SCOTTISH EXECUTIVE

Health Department
Chief Medical Officer Directrorate

St Andrew's House
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Dear Colleague

31 March 2006

Addresses

For action
NHS Board Chief Executives
HR Directors

For information
Medical Directors
Nursing Directors
Scottish Partnership Forum (SPF)
Scottish Workforce and Staff Governance Committee (SWAG)

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GUIDANCE FOR NHSSCOTLAND ON RELATIONS WITH THE ARMED FORCES

1. Introduction

I am pleased to introduce this circular which updates arrangements for the treatment of Service personnel in NHSScotland hospitals, and comes into effect from 1st April 2006. It sets out the broad policy agreed between the Ministry of Defence (MOD) and the Scottish Executive on the treatment of Service Patients in NHSScotland hospitals, and describes the administrative procedures for informing the MOD when Service personnel are treated by Scottish NHS hospitals. The Guidance will be subject to regular review and, where appropriate, updated.

2. Background

To support joint working between the UK-wide NHS and the Defence Medical Service (DMS), on 10th March 2005 ministerial representatives from the health departments of the four United Kingdom health departments and the Ministry of Defence signed *Delivering Our Armed Forces' Healthcare Needs: A concordat between the United Kingdom Departments of Health and the Ministry of Defence Armed Forces*, confirming their joint intent to renew and strengthen the partnership between the defence and civil healthcare services at national level. The partnership aims to enable the UK-wide NHS and the DMS to collaborate with and support each other, and give value for money to the taxpayer, continuing high standards to patients and effective defence for the nation.

3. Principles

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 NHSScotland Health Board or other provider as appropriate, in return for enhanced payments as negotiated by MOD Central Budgets (Commercial) Medical with the Health Board or other provider;
- The provision of healthcare to Service personnel, and hence operational effectiveness, should benefit from improved performance within NHSScotland;
- Host NHSScotland Health Boards should not be financially disadvantaged as a result of hosting, employment of DMS personnel or of provision of treatment, should this be necessary.

3. Entitlement

Members of the United Kingdom armed forces are entitled to full use of UK-NHS hospitals on the same basis as civilians. NATO forces are entitled to full use of UK-NHS hospitals on the same basis as United Kingdom civilians if appropriate military provision is not available. Personnel of foreign and Commonwealth Forces that are not part of NATO, serving in the United Kingdom attached to Foreign Embassies, High Commissions, United Kingdom Armed Forces or other NATO forces serving here are also entitled to full use of UK-NHS hospitals on the same basis as United Kingdom civilians if appropriate military provision is not available.

Arrangements need to be in place to ensure that all Service Personnel who leave the Armed Forces who are entitled to NHS medical care receive appropriate services, including the small minority who have a significant and debilitating illness at the time of medical discharge.

To support joint working between the NHS and the Defence Medical Service (DMS), ministerial representatives from the four United Kingdom health departments and the Ministry of Defence have signed a Concordat confirming their joint intent to renew and strengthen the partnership between the defence and civil healthcare services at national level.

4. Information Pack

An information pack has been included with this letter to help you and your staff know more about how to ensure that arrangements are in place for any engagement with Service Personnel through NHSScotland. This information can be accessed from the Scottish Executive and SHOW websites and the NHSScotland workforce website www.workinginhealth.com. The following guidance is enclosed:-

ANNEX A- The treatment of Service Personnel in NHSScotland hospital

ANNEX B- The event of a major MOD Deployment

ANNEX C - Continuing Medical Care of Service Personnel on Retirement or Discharge from the Armed Forces.

ANNEX D - Future planning and working together by NHSScotland and the Defence Medical Services. To include: -

D1 - The use of military medical personnel in NHS Boards
D2 - List of NATO countries and Military Defence Hospital Units (England)

5. What happens next?

As leaders in NHSScotland, you should be engaging in the following actions:-

- Consider the arrangements you have in place for the treatment and receiving of Service personnel into your care and ensure this complies with this guidance.

- Identify any individuals from your organisation who are members of the Reserve Forces. These individuals should proactively share with you are their employer their reserve committment. This knowledge will enable you to be prepared should a major deployment occur.

- Directors of Human Resources from each Health Board should use the knowledge of their Reserve Force employees within the development of the local workforce plans as appropriate.

- Be aware that NHSScotland/MOD partnership is part of Scotlands joint working agreement between the UK-wide NHS to give value for money and support to one another, continuing to provide high standards to patients and effective defence or the nation.

6. Further information

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.

While the Navy and RAF have a single point of contact, the Army has regional co-ordinators - Military Administrative Officers (Civilian Hospitals) or MAO(CH)s - which more effectively meet their single-service requirements. In addition, the responsibility for RAF personnel usually rests with the individual's Parent Medical Unit (PMU).

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

For the Army
The relevant Military Administrative Officers (Civilian Hospitals) (MAO (CH)) is
MAOCH Craigiehall
Medical Branch
Headquarters 2nd Division
Craigiehall
South Queensferry
West Lothian
EH30 9TN
Tel: (0131) 310 2609
Fax: (0131) 310 2607

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

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

DEFENCE MEDICAL REHABILITATION CENTRE
Headley Court
Epsom
Surrey
KT18 6JN
Tel. 01372 378271

Please ensure that you read this guidance thoroughly and make every effort to make staff aware of its content. If you have any questions regarding the arrangements, please direct them to the office of the Chief Medical Officer at the Scottish Executive on 0131 244 2264 or cmo@scotland.gsi.gov.uk

Yours sincerely

DR HARRY BURNS
Chief Medical Officer

Annex A

The Treatment of Service Personnel in NHSScotland Hospitals

1. 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.

2. NHSScotland Health Boards 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

Members of Her Majesty's Armed Forces:

3. 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. For contacts, see Appendix 1. contacts miaoc in scotland

4. Service Patients who are members of the Territorial Army or other Reserve Forces should be considered for transfer to a suitable NHSScotland hospital nearer their home, according to the best interests of the patient.

Members of NATO Forces:

5. 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 United Kingdom residents. It is essential that the most relevant Service Authority is advised of any admission of NATO personnel. A list of NATO countries is attached at Appendix 3.

Members of Other Foreign and Commonwealth Forces:

6. 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 United Kingdom, unless they are attached to Foreign Embassies, High Commissions or to the United Kingdom 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 that ensued from such treatment.

Admission of Service Patients

7. In addition to the normal action taken by NHSScotland hospitals to ensure the relatives are notified of the admission of 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 patient concerned being reported as absent without leave from his/her unit.

8. Notification to the Service Authority may be made by telephone or fax and should, where possible, include the following details in respect of the 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

9. 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

10. Service Patients should be treated in NHS hospitals in the same way as civilian patients. 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.

11. 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 Service Authority, and is available. 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 patient's own request, the patient should be required to pay the charges in the same way as a civilian patient.

Discharge of Service Patients

12. The individual's Parent Medical Unit or appropriate Service Authority should be notified when the 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 patient should report direct to his/her unit. In the first instance, on discharge, Service patients should have travel arranged to their unit where sick leave and other arrangements can be made.

Rehabilitation

13. 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; the address and telephone number are at appendix 1.

    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 – be this physical or mental impairment or injury.

    Further information is available from the Service Authorities. NHSScotland Health Boards should liaise directly with the evaluation and coordination cell at DMRC Headley Court to ensure continuity and ongoing care after a Service Patient leaves hospital.

Medical Records of Service Patients

14. On discharge of a Service Patient from an NHSScotland hospital, a medical report should be compiled containing a clinical account of the 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 Patient's Primary Care record. All clinical information provided will be treated as "medical in confidence" for use only by medical staff and/or appropriate administrative liaison staff.

Service Patients Who Become Seriously Ill or Die

15. 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.

16. 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 (eg outside normal working hours), particulars should be notified to the Joint Casualty and Compassionate Centre (JCCC) for the Armed Forces. The JCCC (details below) manages all casualty reporting functions for the Armed Forces. The JCCC duty officer may call a NHS hospital seeking advice on the status of a Service patient in order to inform next of kin and, if appropriate, arrange for the next of kin to be brought to the hospital by the fastest possible means.

Joint Casualty and Compassionate Centre (JCCC)
Building 182
RAF Innsworth
Gloucester GL3 1HW
Tel: 01452 519951
Fax: 01452 510807 "

17. If a Service Patient dies in an 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 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.

Annex B

Arrangements to be adopted in the event of a Major MOD Deployment

Statement of Principle

18. *MOD accepts that, in the event of a major deployment, certain additional costs falling on 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 MOD medical 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 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 was guaranteed to be made available for casualties.

    c. Exceptionally, new capacity might be required where the guaranteed level of provision required 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.

19. The MOD will not pay for routine treatment costs for MOD personnel but for accelerated treatment in non-medical urgent cases

Procedures to be followed

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

21. 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. Institute payment on a monthly, as opposed to quarterly, basis when the net hosting payments fall below zero. When net hosting payments become positive, quarterly payment should be reinstated.

22. Negotiations on the compensation arrangements for withdrawal of military medical manpower should be conducted between Defence Medical Education & Training Agency (DMETA) and the Host Trusts 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.

23. Separate arrangements apply to compensation for Reserve personnel mobilised for an operation or deployment.

24. In the case of ring-fenced capacity, activity will be co-ordinated by the MOD with the Scottish Executive Health Department. MOD will advise the Scottish Executive Health Department of its requirement for ring-fenced capacity, by specialty, preferred location and estimated duration, as soon as practicable. The Scottish Executive Health Department 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 Medical Operational Capability and Director General Healthcare and they will take the lead in any discussions with the Scottish Executive Health Department. MOD will pay compensation for demonstrable lost income and bought-in capacity, e.g. from the private sector.

25. Arrangements for new capacity will be similar to those for ring-fenced capacity and will also be co-ordinated by MOD with the Scottish Executive Health Department. MOD will advise the Scottish Executive Health Department of its requirement and the Scottish Executive Health Department will determine whether it can be met from existing capacity within NHSScotland. If it cannot, the Scottish Executive Health Department will provide an estimate of the cost of providing new capacity, which, subject to consideration by the Director General Healthcare (DMSD), will be paid by MOD. Any assets acquired under these procedures will be the property of the Health Board 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.

26. Set-up costs and administrative costs for patients treated under the Geneva Convention 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 otherwise of the claim) will have to be discussed and determined at the time, subject to the principles set out above.

27. In all cases a full audit trail should be retained by NHSScotland organisations / agencies.

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

28. 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 United Kingdom. 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.

29. 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.

30. 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 LHB 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 LHB.

31. 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 LHB 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.

32. 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.

33. 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 guidance is set out in WHC (2003) 065

34. 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. The Contact Details are:

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

Annex D

Future planning and working together by NHSScotland and the Defence Medical Services.

35. In support of the twin health goals required by Defence i.e. a trained and deployable healthcare capability, and the maintenance of a fit and healthy Service population by means of effective health promotion and injury prevention policies and the provision of prompt and effective diagnosis, treatment and rehabilitation, the DMS will benefit from

    - arrangements with NHS organisations which enable DMS clinical personnel to be trained, to maintain their skills, and to be released to support deployed operations and exercises when required
    - development of joint initiatives to encourage NHS personnel to join volunteer Reserves, or to support defence medical requirements in other ways
    - assistance with loan or secondment to the DMS of NHS personnel to fill civilian medical management appointments in the DMS
    - NHS expertise to assist in the development of overall defence-wide health needs analysis and health care strategy
    - encouraging and supporting NHS staff to become members of the Volunteer Reserve Forces, enabling them to develop new skills, both professional and personal., and help them achieve a healthy balance between work and their life and interests outside
    - a co-ordinated approach to planning for the provision of primary care to Armed Forces personnel and their dependants
    - high standards of clinical care, developed and sustained through training, life-long learning and clinical governance.

36. The NHS will benefit from working closely with the DMS to improve delivery of NHS services, including:

    - making optimal use of the skills of DMS clinicians to meet NHS requirements when not on deployed operations and exercises
    - identifying critical issues of common concern, which might be addressed through joint DMS/NHS work
    - a co-ordinated approach to planning for the provision of appropriate secondary and tertiary care, including rehabilitation, to Armed Forces personnel, both at home and on operations and exercises
    - using opportunities for clinical attachments and secondments to MOD facilities in the United Kingdom and overseas, providing professional development for NHS clinicians and benefits to the NHS in terms of development of leadership skills
    - access to defence medical establishment and units, offering professional clinical, research and training opportunities for NHS staff.

37. The Concordat is an enabling document, leaving detailed decisions about service delivery to be made locally by those who understand the delivery of services and the needs and best interests of the Armed Forces and their families. The effectiveness of the agreement will be monitored through the MOD/Partnership Board, on which the Scottish Executive Health Department is represented, by the Chief Medical Officer, and which will explore mutual areas of co-operation.

Annex D1 - for the use of military medical personnel in NHSScotland Health Boards

38. Ministry of Defence Hospital Units (MDHUs) were set in England up following Defence Cost Study 15 (1994), which led to the closure of the military hospitals. MDHUs were established and integrated with host NHS Trusts. They contribute to the NHS clinical capacity and enable military medical staff to maintain their clinical expertise while maintaining their military skills and ability to deploy quickly to areas of conflict in support of frontline forces. No MDHUs have been established in Scotland, however should these be deemed appropriate at some later date, the guidance relating to MDHU's would apply (in the first instance). Current arrangements regarding MDHUs are set out in the guidance *Health service guidance covering arrangements between the Ministry of Defence and the NHS* available on the Department of Health website. A list of these MDHU's is attached in Appendix 2.

While the current use of military medical personnel in NHSScotland is only as singleton placement, it is appropriate to make clear what guidance should be followed if this situation changes and training places were to be procured. <u>This section is therefore to be noted only</u>.

Junior Doctors / Training Places

39. Doctors employed by the Defence Medical Services (DMS) are part of the overall National Healthcare Asset Base and for the majority of their Service careers will provide a clinical input into the English NHS. The NHS at large facilitates the training of these doctors.

40. 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. Training within the English 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.

41. When a DMS Junior Doctor fills an Accredited Funded Post the MOD will remain liable for payment of the individual's salary, but the English 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.

Singleton Placements

42. There will be occasions when MOD wishes to appoint personnel to an English NHS Trust that is not Host to an MDHU. Where this occurs, the MOD will enter into a Singleton Contract with the Trust concerned. In recognition of the contribution that the individual will make to the clinical activities of the Trust, MOD will receive commensurate payments from the Host Trust. Such payments shall be calculated as set out in chapter 2 paragraph 9 of *Health service guidance covering arrangements between the Ministry of Defence and the NHS.*

43. The Contract will clearly detail the Military Protected Time (MPT) and Trust Protected Time (TPT) used in this calculation. Any significant professional military commitment, such as being a Defence Consultant Adviser, will be undertaken as part of MPT.

44. Where MOD identifies a DMS person who needs additional support, requirements will be agreed between the NHS Trust and MOD (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 an NHS equivalent.

MOD will provide 100% of TPT agreed in Job Plans. If not achieved, and dependent on the reasons for this, MOD will make good the loss of output by reimbursing in full the cost of recovering the lost output, on a case by case basis including use of private sector capacity.

D2 - LIST OF NATO COUNTRIES AND MILITARY DEFENCE HOSPITAL UNITS

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

Ministry of Defence Hospital Units:

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
Portsmouth Hospitals NHS Trust
Gosport
Hants PO12 2AB

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

MDHU Northallerton
South Tees Hospitals NHS Trust
Northallerton
North Yorkshire
GL6 2JG

MDHU Birmingham
University Hospital Birmingham NHS Trust
and Centre for Defence Medicine.
Birmingham
B29 6JD