial compensation mechanisms described in Chapter 6 will come into play. In all other cases (eg unplanned absences arising from small deployments or long term sickness) resulting in a shortfall in WTE, compensation arrangements will be as set out in paragraphs 12 and 15.

Pricing Principles

9. The NHS Trust will pay MOD the NHS-equivalent value of the WTE of DMS personnel appointed to the Trust. This payment will be agreed annually between MOD and the Trust in accordance with the following principles:
 - a. The number of DMS personnel appointed to Standalone Posts and Squads;
 - b. The availability of DMS personnel (in terms of TPT and WTEs);
 - c. NHS salary scales as currently applicable in the host Trust.

The price payable for each DMS person will be based on the NHS equivalent capitation rate.

10. The baseline for NHS consultants is 10x4 hour PAs. However, there is variation between NHS Trusts, and within different departments within NHS Trusts. DMS consultants will be expected to work the same number of PAs as their NHS colleagues, up to a maximum of 12, with these split between Military and Trust Protected Time. The NHS Trusts will only reimburse the MOD for the PAs included in Trust Protected Time.
11. Additional PAs undertaken by DMS Consultants for waiting list initiatives and the like, over and above the contractual baseline, do attract additional payments from the NHS Trust. DMS consultants are entitled to earn such payments from the NHS Trust as long as the work is not conducted either in TPT or MPT.

Performance

12. MOD and the NHS Trust will agree TPT and WTE for each Standalone Post and Squad respectively. Availability of DMS personnel will be measured periodically against the agreed TPT/WTE. For each Standalone Post and Squad, there will be a calculation of the daily average achievement of TPT/WTE over the preceding period, and:
 - a. If the average provided is less than that agreed, the MOD will pay a sum that will reflect the margin between the average provided and the agreement; or
 - b. If exceeded, then the excess will be discussed during negotiations for the following year.
13. TPT and WTE will include allowances for professional training/Continuous Personal Development (CPD) and for sickness absences. Both TPT and WTE will be measured to ensure that MOD delivers these on average in an agreed period of time.

14. Pre and Post-Operational Tour Leave will be part of MPT, as will annual leave for members of Squads. Standalone posts shall have the annual leave split between MPT and TPT in the agreed ratio. When DMS personnel are on 24 hrs standby, this will be counted as MPT even if they are still able to work in the Trust.

Replacement Personnel

15. The unplanned absence of DMS Personnel will be dealt with as follows:
 - a. **Short Term** (7 calendar days or less). These will be managed and funded by the NHS Trust in the same way as for its own staff.
 - b. **Long Term** (more than 7 calendar days). If a DMS person appointed to a Standalone Post is absent unexpectedly, and this absence is likely to breach TPT over the agreed period for measurement, the NHS Trust will invite MOD to appoint a replacement person. If appropriate, MOD will authorise and pay for the NHS Trust to employ a locum or agency staff for the period of the absence. The MOD will also consider the employment of a replacement on a longer term employment on a case by case basis. The NHS Trust shall not employ replacement staff without the express prior permission of MOD, through a POC established at DMETA.

Management of and Support to DMS Personnel

16. There will be an MDHU Headquarters organisation at each NHS Trust, which will provide line management and administrative support to the DMS Personnel appointed to the MDHU and to Service patients using the NHS Trust Hospital. The accommodation and facilities that the NHS Trust will provide to the MDHU HQ will be part of the Business Arrangement.
17. In addition to a price for accommodation and facilities at MDHU Headquarters, the MOD will pay an administrative charge to facilitate the integration of the MDHU into the organisation of the NHS Trust.
18. Charges for the provision of accommodation, facilities and integration will be agreed in the Business Arrangement.

Forward Planning

19. The MOD will use its best endeavours to give as much notice as possible of the unavailability of MDHU personnel. For exercises and planned deployments, this will usually be no less than 4 months. The MOD reserves the right to remove individuals at 24 hours notice to cover unforeseen requirements.
20. Regular review meetings will be held and in-year adjustments mutually agreed. MOD will endeavour to give NHS Trusts as much notice as possible of consultant placements, with a target of initial enquiry at 2 years. Significant changes to hosting numbers as a result of changes in DMS overall strength as opposed to operational deployments will also be notified as early as possible; again with a target of 2 years. NHS Trusts should also use these review meetings as an opportunity to keep MOD informed of both their long and short-term requirements.

Chapter 3
DMS PERSONNEL IN NHS TRUSTS NOT HOSTING MDHUs
(SINGLETON PLACEMENTS)

1. MOD's preference will always be to place consultants in MDHUs whenever possible. However, there will be occasions when MOD wishes to appoint DMS personnel to a NHS Trust that is not host to a MDHU. Where this occurs, MOD will enter into a Singleton Contract with the NHS Trust concerned.
2. In recognition of the contribution that the individual will make to the clinical activities of the NHS Trust, MOD will receive commensurate payments from the host NHS Trust. Such payments shall be calculated as set out in Chapter 2 Para 9.
4. The Contract will clearly detail the Military Protected Time (MPT) and Trust Protected Time (TPT) used in this calculation. Any significant military commitment, such as being a Defence Consultant Adviser, will be undertaken as part of MPT.
5. Where MOD identifies a DMS person who needs additional support, requirements will be agreed between the NHS Trust and MOD in accordance with the Business Arrangements (i.e. if the DMS person has additional responsibilities that require extra clerical support then the MOD will meet reasonable extra costs). They are likely to be on a par with those provided to a NHS equivalent.
6. MOD will provide 100% of TPT agreed in Job Plans. If not achieved, and dependant on the reasons for this, MOD will make good the loss of output by reimbursing costs of recovering the lost output, on a case by case basis including use of private sector capacity.
7. Where a singleton consultant appointment is being considered in the locality of an existing MDHU, the MDHU host NHS Trust will be informed prior to DMETA making a firm commitment.

Chapter 4

JUNIOR DOCTORS / TRAINING PLACES

1. DMS Junior Doctors are part of the overall National Healthcare Asset Base and for the majority of their Service careers will provide a clinical input into the NHS. The NHS facilitate the training of these doctors.
2. There are currently two Treasury-approved funding streams for the salaries of Junior Doctors under training; one within the NHS via the Regional Deans, and one through the MOD via the Single Services.
3. Training within the NHS Trust Hospitals falls into two categories; Accredited (NHS/Deanery) Funded Posts; and Accredited (NHS/Deanery) Non-Funded Posts. DMS personnel can fill either post.
4. When a DMS Junior Doctor fills an Accredited Funded Post the MOD will remain liable for payment of the individual's salary, but the NHS Trust will reimburse the MOD, with those employment costs not covered by the Deanery. When a DMS Junior Doctor fills an Accredited Non-Funded post, the salary costs will fall to whichever MOD Single Service employs the individual. All payments for additional hours worked will be paid directly to the MOD Single Service.

Chapter 5

BUSINESS ARRANGEMENTS

1. This chapter sets out a framework for the Business Arrangements to be agreed between the Department of Health (DH), NHS and MOD. In each MDHU there should be a specific contract, reflecting the provisions included in this Chapter while encompassing in addition current MOD and DH guidance and including provisions that are general to Business Arrangements, such as Data Protection, Discrimination and Prompt Payment. MOD Commercial Branch, Central Budgets (Commercial) Medical is the MOD Authority for setting up and amending the Business Arrangements.

Placement of Personnel

2. In the case of squaddened personnel, MOD should discuss with the NHS Trusts the mix of skills and experience that will go into a particular squad. As part of these discussions, and in accordance with local NHS recruitment practice, the host NHS Trust reserves the right to refuse an individual for placement.
3. If a DMS Person is, in the NHS Trust's view, not contributing to the productivity and governance of the NHS Trust, the NHS Trust may ask for that person to be removed.
4. In exercising these rights, the NHS Trust is likely to be required to substantiate their reasons.

Pricing and Payment

5. Prices should be set at the start date of the Business Arrangement, and, if required, varied in accordance with Variation of Price conditions to be agreed.
6. Prices for the placement of DMS personnel should be comparable to NHS equivalent value and agreed between MOD and the host NHS Trust.
7. Prices for the provision of treatment should be agreed between MOD and each NHS Trust including a premium for fast-track work.

Performance Management

8. **Hosting.** Each MDHU HQ should maintain a record of all absences of DMS personnel and reasons for absence. At intervals to be agreed within the Business Arrangement, the MDHU HQ should provide a report on the availability of DMS personnel over the preceding period. These reports should be used to calculate the sums payable by the Trust in respect of Hosting and for planning purposes for subsequent periods.
9. **Treatment.** Delivery of treatment should be in accordance with targets to be agreed within the Business Arrangement. Performance should be reviewed at intervals agreed within the Business Arrangement. Payment of premium rates for fast-track treatment should be dependent on the achievement of agreed targets for such provision.

Clinical Governance

10. The host NHS Trusts have prime responsibility for determining Clinical Governance (CG) policy within their hospitals, and DMS personnel should work in accordance with the Host NHS Trust's protocols and procedures. Where there is conflict between these and the Defence Medical Education and Training Agency (DMETA) CG policy (with which DMS personnel also have a mandate to comply), HQ DMETA should inform the Host NHS Trust and the two organisations should work together to resolve the issue.

Dispute Resolution

11. In the event of a dispute, MOD and the Trust should attempt to settle the dispute by negotiation between the parties. If the dispute remains after a reasonable period of negotiation (to be determined in the Business Arrangement), either party may refer the dispute to the MOD/UK Health Departments Board for advice. Either party may also invoke the dispute resolution procedures specified in the Business Arrangement

Chapter 6

ARRANGEMENTS TO BE ADOPTED IN THE EVENT OF MAJOR MOD DEPLOYMENT(S)

Statement of Principle

- 1. MOD accepts that, in the event of major deployment(s), certain additional costs falling on either the host NHS Trusts or other NHS agencies should be reimbursed by MOD. A major deployment, for the purpose of this guidance, is a MOD medium scale deployment (or above) or two concurrent small scale operations. A medium scale deployment is a deployment of brigade size or equivalent for war-fighting or other operations. Two concurrent small scale deployments are the concurrent deployment of 2 battalion size or equivalent. In such circumstances, MOD will reimburse the following costs:
 - a. The costs of replacing regular DMS personnel who are withdrawn from an NHS hospital to be deployed on the operation. Such costs could take the form of temporary agency staff or locums, overtime payments to NHS staff or out-sourced capacity, e.g. from the private sector.
 - b. The costs of ring-fencing capacity within NHS hospitals to ensure that a guaranteed level of provision is available. MOD might, for example, ask the NHS to ensure that a minimum number of burns beds were guaranteed to be made available for casualties.
 - c. Exceptionally, new capacity might be required where the guaranteed level of provision needed by MOD was such that it could only be made available at the cost of providing an inadequate level of service to the general UK population.
 - d. Set up costs associated with the deployment. Examples would be attendance at MOD-NHS planning meetings and administration costs associated with setting up contracts with the private sector.
 - e. Waiting time for ambulance staff at airheads for the reception of casualties.
 - f. Treatment costs for prisoners-of-war or civilians treated under the provisions of the Geneva Convention.
 - g. Administrative costs associated with the treatment of prisoners-of-war or civilians treated under the provisions of the Geneva Convention. This would include costs such as interpreters, accommodation for relatives and funeral expenses.
 - h. Reception Arrangements for Military Patients (RAMP) procedures will be applied as appropriate.
- 2. MOD will not pay for treatment costs for MOD personnel outside MDHUs which are the responsibility of the local PCT.

Procedures to be followed

Replacement of Regular DMS personnel

- 3. The Whole Time Equivalent (WTE) arrangements set out in the main body of this Guidance take account of all current operations and should provide sufficient flexibility to cover normal training requirements.

4. In the event of a major military deployment being instituted, MOD will:
 - a. As soon as practicable, warn the Trusts whose DMS personnel are to be deployed of the numbers of personnel likely to be deployed and the anticipated duration of the deployment.
 - b. if applicable, when the net hosting payments fall below zero, institute payment on a monthly (as opposed to quarterly) basis. When net hosting payments become positive, quarterly payment should be reinstated.
5. Negotiations on the compensation arrangements for withdrawal of DMS personnel should be conducted between DMETA and the NHS Host Trust(s) direct. In the event of agreement not being reached between the two parties after a reasonable period of negotiation (to be determined in the Business Arrangement), either party may refer the dispute to the MOD/UK Health Departments Partnership Board for advice. Either party may also invoke the dispute resolution procedures specified in their Business Arrangement.
6. Separate arrangements apply to compensation for Reserve personnel mobilised for an operation or deployment.

Ring-fenced capacity

7. In this case, activity will have to be coordinated by MOD with DH rather than with the Host NHS Trusts. MOD will advise DH of its requirement for ring-fenced capacity by specialty, preferred location and estimated duration, as soon as practicable. DH will provide details of the facilities to be set aside, with an estimate of the cost. This will be checked against the requirement by the Defence Medical Services Department (DMSD)'s Director of Medical Operational Capability and Director Healthcare and they will take the lead in any discussions with DH. MOD will pay compensation for demonstrable lost income and out-sourced capacity including use of the private sector.

New capacity

8. Arrangements for new capacity will be similar to those for ring-fenced capacity and will also be coordinated by MOD with DH. MOD will advise DH of its requirement and DH will determine whether it can be met from existing capacity within the NHS. If it cannot, DH will provide an estimate of the cost of providing new capacity, which, subject to consideration by D Healthcare DMSD, will be paid by MOD. Any assets acquired under these procedures will be the property of the NHS Trust at which they are located. MOD will have no liability for the operating costs of such assets beyond the duration of the operation for which they were acquired.

Set-up Costs/Waiting Time/Administrative Costs for patients treated under the Geneva Convention

9. These should be submitted on an as required basis. As it is difficult to be precise about these costs, it is inevitable that details (and the appropriateness of the claim) will have to be discussed and determined at the time, subject to the principles set out above.

General

10. In all cases a full audit trail should be retained by NHS agencies.

Chapter 7
TREATMENT OF SERVICE PATIENTS IN NHS HOSPITALS

Executive Summary

1. This chapter sets out the overarching policy agreed between the Ministry of Defence (MOD) and the Department of Health (DH) on the treatment of Service patients in NHS hospitals. It also describes the administrative procedures for informing the MOD when Service personnel are admitted to NHS hospitals.
2. Members of the UK Armed Forces are entitled to full use of NHS hospitals on the same basis as civilians. NATO forces are entitled to full use of NHS hospitals on the same basis as UK civilians if appropriate military provision is not available. Personnel of foreign and Commonwealth Forces that are not part of NATO, serving in the UK attached to Foreign Embassies, High Commissions, UK Armed Forces or other NATO forces serving here are also entitled to full use of NHS hospitals on the same basis as UK civilians if appropriate military provision is not available.
3. The term “Service Patient” in this guidance is defined as:
 - All full time members of the Royal Navy (RN), Royal Marines (RM), Army and Royal Air Force (RAF);
 - All members of Reserve, Volunteer and Auxiliary forces whilst in service and undergoing training;
 - All members of NATO forces serving in the UK for whom there is no alternative military provision;
 - All members of the Armed Forces of Foreign and Commonwealth countries serving in the UK who do not have alternative military provision;
 - Prisoners of War/civilians being treated under the terms of the Geneva Convention, for whom the arrangements at Annex E apply.
4. NHS Trusts treating Service patients are entitled to seek compensation from MOD for any extra administrative costs incurred (e.g. on security grounds) in meeting these requirements

Service Patients treated in NHS Trusts hosting Ministry of Defence Hospital Units (MDHUs)

5. MOD will have Business Arrangements with each NHS Trust hosting an MDHU, to deliver routine and fast-track secondary care treatment for Service patients. These Business Arrangements do not preclude Service patients from being treated at any other NHS hospital along similar lines to any other NHS patient. The Business Arrangements are subject to annual review. Administrative arrangements covering Service patients in the NHS Trust hosting a MDHU will be the responsibility of the Commanding Officer of the MDHU and his/her Staff. A list of MDHUs is at Appendix 1.

Patients treated in NHS Trusts other than those hosting MDHUs

Members of Her Majesty’s Armed Forces:

6. If the treatment of a Service patient, initially admitted to an NHS hospital as an emergency, is likely to be prolonged, the relevant Service Authority should be advised. A list of Service Authorities is at Appendix 3.
7. Service patients who are members of the Territorial Army or other Reserve Forces’ should be considered for transfer to a suitable NHS hospital nearer their home, according to the best interests of the patient.

Members of NATO Forces:

8. The NATO Status of Forces Agreement provides that where troops and attached civilians of other NATO countries, and their dependants, are stationed in the United Kingdom, and where medical or dental facilities at their base are not adequate to meet their needs, they are entitled, in the first instance, to use the facilities of the NHS on the same terms as UK residents. A list of NATO countries is attached at Appendix 2.

Members of other Foreign and Commonwealth Forces:

9. Members of Foreign and Commonwealth Forces belonging to countries not covered by the NATO Status of Forces Agreement, who are stationed in the United Kingdom, should be regarded in the same way as civilian visitors to the UK, unless they are attached to Foreign Embassies, High Commissions or to the UK Armed Forces, in which case they would be regarded as eligible for the full range of NHS treatment. The individual's sponsor would be liable for any charges which ensued from such treatment.

Admission of Service patients

10. In addition to the normal action taken by NHS hospitals to ensure the relatives are notified of the admission of Service patients, it is essential that the appropriate Service Authority is notified as quickly as possible in order that the necessary administrative action can be performed. Failure to inform the Service Authority may lead to the Service patient concerned being reported as absent without leave from his/her unit.
11. Notification to the Service Authority may be made by telephone or fax and should, where possible, include the following details in respect of the Service patient:
 - Name and address of the reporting hospital
 - Service number
 - Rank, name and initials
 - Unit and Address
 - Date of admission
 - Ward
 - Next of kin details, address and telephone number
 - Whether next of kin has been notified.

Enquiries from Service patients and relatives

12. Enquiries from Service patients and their relatives about such matters as pay, leave, railway warrants etc should be referred to the appropriate Service Authority.

Privacy of Accommodation

13. Service patients should be treated in NHS hospitals in the same way as civilian patients, subject to any additional security concerns. Where a Service patient referred under Service arrangements needs privacy of accommodation on medical grounds, a bed in a single room or small ward should be made available on the same basis as to other NHS patients with similar needs.
14. Where privacy of accommodation is not necessary on medical grounds, amenity or pay bed accommodation may be provided in the normal way if requested by the Services. The Service Unit authorising such accommodation is responsible for the ensuing charges, including where privacy is requested for reasons of security. Where such arrangements are made at the Service patient's own request, the Service patient should be required to pay the charges in the same way as a civilian patient.

Discharge of Service Patients

15. The individual's Parent Medical Unit or appropriate Service Authority should be notified when the Service patient is to be discharged. They will then deal with any difficulties relating to the discharge procedure, and determine, in consultation with the medical staff, whether the Service patient should report direct to his/her unit.

Rehabilitation

16. The MOD has its own rehabilitation services, which provide extensive support to ensure optimal functional outcome is achieved following injury or illness. Facilities include:
 - a. A dedicated rehabilitation centre, the Defence Medical Rehabilitation Centre (DMRC), Headley Court, that provides an in-patient facility for the rehabilitation of Service patients, including poly-trauma cases with or without brain injury;
 - b. A number of regional facilities across the UK that provide planned rehabilitation programmes to return Service patients to maximum fitness for their role within a military setting.

Further information is available from the Service Authorities. NHS Trusts hosting MDHUs and other NHS Trusts should liaise directly with either DMRC or the Service patient's local Regional Rehabilitation Unit (RRU) prior to their discharge to ensure continuity and ongoing care after a Service patient leaves hospital.

Medical Records of Service Patients

17. On discharge of a Service patient from an NHS hospital, a medical report should be compiled containing a clinical account of the Service patient's history, investigations, treatment and progress. This should include sufficient detail to enable an assessment to be made, and, where necessary, to facilitate continuity of treatment by Service medical facilities. This report should be forwarded to the Parent Medical Unit or the appropriate Service Authority for inclusion in the Service patients' Primary Care record. All clinical information provided will be treated as "medical in confidence" for use only by medical staff.

Service Patients Who Become Seriously Ill or Die

18. Within the Services the definitions of Very Seriously Ill (VSI) or Seriously Ill (SI) are as follows:
 - VSI – A Service patient is Very Seriously Ill when his/her illness is of such severity that life is imminently endangered.
 - SI – A Service patient is Seriously Ill when his/her illness is of such severity that there is cause for immediate concern but there is no imminent danger to life.
19. In the event of very serious/serious illness and /or death of a Service patient in a NHS hospital, urgent contact should be made by the NHS hospital in the normal way (if the whereabouts of UK next of kin, relatives or friends are known). In addition, if the appropriate Service Authority is not available (e.g. outside normal working hours), particulars should be notified to the following:

For Royal Navy and Royal Marines personnel
2SL Duty Staff Officer
Tel: 07850 642093

For Army Personnel
PS4 (Army) Casualty Cell
Tel: (01980) 615790 or 615791
Fax: (01980) 615799

For Royal Air Force Personnel
RAF Duty Personnel Officer
Tel: (01452) 712612 x 7045 or 7080
Fax: (01452) 510800

20. The civil police may also be called in to help as necessary.
21. If a Service patient dies in a NHS hospital, a Service representative (usually from the deceased patient's unit) will be responsible for the disposal of personal effects. Additionally, the appropriate Service Authority will write to the Health Records Manager of the hospital concerned requesting provision of a clinical account of the deceased Service patient's history, investigations, and treatment. In those cases which are not the subject of a coroner's inquest, the Service authority will also request, where applicable, provision of a copy of the post-mortem report.

Ministry of Defence Hospital Units (MDHUs):

MDHU Derriford
Derriford Hospital
Derriford Road
Plymouth
Devon PL6 8DH

MDHU Frimley Park
Frimley Park Hospital
Portsmouth Road
Frimley
Camberley
Surrey GU16 5UJ

MDHU Portsmouth
Royal Hospital Haslar
Gosport
Hants PO12 2AB

MDHU Peterborough
Administrative Headquarters
Peterborough District Hospital
Thorpe Road
Peterborough PE3 6DA

MDHU Northallerton
Friarage Hospital
Northallerton
North Yorkshire
DL6 2JG

MDHU Birmingham
K Block
Selly Oak Hospital
Birmingham
B29 6JD

LIST OF NATO COUNTRIES

Belgium
Bulgaria
Canada
Czech Republic
Denmark
Estonia
France
Germany
Greece
Hungary
Iceland
Italy
Latvia
Lithuania
Luxembourg
Netherlands
Norway
Poland
Portugal
Romania
Slovakia
Slovenia
Spain
Turkey
United Kingdom
United States of America

Service Administration

1. A Service Authority provides the necessary administrative support required by each military Service, and should in most circumstances be the initial point of contact when a Service patient is admitted to an NHS Hospital.
2. Whereas the Navy and RAF have a single point of contact, the Army has regional co-ordinators - Military Administrative Officers (Civilian Hospitals) (MAO(CH)s) - which more effectively meet their single-service requirements. The ultimate responsibility for RN and RAF personnel usually rests with the individual's Parent Medical Unit (PMU).

Addresses and contact points.

3. **For the Royal Navy and Royal Marines**
Local Administration is undertaken by the patient's unit, as nominated by:
SO2 Medical Co-ordinator
MDG(N)
Victory Building
HM Naval Base
Portsmouth
PO1 3LS
Tel: 02392 – 727812
Email: 2slmdgnmedcoord@a.dii.mod.uk
4. **For the Army**
See Appendix 4 for the network of Military Administrative Officers (Civilian Hospitals) (MAO (CH)).
5. **For the Royal Air Force**
Local Administration is undertaken by the patient's unit or the nearest RAF unit, as nominated by:
Personnel Holding Flight
PMA Medical
HQ PTC
RAF Innsworth
Gloucester
GL3 1EZ
Tel: 01452-712612
Fax: 01452 – 510800

Military Administrative Officers (Civilian Hospitals)

Division	Counties Covered	Address	Contact Numbers
HQ 2nd Division (Scotland)	Scotland	MAOCH Edinburgh Medical Branch HQ 2 Div Craigiehall South Queensferry EDINBURGH EH30 9TN	Tel: (0131) – 310-2609 Fax: (0131) – 310 – 2607
HQ 2nd Division (East)	Cleveland, Durham, Humberside, Northumberland, North Lincs, Tyne & Wear, Greater Yorkshire	MAOCH York Medical Branch HQ 2 Div (Forward) Imphal Barracks Fulford Road YORK YO10 4AU	Tel: (01904) – 662515 Fax: (01904) – 665616
HQ 2nd Division (West)	Cheshire, Cumbria, Greater Manchester, Isle of Man, Lancashire, Merseyside	MAOCH Preston Medical Branch HQ 2 Div (Forward) Fulwood Barracks PRESTON PR2 4AA	Tel: (01772) – 260540 Fax: (01772) – 262390
HQ 4th Division (South)	London & Greater London, Berkshire, Buckinghamshire, Hampshire, Isle of Wight, Kent, Oxfordshire, Surrey, Sussex	MAOCH Aldershot Medical Branch Steeles Road ALDERSHOT Hants GU11 2DP	Tel: (01252) – 347397 Fax: (01252) – 342043
HQ 4th Division (North)	Bedfordshire, Cambridgeshire, Derbyshire, Essex, Hertfordshire, Lincolnshire, Leicestershire, Nottinghamshire, Norfolk, Northamptonshire, Suffolk	MAOCH Colchester Victoria House Poperinghe Road COLCHESTER Essex CO2 7NL	Tel: (01206) – 782223 Fax: (01206) – 782233
HQ 5th Division	Avon, Cornwall, Devon, Dorset, Gloucestershire, Herefordshire, Isle of Man, Scilly isles, Shropshire, Staffordshire, Somerset, Wales, Warwickshire, West Midlands, Worcestershire, Wiltshire	MAOCH Shrewsbury Medical Branch Cophorne Barracks SHREWSBURY SY3 8LZ	Tel: (01743) – 262423 Fax: (01743) – 262046
Northern Ireland	Northern Ireland	MAOCH Belfast Military Wing Musgrave Park Hospital BFPO 801	Tel: (02892) – 266316 Fax: (02892) – 266923

CONTINUING MEDICAL CARE OF SERVICE PERSONNEL ON RETIREMENT OR DISCHARGE FROM THE ARMED FORCES

1. The NHS is responsible for the medical care of Service personnel on leaving the Armed Forces provided the individual is entitled to residency in the UK. It is the responsibility of the individual to register with a general medical practice and any outstanding or on-going care will usually have been arranged prior to discharge. That said, the vast majority of personnel leave the Services fully fit or with minor ailments only.
2. Some Service personnel require medical discharge or reach their planned retirement date with a more serious illness. The vast majority of these personnel are able to register with a general medical practice and, through this route, arrange on-going care needs.
3. There remains a very small group who have a significant and debilitating illness at the time of medical discharge. Examples would include those who have multiple injury, with or without brain injury, and those with severe mental illness. For these individuals, it is essential that the MOD is able to engage as soon as possible with the PCT of future residence to ensure that there is a seamless transfer of care between that managed by the MOD and the future care that will be provided and/or commissioned by the PCT.
4. The MOD will have made every effort under its duty of care to the Serviceman/woman to ensure that the maximal functional outcome has been achieved prior to medical discharge and the PCT might wish to continue this support following discharge to enable maximum self-sufficiency is acquired. Agreement on the future care pathway should be achieved prior to discharge from the Service.

The Role of the Veterans Agency

5. The war pensions scheme is administered by the Veterans Agency. Awards are made to claimants for any disablement caused or exacerbated by military service. Claims, however, may only be made at or beyond service termination. The nature and extent of the award depends upon the medically assessed level of disablement and pensioners may request an Agency review on any grounds and at any time. In addition to disablement awards, the scheme pays death and dependants' benefits, including a series of supplementary allowances. Most decisions in the scheme carry a right of appeal to the independent Pensions Appeals Tribunal (PAT), a component of the Department of Constitutional Affairs.
6. From 1948 successive governments have held the view that war pensioners should be treated in the NHS. In the early 1950s a system of Priority Treatment was introduced for pensioned disablements. The relevant authoritative document HSG (97)31 is held by all Trusts.
7. In 2001 the Prime Minister appointed a Minister for Veterans, and the Veterans Initiative was launched with the key aim of better delivery of public services for veterans. The Veterans Agency Welfare Service is part of the Veterans Agency and provides a unique service to war pensioners.
8. Contact Details:

Veterans Agency
Helpline: 0800 169 2277 (Free)
Textphone: 0800 169 3458
Tel (Overseas): +44 1253 866043
www.veteransagency.mod.uk
email: help@veteransagency.mod.uk

Chapter 9
GLOSSARY OF TERMS AND ACRONYMS

ACRONYMS

DMETA	Defence Medical Education & Training Agency
DMRC	Defence Medical Rehabilitation Centre
DMS	Defence Medical Services
MAO(CH)	Military Administrative Officer (Civilian Hospital)
MDHU	Ministry of Defence Hospital Unit
MPT	Military Protected Time (Time allocated by DMS personnel to military duties)
NVSP	NHS Value of Service Personnel (The price payable for each DMS person, based on the appropriate place on the relevant NHS salary scale, plus Employers' National Insurance and Superannuation)
RCDM	Royal Centre for Defence Medicine
TPT	Trust Protected Time (Time allocated by DMS personnel to clinical input into an NHS Trust)
WTE	Whole Time Equivalent : the clinical effort, expressed in terms of posts, that the Trust would have had if they had employed NHS personnel

TERMS

Accredited Funded Post

- Post within an NHS Trust for which the MOD remains liable for the salary of the Junior Doctor filling that post (although the Trust will reimburse the MOD with the full value of the post, as funded by the Regional Dean).

Accredited Non-Funded Post

- Post within an NHS Trust for which the salary costs of the Junior Doctor filling that post will fall directly to the appropriate MOD Single Service

Appropriate Military Provision

- Provision of medical treatment within a MDHU or other military medical organisation

Clinical Governance

- "A framework through which NHS organisations are accountable for continually improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish." [G Scally and L J Donaldson, 'Clinical governance and the drive for quality improvement in the new NHS in England' BMJ (4 July 1998): 61-65]

Defence Consultant Advisor

- Accredited medical specialist, providing advice to the Surgeon General on that particular specialty

Defence Cost Study 15 (1994)

- DCS (15) examined the structure and funding processes of the Defence Medical Services. It recommended a significant restructuring of the various organisations, with the aim of providing sufficient rapidly deployable units, primarily manned by service personnel, to support forces deployed on operations. These would be reinforced by a more efficient and cost-effective support structure, including the establishment of agencies to provide secondary medical care and recognised training for medical personnel.

Defence Medical Services Personnel

- This encompasses all military medical personnel, including consultants, junior hospital doctors and nurses, as well as Allied Health Professionals (AHPs) and Medical Assistants (MAs)/Combat Medical Technicians (CMT)

Director Healthcare

- The Defence Medical Services Staff Officer responsible for healthcare plans and strategy

Director Medical Operational Capability

- The Defence Medical Services Staff Officer responsible for Joint Operational medical policy, programmes and plans.

Fast Track

- Arrangement whereby Service Personnel (especially those required for operational deployments) receive priority diagnosis and/or treatment in order to enable them to return to duty as soon as possible.

Geneva Convention

- International Provisions for the Treatment of Prisoners of War. Adopted on 12 August 1949 by the Diplomatic Conference for the Establishment of International Conventions for the Protection of Victims of War, held in Geneva.

Major Deployment

- Defined for the purpose of this guidance as an MOD medium scale deployment (or above) or two concurrent small scale operations. A medium scale deployment is a deployment of brigade size or equivalent for war-fighting or other operations. Two concurrent small scale deployments are the concurrent deployment of 2 battalion size or equivalent.

MoD Commercial Branch

- The sole authority for committing the Ministry of Defence, and therefore DMETA and Director Healthcare, to contracts relating to this Circular is the organisation Central Budgets (Commercial) Medical

MOD/DH Partnership Board

- Jointly chaired by senior MOD and DH officials, the Partnership Board meets three times a year to explore mutual areas of co-operation between the MOD, DH and the NHS, with the aim of delivering across-the-board benefits to the organisations.

NHS Trust

- A self-governing body in the NHS, which provides health care services. They employ a full range of health care professionals including doctors, nurses, dieticians, physiotherapists etc.

Outreach Clinic

- A clinic for outpatients held near to where they live, rather than in the hospital where they may have received treatment

Parent Medical Unit (PMU)

- The responsibility for RAF personnel usually rests with the individual's Parent Medical Unit (PMU)

Postgraduate Deaneries

- Organisations that commission, manage and develop postgraduate medical and dental education. They are responsible for the training of all medical and dental trainees within their region or part of a region (deanery). There are 21 Regional Deaneries, including the MOD Tri-Service Deanery at the RCDM Birmingham.

Post-Operational Tour Leave (POTL)

- All personnel returning from operational tours are granted POTL in addition to the Annual Leave Allowance.
- .

Service Authority

- A Service Authority provides the necessary administrative support required by each military Service:

Service Patient

- See Chapter 7 para 3

Singleton Placements

- When a DMS person is appointed to an NHS Trust that is not host to an MDHU.

Squad

- In order to protect Military Protected Time (MPT), while guaranteeing a specific level of Trust Protected Time (TPT) to the Trust hosting an MDHU, the principle of “squads” has been developed. For example, 10 DMS nurses could be grouped into a “squad”, which could be used to guarantee to the Trust a Whole Time Equivalent of 5 nurses.

Standalone Posts

- A post in an NHS Trust which, by virtue of the appointment, qualifications and experience required, cannot readily be filled effectively by utilising a squad. MOD and the Trust will agree a job plan upon which TPT will be based.