House of Commons
Defence Committee

Medical care for the Armed Forces

Seventh Report of Session 2007–08

Report, together with formal minutes, oral and written evidence

Ordered by The House of Commons
to be printed 5 February 2008
The Defence Committee

The Defence Committee is appointed by the House of Commons to examine the expenditure, administration, and policy of the Ministry of Defence and its associated public bodies.

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Publications

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the Internet at: www.parliament.uk/defcom.

Committee staff

The current staff of the Committee are Mike Hennessy (Clerk), Eliot Wilson (Second Clerk), Ian Rogers (Audit Adviser), Stephen Jones (Committee Specialist), Richard Dawson (Committee Assistant), Christine McGrane (Secretary) and Stewart McIlvenna (Senior Office Clerk).

Contacts

All correspondence should be addressed to the Clerk of the Defence Committee, House of Commons, London SW1A 0AA. The telephone number for general enquiries is 020 7219 5745; the Committee’s email address is defcom@parliament.uk. Media inquiries should be addressed to Alex Paterson on 020 7219 1589.
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Summary

The Defence Medical Services (DMS) provide a range of healthcare, from treating Service personnel injured in combat to providing rehabilitation for sports injuries in the UK.

The clinical care for Servicemen and women seriously injured on operations is second to none. DMS personnel, working with the NHS, provide world-class care and we pay tribute to them. Recent improvements at the Royal Centre for Defence Medicine in Birmingham in areas such as ward management and welfare support are welcome. We acknowledge this progress, and encourage the Ministry of Defence to continue it, and to incorporate these considerations into its plans for developing the facilities in and around Birmingham. There has been considerable inaccurate reporting about the care at Selly Oak. We strongly deprecate this behaviour, and believe editors have a responsibility to ensure that their newspapers report on the basis of facts rather than hearsay.

The DMS's rehabilitation services, especially at Headley Court, are exceptional, and are contributing enormously to the welfare of injured Service personnel. We welcome the review of Headley Court in the light of the continued high operational tempo, and look forward to its results.

Services are delivered to Armed Forces personnel by the MoD, the NHS, and charities and welfare organisations. We believe this is right, and builds on a proud tradition in the UK of linking the community with the Service personnel who have been injured fighting on their behalf. However, the Government and voluntary organisations should engage with a wider public debate about which services are most appropriately provided by each sector.

The MoD’s decision to base its secondary care around units embedded in NHS Trusts was, and remains, a sound one. It allows DMS personnel to work side by side with civilian clinicians to develop and maintain their skills, while offering the opportunity for Servicemen and women to be treated in a semi-military environment. However, more needs to be done to address the sharing of best practice between the DMS and the NHS.

Devolution means that the MoD must cooperate with a number of different health departments to provide the full range of appropriate services for Armed Forces personnel, their families and veterans. This cooperation is usually good, but we found that in Scotland it was often inadequate. The MoD must review the structures through which it engages with other departments and administrations. The Scottish Executive must also examine its procedures for engagement and cooperation and look at how improvements could be made.

We welcome the Government’s extension of the priority access to healthcare available to veterans but we are not sure that adequate procedures are in place to identify veterans and to ensure that priority access. The MoD’s reliance on self-identification is simply not good enough. We are also concerned that medical records are not transferred efficiently enough from military to civilian clinicians. An automatic system of transferring medical records and tracking veterans in the NHS, with an option to opt out, would provide a more robust system which took account of individuals’ privacy.
The MoD provides high-quality healthcare for Service families abroad, but spending has lagged behind that in the NHS. There are also doubts about the long-term viability of the stand-alone hospitals in Cyprus and Gibraltar. The MoD must say what plans it has made for the facilities, and how it will continue to provide healthcare for Service communities overseas. It should also set out a timetable for tackling this issue.

Mental health is a vital responsibility for the DMS. We acknowledge the progress they have made and their adoption of a preventative approach where possible. Their community-based system of mental healthcare is in line with NHS best practice. We pay tribute to the work of Combat Stress in assisting veterans with mental health needs, but we are concerned that the identification and treatment of these veterans is not sufficiently thorough or systematic. The NHS needs both a robust method of tracking veterans, and a detailed understanding of their problems.

Reserve personnel play a critical role in the delivery of military healthcare. The Territorial Army has so far met around half of the Armed Forces’ medical commitment in Iraq and Afghanistan. The public should recognise the contribution which the Reserve forces make to the military and to society as a whole. The MoD needs to make sure that the Reserve forces are not overstretched and that recruitment and retention remains buoyant.
1 Introduction

Scope of the inquiry

1. In October 2006, the Defence Committee decided to undertake a wide-ranging inquiry into the provision of healthcare for the Armed Forces. While there was at the time considerable media interest in the treatment of casualties from operations in Iraq and Afghanistan, we wanted to look at the subject in the broadest sense, and to examine how Service personnel and their families were cared for. We were also keen to examine the arrangements made for veterans and the way in which the Ministry of Defence (MoD) cooperated with the National Health Service (NHS) to deliver appropriate care.

2. We decided to examine six key areas. The first was the treatment of personnel seriously wounded on operations, and the procedures for caring for them, from the point of wounding to evacuation to and treatment in the United Kingdom. The second, interrelated, area was the rehabilitation work for those with serious, generally musculoskeletal or neurological, injuries. The third was the relationship between the Ministry of Defence and the National Health Service in terms of delivering healthcare. The fourth area we examined was the care for veterans and Service families. The fifth issue was mental healthcare, both for Service personnel and for veterans. Finally, we examined the role of Reserve personnel in the Defence Medical Services.

3. During the course of our inquiry, we conducted a number of visits. In November 2006, during a visit to Cyprus, we were shown round The Princess Mary Hospital (TPMH) at RAF Akrotiri. In June 2007, we visited the Defence Medical Rehabilitation Centre (DMRC) at Headley Court; Combat Stress’s care home, Tyrwhitt House, in Leatherhead; and the Royal Centre for Defence Medicine (RCDM) and Selly Oak Hospital in Birmingham. During our visit to Iraq in July 2007, we saw the deployed field hospital in the Contingency Operating Base (COB) at Basra Air Station, which we had previously visited when it was at Shaibah Logistics Base in 2006. In September 2007, we visited the Primary Casualty Receiving Facility (PCRF) on board RFA Argus, a Royal Fleet Auxiliary vessel, on exercise in the Solent. In October 2007, we visited 2 Medical Brigade and the Army Medical Service Training Centre at Strensall in Yorkshire, and the Regional Rehabilitation Unit (RRU) and Medical Reception Station (MRS) at Redford Barracks in Edinburgh. In addition, some of us visited the Ministry of Defence Hospital Units (MDHUs) at Frimley Park, Portsmouth, Plymouth and Northallerton.

4. We held four evidence sessions in the course of this inquiry. On 12 June 2007, we took evidence from representatives of Service welfare organisations. On 21 June 2007, in Birmingham, we took evidence from the University Hospital Birmingham NHS Foundation Trust, the five Trusts which cooperate with the MoD to run MDHUs, and the British Medical Association. On 11 October 2007, in Edinburgh, we took evidence from the Royal College of Psychiatrists, the St John and Red Cross Defence Medical Welfare Service, and officials from the Scottish Executive. On 27 November 2007, we took evidence from Ministers and officials from the Ministry of Defence and the Department of Health.
5. In addition to our evidence sessions and visits, we conducted a two-stage Internet-based consultation, in summer and autumn 2007, the results of which are summarised in Annex B.

Earlier reports

6. Our predecessors have inquired into Armed Forces medical care on a number of occasions. Key reports were produced during the mid- to late 1990s, a period of profound change for the UK Armed Forces following the end of the Cold War and the attempt to make good on the so-called ‘peace dividend’. There were reports in 1995\(^1\), 1997\(^2\) and 1999\(^3\).

7. All of these reports examined the way in which military healthcare was adapting to the changing circumstances, military requirements and resource constraints of the 1990s. An understanding of current health provision for the Armed Forces needs to take account of the changes of the past fifteen years, and we examine those changes in more detail below.

Changes in the provision of military healthcare

8. The first major post-Cold War review of the UK’s military requirements was 1990’s *Options for Change*. This included a review of defence secondary care in the UK, which proposed a rationalisation of the seven existing military hospitals to three single-Service facilities, at Haslar (Royal Navy), Aldershot (Army) and Wroughton (Royal Air Force). Secondary care for overseas garrisons such as Cyprus and Gibraltar was to remain the responsibility of the existing stand-alone hospitals.

9. The care provided by the three Service hospitals was to be augmented by 300 beds based in National Health Service hospitals, staffed by military personnel. These would be known as Military District Hospital Units or MDHUs (though they were subsequently renamed Ministry of Defence Hospital Units, retaining the original acronym). Engagement with the NHS was intended not only to ease the burden on MoD resources but also to encourage the broadening of clinical skills and the interchange of experience.

10. There was a further review the following year, 1994, as part of *Front Line First*. This recommended the closure of Aldershot and Wroughton, and the consolidation of provision at a tri-Service hospital at Haslar. The review also re-endorsed the creation of three MDHUs, and suggested the creation of four ‘Next Steps’ agencies, to manage: secondary care, dental care, medical training and medical supplies. Each agency was to have a Chief Executive who would report to the Surgeon-General.

11. Although the MoD had originally planned to maintain the Royal Hospital Haslar, primarily as a centre for training, after the closure of the hospitals at Aldershot and Wroughton, it was found that the number and range of cases required to maintain skills and make clinical services viable was not available. Therefore, in December 1998, the

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1 Defence Committee, Fifth Report of Session 1994-95, *Defence Costs Study Follow-up: Defence Medical Services*, HC 102
2 Defence Committee, Third Report of Session 1996-97, *Defence Medical Services*, HC 142
Government took the decision to close Haslar in phases and to consolidate its training activities within the NHS, based around the MDHUs. Haslar ceased to be a military unit on 31 March 2007, though it continues to be owned by the MoD and will continue to function until late 2009, when clinical services will transfer to the Queen Alexandra Hospital at Cosham in Portsmouth.

12. The realignment of medical care, and especially the provision of secondary care, was not without its problems, as our predecessor committees found. It is also clear to us, especially from contributions to our web-based consultation on this inquiry, that there remains considerable strength of feeling in the Service community and beyond. Many passionately opposed the closure of Service hospitals and continue to regard it as a mistaken policy. The existence of identifiable, military-owned and run facilities was clearly important and a source of much pride and affection, and a number of the contributors to our web forum wanted to see them re-established.

13. We acknowledge that stand-alone military hospitals were important to the Service community, and we also appreciate the argument that it is beneficial to injured Service personnel to be treated in their own community, in familiar surroundings. On our visit to Headley Court in June 2007, we saw for ourselves the benefits to be gained from harnessing the power of the camaraderie of the Armed Forces to help the healing process, both mentally and physically. We further acknowledge the existence of such facilities in the United States, to which opponents of the closure of military hospitals often point.

14. However, we find the arguments in favour of the closure of the stand-alone Service hospitals irresistible. We accept that the reduction in numbers of personnel which took place in the Armed Forces after the end of the Cold War meant that there was insufficient patient volume to make the military hospitals viable in the long term, a situation which can still be seen, for example, at The Princess Mary Hospital at RAF Akrotiri, which we visited in November 2006. We are also persuaded that the small volume of patients, combined with the limited case range presented by the Service population, was inadequate to maintain the skills of Armed Forces medical personnel. The principle behind the decision to move from stand-alone military hospitals to facilities which co-operate with the NHS was the right one, from a clinical, administrative and financial point of view, and we see no evidence that the care offered to military personnel has suffered as a result. Indeed, we believe that Armed Forces clinicians now have experience of a much broader range of cases, which benefits their training. We also support the decision by the MoD to disengage from the Haslar site. We heard from Service personnel on a number of our visits that the current arrangements were much preferable in clinical terms to stand-alone Service hospitals.

15. There was further administrative streamlining of the Defence Medical Services in 1998. Defence Medical Services: A Strategy for the Future gave the Surgeon-General complete oversight of the DMS by making the individual Service Medical Directors-General report to him rather than to their Chiefs of Staff. The administration of medical services was further altered in 2002, with the appointment of a non-medical Deputy Chief of the Defence Staff (Health) to manage the administrative work of the Defence Medical Services.
Medical care for the Armed Forces

Department, while clinical services remained the responsibility of the Surgeon-General. In November 2007, we took evidence from the Surgeon-General, Lieutenant-General Louis Lillywhite MBE QHS, and the Deputy Chief of the Defence Staff (Health), Lieutenant-General Robert Baxter CBE, and we are satisfied that this ‘double headed’ approach is an efficient and effective one.

Current organisation of Armed Forces medical care

16. The Surgeon-General and the Deputy Chief of the Defence Staff (Health) jointly oversee the work of three organisations. These are:

- The Defence Medical Services Department (DMSD): the administrative headquarters of the DMS, which is responsible for strategic direction;

- The Defence Medical Education and Training Agency (DMETA): a tri-Service organisation which provides personnel to meet the secondary care requirements of operational deployments as well as educating and training medical personnel. DMETA has command and control over:
  - Ministry of Defence Hospital Units;
  - The Royal Centre for Defence Medicine (RCDM);
  - The Defence Medical Rehabilitation Centre (DMRC) at Headley Court;
  - The Defence Medical Service Training Centre (DMSTC) at Keogh Barracks;
  - The Defence Medical Postgraduate Deanery, and
  - Retained military tasks at the Royal Hospital Haslar, managed in conjunction with Portsmouth Hospitals NHS Trust and due to close in late 2009.

- Defence Dental Services: a tri-Service organisation which employs both military and civilian personnel and provides dental services in the UK and on operations.

17. The individual Services each have a responsibility for delivering primary healthcare and the requisite medical support on operations. The Surgeon-General and the Deputy Chief of the Defence Staff (Health) produce medical policy for the Royal Navy, Army and Royal Air Force Medical Services, which are responsible to the Service Chiefs of Staff.

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4 The first DCDS (Health) was Lieutenant-General Kevin O’Donoghue, now General Sir Kevin O’Donoghue, Chief of Defence Materiel.

5 Ev 89-90
2 Treatment of casualties from operations

Procedures for operational casualties

18. DMS personnel are deployed on operations in both of the major theatres, on Operation HERRICK (Afghanistan) and Operation TELIC (Iraq). Personnel are deployed on a tri-service basis, and there is heavy reliance on Reservists, especially in terms of deployed hospital care and specialist roles. Around half of the Army’s deployed secondary care capability has been met by the Territorial Army, and four TA field hospitals have provided services for a 12-month commitment in Afghanistan (HERRICK 6 and 7), beginning in April 2007.

19. The medical personnel deployed on operations provide assessment and immediate treatment for all casualties, whether injured in combat or otherwise, through Incident Response Teams (IRTs). There are also Deployed Rehabilitation Teams (DRTs) and Deployed Mental Health Teams (DMHTs) in-theatre to provide a first line of treatment and guidance on any further treatment or referral necessary.

20. Seriously injured casualties are generally given initial treatment and stabilised by medical personnel in theatre then aeromedically evacuated to the UK when appropriate. The deployment of a full range of clinical staff to field hospitals has allowed much more extensive treatment of casualties in-theatre. The decision to evacuate is a clinical one. Between January 2006 and April 2007, 367 UK personnel were evacuated from Afghanistan and 866 from Iraq (although not all of these were battle injuries).

Birmingham as the centre for treating operational casualties

21. Since 2001, the main receiving unit for casualties evacuated from operational theatres has been the Royal Centre for Defence Medicine, based at the University Hospital Birmingham Foundation Trust (UHBFT) (though there was some use made of The Princess Mary Hospital at RAF Akrotiri in Cyprus during the most intense phase of Operation TELIC 1 in Iraq in 2003). The decision to establish a partnership with UHBFT was taken because, according to the Ministry of Defence, “the medical needs of the Armed Forces are best served through access to facilities and training in a busy acute care hospital that is managing severe trauma on a daily basis”. Selly Oak Hospital, one of the five specialist hospitals within UHBFT and the home to most of the treatment received by operational casualties, is highly experienced in treating the most common types of injuries sustained by Service personnel, such as polytrauma. In addition, the main arrival point for casualties is RAF Brize Norton, with which Selly Oak has good links.

22. Julie Moore, Chief Executive of UHBFT, explained that Birmingham had been a particularly suitable partner for the MoD:

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6 That is, transported by air, accompanied by medical personnel.
7 Ev 91
8 Ibid.
In terms of its central location, located near to a big airport and its good road networks, I think that was one of the major factors in choosing it so that patients can be easily transported when they are aeromedically evacuated back to Birmingham. In addition, it has got very strong partnerships with local universities, again feeding the training environment at the Royal Centre for Defence Medicine.9

Dr David Rosser, the Medical Director at UHBFT, added that:

The range of clinical specialties we have is very extensive. The only major specialties we do not provide are paediatrics and obstetrics and gynaecology. If one is injured in any form of major trauma any part of the body can be affected and we have surgical specialists particularly skilled in dealing with virtually every part of the body.10

23. We heard evidence from the Army Families Federation (AFF), the Royal British Legion (RBL), SSAFA, Combat Stress and the Royal Air Forces Association (RAFA) to support the decision to work with UHBFT, and to attest that the clinical care offered at the RCDM was first-class. Ms Sammie Crane, Chief Executive of the AFF, told us that:

The feedback I have had is that the clinical care at Selly Oak is so good it could not be replicated elsewhere and therefore that it is the correct place to which serious casualties should be taken.11

24. UHBFT stressed that the arrangements which were put in place were “to operate in peacetime not in times of conflict or war”.12 Instead, a plan by which the NHS as a whole would become involved in the treatment of substantial numbers of casualties was devised, the Joint Casualty Reporting and Reception Plan (JCRRP). This was refined in 2002 into Reception Arrangements of Military Personnel (RAMP). That notwithstanding, RAMP has been used only once, in 2003. UHBFT has taken all other casualties sent back from Operations TELIC and HERRICK.

25. UHBFT suggested that it has become the dominant reception centre for casualties because there was a strong preference for using it among military personnel. Aeromedical staff preferred to transfer to UHBFT because it was a regular occurrence, and the clinical staff were familiar with the procedure. Military doctors in Afghanistan and Iraq preferred to return casualties to an atmosphere which they knew and trusted.13

Clinical care and welfare services

26. In order to achieve the level of specialised treatment which was required for injured Service personnel, it was deemed necessary to place casualties in the appropriate clinical environment—burns patients were treated in the burns unit, neurosurgical injuries in the neurosurgical unit and so on. UHBFT told us that its initial contract with the MoD specifically asked for military casualties to be treated in the appropriate area, rather than in

9 Q 108
10 Q 109
11 Q 2 (Ms Crane)
12 Ev 107
13 ibid.
a specific ward. Similarly, military clinical staff were deployed in different areas within the hospital rather than on a specific ward, in order to give them the most appropriate experience and opportunity for training and skills development.

27. Initially, there was also a military-managed ward to allow DMS staff to gain experience of clinical management. It was not a trauma unit but a mixed-sex general surgical ward. However, this arrangement was brought to an end when the majority of the ward staff were deployed to Afghanistan at 24 hours’ notice.\textsuperscript{14}

28. Prior to our inquiry, there had been considerable, often adverse, press coverage of the standards of care at Selly Oak Hospital in particular. This included allegations that patients had been asked to remove their uniforms for fear of causing offence and had been verbally abused by visitors who opposed the war in Iraq. We asked Ms Moore, the Chief Executive of UHBFT, if there had been any complaints related to the stories highlighted from a number of newspapers. These included a report in the \textit{Daily Telegraph} that an injured paratrooper had been verbally abused by a Muslim visitor, a story in the \textit{Daily Star} that an injured Servicemen had been told to remove his uniform for fear of causing offence and an article in the \textit{Mail on Sunday} that a soldier at Selly Oak had been accosted by a group of Muslim women.\textsuperscript{15} She confirmed that the trust had received no complaints. She went on to tell us that scrutiny by the press had placed considerable demands on the Trust:

\begin{quote}
The time taken to deal with this has been quite considerable. The senior nurse in charge of the ward at one time said she felt she was doing organised visits round the ward instead of looking after patients, and that cannot be right.\textsuperscript{16}
\end{quote}

Her written memorandum on behalf of the Trust highlighted the same concern.

\begin{quote}
My concern is that these debates [over the standard of care] were played out in the press rather than by considered discussion between those concerned and senior hospital staff. This sustained negative press campaign has had a significant demoralising effect on clinical staff, NHS and military, I am sure it has affected the morale of deployed troops and their families and it has certainly affected our reputation with our own population and patients.\textsuperscript{17}
\end{quote}

29. The evidence from UHBFT, that the negative press coverage had not been based on accurate representations of factual cases, echoed what we had been told by the MoD. \textit{It seems clear that there has been much inaccurate and irresponsible reporting surrounding care for injured Service personnel at Birmingham, and that some stories were printed without being verified or, in some cases, after the Trust had said that they were untrue. We condemn this completely. Editors have a responsibility to ensure that their newspapers report on the basis of verified fact, not assumption or hearsay. The effect of such misrepresentation on the morale of clinical staff and Service personnel and families was considerable. We consider the publication of such misleading stories as reprehensible.}

\begin{footnotes}
14 Ev 106
15 Q 161
16 Q 159
17 Ev 107
\end{footnotes}
30. Another criticism in some sections of the media was the loss of the military-managed ward, with some people emphasising the importance of Service personnel being treated in a military atmosphere in which they would be comfortable. In response to this, in late 2006 UHBFT was asked to provide a new Military Managed Ward (MMW), in which the senior nurse in charge would be a military nurse. The preference of the DMS was that this should be the trauma ward where most injured Service personnel are treated. However, there was not a military nurse with the required skills and experience to manage a ward, so it was necessary to train someone to fulfil that role. Furthermore, there were insufficient military nurses to staff the ward, and it was claimed at the time that it would not be possible to reach the required numbers to have a 70% military staffing level until July 2007.18

31. We asked the Minister about progress on the Military Managed Ward when he appeared before us in November 2007. He explained that there were around 39 military nurses at Selly Oak, a Regimental Sergeant-Major ward manager to deal with discipline and matters relating to Service life, and two liaison facilities who maintained links with patients’ parent units. He concluded:

You walk around Selly Oak now, and it is like new. There are a lot more military people and uniforms […] the hope going to the new ward is that we can put in an actual ward manager who would have responsibility on that ward for all the things that happen in that ward.19

32. There were also criticisms of the welfare and support services provided at Selly Oak. When we spoke to representatives of welfare organisations in June 2007, they assured us that the clinical care at Selly Oak was of a very high standard, but that, in the words of one witness, “support for people who visit and for the individuals whilst there in terms of providing basic essentials is currently provided by charities which some […] suggest is perhaps not appropriate”.20 Among the issues identified were travel assistance for families of injured Service personnel, provision of toiletries and basic clothing for Service personnel who had been separated from their possessions, and accommodation for relatives of patients. Improvements were taking place, but some of the slack had been taken up by welfare organisations. For example, the Army Families Federation had paid for the temporary refurbishment of flats originally built for doctors and nurses so that they could be used by patients’ families.21

33. One significant development which bridged the gap between clinical care and welfare was the appointment of a Standing Joint Commander (Medical), who was an experienced infantry officer. His role has been to take responsibility of command and control issues and to coordinate the care pathways for casualties brought into Birmingham. Lieutenant-General Baxter stressed the importance of this appointment: “an experienced soldier is going in there, he knows the issue in the operational theatres, he knows what it is like looking after soldiers”.22

18 Ev 107
19 Q 409 (Mr Twigg)
20 Q 3 (Ms Freeth)
21 Q 23
22 Q 409 (Lieutenant-General Baxter)
34. We acknowledge the progress which has been made at Selly Oak in terms of creating a military environment, to take advantage of the healing process of being surrounded by those who have been through similar experiences, to make patients feel comfortable and give them familiar surroundings. The MoD has made substantial efforts in this regard, and we look forward to hearing of further progress in the response to this report. The MoD must make sure that the issues of welfare for patients and families are central to its planning in developing its medical facilities in and around Birmingham.

35. We also welcome the improvements in welfare provision and pay tribute to the work of welfare and charitable organisations. We consider that there is nothing intrinsically wrong in welfare and charitable organisations contributing to the support of our injured Service personnel. Indeed, quite the reverse is the case, since it builds on a proud tradition in the United Kingdom of linking the community with the Service personnel who have been injured fighting on their behalf. The MoD and the voluntary sector should engage openly with the debate about which services are more appropriately provided by the Government and which by charities and voluntary groups.

36. However, we also underline the fact that many of the improvements set out above are relatively recent, and there has been a great deal of change over the past 18 months. The MoD should not be complacent: they have had to learn important lessons and it is clear that the picture at Selly Oak was not always so positive. Nor should progress now stop, but the MoD should continue to learn lessons from its experiences in treating injured Service personnel at Selly Oak.

The concentration of services: criticisms and plans

37. While there was almost unanimous praise for the clinical standards at Selly Oak, the decision to site a single trauma unit in Birmingham was questioned by Mr Terence Lewis, Medical Director of Plymouth Hospitals NHS Trust. Mr Lewis pointed out that his trust had one of the biggest hospitals in Europe under one roof, was a major tertiary care provider and was home to one of only a handful of level-one trauma units in the UK. He therefore regarded it as “a great pity” that his trust did not provide any trauma infrastructure to military personnel.23

38. We put this criticism to the Parliamentary Under-Secretary of State for Defence, Derek Twigg MP, in November 2007. He told us that the advice he had received was that the use of Birmingham as a single site for the treatment of operational casualties was right “because of the concentration of our medical expertise and the range of cases that our people are seeing and, of course, the NHS people are seeing as well”. He added that “there is an argument as well—and this has come over quite strongly from the individual Service personnel—that they like to be grouped together, which of course we can do.” He concluded that the numbers of operational casualties, while higher than they had been before 2001, were relatively small compared to other conflicts, and were not high enough to require or allow the treatment in several different locations.24

23 Q 168 (Mr Lewis)
24 Q 407 (Mr Twigg)
39. The Surgeon-General added two points in support of the Minister’s answer. The first was that a criterion in choosing Birmingham had been the presence of a university, which there had not been at that time in Plymouth. The second was that Birmingham was a large conurbation, which would allow the MoD to “spread out in a local way should the number of casualties exceed the capability of whatever it was that we chose”. He noted that the three short-listed facilities had been in large conurbations: Birmingham, Newcastle-upon-Tyne and Guy’s and St Thomas’ in London.25

40. Another criticism of the Birmingham site which we heard from Service personnel when we visited in June 2007 was that it was not close to any major Service population (unlike, say, Plymouth or Portsmouth), which meant that the families of the injured being treated there often had to travel considerable distances, and that personnel serving in Birmingham did not feel that there was a sense of community, sometimes making it an unpopular posting.

41. The MoD has plans to develop the facilities in and around Birmingham. When we visited the RCDM, we were told that it had been involved from a very early stage in the Birmingham New Hospitals Project, which would provide brand new facilities, including dedicated military areas. We were also told that there were plans to develop facilities for training and messing at Whittington Barracks in Lichfield. This was part of the Midland Medical Accommodation (MMA) project, which would bring together on one site the headquarters of the DMS, DMETA, the Defence Medical Services Training Centre and 33 Field Hospital (currently based at Gosport).26

42. Lieutenant-General Baxter explained to us in oral evidence that the MoD intended Birmingham and Lichfield to form a “dumb-bell” in terms of shape:

> We are looking […] to continue to build on that, if you like, fissionable mass, bringing the various components together, making sure the thinking piece goes into the training and the education and to look at concentrating other bits of training. Our eyes are on taking Whittington Barracks and converting that into a satellite to the main Birmingham piece. We are looking at plans now, we are looking at budgets and we are looking to what we call a Main Gate submission, the investment decision, early in the New Year [2008].27

43. We acknowledge the case for concentrating the main clinical and training assets of the DMS and DMETA on one cluster of sites. While Birmingham may not be close to a major Service community, we accept that it is suitable in terms of transport links and proximity to a university, both of which are important factors. However, the MoD needs to make its case for the Birmingham-Lichfield ‘dumb-bell’ more explicitly, and we expect the Government response to our report to set out in detail the plans and progress on this. The MoD and, where appropriate, the voluntary sector should also make sure that there are adequate travel and accommodation arrangements for

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25 Q 407 (Lieutenant-General Lillywhite)
26 Ev 97
27 Q 406 (Lieutenant-General Baxter)
families visiting patients in Birmingham, and, as important, that these are easily understood and accessible.

44. The UHBFT/RCDM services are delivered at Selly Oak in buildings which are in many cases ageing. Delivery of the PFI development is scheduled to bring new, state-of-the-art buildings and facilities by 2012. We expect the MoD, as part of its annual reporting process, to state whether delivery on the Birmingham New Hospitals project is on target.
3 Rehabilitation and aftercare

45. Another main element of the work of the DMS is rehabilitation and aftercare. The MoD’s Defence Rehabilitation Plan operates a tiered approach to the delivery of services. The first point of contact is one of 70 Primary Casualty Receiving Facilities, which treat around 80% of problems. The PCRFs, in turn, can refer patients to one of 15 Regional Rehabilitation Units (RRUs), staffed by multi-disciplinary teams including doctors, physiotherapists and rehabilitation instructors, which concentrate on the assessment of musculo-skeletal injuries and sports medicine. The MoD’s memorandum claimed that the benefits brought by the use of RRUs included successfully treating more than four-fifths of patients through physiotherapy and rehabilitation alone, with no surgical intervention, and discharging the “vast majority” of patients fully fit for task.28 We visited an RRU in Edinburgh in October 2007.

46. The principle underlying the DMS’s approach to the treatment of musculo-skeletal injuries is that, wherever possible, care should be provided at a local level, and should make the best possible use of physiotherapy and rehabilitation rather than surgical intervention. This has the additional benefit of avoiding patients spending long periods on waiting lists for assessment and treatment.

47. We were very impressed by the services at the Regional Rehabilitation Unit we visited in Edinburgh and commend the staff for their excellent work. The MoD’s approach to musculo-skeletal injuries is forward-looking and sensible, and we are persuaded that it has been of significant benefit to Service personnel as patients, and to the efficiency and effectiveness of their units.

48. The final link in the rehabilitation chain is the Defence Medical Rehabilitation Centre at Headley Court in Surrey, which we visited in June 2007. The Centre, which was opened in 2004, deals principally with patients suffering from polytrauma and brain injuries. It has 220 staff, half military and half civilian, with 156 patient beds, 36 of which are ward-based. It provides physiotherapy and rehabilitation for complex musculo-skeletal injuries and specialised neuro-rehabilitation for patients with brain injuries. Since June 2006, it has also been home to the Complex Rehabilitation and Amputee Unit, and has a contract with a private company for the production of prosthetics. These are manufactured on site and individually tailored to the patients’ needs.

49. The principle underlying the work of the Centre is to return patients to functional independence, and, where possible, to active military duties. Historically, around 95% of patients have returned to military duties, but this has fallen to 85-90% in the recent past, given the increasingly serious injuries with which patients are presenting. Only around half of those patients with serious brain injuries tend to return to military duties.29

50. The facility had been requisitioned from Lord Cunliffe by HQ Canadian Forces during the Second World War, after which it was bought by the Estate Agents and Auctioneers Institute (now the Royal Institute of Chartered Surveyors) to endow as a rehabilitation unit.

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28 Ev 100
29 Ev 92, information from visit
for aircrew in memory of the deeds of RAF aircrew during the War. It remains governed by a trust, the deeds of which include the rehabilitation of all Armed Forces personnel.

51. The MoD told us that there was an ongoing review of Headley Court, to look at future anticipated needs and development of the site, and that Mole Valley Council had been involved in discussions about the process. The Minister maintained that Headley Court was currently “very fit for purpose”, but added that the MoD “want[ed] to look at the longer, short to medium term future in terms of any developments that need[ed] to take place”.

52. There had been some press comment suggesting that some of the facilities available at Headley Court were insufficient to meet the demand placed upon them. Specifically, it had been alleged that the lack of availability of the hydrotherapy pool had forced the Centre to take patients by bus to Leatherhead public swimming pool. It was further alleged that there had been an incident in which members of the public had expressed dissatisfaction with this arrangement on the grounds that the presence of obviously injured personnel might distress other users of the pool, especially children.

53. We put this allegation to the Minister in November 2007. He explained that it was in part founded on a misapprehension of the purpose of different types of pool. The hydrotherapy pool at Headley Court was heated to a relatively high temperature, and was not suitable for those with cardiovascular issues. For those patients, a standard swimming pool was more suitable. Therefore, it was not the case that the hydrotherapy pool was unable to deliver the required capacity, but rather that some patients had different requirements. The Surgeon-General added that the administration at Headley Court had at no point suggested that the arrangements to use the public swimming pool in Leatherhead were ineffective, inadequate or inappropriate, complaints to which the DMS would have responded.

54. We readily acknowledge the extraordinary work which is carried out at Headley Court and have nothing but praise for the staff, who have had to cope with an increased tempo of operations and treat patients with injuries which, only a few years ago, would have been fatal. We regard this as a good example of the Government and charities cooperating to provide those services which they can most appropriately deliver. We were astonished by the ability of some gravely-injured Service personnel to be successfully treated, and to return to active military duty. However, we are concerned by reports of problems with the local community in terms both of developing the facilities at Headley Court and of using local authority amenities. If it is true that some local residents objected to the presence of Service personnel, we find that attitude disgraceful. The Government should make the outcome of the current review into the facilities at Headley Court fully available, and should explain what planning it has done to account for the increased operational tempo and its implications for Headley Court.
4 Cooperation with the NHS

Ministry of Defence Hospital Units: secondary care and training

55. Following the closure of the military hospitals in the 1990s, the decision was taken to establish a number of military units within NHS facilities, both to provide a degree of secondary care for Armed Forces personnel, and to allow for the training and skills maintenance of military medical staff. There are currently five of these Ministry of Defence Hospital Units:

- MDHU Portsmouth (Queen Alexandra Hospital, Portsmouth Hospitals NHS Trust)
- MDHU Derriford (Derriford Hospital, Plymouth Hospitals NHS Trust)
- MDHU Frimley Park (Frimley Park Hospital NHS Foundation Trust)
- MDHU Northallerton (Friarage Hospital, South Tees Hospitals NHS Trust)
- MDHU Peterborough (Peterborough and Stamford Hospitals NHS Foundation Trust)

The MDHUs assumed most of the twin burdens of clinical care and training because there were insufficient numbers of patients and too small a range of cases to allow military medical personnel to develop and maintain the required skills.

56. MDHUs are not stand-alone units or wards. Rather, their purpose is “to provide administrative, business and training functionality”, leaving clinical staff to concentrate on their medical work. Service medical personnel in MDHUs are integrated throughout the host NHS Trusts, thereby providing a double benefit: the volume and range of cases which pass through the NHS facilities allow them to develop and maintain their skills, which means that they are at full readiness for deployment when necessary. They also contribute to overall NHS capacity and capability. MDHUs employ a substantial number of Reserve personnel. We examine this issue in more detail in Chapter 7.

57. A key role of MDHUs is to provide a pool of deployable personnel, and there are certain challenges in managing this. Terence Lewis, the Medical Director of Plymouth Hospitals NHS Trust, told us: “We have 260 Regular staff in our organisation, 250 of whom departed to Iraq with virtually no notice”.35 These were people who were “absolutely crucial to the organisation […] [and] losing those in an organisation such as ours has a very major effect”.36 The Health Minister told us that, while workforce planning was the responsibility of individual trusts under the guidance of their Strategic Health Authorities, the increase in the number of clinical personnel being trained would inevitably ease any problems caused by the deployment of personnel.37 Andrew Cash, Co-Chair of the DH/MoD Partnership

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34 Ev 96
35 Q 175
36 Q 189
37 Q 475 (Mr Bradshaw)
Board, added that workforce planning was one of the three key areas which his Board was currently examining, and it was acutely aware of the need for cooperating to manage the deployment of medical personnel.\textsuperscript{38} We are satisfied that the MoD and the Department of Health are aware of the management problems which the deployment of personnel from MDHUs poses for the Trusts in which they are based and that they are working in a coordinated way to minimise these problems.

58. The General Medical Council (GMC) attested that the training provided in MDHUs was as good as that in the NHS. It explained that the training posts “are fully integrated into foundation training, carry full educational approval and deliver the required competencies of the Foundation Training Programme”.\textsuperscript{39}

59. While the training role which MDHUs play is important, they also provide considerable clinical care for the Armed Forces. The Health Minister told us that around 65% of Service personnel received elective treatment in MDHUs as opposed to in mainstream NHS facilities. However, we heard concerns that, while MDHUs offer swift access to high-quality care for Service personnel, some had to travel considerable distances to receive that treatment.\textsuperscript{40} The Surgeon-General told us that the MoD attempted to balance clinical need against local access to healthcare.\textsuperscript{41}

60. The Department of Health’s memorandum explained that, where appropriate military healthcare was not available, Service personnel based in the UK were entitled to the full use of NHS facilities on the same basis as civilians, while personnel based abroad were similarly entitled to NHS secondary care if they returned for treatment. The provision of this care was the responsibility of Primary Care Trusts.\textsuperscript{42}

61. The principle which underlies MDHUs is a sound one. We believe that embedding DMS personnel in NHS trusts to work side by side with civilian clinicians is the best way to develop and maintain their skills, as well as providing an opportunity for Servicemen and women to be treated in a semi-military environment. We were impressed by the MDHUs which we visited and are satisfied that they deliver high-quality care to military and civilian patients.

62. One of the aims of integrating Service medical personnel was said to be the exchange of skills and best practice between military and civilian clinicians.\textsuperscript{43} However, when we visited the headquarters of 2 Medical Brigade at Strensall in Yorkshire, we were told that some of the trauma care which Service medical personnel provide in operational theatres was far in advance of that which the NHS could offer. In particular, we were told that the time from point of trauma to treatment was very much shorter in Afghanistan and Iraq than was the norm in the NHS. This suggested that there was more work to be done in terms of sharing best practice. The Health Minister, Ben Bradshaw, admitted that best practice was “not as
widespread as it should be”. He added that the Department of Health was considering putting more explicit advice in the annual operating framework about the need to encourage Reservists, which would assist the “cross-fertilisation of cultures”. The MoD and the Department of Health should address the sharing of best practice as a matter of urgency. More structured exchange of skills and techniques is in the interests of the NHS and Service personnel. We also consider it probable that the MoD, when working alongside forces from other countries, will learn lessons from differing approaches adopted by those other countries which could usefully be shared with the NHS. We expect the response to this report to explain in detail what steps will be taken to encourage this.

63. Some of us visited four of the five MDHUs. One striking characteristic of some of the units we visited was a strong single Service ethos, despite the notional tri-Service nature of MDHUs. Indeed, they were on one occasion described to us in explicitly single-Service terms: Derriford and Portsmouth being Royal Navy, Frimley Park and Northallerton being Army and Peterborough being RAF. The Deputy Chief of the Defence Staff (Health) explained that this was due to historic connections with specific Service communities. We appreciate the strength of Service loyalties and the power of traditional connections, but we suggest that more needs to be done to ensure that MDHUs are representative of a genuinely tri-Service DMS.

‘Fast track’ treatment in the NHS

64. The MoD told us that there was a distinction between ‘fast track programming’ and ‘accelerated access’. The latter refers to the treatment which Service personnel receive in MDHUs, for which the MoD pays the host trusts. However, there is also a system of ‘fast track programming’, under which Service personnel can receive fast access to treatment (generally for musculo-skeletal disorders) over and above the arrangements with MDHUs. This treatment can be in the MDHU host Trusts, in other NHS Trusts or in the independent sector. This distinction between ‘fast track programming’ and ‘accelerated access’ was not at first explained clearly and it took prolonged examination to discover the full details. The priority in the treatment of injured Service personnel must be to return them as quickly as possible to operational effectiveness, so it is sensible for the DMS to use whatever mechanism delivers this objective most efficiently. The MoD should express more clearly the arrangements for ‘fast track programming’, and we are concerned that they are not fully or properly understood by all parties involved.

The devolved administrations

65. The MoD has responsibility for Service personnel across the UK but must cooperate with a number of jurisdictions to access civilian medical services. While the relationship between the MoD and the Department of Health seems to be a good one, the situation in Scotland seems to be less satisfactory, judging by the evidence we took from officials from

44 Q 438
45 Q 425 (Lieutenant-General Baxter)
46 Ev 144
the Scottish Executive in October 2007. Health ministers from the devolved administrations signed up to the concordat between the MoD and the Department of Health, and, as there is no MDHU in Scotland, the MoD deals with individual health boards when it is necessary for Service personnel to receive clinical care.47

66. The structure of the NHS in Scotland differs substantially from that in England. Since April 2004, healthcare provision has been the responsibility of 14 geographically-based NHS Boards and a number of Special Health Boards. Hospitals not managed by Special Health Boards are managed by, and GPs contracted in by, the local NHS Board. Provision of community health care and most mental health care is also the responsibility of local Boards.

67. We asked officials from the Scottish Executive about cooperation with the MoD on a variety of issues: giving help to Service families returning from overseas postings, the provision of mental health care for veterans, the transfer of medical records for those leaving the Armed Forces, the employment and conditions of Reserve personnel. On too many of these issues, the response was one of confusion, incomprehension or ignorance. On the subject of Service families returning from overseas and registering with a GP, for example, an official said:

Any family coming into a community has an entitlement to register with a general practice in their area, so there is no difference there. I suppose it is the local intelligence of knowing where to go, if you like, when the family gets back.48

On the subject of dentists, she added:

There is an obligation on the health boards to provide a general medical practitioner for every citizen whereas there is not for an NHS dentist. I have no knowledge of whether Service families have particular difficulties over and above the rest of the population.49

68. Overall, there was too much reliance on guidance issues to health Boards, and when we pressed officials on monitoring the implementation of this guidance, we were told:

We have not got a measure that would enable us to do that. I guess our major measure of these kinds of issues would be are we getting a lot of complaints about them, and we are not […] it is impossible to monitor how every bit of guidance that goes out is implemented […] some of this is about the actual clinical interaction between a GP or a practice nurse or a frontline clinician and a veteran, and unless you are sitting on top of that interaction it is an extremely difficult thing to measure.50

69. Our visit to Scotland left us deeply concerned. It is unreasonable to expect any administration, whether in Whitehall or one of the devolved assemblies, to

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47 Qq 265-68, Qq 280-81
48 Q 308
49 Q 309
50 Qq 296, 298
micromanage the agencies which execute its policies. But depending on guidance and taking a laissez faire approach to making sure that such guidance is implemented is totally inadequate, and reinforces our view that the issues confronting Service personnel and their families are not sufficiently high up the list of priorities for the Scottish Executive.

70. We accept that plurality is an inevitable outcome of the devolution settlement. However, we are concerned that the provision of some aspects of healthcare in Scotland, for Service personnel and their families, is not always given the priority it deserves because of poor cooperation and communication. The MoD must review the structures through which it engages with other departments and administrations, and explain how it intends to improve the situation. We also expect the Scottish Executive to review its arrangements in response to our report.
5 Care for veterans and Service families

Priority access for veterans

71. Medical care for ex-Service personnel is the responsibility of the NHS. However, since 1948, there has been an entitlement to priority access for war pensioners to treatment for conditions relating to their service.\(^51\) On 23 November 2007, the Government announced that this priority access would be extended to all veterans for conditions which were believed to derive from service. This followed a pilot project run by Hull Primary Care Trust, and the Health Minister estimated that it would extend priority access from around 170,000 veterans across the UK to a figure in the region of 5,000,000.\(^52\)

72. Just as important as priority access to treatment for veterans is ensuring that those who are eligible are aware of their entitlement and how to benefit from it. Andrew Cash, Co-Chair of the DH/MoD Partnership Board, said that this was a two-part process: personnel would be informed of their entitlement while in the Armed Forces, while the arrangements would also be explained in the operating framework issued to PCTs and to general practitioners.\(^53\)

73. The new system will, therefore, rely on self-identification by veterans, some of whom may be reluctant to make their status known. This seems to present a fundamental problem. Even assuming the seamless transfer of medical records (which we consider in paragraphs 77-79 below), a clinician will not automatically have any way of knowing that a patient has served in the Armed Forces, let alone that his or her condition may be related to the period of service. This is all the more problematic given that some conditions can show symptoms months or years after the patient has left the Armed Forces (particularly in relation to mental health, which we consider in Chapter 6 below).

74. In response to these criticisms, the Surgeon-General counselled caution. He told us that:

Not all veterans want it to be known that they are veterans, so we just need to be careful about being too proactive in some cases. An individual who has left the Armed Forces, in some cases, not many but in some cases, may wish that severance to be complete, and we need to be very careful about being too proactive and overriding an individual’s wish.\(^54\)

75. We welcome the Government’s extension of the priority access available to veterans in England. However, the MoD must explain clearly what it is doing in conjunction with the devolved administrations to ensure that this entitlement extends across the UK. It should also give a clear definition of who qualifies as a veteran and is therefore entitled to this treatment.

\(^{51}\) Ev 95
\(^{52}\) Q 373
\(^{53}\) Q 385
\(^{54}\) Q 390
76. We also acknowledge that the implementation of the policy will present some challenges in terms of privacy. However, the MoD and the Department of Health need to do much more to make sure that the entitlement to priority access is widely understood and taken up by those who need it. We do not believe that there is currently a sufficiently robust system for tracking veterans in the NHS, and we expect the MoD’s response to this report will set out the Government’s thinking on how this could be improved. Simply to rely on the individual to bring his or her status as a veteran to the attention of a clinician, given some of the conditions which are common among ex-Service personnel, is inadequate and an abdication of responsibility. We believe that an automatic tracking system with an ‘opt-out’ provision would balance the need for robustness with the protection of individuals’ privacy.

Transfer of records

77. An issue which goes hand in hand with priority treatment for veterans is the transfer of medical records from the military to the civilian clinician. The system as it was explained to us is that those leaving the Armed Forces, after having a medical examination, are given a summary of their medical history to present to a civilian general practitioner upon registering. The GP can then, if necessary, request the full medical records of his or her patient from the MoD, relating to the period of service in the Armed Forces.\(^55\) The Health Minister also claimed that the transfer of the summary would become automatic under the NHS National Programme for IT when the NHS and MoD computer systems were integrated.\(^56\) The Surgeon-General added that he did not think the system was ineffective, as there was currently no backlog of requests from GPs for military medical records.\(^57\)

78. The system remains essentially reactive. It is the responsibility of the individual veteran to present the GP with a summary medical report, and the responsibility of the GP to request the full records if necessary. We heard anecdotal evidence from Service personnel that the procedures do not always operate as they should, that records are not transferred, are not fully disclosed, and are not always accepted by clinicians, for example when needed for insurance policies. Commodore Elliott, Chief Executive of Combat Stress, put the problem plainly:

> The procedures for medical discharge involve handing the patient across to the National Health Service, and the medical records go with the patient into the NHS. All too frequently the problem is that the Services do not know where that patient will end up. He has nowhere to go. A lot of servicemen who are being discharged will not contact their local GPs and all the services that they should connect up to until they are in trouble, and therein lies a huge problem.\(^58\)

79. We remain concerned that medical records do not transfer as seamlessly from the Armed Forces to civilian life as they could. Too much is left to the initiative of the patient, and on our visits we heard that the existing system often works imperfectly. We
recommend that the MoD re-examine its procedures with regard to medical records and examine ways in which there could be an automatic transfer of records and a more effective safety net for those who, for whatever reason, do not take the initiative in transferring or requesting records. We also ask the MoD to give us an update on the progress of its IT system, the compatibility with the NHS National Programme for IT, and its anticipated schedule for implementation of the new system.

Wider implications

80. The care of veterans is important not just in terms of making sure that first-class healthcare is available swiftly and easily to those who have served the country. It has a wider impact on the perception of Service life, both in terms of Service personnel and their families, and in terms of the community at large. We have already expressed concern over the issue of recruitment and retention of personnel by the Armed Forces. We believe that providing first-class healthcare for veterans, and making sure that people have confidence that they will be able to access and will receive such treatment, is an integral part of the debt which society owes to those who serve in the Armed Forces, and, as such, has an impact on recruitment and retention.

Service families overseas

81. The MoD is responsible for the delivery of healthcare to Service families posted abroad. It is provided in a number of different ways. In Germany, British Forces Germany Healthcare Services (BFGHS) is a partnership between the MoD, Guy’s and St Thomas’ NHS Foundation Trust, the Defence Medical Welfare Service, SSAFA Forces Help and the Defence Dental Service which provides “seamless primary, community, secondary and tertiary care”. Hospital facilities are the responsibility of Guy’s and St Thomas’, which subcontract with five German provider hospitals. In the Permanent Joint Operating Bases (PJOBs) at Cyprus and Gibraltar, primary healthcare is provided by PJHQ, using primarily Service personnel, while secondary care is provided by The Princess Mary Hospital (Cyprus) and the Royal Naval Hospital (Gibraltar). There are also contracts with some local healthcare providers and UK-based NHS hospitals to provide access to services which MoD resources cannot supply.

82. SSAFA Forces Help, which is involved in providing some healthcare services for families abroad, observed that the standard of care offered was “generally very satisfactory and indeed in most cases excellent”. However, it warned that the substantial increases in funding for the NHS had not been matched by the MoD in terms of funding healthcare abroad: the NHS budget had risen by 5% a year since 2002, while the MoD’s expenditure had risen by only 2%. Given that it was necessary to pay military clinicians comparable salaries to those of civilian staff, the funding gap was exacerbated. The Minister accepted that the MoD had not been able to match the rate of increase in expenditure enjoyed by the

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60 Ev 95
61 Ev 112
NHS. He told us in November that it was a subject of ongoing discussions with the Treasury.\textsuperscript{62}

83. We acknowledge that Service families posted overseas generally receive very good healthcare through sensible partnership arrangements. We are glad that the MoD accepts that its spending has lagged behind that of the NHS. It is essential that medical care for our Service personnel posted overseas should keep pace in every way with the NHS, so that they are not penalised for joining the Armed Forces.

84. Another issue which is under review is the continuing existence of stand-alone hospitals for Service communities overseas in Cyprus and Gibraltar. When we visited The Princess Mary Hospital at RAF Akrotiri in November 2006, we saw a facility which was clinically of a very high standard, but which was serving a population of a size so small that the facility was underused and overstaffed. However, it was not possible to outsource the provision of all services to local providers. Equally, it was reliant on visiting clinicians or locums from the UK for some services. This made clinical continuity and the maintenance of skills difficult.

85. We doubt if the establishments in Cyprus and Gibraltar are clinically or financially viable in the long term. The MoD should make clear how it intends to address this problem and what options are being explored for maintaining healthcare provision for Service communities in a more effective and efficient manner. It should also set out a timetable for tackling this issue.

**Service families in the UK**

86. One of the major issues for Service personnel and families returning from overseas postings is making the transition from a situation in which the MoD provides healthcare, to a situation in the UK in which families (though not Servicemen and women) are entirely reliant on local NHS services. Particular concerns have included the process of registration with NHS general practitioners and dentists (pressure on the latter is particularly acute, as has been reported widely in the media), and the management of expectations when transferring from one regime to the other.

87. The problem of dentistry in particular was put to us by Sammie Crane of the Army Families Federation. She identified two aspects of this problem. The first was that Service families move so regularly that it could be very difficult to get to the top of a waiting list for an NHS dentist, while such lists are non-transferable. The second, anecdotal, issue was that families in which both parents are Service personnel, and whose dentistry needs are taken care of by the MoD, often found that dental practices would not register children unless one parent was also registered with that practice.\textsuperscript{63}

88. There appeared to be an acute lack of support for families in Scotland making the transition from postings abroad to those in the UK. The Scottish Executive told us that “these are really matters for the MoD”, and demonstrated no substantial awareness of the

\textsuperscript{62} Qq 467-69

\textsuperscript{63} Q 57
problems which Service families faced.64 Asked whether more could be done to ease the transition, one official responded, “I suppose they [the MoD] could give them an information pack”.65 The impression was created that Service families would have no more information and support in getting access to healthcare after prolonged absence overseas than any other sector of the population.

89. We acknowledge that the healthcare of Service families in the UK is the responsibility of the NHS. However, the MoD has a part to play, and should be doing more to support Service families during the transition from overseas postings to reliance on NHS healthcare. There should be better cooperation between the MoD and health departments across the UK. The Scottish Executive also has a responsibility to improve its procedures in this regard. Providing this sort of support is a vital part of maintaining morale among Service personnel themselves and their families, which has such a profound effect on the retention of experienced Servicemen and women.
6 Mental health

Mental healthcare for Service personnel

90. We now turn to another key aspect of healthcare for Servicemen and women, mental health. In 2002, the MoD published the conclusions of its Medical Quinquennial Review, as a result of which there was a reconfiguration of mental health services it provided. These were based on the principle of community mental health and carried out primarily through 15 military Departments of Community Mental Health (DCMHs), with satellite centres overseas. These are staffed by mental health teams comprising psychiatrists, mental health nurses, clinical psychologists and mental health social workers. The MoD’s aim is to treat personnel who present with mental health needs as out-patients where possible.66

91. For in-patient care, since the Duchess of Kent Psychiatric Hospital at Catterick closed in April 2003, the MoD has used a central contract with the Priory Group of hospitals to treat Service personnel in psychiatric units which it claims allows patients to be treated much closer to their parent units than was the case when the Armed Forces operated its own psychiatric hospitals. There is close liaison between local DCMHs and Priory units to manage the in-patient care of Service personnel.67 There are agreed communication protocols between the Priory Group and the MoD at admission, after 48 hours, at 14 days if further inpatient stay has been requested, and at discharge.68

92. In terms of preventative measures, we heard on several occasions about efforts to provide opportunity for ‘decompression’—that is, for personnel returning from front-line duty to have an opportunity to recover in a group setting and absorb their often traumatic experiences before returning to their families and friends. The Minister noted that this was a problem made more acute by reduced travel time.

In the old days where you might spend a few months coming home, whether you were in the Second World War or elsewhere, on a ship for a long time, has of course gone in the main now.69

93. When we visited Cyprus in October-November 2006, we were told that one of the facilities offered by the development of the Forward Mounting Base was space to allow this decompression. For example, the 3 Para battle group had used Bloodhound Camp for this purpose after returning from a tour of duty in Afghanistan. The Royal Marines have formalised a comparable arrangement known as Trauma Risk Management or TRiM. The Minister described this as “a sort of a buddy system led by warrant officers in terms of talking through their issues or concerns with each other”, and noted that it seemed to be working well.70

66 Ev 93
67 ibid.
68 Ev 110
69 Q 440
70 ibid.
94. The MoD’s memorandum noted that medical discharge from the Armed Forces due to psychological illness was low. Only around 150 personnel, less than 0.1%, were discharged annually for mental health reasons “whatever the cause”.71

95. We heard some criticism of the contract with the Priory Group. Dr Christopher Freeman, a consultant psychiatrist at the Royal Edinburgh Hospital and a Fellow of the Royal College of Psychiatrists, said that he was not convinced that the Priory’s clinicians had the relevant expertise, and that they lacked the ability to relate to the experience of Service personnel. He also expressed an anxiety that “the private sector makes its money by keeping people in beds, the longer someone is in hospital, the more money they get, and that is a tension between the NHS and the private sector”.72

96. In general, Dr Freeman characterised the MoD’s mental health provision for serving personnel as “an okay job but not a great job”. He took the view that assessment and monitoring of mental health needs was good overall, but that the psychiatric services were stretched. MoD and Department of Health witnesses were more positive. They stressed that the concentration on community care was the right one, and that the relationship with the Priory group, with its “joined-up regional, across-the-UK footprint”, was bearing fruit.73 Professor Louis Appleby, the Department of Health’s Mental Health Clinical Director, added:

> The model that is being described is very much in line with current service provision. The modern idea of providing mental health care is that it is primarily community-based, that small in-patient units provide back-up of a very specialist kind linked to what is then provided in the community. It seems to me from what I know of the MoD version of mental health care that it is very much in line with those NHS principles.74

97. We consider that the MoD provides adequate mental healthcare for serving members of the Armed Forces. We have been told on visits that there is a culture of individuals ‘bottling things up’ inherent in the Services, but we note with approval the steps which have been taken to attempt to prevent problems through ‘decompression’. This should be an integral part of the procedures for all personnel returning from operational tours. It is also important that the problems which can arise are recognised throughout the Services, so that early warning signs can be spotted and dealt with before problems get worse. We believe it is sensible to approach mental healthcare from community-based provision, delivered in conjunction with local military units, in-patient treatment being a last resort. The MoD should also review its contract with the Priory Group to assess its effectiveness.

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71 Ev 93
72 Q 215
73 Q 441 (Lieutenant-General Baxter)
74 Q 451
Mental healthcare for veterans

98. One of the problems in dealing with the mental health needs of Service personnel arising from traumatic experiences during combat is that the effects can remain hidden for many years and only become apparent when they have left the Services. The MoD cooperates with the Department of Health and the Ex-Services Mental Welfare Society (Combat Stress) “to ensure that good quality and appropriate services are available for those who need them.”75 The stated aim is to:

Bring Combat Stress services into alignment with current best practice and to achieve greater integration with the NHS services to allow appropriate and speedy referral for those who need it.76

99. Shortly before the Ministers, Derek Twigg and Ben Bradshaw, appeared in front of us, the MoD and the Department of Health announced the establishment of six two-year pilot schemes for mental health for veterans, at the initial cost of £500,000. These schemes are intended to work:

via the veterans units as well as with the NHS providers of mental health in these locations and that will be really to enable clinicians in the Health Service to gain a better understanding of the issues around those who have served in the Armed Forces and the issues that might arise, which often impact on their mental health.77

The pilot projects were announced as being in Camden, Stafford, St Austell, Newcastle-upon-Tyne, Cardiff and somewhere in Scotland.

100. There are two major challenges facing the MoD and its partners in dealing with mental healthcare for veterans. The first, given the decision to work so intimately with a private organisation like Combat Stress, is making sure that there are adequate resources to manage demand. The second is identifying those veterans with mental health needs and directing them towards the appropriate treatment.

101. We took evidence from Combat Stress, and visited their facility at Leatherhead in Surrey, in June 2007. In its written memorandum, it said that major reports in 2003 and 2005 had found the provision of healthcare for veterans with mental health issues was inadequate. Combat Stress acknowledged that those veterans were a group with which it was difficult to engage, and noted that younger veterans were also starting to become much more prominent in its treatment centres, bringing new challenges.78

102. Commodore Elliott, Chief Executive of Combat Stress, expressed his organisation’s difficulties to us.

We have had a very large increase in the number of referrals. In the past three years we have had a 27 per cent increase, or nearly 1,000 referrals a year. For a small organisation like ours that is causing us a great deal of overstretch. I am prepared to

75 Ev 138
76 ibid.
77 Q 372
78 Ev 108-09
use that term. I also use it when speaking to the Secretary of State and the Veterans Minister whenever I possibly can.79

He went on to explain that referrals to Combat Stress came from three different sources: 10% came from the NHS and social services, 30% came from ex-Service organisations such as the Royal British Legion and SSAFA, but the majority, around 60%, were self-referrals.

103. In terms of funding, Combat Stress received money from the Veterans’ Agency and from the war pension treatment and travel allowance. However, this was in itself problematic, as a very small proportion of those whom it treated (around 2% in 2006) were in receipt of a war pension. Commodore Elliott explained that “we do not turn them away; we worry about them first and how the hell we are to fund what we are doing for them comes second” 80

104. The MoD announced in November 2007 that it was increasing the fees it paid to Combat Stress from £2.5 million in 2006–07 “rising to 45 per cent. from January 2008 to enable them to enhance their capability to treat veterans”.81 We welcome this additional funding, and pay tribute to the work which Combat Stress is doing. The MoD is right to engage with private organisations such as Combat Stress where that is appropriate, but it must continue to ensure that the organisation is adequately funded and has the clinical capability to deal with the patients who are referred to it. The MoD should also think more strategically about, and explain in their response to this report, their relationship with private and charitable organisations, and the extent to which they should provide services on behalf of the Government.

105. One of the reasons that the NHS must bear much of the burden in terms of mental health needs arising from service in the Armed Forces is that these can take many years to emerge, as mentioned in paragraph 98. Combat Stress told us that the average period between leaving the Services and developing mental health problems was around 15 years.82 The problem of early intervention with veterans suffering from mental health problems was identified to us by Dr Freeman. He was particularly critical of the lack of proactive provision of mental healthcare for veterans, saying that the NHS “hardly deals with them at all”.83 His diagnosis was that substantial change was needed:

I think what we do need is a really good monitoring system, a central point of referral so that these men who find it very difficult to seek help can have walk-in shop front clinics where they can go, where they can see other veterans working as volunteers, where they can have an assessment triage for their appropriate treatment. After that stage, and they may well still link in with that shop front service for many years, they would go for their specialist treatment, getting psychotherapy or drug addiction treatment or whatever. It is the point of entry we need to manage better. It would

79 Q 96
80 Q 97 (Commodore Elliott)
81 HC Deb, 21 November 2007, col 891W
82 Q 45
83 Q 211
cost hardly any money to have a triage system like that, an assessment service for veterans. 84

106. Commodore Elliott identified a similar shortcoming in the NHS, telling us that veterans’ problems were not always understood by civilian clinicians. A veteran who had undergone a traumatic experience in battle could find himself referred to a Post-Traumatic Stress Disorder (PTSD) support group with people who had been in car accidents or had suffered traumatic childbirths. This, he argued, was inappropriate: "when it comes for him to talk about his experience […] either he bottles out and leaves the group straight away or reduces the group, including the therapist, to tears. He traumatises the group. They just do not fit in." 85

107. This problem requires a twofold solution. First, it is only possible to treat veterans with mental health needs if there is a robust system for tracking and identifying patients who have served in the Armed Forces (as we have discussed in Chapter 5 above). Second, the NHS has to be able to respond to the particular needs of veterans, and be aware of the symptoms with which they may present.

108. We also received a memorandum from Major General Robin Short, former Director-General of Army Medical Services, and others, which focused on the treatment of PTSD. 86 The memorandum argued that PTSD was a considerable problem, both among Service personnel and among veterans, and that the extent of the problem was likely to grow due to the high tempo of operations. It also argued that the MoD was failing to learn lessons from the way in which the US military had improved the treatment of PTSD. The US had made progress in de-stigmatising PTSD, and now included psychological maintenance as an integral part of post-deployment activity. By contrast, the MoD lacked a coherent policy towards the detection and treatment of PTSD, and, indeed, he asserted, had not even acknowledged the existence of the condition. 87

109. Derek Twigg denied that the MoD did not pay adequate attention to the issue of PTSD. He told us in November 2007 that only between 25 and 30 Service personnel each year were discharged with PTSD, but “that is not in any way belittling the fact that for those people that is a tremendous difficulty and is affecting their lives.” 88

110. We are concerned that the identification and treatment of veterans with mental health needs relies as much on good intentions and good luck as on robust tracking and detailed understanding of their problems. If the NHS does not have a reliable way of identifying those who have been in the Armed Forces, then it already has one hand behind its back when it comes to providing appropriate clinical care. We repeat our belief that there must be a robust system for tracking veterans in the NHS, and this should feed into enhanced facilities for addressing their specific needs.

84 Q 221
85 Q 98 (Commodore Elliott)
86 Ev 121-27
87 ibid.
88 Q 439
7 The role of Reserve medical personnel

111. The DMS is particularly heavily reliant on Reserve personnel, who serve alongside their Regular colleagues on operations. This reliance has increased due to the higher tempo of operations, combined with smaller numbers of deployable Regular DMSD personnel. This is part of a balance: while Reservists volunteer in order to use their skills, there is a danger of deploying them so often that the pressure upon them becomes excessive.

112. The Surgeon-General explained that a degree of the reliance on Reservists had been necessitated by Manning shortfalls. However, he argued that the situation was “significantly improving”, and that this would ease some of the pressure. For example, in 2002, there had been serious shortfalls in the number of anaesthetists, with only 20 posts out of 95 filled. There were now 45 filled and by 2012 that figure would rise to 71. “That, of course, will automatically reduce the reliance on the Reserves.”

113. Workforce planning within the NHS plays an important part in the management of Reserve forces. Andrew Cash told us that the MDHUs, in which large numbers of Reservists were employed, had to ensure that they were not placed under unmanageable pressure, for example by the deployment of Reserve forces at that same time as the Regulars were sent on an operational tour. This was an objective of the DH/MoD Partnership Board.

114. When we visited the Headquarters of 2 Medical Brigade at Strensall in Yorkshire in October 2007, we were told that the TA had so far met around 50% of the Armed Forces’ medical commitment for Operations TELIC and HERRICK, and that there were currently substantial numbers of TA medical personnel in Afghanistan (the numbers in Iraq were much smaller as medical provision for Operation TELIC is currently a Regular commitment). We also saw a TA unit, 201 (Northern) Field Hospital (Volunteer), preparing and training for operational deployment as part of Operation HERRICK. We were told that TA recruitment remained steady, but there was a need to recruit younger people, as the TA medical service represented an ageing population, with medical specialists taking a long time to train.

115. Another issue affecting Reserve medical personnel is the attitudes of employers. With increasing commercial orientation and focus on targets in the NHS, the BMA argued that “given the choice of two equal candidates for a consultant post [an employer is likely] to appoint the candidate with no reserve liability”. Furthermore, similar problems were likely to exist in general practice: “reserve liability […] will often be considered a handicap and a disincentive to recruit”. It concluded that “these situations are driven […] by the medical workforce shortage coupled with the severe lack of contingency capacity in most NHS organisations and general practices.”

116. Witnesses from the Department of Health did not accept the scale of this problem. Mr Cash told us that he had “not specifically” encountered this kind of discrimination against
Reservists, and stressed that NHS employers fully supported staff who had to undertake their annual 15-day commitment to the Reserve forces. The Health Minister went further, saying that he would urge Reservists who felt that they had suffered discrimination to use the complaints procedure to seek redress.

117. Officials admitted that more could be done in terms of providing support for Reservists returning from operations. There were procedures in place for occupational health departments to debrief personnel, for line managers to discuss relevant issues with staff, and generally to create an environment in which participation in the Reserve forces was encouraged. However, Mr Cash admitted that “there is room for more and I think that is why we have picked this up as an issue in our next phase of work, to really restate that we support this”.

118. We understand and appreciate the vital role which Reservists play in delivering the Armed Forces’ healthcare capabilities, and believe that they are an integral component of the DMS. We have seen ample evidence of excellent cooperation between Regular and Reserve forces, and believe that Reservists bring important skills to the Armed Forces. We also think that operational deployment gives members of the Reserve forces the opportunity to make use of their training when back in the UK.

119. The MoD must not take the integral involvement of Reservists for granted. It must make sure that recruitment remains buoyant and that retention is sufficient to guard against any degradation of capability. It must also ensure that members of the Reserve forces receive proper support, both from their civilian employers, and from the Armed Forces when they return from operational deployments. The public should recognise the contribution which the Reserve forces make to the military and to society as a whole.

92 Q 476 (Mr Cash)
93 Q 476 (Mr Bradshaw)
94 Qq 479-81
Conclusions and recommendations

1. We find the arguments in favour of the closure of the stand-alone Service hospitals irresistible. We accept that the reduction in numbers of personnel which took place in the Armed Forces after the end of the Cold War meant that there was insufficient patient volume to make the military hospitals viable in the long term (Paragraph 14)

2. The principle behind the decision to move from stand-alone military hospitals to facilities which co-operate with the NHS was the right one, from a clinical, administrative and financial point of view, and we see no evidence that the care offered to military personnel has suffered as a result. Indeed, we believe that Armed Forces clinicians now have experience of a much broader range of cases, which benefits their training. We also support the decision by the MoD to disengage from the Haslar site. (Paragraph 14)

3. It seems clear that there has been much inaccurate and irresponsible reporting surrounding care for injured Service personnel at Birmingham, and that some stories were printed without being verified or, in some cases, after the Trust had said that they were untrue. We condemn this completely. Editors have a responsibility to ensure that their newspapers report on the basis of verified fact, not assumption or hearsay. The effect of such misrepresentation on the morale of clinical staff and Service personnel and families was considerable. We consider the publication of such misleading stories as reprehensible. (Paragraph 29)

4. We acknowledge the progress which has been made at Selly Oak in terms of creating a military environment, to take advantage of the healing process of being surrounded by those who have been through similar experiences, to make patients feel comfortable and give them familiar surroundings. The MoD has made substantial efforts in this regard, and we look forward to hearing of further progress in the response to this report. The MoD must make sure that the issues of welfare for patients and families are central to its planning in developing its medical facilities in and around Birmingham. (Paragraph 34)

5. We also welcome the improvements in welfare provision and pay tribute to the work of welfare and charitable organisations. We consider that there is nothing intrinsically wrong in welfare and charitable organisations contributing to the support of our injured Service personnel. Indeed, quite the reverse is the case, since it builds on a proud tradition in the United Kingdom of linking the community with the Service personnel who have been injured fighting on their behalf. The MoD and the voluntary sector should engage openly with the debate about which services are more appropriately provided by the Government and which by charities and voluntary groups. (Paragraph 35)

6. However, we also underline the fact that many of the improvements set out above are relatively recent, and there has been a great deal of change over the past 18 months. The MoD should not be complacent: they have had to learn important lessons and it is clear that the picture at Selly Oak was not always so positive. Nor
should progress now stop, but the MoD should continue to learn lessons from its experiences in treating injured Service personnel at Selly Oak. (Paragraph 36)

7. We acknowledge the case for concentrating the main clinical and training assets of the DMS and DMETA on one cluster of sites. While Birmingham may not be close to a major Service community, we accept that it is suitable in terms of transport links and proximity to a university, both of which are important factors. However, the MoD needs to make its case for the Birmingham-Lichfield ‘dumb-bell’ more explicitly, and we expect the Government response to our report to set out in detail the plans and progress on this. The MoD and, where appropriate, the voluntary sector should also make sure that there are adequate travel and accommodation arrangements for families visiting patients in Birmingham, and, as important, that these are easily understood and accessible. (Paragraph 43)

8. The UHBFT/RCDM services are delivered at Selly Oak in buildings which are in many cases ageing. Delivery of the PFI development is scheduled to bring new, state-of-the-art buildings and facilities by 2012. We expect the MoD, as part of its annual reporting process, to state whether delivery on the Birmingham New Hospitals project is on target. (Paragraph 44)

9. We were very impressed by the services at the Regional Rehabilitation Unit we visited in Edinburgh and commend the staff for their excellent work. The MoD’s approach to musculo-skeletal injuries is forward-looking and sensible, and we are persuaded that it has been of significant benefit to Service personnel as patients, and to the efficiency and effectiveness of their units. (Paragraph 47)

10. We readily acknowledge the extraordinary work which is carried out at Headley Court and have nothing but praise for the staff, who have had to cope with an increased tempo of operations and treat patients with injuries which, only a few years ago, would have been fatal. We regard this as a good example of the Government and charities cooperating to provide those services which they can most appropriately deliver. We were astonished by the ability of some gravely-injured Service personnel to be successfully treated, and to return to active military duty. However, we are concerned by reports of problems with the local community in terms both of developing the facilities at Headley Court and of using local authority amenities. If it is true that some local residents objected to the presence of Service personnel, we find that attitude disgraceful. The Government should make the outcome of the current review into the facilities at Headley Court fully available, and should explain what planning it has done to account for the increased operational tempo and its implications for Headley Court. (Paragraph 54)

11. We are satisfied that the MoD and the Department of Health are aware of the management problems which the deployment of personnel from MDHUs poses for the Trusts in which they are based and that they are working in a coordinated way to minimise these problems. (Paragraph 57)

12. The principle which underlies MDHUs is a sound one. We believe that embedding DMS personnel in NHS trusts to work side by side with civilian clinicians is the best way to develop and maintain their skills, as well as providing an opportunity for
Servicemen and women to be treated in a semi-military environment. We were impressed by the MDHUs which we visited and are satisfied that they deliver high-quality care to military and civilian patients. (Paragraph 61)

13. The MoD and the Department of Health should address the sharing of best practice as a matter of urgency. More structured exchange of skills and techniques is in the interests of the NHS and Service personnel. We also consider it probable that the MoD, when working alongside forces from other countries, will learn lessons from differing approaches adopted by those other countries which could usefully be shared with the NHS. We expect the response to this report to explain in detail what steps will be taken to encourage this. (Paragraph 62)

14. We appreciate the strength of Service loyalties and the power of traditional connections, but we suggest that more needs to be done to ensure that MDHUs are representative of a genuinely tri-Service DMS. (Paragraph 63)

15. The priority in the treatment of injured Service personnel must be to return them as quickly as possible to operational effectiveness, so it is sensible for the DMS to use whatever mechanism delivers this objective most efficiently. The MoD should express more clearly the arrangements for 'fast track programming', and we are concerned that they are not fully or properly understood by all parties involved. (Paragraph 64)

16. Our visit to Scotland left us deeply concerned. It is unreasonable to expect any administration, whether in Whitehall or one of the devolved assemblies, to micromanage the agencies which execute its policies. But depending on guidance and taking a laissez faire approach to making sure that such guidance is implemented is totally inadequate, and reinforces our view that the issues confronting Service personnel and their families are not sufficiently high up the list of priorities for the Scottish Executive. (Paragraph 69)

17. We accept that plurality is an inevitable outcome of the devolution settlement. However, we are concerned that the provision of some aspects of healthcare in Scotland, for Service personnel and their families, is not always given the priority it deserves because of poor cooperation and communication. The MoD must review the structures through which it engages with other departments and administrations, and explain how it intends to improve the situation. We also expect the Scottish Executive to review its arrangements in response to our report. (Paragraph 70)

18. We welcome the Government’s extension of the priority access available to veterans in England. However, the MoD must explain clearly what it is doing in conjunction with the devolved administrations to ensure that this entitlement extends across the UK. It should also give a clear definition of who qualifies as a veteran and is therefore entitled to this treatment. (Paragraph 75)

19. We also acknowledge that the implementation of the policy will present some challenges in terms of privacy. However, the MoD and the Department of Health need to do much more to make sure that the entitlement to priority access is widely understood and taken up by those who need it. We do not believe that there is currently a sufficiently robust system for tracking veterans in the NHS, and we
expect the MoD’s response to this report will set out the Government’s thinking on how this could be improved. Simply to rely on the individual to bring his or her status as a veteran to the attention of a clinician, given some of the conditions which are common among ex-Service personnel, is inadequate and an abdication of responsibility. We believe that an automatic tracking system with an ‘opt-out’ provision would balance the need for robustness with the protection of individuals’ privacy. (Paragraph 76)

20. We remain concerned that medical records do not transfer as seamlessly from the Armed Forces to civilian life as they could. Too much is left to the initiative of the patient, and on our visits we heard that the existing system often works imperfectly. We recommend that the MoD re-examine its procedures with regard to medical records and examine ways in which there could be an automatic transfer of records and a more effective safety net for those who, for whatever reason, do not take the initiative in transferring or requesting records. We also ask the MoD to give us an update on the progress of its IT system, the compatibility with the NHS National Programme for IT, and its anticipated schedule for implementation of the new system. (Paragraph 79)

21. We believe that providing first-class healthcare for veterans, and making sure that people have confidence that they will be able to access and will receive such treatment, is an integral part of the debt which society owes to those who serve in the Armed Forces, and, as such, has an impact on recruitment and retention. (Paragraph 80)

22. We acknowledge that Service families posted overseas generally receive very good healthcare through sensible partnership arrangements. We are glad that the MoD accepts that its spending has lagged behind that of the NHS. It is essential that medical care for our Service personnel posted overseas should keep pace in every way with the NHS, so that they are not penalised for joining the Armed Forces. (Paragraph 83)

23. We doubt if the establishments in Cyprus and Gibraltar are clinically or financially viable in the long term. The MoD should make clear how it intends to address this problem and what options are being explored for maintaining healthcare provision for Service communities in a more effective and efficient manner. It should also set out a timetable for tackling this issue. (Paragraph 85)

24. We acknowledge that the healthcare of Service families in the UK is the responsibility of the NHS. However, the MoD has a part to play, and should be doing more to support Service families during the transition from overseas postings to reliance on NHS healthcare. There should be better cooperation between the MoD and health departments across the UK. The Scottish Executive also has a responsibility to improve its procedures in this regard. Providing this sort of support is a vital part of maintaining morale among Service personnel themselves and their families, which has such a profound effect on the retention of experienced Servicemen and women. (Paragraph 89)
25. We consider that the MoD provides adequate mental healthcare for serving members of the Armed Forces. We have been told on visits that there is a culture of individuals ‘bottling things up’ inherent in the Services, but we note with approval the steps which have been taken to attempt to prevent problems through ‘decompression’. This should be an integral part of the procedures for all personnel returning from operational tours. It is also important that the problems which can arise are recognised throughout the Services, so that early warning signs can be spotted and dealt with before problems get worse. We believe it is sensible to approach mental healthcare from community-based provision, delivered in conjunction with local military units, in-patient treatment being a last resort. The MoD should also review its contract with the Priory Group to assess its effectiveness. (Paragraph 97)

26. We welcome this additional funding, and pay tribute to the work which Combat Stress is doing. The MoD is right to engage with private organisations such as Combat Stress where that is appropriate, but it must continue to ensure that the organisation is adequately funded and has the clinical capability to deal with the patients who are referred to it. The MoD should also think more strategically about, and explain in their response to this report, their relationship with private and charitable organisations, and the extent to which they should provide services on behalf of the Government. (Paragraph 104)

27. We are concerned that the identification and treatment of veterans with mental health needs relies as much on good intentions and good luck as on robust tracking and detailed understanding of their problems. If the NHS does not have a reliable way of identifying those who have been in the Armed Forces, then it already has one hand behind its back when it comes to providing appropriate clinical care. We repeat our belief that there must be a robust system for tracking veterans in the NHS, and this should feed into enhanced facilities for addressing their specific needs. (Paragraph 110)

28. We understand and appreciate the vital role which Reservists play in delivering the Armed Forces’ healthcare capabilities, and believe that they are an integral component of the DMS. We have seen ample evidence of excellent cooperation between Regular and Reserve forces, and believe that Reservists bring important skills to the Armed Forces. We also think that operational deployment gives members of the Reserve forces the opportunity to make use of their training when back in the UK. (Paragraph 118)

29. The MoD must not take the integral involvement of Reservists for granted. It must make sure that recruitment remains buoyant and that retention is sufficient to guard against any degradation of capability. It must also ensure that members of the Reserve forces receive proper support, both from their civilian employers, and from the Armed Forces when they return from operational deployments. The public should recognise the contribution which the Reserve forces make to the military and to society as a whole. (Paragraph 119)
# Annex A: List of Abbreviations

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<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>AFF</td>
<td>Army Families Federation</td>
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<td>AMSTC</td>
<td>Army Medical Service Training Centre</td>
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<td>BFGHS</td>
<td>British Forces Germany Healthcare Services</td>
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<td>BMA</td>
<td>British Medical Association</td>
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<td>COB</td>
<td>Contingency Operating Base</td>
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<td>DCMH</td>
<td>Department of Community Mental Health</td>
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<td>DH</td>
<td>Department of Health</td>
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<td>DMETA</td>
<td>Defence Medical Education and Training Agency</td>
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<td>DMHT</td>
<td>Deployed Mental Health Team</td>
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<td>DMS</td>
<td>Defence Medical Services</td>
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<td>DMSD</td>
<td>Defence Medical Services Department</td>
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<td>DMSTC</td>
<td>Defence Medical Services Training Centre</td>
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<td>DMRC</td>
<td>Defence Medical Rehabilitation Centre</td>
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<td>DMWS</td>
<td>Defence Medical Welfare Service</td>
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<td>DRT</td>
<td>Deployed Rehabilitation Team</td>
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<td>GMC</td>
<td>General Medical Council</td>
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<td>GP</td>
<td>General Practitioner</td>
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<td>HIVE</td>
<td>Help Information Volunteer Exchange</td>
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<td>IRT</td>
<td>Incident Response Team</td>
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<td>IT</td>
<td>Information Technology</td>
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<td>JCRRP</td>
<td>Joint Casualty Reporting and Reception Plan</td>
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<td>MDHU</td>
<td>Ministry of Defence Hospital Unit</td>
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<td>MMA</td>
<td>Midland Medical Accommodation</td>
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<td>MMW</td>
<td>Military Managed Ward</td>
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<td>MoD</td>
<td>Ministry of Defence</td>
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<td>MRS</td>
<td>Medical Reception Station</td>
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<td>NHS</td>
<td>National Health Service</td>
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<td>Acronym</td>
<td>Description</td>
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<tr>
<td>PCRF</td>
<td>Primary Casualty Receiving Facility</td>
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<td>PCT</td>
<td>Primary Care Trust</td>
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<td>PFI</td>
<td>Private Finance Initiative</td>
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<td>PJHQ</td>
<td>Permanent Joint Headquarters</td>
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<td>PJOB</td>
<td>Permanent Joint Operating Base</td>
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<tr>
<td>PTSD</td>
<td>Post-Traumatic Stress Disorder</td>
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<td>RAF</td>
<td>Royal Air Force</td>
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<td>RAFA</td>
<td>Royal Air Forces Association</td>
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<td>RAMP</td>
<td>Reception Arrangements of Military Personnel</td>
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<td>RBL</td>
<td>Royal British Legion</td>
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<td>RCDM</td>
<td>Royal Centre for Defence Medicine</td>
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<td>RFA</td>
<td>Royal Fleet Auxiliary</td>
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<td>RRU</td>
<td>Regional Rehabilitation Unit</td>
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<tr>
<td>SSAFA</td>
<td>Soldiers, Sailors, Airmen and Families Association</td>
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<td>TA</td>
<td>Territorial Army</td>
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<td>TPMH</td>
<td>The Princess Mary Hospital (RAF Akrotiri)</td>
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<tr>
<td>TRiM</td>
<td>Trauma Risk Management</td>
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<tr>
<td>UHBFT</td>
<td>University Hospital Birmingham Foundation Trust</td>
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Annex B: Report on the Committee’s web forum

The Committee ran a web forum in two stages during 2007. The first stage began in May and was extended into June, while the second ran in November and was extended by a week into December.

The purpose of the web forum was to attempt to engage directly with Service personnel, their families and others, and to hear the views of those who would not normally submit evidence to an inquiry by a select committee of Parliament. The forum was advertised by press release and publicised to, among others, Service welfare groups, HIVEs, health organisations and unofficial Service internet sites.

The first stage addressed three main areas. These were the care provided for Service personnel injured on operations, the provision of healthcare for Service families at home and abroad, and the ways in which the Ministry of Defence and the National Health Service cooperate to deliver healthcare for the Armed Forces.

The second stage invited contributions on mental health, Reserve personnel, cooperation between the MoD and the NHS, and the progress of the inquiry up to that point.

The web forum was created by Parliamentary Information Communication and Technology (PICT) in conjunction with an independent consultant.

In order to contribute directly, interested parties were required to create an account. At registration, a set of basic terms and conditions were made available, as well as a clear explanation of the forum’s moderation policy. Once they had created an account, they received a username and password that allowed them to access and submit to the forum. Users were also able to read the posts and discussions without logging in.

During the course of the forum, Committee staff, with support from the Committee Office Scrutiny Unit, were responsible for ‘facilitation moderation’. The Chairman posted comments to facilitate discussions, asking for additional comments on an issue posted on the web pages, or introducing a new topic to move the discussion along.

The web forum closed in December 2007, but contributions can still be viewed at http://forums.parliament.uk/defence-medical.
Formal minutes

Tuesday 5 February 2008

Members present:

Mr James Arbuthnot, in the Chair

Mr David S Borrow Mr Brian Jenkins
Mr David Crausby Mr Kevan Jones
Mr David Hamilton Robert Key
Mr Dai Havard John Smith
Mr Adam Holloway

Draft Report (Medical care for the Armed Forces), proposed by the Chairman, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 119 read and agreed to.

Annexes (List of Abbreviations and Report on the Committee’s web forum) and Summary agreed to.

Resolved, That the Report be the Seventh Report of the Committee to the House.

Ordered, That the Chairman make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report, together with written evidence reported and ordered to be published on 22 May, 24 July, 9 October, 21 and 28 November and 11 December.

Written evidence was ordered to be reported to the House for placing in the Library and Parliamentary Archives.

[Adjourned till Tuesday 19 February at 10.00am]
Witnesses

Tuesday 12 June 2007

Ms Sammie Crane, Chief Executive, Army Families Federation (AFF), Commodore Toby Elliott RN, Chief Executive, Ex-Services Mental Welfare Society (Combat Stress), Air Commodore Edward Jarron, Secretary-General, Royal Air Forces Association (RAFA), Ms Sue Freeth, Director Welfare, The Royal British Legion, and Mrs Elizabeth Sheldon, Project Manager, In-Service Support, Soldiers, Sailors, Airmen and Families Association (SSAFA) Forces Help.

Thursday 21 June 2007

Ms Julie Moore, Chief Executive, and Dr David Rosser, Medical Director, University Hospital Birmingham NHS Foundation Trust.

Mr Terence Lewis, Medical Director, Plymouth Hospitals NHS Trust, Mr Andrew Morris, Chief Executive, Frimley Park Hospital NHS Foundation Trust, Mr Neil Permain, Director of Operational Services, South Tees Hospitals NHS Trust, and Ms Chris Wilkinson, Director of Nursing, Peterborough and Stamford Hospitals NHS Foundation Trust.

Dr Brendan McKeating, Chairman, Armed Forces Committee, British Medical Association.

Thursday 11 October 2007

Dr Christopher Freeman, Consultant Psychiatrist, Royal Edinburgh Hospital.

Dr J Gordon Paterson OBE, Chairman, St John and Red Cross Defence Medical Welfare Service.

Mr Derek Feeley, Director of Healthcare Policy & Strategy Director, Mr Geoff Huggins, Head of Mental Health Division, Healthcare Policy & Strategy, and Dr Nadine Harrison, Medical Adviser, Primary & Community Care Directorate, Scottish Health and Wellbeing Directorate.

Thursday 27 November 2007

Derek Twigg MP, Parliamentary Under Secretary of State for Defence, Lieutenant-General Robert Baxter CBE, Deputy Chief of the Defence Staff (Health), and Lieutenant-General Louis Lillywhite MBE QHS, Surgeon-General, Ministry of Defence, and Mr Ben Bradshaw MP, Minister of State for Health Services, Professor Louis Appleby, Mental Health Clinical Director, and Mr Andrew Cash, Co-Chair, DH/MoD Partnership Board, Department of Health.
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List of unprinted evidence

The following memoranda have been reported to the House, but to save printing costs they have not been printed and copies have been placed in the House of Commons Library, where they may be inspected by Members. Other copies are in the Parliamentary Archives, and are available to the public for inspection. Requests for inspection should be addressed to The Parliamentary Archives, Houses of Parliament, London SW1A 0PW (tel. 020 7219 3074). Opening hours are from 9.30 am to 5.00 pm on Mondays to Fridays.

The Commission for Healthcare Audit and Inspection

Mrs Ann McDonald

Dr Richard Ashton
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Oral evidence

Taken before the Defence Committee
on Tuesday 12 June 2007

Members present:
Mr James Arbuthnot, in the Chair

Mr David Crausby
Mr Adam Holloway
Mr Bernard Jenkin
Mr Brian Jenkins
Linda Gilroy
Robert Key
Willie Rennie
John Smith

Witnesses: Ms Sammie Crane, Chief Executive, Army Families Federation (AFF), Commodore Toby Elliott RN, Chief Executive, Ex-Services Mental Welfare Society (Combat Stress), Air Commodore Edward Jarron, Secretary-General, Royal Air Forces Association (RAFA), Ms Sue Freeth, Director Welfare, The Royal British Legion, and Mrs Elizabeth Sheldon, Project Manager, In-Service Support, Soldiers, Sailors, Airmen and Families Association (SSAFA) Forces Help, gave evidence.

Q1 Chairman: We welcome our witnesses. We are about to begin the first evidence session of our inquiry into medical care for the Armed Forces. We intend to hold several evidence sessions on this matter and make several visits. We are also in the course of doing a web forum and have just extended that forum. One of the ongoing threads in that web forum is criticism that it is stopping discussion. If you would encourage people to take part in the web forum it would be very helpful. Even if they want to have a go at me it would be a very good idea for people to get involved in the web forum. It is the modern way to find out things. We hope to publish a report towards the end of the year because this is an extremely important subject. Perhaps you would begin by introducing yourselves and saying what your organisation does and your role in it.

Ms Crane: My name is Sammie Crane, chief executive of the Army Families Federation. The federation works to make sure that army families are treated fairly, secure a fair deal and are represented in the decision-making process on policy and legislation.

Commodore Elliott: I am Commodore Toby Elliott, chief executive of Combat Stress, more properly known as the Ex-Services Mental Welfare Society. My charity looks after veterans of all three Services and the merchant navy who suffer psychological injuries as a result of service.

Air Commodore Jarron: I am Air Commodore Edward Jarron, chief executive of the RAFA Association. That is a membership association which offers comradeship and welfare. Approximately 10 per cent of its turnover is spent on comradeship and 90 per cent on welfare support for the Royal Air Force.

Ms Freeth: My name is Sue Freeth, director of welfare of The Royal British Legion. I am sure that many of you know of the work we do. The three pillars of our provision are: comradeship, remembrance and welfare. We provide a wide range of welfare activities for both the serving and ex-serving community.

Mrs Sheldon: I am Liz Sheldon, project director for in-service support at SSAFA. We provide a broad range of social welfare support for in and ex-service people and their families. We look after and help 50,000 people a year.

Chairman: I want to run briefly through the structure of the areas that I hope we will cover this morning so that if there is a particular subject that you want to deal with we will get to it at some stage. If there is not a particular subject that you want to deal with you can pop it into one or two of your other answers. We will deal with the following: medical care for operational casualties; rehabilitation for service personnel; healthcare for service families; care of service personnel after discharge; mental health; and the general role of the voluntary sector. It may well be that you believe you have something to add to what another witness has already said. Because there are five of you there is no need to come in on every question unless you want to add a nuance or give a different experience of the answer to that question. Let us begin with medical care for operational casualties.

Q2 Mr Crausby: The treatment of service personnel, especially those injured in operations in Iraq and Afghanistan, has been a matter of considerable public concern and debate particularly in the media. Turning first to the Royal Centre for Defence Medicine in Birmingham, can you tell us whether you believe that the principle of having a single receiving centre for casualties in an NHS acute hospital is the best way to deal with them?

Ms Crane: My name is Sammie Crane, chief executive of the Army Families Federation. The federation works to make sure that army families are treated fairly, secure a fair deal and are represented in the decision-making process on policy and legislation.

Commodore Elliott: I am Commodore Toby Elliott, chief executive of Combat Stress, more properly known as the Ex-Services Mental Welfare Society. My charity looks after veterans of all three Services and the merchant navy who suffer psychological injuries as a result of service.

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holistically in terms of looking after the emotional needs of patients and their families not only at Selly Oak but onwards.

**Q3 Chairman:** We will come to the care of service personnel after discharge.

**Mrs Sheldon:** This is in-service care.

**Commodore Elliott:** One cannot refute the priority that casualties must be given the best that is available in this country. If the surgeon general says that he cannot do it with his Defence Medical Services then we have no argument about from where it should come. If Selly Oak can provide it that is fantastic.

**Ms Freeth:** We have made two trips there in the past three months. I reiterate other comments here. We are very satisfied with the medical care being provided there. I believe that the therapeutic value of being in a military-managed environment is absolutely critical to the improvement and rehabilitation process and the care when casualties are evacuated. The interface with health and personal care for individuals whilst there is perhaps the point where further improvement needs to be made. At the moment healthcare is extremely good, but support for people who visit and for the individuals whilst there in terms of providing basic essentials is currently provided by charity which some of suggest is perhaps not appropriate. These are essential things like toiletries and clothing for people who have been separated from their possessions and travel assistance for visiting families. It is particularly difficult for single personnel. I think that those are areas where we encourage further consideration.

**Q4 Mr Holloway:** Do families not get rail warrants to visit injured soldiers?

**Mrs Sheldon:** They do. There are regulations which give help with transport and accommodation for seven days when the patient is either seriously ill or very seriously ill. Once the patient moves off that list public funding stops. One can imagine that it is very difficult for families travelling from one end of the country to the other, or from overseas, to visit patients. One has foreign and commonwealth families. Fijian and South African families come over and suddenly find themselves stranded in the UK because funding has stopped. That is where the charities are stepping in because public funding has stopped.

**Air Commodore Jarron:** I agree with the broad point that in order to provide the level of medical expertise that is required for battle casualties being part of a teaching hospital is the way to go. I do not think any of us would disagree with that. In terms of support for families, the Royal Air Forces Association is at the beginning of that process. We have been largely a veterans organisations and we are now focusing far more on current Royal Air Force support. Like The Royal British Legion, we are looking at ways to support people who have often been hauled off the battlefield, treated in theatre and then sent straight back. Little items like toiletry packs are things that we are starting to put in place.

**Ms Crane:** As to travel, the travel allowance that is given to families is supposedly for seven days initially. It can be and frequently is extended. It applies when someone is seriously or very seriously ill and once the individual is no longer on that list the amount of travel assistance available reduces.

**Q5 Mr Crausby:** Therefore, it relates to serious illness, not the seven days?

**Ms Crane:** The amount of travel assistance for families applies whilst service personnel are seriously ill or very seriously ill.

**Q6 Mr Holloway:** If someone who has not seen his family for ages gets hurt in Afghanistan and may die assistance is available for seven days, but if he gets better and is there for a month or two and is not in danger the family end up paying for it?

**Ms Crane:** Yes.

**Q7 Mr Holloway:** That is incredible, and it should be all over the press.

**Ms Crane:** I should like more clarification about when it does and does not, because when I have talked to them they have said they have extended the allowance whenever it has been requested.

**Ms Freeth:** Clearly, there are lots of people involved in advising individuals. For some people what is available in principle and what they hear about and are able to access therefore is too variable.

**Q8 Chairman:** Did you say that the allowance had been extended whenever the request had been made?

**Ms Crane:** Yes.

**Q9 Chairman:** So, people are not aware that they should be making the request to extend the allowance?

**Ms Crane:** That is my point. I have asked that there is more information about how families request that additional grant. The feedback we have had is that quite often people are very proud; they feel that they are asking for charity and it is not at the top of their mind. There ought to be a pamphlet or something giving that information.

**Mrs Sheldon:** There is quite a lot of confusion and a number of people are involved in trying to address the issue. But people at Selly Oak are pretty hard pressed in trying to see if they can extend people’s stay there. They could be looking at all sorts of different channels to get funding and assistance from the charitable sector, or perhaps welfare funding within the MoD. For the people who are trying to deliver the service, let alone families, it is very confusing.

**Q10 Mr Jenkin:** I am somewhat astonished by this. I always imagined that when a serviceman was injured and shipped back home there would be a single point of contact for the family. Whether or not it be home representation of the unit, there would be somebody who was the point of reference for that family and the red carpet would be rolled out. What is missing from that?
Ms Freeth: The CO is responsible.

Q11 Mr Jenkin: COs are usually pretty busy in theatre so that is not viable.

Ms Freeth: When a casualty occurs the provision for the family is exceptional. People are found everywhere and brought to wherever that soldier goes, whether it is to Germany—Ramstein—or Selly Oak. That is very successful, and heaven and earth are moved to make sure that the family gets to the soldier. What we are talking about here are days, weeks and months later when the soldier is not in such a critical condition and then the travel allowances reduce and confusion arises, but the initial stage is very good.

Q12 Linda Gilroy: Ms Crane, have you dealt with individual cases of that kind? Are you able to give us more precise examples of what you have said?

Ms Crane: I can access them and have been told about them. Very few families have contacted us to complain about their treatment at Selly Oak.

Q13 Linda Gilroy: One of the difficulties facing the Committee is that it hears about cases and it fully understand why people may be reluctant to come forward. But it would help us enormously if through your organisations people can contact us with examples of these things rather than just hearsay.

Ms Crane: What I am saying is that it is positive.

Q14 Chairman: You may be able to give us a case study, perhaps with the names removed if people wanted to remain anonymous.

Ms Freeth: Most of the cases we have seen are those involving single soldiers. They do not have those family arrangements. Those are the individuals in respect or whom we have been approached to help finance travel allowances. We have done that in a number or cases and I am sure we can provide details on those individuals.

Q15 Chairman: I want to come back to the issue referred to by Sammie Crane. She said that if there was a request the allowance would be extended. Have you been aware of that? If so, presumably you would say to the individual soldier that he should ask for an extension of the allowance.

Ms Freeth: That is not always understood in terms of the individuals. The unit welfare officer is dealing with the individual concerned. Inevitably, we send people back to challenge whether there is already something available for them, but they come back and are told it is not there. Maybe there is not enough information. The people who are assisting people in the whole process are not always the best informed, perhaps not for want of trying, and so it is still very variable.

Q16 Chairman: Therefore, the unit welfare officers are not aware that they should be extending the allowances?

Ms Freeth: In some cases I believe so.

Mrs Sheldon: One of the issues here is that from Selly Oak to Headley Court is not just a straight patient pathway; people dip into and out of specialist units and go backwards and forwards maybe from Selly Oak. It could take some time for them to reach Headley Court, if at all. It is very confusing for all the people who are trying to manage the process and communications and get clarity about entitlements and allowances. We have helped in instances where people, both single soldiers and families, have been sent to other specialist units and have needed help with transport, so we can supply information.

Q17 Mr Holloway: To go back to the point about people receiving this benefit if they are told about it, are we really saying that the main mechanism for looking after people when they are no longer critically ill is the dead wood in the rear party?

Ms Freeth: The unit welfare officer under the new SAM system is responsible for ensuring that local contact is maintained with the individual on his or her return, deployment or discharge. That will depend very much on the experience they have had. I do not know how much training they have received.

Q18 Mr Holloway: There is no quality control whatever.

Ms Freeth: I believe that the new SAM system for local control and involvement has been in place for less than 12 months, so perhaps it is a little early to challenge it, but it certainly needs scrutiny.

Q19 Mr Holloway: But not for families.

Ms Crane: I think it is slightly unfair to call them “dead wood”.

Mr Holloway: I was in the Army and I know that sometimes among the people who do those jobs there is dead wood.

Chairman: I entirely agree with Ms Crane that to talk about dead wood in the rear party is pejorative.

Q20 John Smith: I think we should stick to accurate and factual information.

Ms Crane: I am sideswiped by it because I rely so heavily on unit welfare officers. The SAM system is now in place and it is the CO who is responsible. Whether or not that works and is effective is a really important factor in looking after sick and wounded troops. It is critical that the resources and manpower are put in to support it so there is focus. It is true that we must have more focus on where individuals are. Interestingly enough, the reserves are doing it very well. They have a track and trace from Selly Oak on all those troops who are not fit for discharge. That has been very successful. I hope that the SAM system will produce a better method for families. We have discussed Selly Oak, but to my mind the area that we really ought to be looking at is discharge from that establishment before rehabilitation at Headley Court. That is the area of concern for most of us here.
Commodore Elliott: I sit on the defence medical discharge policy committee as the ex-service representative. I have watched the Army roll in the new sickness and absent management system. By comparison with the Y list that went before it, this is a fantastic step forward. I think it is too early to judge whether it is just a success or a great success, but it is a major change in the way things are going.

Q21 Mr Jenkins: I want to go back about 15 minutes to the discussion on the central unit. We decided to use a central unit for bringing back personnel. We know that teaching hospitals in London are fully occupied. Birmingham is approximately the centre of the country and Selly Oak is conveniently there. On reflection, do you think that the Selly Oak unit is the best location for the siting of that facility?

Ms Crane: It is the closest to the main recruiting areas and I think that is a major point for families. It also has good communication to and from it. Possibly the only weakness is the lack of military units nearby and therefore support to begin with has been confused, but I believe that has been taken on board by them.

Q22 Mr Jenkins: We do not want to base our garrisons in the south of England where we do not recruit anyone. We have had that argument. I fully agree with you. We need a garrison in the Midlands and more personnel there.

Ms Crane: Which you now have with Stafford which is very close to Birmingham.

Ms Freeth: In terms of relevant medical expertise Selly Oak has a great deal to offer. I think that the foundation trust is in the process of building new facilities and some of the shortcomings and future improvements could be taken into account in that redevelopment. An area that we are particularly concerned about is accommodation and recognition that some families and visitors will have to stay there for considerable amounts of time needs to be built in. At the moment I think that investment for that facility relies almost exclusively on charitable support. If this is to become a future centre of excellence and one point of contact for people returning it ought to receive government funding.

Q23 Mr Jenkins: The Government has put a tremendous amount of money into the NHS. If anyone says that we do not have the money for this service believe me he is using a different hymn sheet. I want to come to the MoD’s contribution later. Let us look at the facts rather than run off at a tangent. You say that Selly Oak is the right place to be? Ms Crane: I do not think that could be argued on the clinical side, but we need to look at what facilities are available for patients and families beyond the clinical aspects. We have been very closely involved in setting up temporary accommodation at Selly Oak and working with the MoD on leased flats on the hospital grounds that were originally very grotty hostels for doctors and nurses. We have paid for temporary refurbishment of those flats. It would be fantastic if public funding could set up accommodation within the new PFI build, but in the meantime—over the next five or six years—what will happen? This is where you can say that, yes, public funding should step in and try to find a better interim solution, but equally more use should be made of the agility of the charities to step in and help.

Q24 Mr Jenkins: When injured personnel come back what has been the process? Has the management at Selly Oak been able to deal with those casualties? How has it intermeshed them with its everyday work? Have you had any complaints about the reception and processing of injured personnel in Selly Oak?

Ms Crane: To begin with it was confused and shameful for a period of time. The way people were managed was poor. I am reassured by what has been put in place in the past six months, specifically the introduction of a senior officer in the hospital to liaise directly with the hospital and put chain-of-command control into what is happening there and how we work with the hospital. It is critical that we work very well with Selly Oak.

Q25 Mr Jenkins: So, has the military-managed wing been an improvement?

Ms Crane: Yes.

Q26 Mr Jenkins: Has that been a big step forward?

Ms Freeth: Yes. To sustain that will need continuous commitment. After all, that unit is a very small proportion of the overall Selly Oak budget.

Q27 Mr Jenkins: What concerns me and I believe one or two other Members of the Committee is the constant media coverage. Disgraceful stories have been run. When probed it has been found that the situation described has not happened and does not exist. It has a demoralising effect on the staff at Selly Oak. The NHS does not want the press to be critical of it. We have to fight our own media to get the truth out. Are these stories in accordance with what you have heard? How do some of these stories affect you as individual organisations?

Ms Freeth: I should like to encourage more openness and transparency about when these reported incidents come to light. We know that they are investigated. I think there needs to be more openness about what comes out of those investigations, namely that when there are mistakes we are told what has been done about them and, when they have been looked at and found to be erroneous, we make sure that it is better understood. As organisations we are trying very hard to educate our own membership and the people with whom we have contact to make sure that the true story is told, but individuals and the press are particularly keen to highlight failures in this area. In the past 12 months a number of us who have talked to the press have tried to focus their attention on other areas where we believe there are difficulties. They have been much less interested in drawing attention to that, which is disappointing.
Q28 Mr Jenkins: Therefore, when “The Daily Blurb” runs a story about a soldier being insulted and it is found to be fabricated and has no essence of truth do you believe that its front page story the following day will be “Sorry, we got it wrong. We lied to you again”? Do you think that will ever happen?

Ms Crane: No. In April we conducted a short-term survey asking families their views of the provision for wounded soldiers. The vast majority were concerned but 71 per cent said that their concern came from media reporting. That gives us a very graphic explanation.

Q29 Mr Jenkins: That is the struggle. We have to get it over on our website that people who complain about Selly Oak have never been there; they have read about it in the media. Imagine the effect that has on the families of injured personnel. There is a slanted story in the media. With the best will in the world, how do we overturn it? We conduct an inquiry and say that the story is untrue. That is not printed.

Mrs Sheldon: One wonders whether some of this could be ameliorated if there was clarity about support for patients and families, not just immediately but beyond. People’s perceptions can change. I am sure that initially people are so damned grateful to be in a safe bed and being looked after but as they start to recover and look around and rebuild their lives they begin to ask what else they can do. What can be done for them and how are their families coping? It is a matter of starting to think about getting the systems of support in place and it is clearly communicated. If they are not in place it will cloud people’s perceptions, rightly or wrongly. I believe that that is an extremely important matter that needs to be dealt with.

Ms Freeth: Individual expectations are very high. If they do not receive what they have been led to expect the disappointment factor hits very quickly, particularly if they have lost a career that they have wanted for many years and in which they have been successful. This is why we have to aim for 100 per cent because it is expected.

Q30 Willie Rennie: The military-managed wards are not just for military personnel. Although they are managed by the military they are mixed wards, are they not? Is that an issue for some servicemen? As I have heard from various health professionals and the military, do they prefer to be treated in wards with only their colleagues because only they know whether it happens at Selly Oak, but that practice is still prevalent in the NHS. I hope that our servicemen are not experiencing that if they go to other wards.

Q32 Willie Rennie: I am not quite sure I understand the last bit. Does one go into the military-only section by personal choice or is it determined medically?

Mrs Sheldon: It is based on clinical need.

Ms Crane: The priority must be the saving of life; that is what we all want. Any other consideration comes after that and therefore one must go for the best clinical care. But the majority of injuries will be in the orthopaedic ward. That is where the majority of casualties go and if they go into that ward they go into S4.

Commodore Elliott: As a serviceman, I have been to a military hospital where there have been civilian NHS patients. The experience of being on a ward with demented old ladies in adjoining beds is horrific. It was undignifying for them. I was terribly embarrassed about it. I experienced that in one of the Birmingham hospitals when I became a civilian. There comes a stage for every casualty when he or she is well enough and needs to be recovered into the military environment where he or she sits or lies alongside other veterans of the particular campaign and feels comfortable about that. They should not be with civilians at that stage unless they want to be. There is also the scandal of mixed-sex wards. I do not know whether it happens at Selly Oak, but that practice is still prevalent in the NHS. I hope that our servicemen are not experiencing that if they go to other wards.
Ev 6  Defence Committee: Evidence

12 June 2007  Ms Sammie Crane, Commodore Toby Elliott RN, Air Commodore Edward Jarron, Ms Sue Freeth and Mrs Elizabeth Sheldon

**Commodore Elliott:** I am not saying that, Mr Jenkins. I am saying that I have experienced being on a mixed-sex ward as a patient. It was undignifying for the civilian old ladies there, let alone what I felt about it.

**Q34 Mr Jenkins:** Was it last year?
**Commodore Elliott:** It was about four years ago.
**Ms Crane:** Do not forget that we have female wounded personnel.

**Q35 Chairman:** Ms Crane, earlier you said that 71 per cent of the complaints you were talking about were induced by the media. The Ministry of Defence says that it has received only one formal complaint, but if 71 per cent of the complaints you have talked about come from the media it implies that 29 per cent are based on something other than that. Can you rectify these different figures?
**Ms Crane:** I said that we ran what we call a short-term survey before the welfare conference held in April. We went out and asked families four simple questions. The first one was: “Are you concerned about the medical care provided for wounded and injured soldiers? Yes or no.” The majority, 84 per cent, said that they were worried, but when we asked why they were worried 71 per cent said that their concern came from media reporting. I am not talking about complaints but families’ perception of care.

**Q36 Chairman:** Where did the other 29 per cent come from?
**Ms Crane:** Fourteen per cent said that it came from information from friends and 15 per cent from experience.

**Q37 Chairman:** But there has been only one formal complaint?
**Ms Crane:** We have not had formal complaints.

**Q38 Chairman:** The Ministry of Defence says that it has had only one formal complaint. Can you explain that?
**Ms Crane:** I believe that there have been failings and early on particularly shameful ones, but a lot of the delivery has been successful. Selly Oak has saved a lot of lives. It is the post-operative period and the time after discharge that has caused the most upset for families.

**Q39 Mr Holloway:** How many of the witnesses think the media has been helpful? My impression is that people like Mark Nichol in the *Mail on Sunday* have been almost valiant in standing up for these guys.
**Ms Crane:** I think we needed more focus on it. Media attention does help, but it has been very difficult for the morale of families and troops.

**Q40 Mr Holloway:** Has the media attention led to improvements?
**Ms Freeth:** I believe it has focused attention where necessary and as a result of some of it there have been improvements.

**Q41 Mr Holloway:** So, that has been largely helpful?
**Ms Crane:** I deny that. I believe there was an internal battle in the MoD which was already tackling this and I am not as convinced.

**Q42 Chairman:** Mrs Sheldon, you said that you felt the media were concentrating on the wrong things.
**Mrs Sheldon:** I think that it ought to concentrate on the aftercare and onward management and support of patients and their families. There has been an awful lot of attention on Selly Oak and improvements have been made, but the focus should be on gaps in public funding to support families of patients for onward rehabilitation, not necessarily by the media but it is hoped by decision-makers.
**Ms Freeth:** I think that dislocation and disaffection start once they have left. The support they are able to receive at Selly Oak and access to services back in their own NHS areas is extremely variable. The individuals who are in contact with them and the ability to enjoy the support from colleagues—those with whom they are familiar and who understand them—is a major factor. How that is addressed is a real challenge. There is an expectation that the NHS can just pick it all up. To work that out will be a major challenge for the MoD and the NHS.
**Mrs Sheldon:** It is a risk because families will, if they are feeling unhappy and disaffected, go to the media. Recently, a family which had a high expectation that their son would go on to Headley Court but who landed up in a specialist unit were very disappointed and felt let down. One cannot talk about the rights and wrongs of that, but certainly expectations have been mismanaged, or they have failed to understand what would happen. As a result, they went to the press.

**Q43 Linda Gilroy:** Commodore Elliott mentioned his work on the discharge medical policy committee and some new arrangements.
**Commodore Elliott:** This is the Army’s sickness and absence management system.

**Q44 Linda Gilroy:** That is very new. Will it address the sorts of issues we have just heard, or do other things need to be taken on board to improve that?
**Commodore Elliott:** There is a stage where the wounded casualty will be discharged back to his home whilst he waits to become fit to go back into service or awaits the medical discharge procedure. That is a very dangerous period. Under the old Y list system soldiers were lost to the system; they were forgotten and felt neglected. We have on our books veterans who have been through the Y list and have developed severe and enduring mental health problems which have been caused by being lost in the system. The sickness and absence management system is designed to prevent that happening and I applaud it. I am quite convinced that if it is made to work and the right resources are allocated to it the system will stop a lot of this happening. Having listened to what Mrs Sheldon has said, I believe there is a stage beyond service that we need to consider more than we have so far. Quite recently, we heard
from the director of the Army Welfare Service about additional people who had been allocated to look after very seriously damaged people who have been discharged from hospital. They have run their cases until they are back in their own homes, wherever they happen to be, and when they come up to medical discharge. He also talks about looking after them as veterans, but when you challenge him he says that normally the service looks after veterans until two months after discharge and the absolute maximum is about two years. I think there is a lot of work that ex-service charities need to do together with in-service people to look at life beyond those two months. Frankly, he will not have the resources to manage these cases for the rest of their lives. There is a wonderful challenge there for all of us to work together. I believe this is something that the service community, including the ex-service community, should do. We can look after our own; we have a lot of resources that can help do that.

Q45 Chairman: Commodore Elliott, am I right in thinking that people present to Combat Stress on average about 15 years after they have been discharged from hospital?

Commodore Elliott: Last year we had nearly 1,000 cases. The average length of service was 11 years. We have a lot of very experienced and battle-hardened veterans coming to us, but, sadly, they are not being attracted to us until on average 13 years after discharge. Therein lies a real challenge in service as well as after it to try to pick up these men and women much earlier, because the earlier they are picked up the more effective the help we can give.

Air Commodore Jarron: One area that we are looking at now is how we can give better support to those who are about to be medically discharged. They have had treatment and then go home; they are split from their unit and have no local support. The medical discharge process can take anything up to six months. There is a long void when there is no support whatsoever and it is an area that we are picking up increasingly.

Chairman: Perhaps we may come to that in a few minutes. That is a crucial area on which we want to concentrate.

Mr Jenkins: The difficulty is that we started to shut down the defence hospital units and put them into the NHS. We have now had some experience of this, albeit an unwanted one in view of the number of people coming back wounded. Given that choice and your experience, was it the right decision to put the provision into the NHS? The turnover of clientele and the level of experience can never be matched by defence hospitals. If it was the right decision, can you now see a future for others as well, which is important? What mistakes were made? Is there a catalogue of mistakes? We are trying to find out the truth rather than urban myths. Some people run around with gloom and doom. There are good things and bad things. Let us make sure we get rid of the things that are not good before we extend this programme anywhere else. I want to find out whether it is getting better. Can we have military-managed wards? We may have only one severe burn victim but four beds. It may be impossible to deal with it unless we have four. A smaller number means that given the specialist set of clinical skills we will never get them in, but as soon as we can get them together we will have a ward for military personnel and we can manage that ward. What lessons if any can you offer us? We will go to Selly Oak and ask about their experience. If you have any facts with which you can supply us we would be very grateful. What lessons have we learnt?

Q46 Chairman: Could that be split into two questions? The first question is: was it the right decision to go to Selly Oak with the gloss of military-managed units? The second question is: what lessons should we have learnt from it? First, was it the right decision?

Mrs Sheldon: I do not think it was the right decision at the time because nobody could foresee or build into the planning assumption the number of operations that would be carried out. Let us not forget that Selly Oak started off as a teaching hospital for military medics. They have worked very hard to improve it. That were big mistakes made; but the good thing is that the clinical resources are now centred on the need. That is the right decision but it has come about in an unfortunate way.

Q47 Chairman: It was a wrong decision but it should not now be overturned?

Mrs Sheldon: Yes, absolutely.

Ms Freeth: I believe that it is the right way to go. We do not have access to all the figures. Will one centre there be enough?

Air Commodore Jarron: Clinically and financially, it is very hard to criticise the decision to go there. There is a big emotional issue here. Servicemen like their own things; they love their own regiments and comradeship is very much part of what service is about. Interestingly, at this year’s annual conference there was a resolution moved by a veteran that we should approach government to re-establish our military hospitals in support of our men. It failed because practical arguments were put forward. Nevertheless, there is a very big issue about the emotional wellbeing of these people. It is exactly the right business decision, but what we have to do is make sure that we do not throw out the baby with the bathwater and lose the emotional support that is so important.

Commodore Elliott: We are rather too far down track to go back. I think we have shut the last military hospital. It is interesting that we are about the only country in the western world that has a system where we rely on the NHS to look after our servicemen and women and veterans. The alternative model seems very attractive to me because you end up with a quasi-military environment which is so good for both in-service people and veterans who in the old days went into the military hospitals when there was enough room for them. They gained a huge amount from that.
That is not available to us. I suspect that if we look back at what happened over the past couple of years at Selly Oak we were caught out, but I believe that this is a question for the surgeon general and defence medical services rather than us. We have gone forward quite a bit since being caught out, and from what I have been told I am quite convinced that Selly Oak will be good news in future.

Ms Crane: I agree with what Ms Sheldon said earlier, but this goes wider than just the treatment of those who suffer wounds from operations. A big complaint that comes in all the time is access to medical care for those now serving in the Army who need minor operations to get fit to go back on exercise. That is where the draw-down of the military hospitals is having greatest impact. That applies also to those who are discharged from Selly Oak having had a high level of clinical care and need somewhere to convalesce before they can go on to Headley Court.

Q48 Chairman: Let us turn to the second question about the lessons learnt.

Mrs Sheldon: One thing I have picked up—this is purely anecdotal—is the strain and stress of military and NHS staff at Selly Oak in becoming used to each other’s working practices. For some NHS staff the sight of some of the casualties who have been dealt with has been pretty horrific and traumatising. Taking things forward, one needs to think about the way they are supported. Turning to patients and their families and taking it forward, the question is how best they can be supported emotionally through the journey back to full recovery, or perhaps into a new life in the civilian community, making sure it is properly supported throughout. One can say that the SAM system is a great improvement, but it is also a matter of making sure there are people who are able to help these families in a personal way. The numbers are not particularly big, but, by golly, the problems they have in coming to terms with it are tremendous. Therefore, I think it is absolutely critical to make sure they have someone who almost helps them along that journey.

Ms Freeth: I do not believe one can separate health and social care particularly at Selly Oak. People need all of the information to travel with them right the way through their journey from Selly Oak and on to where they are being referred. That is not happening. We need to learn a lot from that. We need to design in the fact that this is a special place and there is a need for training and support for staff. We also need unusual things one would not expect to have elsewhere that must be planned in for the future rather than thought about afterwards, because they create unnecessary unpleasantness and difficulties for everybody involved. We need to continue independently to evaluate the quality of the service there.

Air Commodore Jarron: It has largely all been said. Fighting the war and winning is relatively easy; what matters is what comes behind it. We have found that elsewhere. It is the long-term recovery process that needs our attention.

Commodore Elliott: I agree with that, but I also pick up Ms Crane’s point about the other injured and ill servicemen who await treatment in the NHS. I have attended a naval medical board of survey. Two of the five case I heard whilst there indicated that these people had waited a huge amount of time to get treatment in the NHS. I suggest that the Committee could take evidence from the MoD about how much down time there is among servicemen awaiting treatment in the NHS which they would not have had in the service hospitals.

Q49 Mr Holloway: You said that people presented 13 years afterwards. I believe that following the Falklands there were 300 suicides and numerous suicides among special forces from Gulf War 1. My understanding was that if you had a bad day it was best to get people back with military people as soon as possible. Do you think that the separation of people from the system and their unit is storing up further problems for us in future?

Commodore Elliott: Most certainly, in the context of mental health we are very interested in whether or not we should be bringing serving soldiers, who are in the sickness and absence system, into the society’s work to prevent the bad day you are talking about. As to the suicides which have been quoted in the press in the past few days, it needs to bottom out. We do not really know how many of the Falklands war veterans have committed suicide since.

Q50 Mr Holloway: Is that not part of the point?

Commodore Elliott: I am keen to do this if no one else is. We need to create a roll of names to be provided by the veterans themselves so we can say whether or not this is true. Veterans are quite upset that the system does not seem to believe them.

Ms Freeth: Suicide research is going on at the moment and we need to learn quite a bit from it. At the moment evidence about the causes is inconclusive.

Q51 Mr Holloway: This is not about verification but about our responsibility to these people who have experienced these things. There have been numerous wars in the past few years. It sounds to me as if we will have a big problem 13 or more years down the line if we carry on in this particular vein. We are not thinking ahead, are we?

Ms Freeth: We can certainly see a growth in people presenting for a whole series of different reasons. All of the charities provide an opportunity which we see benefiting people when they come back into contact with others; they have some direct experience. That familiarity is absolutely critical, but it is not always possible to provide the best care close to the unit.

Q52 Mr Jenkin: We have spoken at length about Selly Oak. The Committee will visit Headley Court and Selly Oak in due course. What is your experience of other Ministry of Defence hospital units? Do you have anything important to say about them?
Commodore Elliott: There are not any.

Mrs Crane: Are you talking about overseas?

Q53 Mr Jenkin: Cyprus, for example.

Mrs Crane: My report would be based purely on the family perspective of care for families overseas and what is happening there. Do you want that to come into this discussion?

Q54 Chairman: Yes.

Mrs Crane: Suitable pay for civilian medical and dental practitioners is an issue for families, particularly in Germany where recruitment has been difficult. That leads to lack of continuity for family medical care which is the MoD responsibility overseas. The same goes for dental care overseas. Those are the kinds of issues of which we have experience at the moment.

Q55 Chairman: We are also talking about units at places like Frimley Park. Are there any comments on other military units in hospitals?

Mrs Crane: I should like to pick up the question of healthcare provision for families overseas.

Chairman: Let us leave the question of families overseas. What about other military units?

Q56 Mr Jenkin: What about Northallerton and Peterborough?

Ms Freeth: In terms of the NHS services for which there are contracts for service healthcare, one bit of feedback is that some people have to travel a long way to access that care. I believe that there are six contracts in place at the moment in NHS services specifically for serving people. There do not appear to be enough of those to enable people to have easy access. It does not appear that the ability to receive sensible treatment that will get people better as quickly as possible is delivered under the current six contracts.

Q57 Mr Jenkin: I think we have already covered this question, but, in case there is anything that you want to add, do you have any concerns about the care that service casualties receive in theatre and during evacuation?

Ms Crane: I think that it is far more successful now than in the past, and well done on delivering it.

Q58 Mr Holloway: Obviously, all the witnesses agree that rehabilitation care has improved over recent years. Where do you think we are with that now, and what further improvements can be made?

Mrs Sheldon: I think that Headley Court is doing a fantastic job, but again the wider, holistic issue is to make sure that patients can support each other and keep family units together at a very important time in their lives. That is something which up until now has not really been properly looked at. At Headley Court there is limited temporary accommodation in the grounds. There are refurbished family quarters which will happily house one family but perhaps not two or three. Sometimes they have to squeeze in people. There is also a small house in the grounds which has a dozen rooms suitable for single person accommodation where service people have generally gone to practise their skills on new equipment and so on. At Headley Court it is really important to have the families with the patients to help them rebuild their lives. That sort of infrastructure is not in place. Again, where necessary we provide charitable funding to help them set up accommodation nearby, but ideally that is something which public funding should provide.

Ms Freeth: There is a short supply of medium-term rehabilitation for people with complex injuries who will need assistance for 18 months or possibly two years and who will not stay at Selly Oak but, it is hoped, go back to their locality. As a service provider of homes we have been approached and over the past five years have taken in some four or five individuals who have stayed with us two or three years. One of our homes specialises in being able to provide support, because we have physio and occupational therapy on site. We have larger numbers of individuals to come through—that looks like a possibility—it would be difficult to find the resources to cater for those people certainly together. It is likely that they will go off to a unit that may have no military input or connection with, or little experience of, long-term military rehabilitation. Looking at the numbers, we do not have enough information as to whether this perhaps should be a new service, but medium and long-term rehabilitation is in short supply. In the NHS it is difficult to get access to day rehabilitation services.

Q59 Linda Gilroy: In terms of the provision of medical care, how well do you think service families are looked after when they return to the UK from overseas postings?

Ms Crane: For most families returning from overseas and moving round the UK the biggest issue is dental care. It is an issue for the whole country. Government tells us that it should improve within the two-year timescale of the new contracts, but for us it is a much bigger issue. We move every two years, so by the time we have found an NHS dentist we are on that waiting list and perhaps are getting close to some sort of care we are moved again and have to start from scratch. It is not a list that is transferred from one practice to another. An additional issue—I do not have a lot of evidence to support it—appears to be that if there are two serving parents, of which there are an increasing number, their dental care is with the MoD and dentists will not sign on children without a parent in a dental practice. That group has a specific issue. Families do not have a problem accessing NHS doctors; we have not picked up an issue in that regard. Sometimes it takes a while to work out where you are when you have just moved, but we believe that a lot of NHS doctors are rather bemused by us. I have had conversations on it. They see us as a rather vulnerable group living in isolated locations. We are not necessarily the same as the rest of the population during this period of high operational tempo. We believe there is a high rate of antidepressant
prescribing which arguably takes place quite quickly rather than after careful consideration. We have considered doing more research on it, but it is a very difficult area to delve into. I certainly do not suggest that all army spouses are manic depressives; we are a very strong bunch.

Q60 Chairman: You are a fascinating and very difficult combination of great vulnerability and self-sufficiency.

Ms Crane: And where we are located has a big impact on it. We reflect in urban areas the number of families that can drive. We have a lot of families living in isolated locations that cannot drive. They are supposedly married, but are single parents and therefore have problems accessing medical care in some cases. Unit welfare officers, who are my heroes, often—

Mr Holloway: I was not criticising any of them but just making the point that a guy who does not tell someone that he is entitled to a travel allowance is dead wood.

Q61 Chairman: I think we have gone into that enough.

Ms Crane: But they do help and during operational deployments they organise assistance for families. At the end of last year I was at a coffee morning and I asked a spouse what she had been doing during the deployment. She said that it had been a difficult pregnancy and she had to get the bus to Salisbury three times a week but it took seven hours. She was only in Larkhill and so was fairly close. I told her that the unit would have helped her and she said that she thought she had to do it. Some of it is our own fault, but how doctors perceive us is a problem. Medical notes also do not follow us very quickly; we do not have access to them. We do not seem to have enough. We need to look out for to provide better support for them.

Mrs Sheldon: I should like to broaden the discussion to the emotional side and the impact that all of these issues can have on relationships. It is a matter of making sure that families have access to professional and independent counselling support which has continuity to help them through some emotional issues can have on relationships. It is a matter of

Ms Freeth: One concern is that the families of former commonwealth soldiers, who are now some six per cent of the force, are entitled to medical care when they are here, but not to other statutory support in the same way. We find an increasing number of complex cases where everyone around them has been unable to assist. That is certainly a group of people we need to look out for to provide better support for them.

Q62 Robert Key: I have experience of a number of cases in Salisbury. The Ministry of Defence has always argued that if you are starting a cycle in Salisbury and are then posted, overseas, for example to Germany or Cyprus, it will fly the wife back to complete the cycle. Is that not the case?

Ms Crane: I think that is the case. The MoD is helpful in those circumstances. The majority of moves are within the United Kingdom. Remember that we are way off the scale compared with the national average for moving outside a local health authority area.

Chairman: You are talking about many of the same issues that came up during our inquiry into the education of service children.

Q63 Linda Gilroy: I believe that my colleague Mr Key will return to the issue of dentistry which is probably highest among the issues that you have mentioned. Do you have any good examples of primary care trusts that have taken particular interest in any of the transitional issues you have mentioned?

Ms Crane: I am ashamed to say that I would probably hear the least where it is most successful. I do not hear an enormous amount about this issue. We are here to discuss it and therefore I will tell you what I know, but generally I think it is working relatively well other than in the dental area and in specialisms such as IVF.

Ms Freeth: One concern is that the families of former commonwealth soldiers, who are now some six per cent of the force, are entitled to medical care when they are here, but not to other statutory support in the same way. We find an increasing number of complex cases where everyone around them has been unable to assist. That is certainly a group of people we need to look out for to provide better support for them.

Mrs Sheldon: I should like to broaden the discussion to the emotional side and the impact that all of these issues can have on relationships. It is a matter of making sure that families have access to professional and independent counselling support which has continuity to help them through some emotional aspects associated with service life which has its own distinct pressures. These things are very complex and cannot always be solved within a two-year posting.

Q64 John Smith: I want to return to IVF. How big a problem is access to IVF for service families? What about access when one is posted overseas, not when one has started treatment and comes back to continue it? Is it a problem?

Ms Crane: I would have enormous difficulty giving you the scale of it because I can go on only those who report it to me. I presume that IVF rates in army families are comparable with the rest of the population. I would have to look back at those statistics. Obviously, where it does not work it is emotive and is a problem. It is a matter on which families approach us. I know that hospitals overseas have provided it as and when they can and generally quite successfully.
Q65 John Smith: Is there any evidence that access to IVF treatment is causing particular difficulties for service families and results in either the break-up of families or the premature termination of service in order to access these medical services?

Ms Crane: I think that it is ongoing treatment that is important. Let us assume one has decided that one wants IVF treatment. Quite a long process is involved. It may be that an area does not want to take on the case because it knows one is moving; it may be that one starts and there is a posting and one cannot finish the treatment. I do not think that the problem lies so much in initial access; the issue is one of ongoing access.

Q66 John Smith: Is there any evidence that there is a difference in access to services, not just IVF but other treatments, as between commissioned officers and other ranks? Are commissioned officers turning more to private treatments because they may be in a financial position to do that because of inadequate access to therapies such as IVF, including dentistry? Is there any such evidence coming through to service family associations and other organisations?

Ms Crane: I have no evidence that that is so other than in the case of dentistry. I know that a high proportion of officers have sought private dental treatment.

Q67 Robert Key: It is perfectly clear that a lot depends on where the service family ends up living. Sometimes one may find oneself in a very large military garrison like Tidworth or Catterick where defence medical services, for example GP services, may be available, but that is quite rare, is it not? Do you think there should be special arrangements—fast-track facilities—for service men and women and their families to access NHS physicians and dentists?

Ms Crane: I would like to see some way in which families can access—never mind a fast track—dentists and specialist therapists on moving, especially those with special needs who have an additional difficulty in this area.

Q68 Robert Key: Given there is no question that there is a huge shortage of NHS dentists, particularly in areas around Salisbury Plain garrison which I know best, do you think it would be a good idea to explore the Ministry of Defence helping to fund private dental treatment, which after all is what most of the population has been forced to do under this Government?

Ms Crane: I think it would be wonderful.

Ms Freeth: We would support that. Obviously, we see veterans. One of the difficulties is the huge mismatch between what people are entitled to when serving, and certainly when they are injured, and what they are entitled to when they leave and become veterans. That difference creates some of the dissonance. We would like to see those services being extended at least for some period whilst individuals are veterans.

Q69 Robert Key: I want to ask about wider health provision for families. Health is not just about sore toes or tonsillitis; it extends into areas of family health including education where there are services for children in local primary schools with, for example, ADHIT and also to social service support where you have a large number of broken families and marriages and the care of children, the burden of which falls on local authorities across the country. Is that a particular problem on which you have views?

Ms Freeth: Those are not areas in which we have had problems brought to us and on which we can report.

Commodore Elliott: I have noticed that in our work we receive more and more calls from carers of soldiers who are extremely worried about their husbands and need quite a lot of advice from us because they are frightened to go to the in-service provision that has been made for them, normally because it is the soldier who does not want to indicate to the authority that there is a problem caused by his psychological injury. We are just rolling out a new service, which we will fund ourselves, to help families of our veterans and that will open up the service to in-service people even though it is not strictly speaking our bailiwick.

Mrs Sheldon: This is one of the areas in which we are very heavily engaged in providing professional social work support to families in Germany, the UK and across the world. We are receiving a lot more calls for help from families that have a lot of pressure because of relationship and emotional problems. It is not just a problem affecting the spouse or partner; it affects the children. There are very serious issues in terms of child care and also mental health problems.

Ms Freeth: In other countries health monitoring of families is available and used. Certainly, I think this is an area that should be considered. Obviously, it is a difficult area but it is important to be able to catch these sorts of issues as early as possible and to respond to them. We know that according to the King’s Fund study of individuals that is being done there is an alarming dependency on alcohol, not necessarily understandably. That also has an effect on family life. Health monitoring is critical. At the moment all we have is a commitment to a short-term piece of work that has been extended, but I believe that it should be a permanent part of the bailiwick.

Mrs Sheldon: This is where a close relationship between the specialist agencies and the unit welfare officer and units on the ground is essential. A unit welfare officer is not trained to spot the symptoms of big problems that arise. Although secondary care within Great Britain is provided by the Army Welfare Service there is still a need to turn to specialist agencies that can help. It is absolutely critical to have people who are trained and are agile enough to spot where problems arise sooner rather than later. There is patchy provision across the MoD in the sense that each service has its own way of providing welfare support. The RAF uses professional social workers, for example, and the Army employs people within the chain of command. There must be a holistic approach. One must be very
careful that one moves initially from the command as the point of contact to the specialist agencies so there is consistency.

**Q70 Robert Key:** Perhaps we may turn to the provision of health services for families abroad. SSAFA has given us evidence that growth in the defence medical services has been less than half that in the National Health Service as a whole. There has been an increase but it is not as great. Another way of putting it is that it is falling behind. Has that impacted on service families abroad? What is your perception of the provision of healthcare to families posted abroad?

**Ms Crane:** I touched on this earlier. There is at the moment a real problem about the provision of doctors and dentists overseas. It all comes back to the fact that the MoD is not signed up with the NHS and the funding comes through the Ministry of Defence. There is no obligation or capability of providing the same facilities overseas as in this country. Much of the facilities overseas are really good, and I have had experience of them in several countries. I have been very grateful for that very familiar and close-knit arrangement, but the lack of doctors means that there is not that continuity of care or empathy from one person. The employment of locums has an effect on the local budget which makes it even more difficult to provide services. That is one of the big issues I raise.

**Mrs Sheldon:** I support Ms Crane. Obviously, what one does is try to provide a service that matches the standards of the NHS. There is an obligation to meet those standards, namely that an adequate number of people are there to provide that service within the community in mainland Britain?

**Q71 Robert Key:** The answer is that in this country local primary care trusts are funded per capita to include military personnel and their dependents, but that does not happen overseas.

**Ms Crane:** But not military personnel because they are not part of NHS funding.

**Ms Freeth:** That is the main issue.

**Mr Jenkins:**: I thought we were comparing it with overseas.

**Mr Jenkins:** The overseas argument is a different one. But in locations in Britain the PCT has a duty and responsibility to provide GPs, dentists and so on. They have been very successful in managing to fund extra dentists in my area, so we do not have a problem with NHS dentistry. Why can they not do the same here? It is a matter for the PCTs; they are the ones who put the contracts in place. Therefore, if your PCT is not doing it someone should start asking why not.

**Q74 Mr Jenkin:** Ms Crane, you have raised a very interesting question. Should not the Ministry of Defence have its own PCT and ring-fenced NHS funding to spend on servicemen and women and their families wherever they may be, whether they be at home or abroad? Then we would not have the problem of competition. By placing so much emphasis on the National Health Service as it is we have put servicemen and women and their families in competition with all the other resources in the NHS. I think that most of the public regard that as unacceptable. Do you agree?

**Ms Crane:**: I would love to look at it.

**Ms Freeth:**: Certainly, with the devolution of spending in particular areas it is very difficult to lobby PCT or authorities to address the needs of their service communities. They are not willing to do that. We need a national arrangement to make sure everybody gets the same quality of support, because at the moment it is very difficult. Each of us would have to lobby individual parts of all of the PCTs and all local authorities and that is simply not something of which we are capable to make sure things are delivered.

**Q75 Robert Key:** When a family hears that it will be posted overseas, are there some places in respect of which it says, “Great! They have wonderful medical services”? If so, which are those places? Do they sometimes groan and say that they do not want to take their families there? If so, name them, please.
Ms Crane: That is a bit unfair out of the blue because some of my information is rather old. A lot of families that go to Germany will say, “This is great.” That is why the reduction in the number of medics there has been so difficult for people. The level of delivery of the Army Medical Service in Germany and Cyprus has been very good. I had experience in Brunei. I had babies in Brunei, Hong Kong and places like that and it was great.

Q76 Robert Key: Which are the places that give rise to a groan? The defence medical services overseas are all wonderful, are they?

Ms Crane: I think it depends on what you want. I do not have a lot of evidence about the Falklands, Belize, Batusi, Brunei, Nepal and Naples. I do not know the detail of each one.

Q77 Willie Rennie: What is the view of health services for military personnel in Scotland? Do you have any evidence of differences between England and Scotland or even Wales?

Commodore Elliott: I have an opinion about Scotland with regard to veterans and mental health. Of all the administrations the Scottish Executive is the most forward thinking in dealing with mental health in the community, including veterans with mental health problems. I get most excited about the discussions that we are having at the moment with the Scottish Executive. In Wales the head of the mental health policy unit believes that veterans should be treated the same as everyone else; in other words, there is no difference. The same is true of Northern Ireland where because of security issues there are problems to which home service veterans are very sensitive. We are going through a process of work in partnership with the MoD during which the funding arrangements for the work we do with veterans will be transferred from the MoD, where under the service pension order we get some of our war pensioners treatment funded—that system avoids a postcode lottery; it is exactly the same for veterans will be transferred from the MoD, where under the service pension order we get some of our war pensioners treatment funded—that system avoids a postcode lottery; it is exactly the same for veterans. I am extremely nervous about going down that route. I quite like Mr Jenkin’s idea that it should be applied to the work of my charity. I would like to have a top slice and my own budget which avoids all of these difficulties and can get on with our work, which is to look after veterans who are very ill and in desperate need of help without having to worry about that.

Q78 Mr Jenkin: We are coming on to ex-servicemen and women. At the moment, what responsibility does the Ministry of Defence demonstrate for the health and welfare of ex-servicemen and women?

Q79 Chairman: Perhaps I can bring you back to the precise question asked by Mr Jenkin. What role does the Ministry of Defence demonstrate in looking after ex-servicemen?

Ms Freeth: Its role is to provide a pension and information service. It does not provide services to veterans in terms of health and social support.

Q80 Mr Jenkin: Has the presence of a minister for veterans made any difference?

Commodore Elliott: Going back to my experience of sitting on a veterans’ forum—which was chaired by the Minister for Veterans on Friday—he meets with veterans’ representatives, that is, the executive of COBSEO and one or two others and representatives of other responsible government departments and those for Wales, Scotland and Northern Ireland.
There are civil servant representatives of the ministers. There is something called the Minister for Veterans task force which seems to have fallen into disarray, or it is not meeting very regularly. I think that the Minister for Veterans is finding it very difficult to get the other government departments to engage to the extent he would like in a co-ordinating role to ensure that veterans get the visibility they need.

Q81 Mr Jenkins: What role should the Ministry of Defence have in providing healthcare for veterans? Commodore Elliott: Healthcare?

Q82 Mr Jenkins: We are talking particularly about healthcare in this inquiry, but if you want to make a broader point do so.

Commodore Elliott: The answer is that the Ministry of Defence has made it quite clear for many years that veterans’ healthcare is provided by the National Health Service. It is absolutely adamant about it and we cannot move the department on that. There is very little that it can do. It has made some arrangements for TA casualties with mental health problems to go to the defence medical services for an assessment and maybe a little bit of treatment, but that is about it.

Ms Freeth: The minister has pressed for the delivery of priority treatment for war pensioners by the NHS, but the ability to leverage that systematically and consistently across the country does not appear to be possible. The legion would like to see the minister ensuring that veterans do get the treatment to which they are entitled and were promised.

Q83 Mr Holloway: Fifteen years ago for a television programme I spent three months living homeless in London. There were a lot of ex-servicemen, admittedly some of the national service generation. How much evidence is there that there are large numbers, or any, homeless ex-servicemen now? Commodore Elliott: About 10 years ago an ex-service action group on homelessness did a study and found that one in four of those sleeping rough in London were ex-servicemen. A study which is about to report indicates that that is down to six per cent, which is a pretty good achievement. The MoD has played a large part in providing housing for single ex-servicemen who leave the Services and have nowhere to go. The ex-service organisations also help in this regard. I believe that six per cent is the lowest we will ever get.

Q84 Mr Holloway: What about temporary accommodation? I have a guy in my constituency who was injured in Iraq. He is staying with his girlfriend’s parents because he cannot get any sort of council housing. What is the situation there? Ms Freeth: There have been improvements. A number of new projects have assisted, but more accommodation is needed and is in the process of being provided around the country. There are two new projects, one in Catterick and one in Yorkshire, that will take place in the next two or three years, but in the meantime housing is a problem. There is a need for short and medium-term housing particularly for the most vulnerable, that is, early service leavers who are not entitled to any of the support that people get if they stay for four years. In both health and social care the biggest group of people with difficulties are the early service leavers who are not entitled to the kind of support that is available once four or five years have been served.

Commodore Elliott: You raise a very important issue. There are people camping out with friends who are invisible to us. That is an area where we must do our best.

Ms Freeth: Work is being done by the minister to try to get the local connection system back in place for individuals so they get priority treatment. Ex-servicemen and women and those who support them still do not know enough about how to access housing provision in their areas through local government.

Q85 Mr Jenkins: When servicemen leave the Services the employer has a duty of care. What does the employer put in place to ensure that when someone leaves he does not have his medical records put in his hand and is simply told to look after himself, but that when he is settled down his medical records will be accessed and sent specifically to the GP of his choice and this is the support he requires, etc? At the practical sharp end we may just have some influence on the MoD to bring about an improvement in that area rather than the provision of housing 15 years down the line. Do they give them that linkage? They cannot give them their medical records because they might lose them, but do they make sure the linkage is there and the records follow ex-service personnel?

Commodore Elliott: The procedures for medical discharge involve handing the patient across to the National Health Service, and the medical records go with the patient into the NHS. All too frequently the problem is that the Services do not know where that patient will end up. He has nowhere to go. A lot of servicemen who are being discharged will not contact their local GPs and all the services that they should connect up to until they are in trouble, and therein lies a huge problem. In fairness to the Ministry of Defence, I think it is an extremely responsible employer in this regard. The resettlement process is probably second to none. I do not think anyone else does resettlement in this country for people who leave their employment. The servicemen themselves have a role to play in all this, inasmuch as they are responsible for doing all the things that need to be done, except in the case of very damaged people where special arrangements are made to make sure local NHS services are provided. I do not think that we should be too worried about this, apart from being aware that some servicemen, whatever we try to do, will not do what they are advised to do.

Ms Freeth: At the moment a lot of information is given to people at the point of departure and when they come to medical discharge they have all the
other problems that go along with that. I believe that there is too heavy a reliance on information on paper that is given to people, which they probably do not read and certainly do not digest. There is just too much of it. We need a more personalised approach to service departure. The new personnel system which the Royal Navy has started and is about to be adopted by all the Services will be an automated one where people terminate themselves. They will go online and their termination papers will be processed electronically. I can understand why that is a perfectly sensible and efficient way to complete the paperwork, but there is a real danger that part of the process of personal preparation will disappear when we should be increasing it rather than diminishing it.

Air Commodore Jarron: One of the problems we have is making contact with veterans because of data protection. Once they have gone there is no way to track them and the MoD is not allowed to pass to us the names and addresses of people who have left. Servicemen are inundated with information on discharge, resulting in a huge pile of paper in which any communication from Veterans organisations is more often than not simply lost or ignored. I think I still have mine from when I left a few years ago. Very often is not immediately after you have left that the problems set in; it is three, four or five years down the track when things are not quite working out as you would have liked. We have no way to go out to these people other than through our network of local welfare officers who hopefully keep a finger on the pulse. It would be extremely helpful to have some way to access veterans.

Ms Freeth: A paper system has been introduced and SSAFA, ourselves and the regimental associations are taking part in this. I think it has been in place since April. There is a piece of paper in the termination pack for people to complete and send on to us. I do not know how many people have left, but every single one has been offered this in the past two months. We have not received one.

Air Commodore Jarron: That is exactly the point I make. A piece of paper in a pile that high will still be lying there two years later.

Q86 Mr Jenkin: Ms Freeth, in your memorandum you describe the lack of a seamless transition from Ministry of Defence care to the NHS, but should not the ministry maintain responsibility particularly for the people who have been on active service, whether or not they have been injured? Should not responsibility for those people be maintained by the Ministry of Defence so that they keep the records, keep track of them and maintain responsibility for making sure that care is delivered? Is that not what the British people would expect for these people who have made such big sacrifices for their country?

Ms Freeth: I suspect that was expected from the creation of a new veterans minister. The ministry has done a great deal in terms of repositioning and valuing the veteran and his contribution to society through public commemoration, but in terms of improving the quality of what is provided for the individual I do not think there has been a huge improvement, which is disappointing. I suspect we may well have felt that we had more leverage when we did not have a minister. We have to go through him to press other government departments. There seems to be almost less influence over those departments than there was when we did not have a veterans minister.

Q87 Mr Jenkin: Do you think that a lot of ex-servicemen, particularly those who have suffered injury and perhaps are unable to work, feel dumped by the system?

Air Commodore Jarron: Yes, they do.

Ms Freeth: Certainly, the people who come to us do feel that. Clearly, we are the people who have the most difficulty. We will know about the exceptions, if you like.

Q88 Mr Jenkin: How widespread is that problem?

Ms Freeth: It is not a massive problem but it is growing. There is a concern about unexpected and increasing injuries, particularly the increased mental health presentations, and something needs to be done to provide better and more joined-up support.

Q89 Linda Gilroy: Some of the witnesses made a remark to the effect that the way in which their organisations are set up prevent them from doing certain things, unlike the RFA. In the wider community there is a move to get the third sector to act as partners to take on services. Is that something that you would want to look at as organisations? You have a long tradition of providing services particularly for veterans. I would have thought that on the whole veterans would prefer to turn to organisations which they feel are of their own rather than necessarily a government service as such.

Air Commodore Jarron: This is exactly the process of which we are trying to take advantage. All too often the funds that one is after are disaggregated down to local level. For a UK-wide operation like Combat Stress that creates a huge problem. I am absolutely convinced that Combat Stress provides exactly what veterans’ mental health problems need, as long as they are not too extreme. It is a case of finding a way to get a nice block of 10 million to provide this service seamlessly for veterans across the United Kingdom using the principle of the third sector that is funded to do the Government’s work. I do not mind; I think we should be doing the Government’s work.

Q90 Linda Gilroy: A number of remarks have been made to the effect that it would be good if government funded this but not necessarily directly.

Air Commodore Jarron: We cannot raise the money charitably to do all of the work that we need to do. We fund about 40 per cent of what we do from charitable income at the moment and we think we are asking as much as we dare from the hugely generous public who keep on saying, “Why ask us to fund you to do the Government’s work?” I do not think there is now an issue about the third sector doing the Government’s work. We are delighted to
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do it; we have a huge and proud tradition going back nearly 90 years and we think we can do it in partnership with the NHS, the Ministry of Defence and everyone else. It is just a case of sorting out the funding.

Ms Freeth: A number of us have been looking at the individual payments programme and have been briefed on that. The ability to be partners locally, however, is not something for which local government is willing to select us because we can provide a service only for our community. Our charitable objects restrict us to working with our community, unlike other organisations that have a broader remit. I think that is unfortunate. In some of the pilot areas for individual payments we would have liked to be part-players, but under the current criteria we are not permitted to be because we cannot provide a general service.

Q91 Mr Holloway: There are very large numbers of ex-servicemen in Iraq working in the private security industry. Will this compound your problems in the future?

Ms Crane: Yes.

Commodore Elliott: When these chaps come home they are referred to us for treatment. We are very concerned about the fact that they go back afterwards. I think they are being rather stupid, but in those cases treatment is funded by their insurance companies, so it makes it much easier to provide what they need.

Q92 Willie Rennie: We have covered the general structure of health services. What about mental health services, in particular the Chilwell Centre for the TA, the Priory Group and its services and the other structures within the services? How is it operating?

Commodore Elliott: It has been very interesting because they have gone through major restructuring. We are talking of in-service mental health provision. They have gone for a community-based mental health service where the community health centres are based in garrison towns, naval towns and so on. I have to say that, based on anecdotal evidence from the soldiers and sailors who have come onto our books, and the fact that we have a very good relationship with many community health practitioners who are serving the Royal Army Medical Corps, naval people and so on, this seems to be very good. It is a great improvement on the past. As to the Priory Group, this is designed for short doses of treatment for very difficult patients. We have no evidence as yet—I do not know whether the MoD has any—about how effectively all this money is spent in terms of treatment outcome. I am not sure how it is being measured, but we will have to wait and see.

Q93 Willie Rennie: Do you have concerns about value for money?

Commodore Elliott: I have a question about it. because I would not mind having the money and contract myself as part and parcel of a service that I believe would be more appropriate, which is to provide a service like that to in-service patients as well as veterans. This is an aspiration.

Q94 Willie Rennie: I have heard contrasting figures of 500 a day to get Priory Group services compared with 200 for the service that you provide.

Commodore Elliott: We are looking for £247 in this year's settlement, but we are not doing what the Priory Group does; we do not have as many doctors as they do and so on, so we are not comparing like with like. They do acute work; we do chronic work. To go back to in service, I think it is much better. Another matter that is so important is that education must be in place so that people understand what it is that is beginning to get to them if they start to suffer the psychological effects of trauma. That is getting much better. For about eight years the Royal Marines have had a system called TRIM—trauma reduction management system—which is a command-led rather than doctor-led scheme. That has been trialled in the Royal Navy, successfully I understand, and at a defence welfare and aftercare conference the other day where I spoke the chief of general staff said that he wanted TRIM for the British Army now. My message is that an occupational hazard of being a serviceman is that you are more likely to end up with psychological wounding than physical wounding. We need to be just as grown up about psychological wounding rather than treating it as something shameful and stigmatising and deal with it on the battlefield and in recovery, just as we do with our physically wounded people where battlefield procedures are second to none, as we know from the people who come home. That message is getting across. We need to be grown up and treat these people in the same honourable way as we do the physically wounded.

Ms Freeth: The ongoing research of the King's Fund demonstrates that the operational tempo is having an impact on top of what Commodore Elliott describes. We can already see that, so we should be preparing for how to respond to it rather than wait until those research reports emerge in two years' time.

Commodore Elliott: If one turns to Chilwell, it was the society who reported first that we were seeing TA soldiers coming to us very soon after returning from active service being discharged into the NHS and not getting what they needed there. They came to us. Subsequently, Professor Wesley produced a study which showed that for psychological casualties from Iraq the figures were four per cent for the TA and two per cent for regulars. He has reported very recently that the TA figure has gone up to six per cent and for the regulars it is four per cent. The society believes that those figures probably hide another couple of percentage points; there are casualties there who do not present because of stigma and the military ethos issue, among other things; or it may be that as soon as the soldier gets back from active service he discharges himself into the community and becomes one of the vulnerable service leavers. They go outside into the community
in the hope that these terrible nightmares and flashbacks will go away but they do not and they start to deteriorate. But I want to be quite positive about what I have seen in service.

Mrs Sheldon: As I understand it, we are looking at the service person but there is also the family. Parents and families are very seriously affected by emotional trauma. Sometimes it is very hard to understand that the person who has come back is completely different from the person who went away. Again, they should be brought within the umbrella of whatever mental health care is offered to make sure their concerns and worries are also taken into account. Perhaps we have a narrow definition here and we ignore this at our peril. At the end of the day, if these issues are not addressed the whole relationship breaks down in the family and that has an impact on the person in either returning to service life or being able to rebuild a new life outside.

Q95 Chairman: Are we ignoring it currently?

Mrs Sheldon: All of us have evidence of cases where it is being ignored. Again, I think it is due to a breakdown in the systematic tracking of families and picking up the symptoms as soon as possible. It is a matter of making sure that professional help is easily and quickly available, not putting barriers in the way that the process is handled both within the service and externally. It is a matter of making sure that within service when people are helped to make the transition to the outside it is understood that the whole family needs to be embraced in the concept, not just the service person.

Commodore Elliott: I could not agree more. The society’s constitution is such that it is supposed to look after only veterans, but that has been broadened. We are now starting to roll out services for veterans’ families and adolescent children. Adolescent children are very badly damaged by the experience of having a father who comes back a changed man and behaves in a really frightening and horrible way. Earlier I spoke about evidence that families in service did not resort to what was available and came to us instead. This is of great concern to us.

Ms Crane: I was at a camp in Cyprus where decompression for units coming out of Iraq takes place. I met a padre there who said that TRIM was being delivered to TELIC 10 that had just returned. The problem with families is that a lot of us are trying to raise awareness about the psychological effect of multiple deployments and operational tempo. Among lots of spouses and children at schools overseas there is increased awareness. People know that this happens and it is not something one should be so ashamed of and there are people who can help. I think it is the more remote families, partners and parents who are particularly vulnerable and we do not see. Unless service people want us to talk to them there is no way we can contact them. Another factor that has a big impact is public opinion and sometimes media pressure. If it is an unpopular deployment that has an additional effect on how people feel.

Chairman: You mentioned padres. It is often the padres and commanding officers who bear the brunt of this. They are expected to be the long stops and themselves have no one with whom they can talk these things through.

Q96 Willie Rennie: Returning to the veterans’ service which we have covered at various points during the session, the age profile has changed. It is a much younger group of people who now come to you. First, what impact does that have on your service? Second, what waiting list do you have? You have referred to funding difficulties. How difficult is funding? Third, from where do most of your referrals come? Is it from community GPs or elsewhere?

Commodore Elliott: As to age profile, we have made a deliberate change in policy and we “outed” this issue about eight years ago. At the same time, we have started a major revision in our clinical uplift for treatment. Whilst we still have a large number of World War II veterans on our books who benefit most from the respite and convalescent aspects of being in a treatment centre, there are a lot of much young veterans. Over the past four years, partly because a lot of the World War II chaps have got beyond the age when they are able to come in for treatment, the age profile has dropped from an average age of 61 to 51. That is a huge decrease in age for those people who understand how data works. At the same time, we have had a very large increase in the number of referrals. In the past three years we have had a 27 per cent increase, or nearly 1,000 referrals a year. For a small organisation like ours that is causing us a great deal of overstretch. I am prepared to use that term. I also use it when speaking to the secretary of state and the veterans minister whenever I possibly can. That has been accepted. I am really pleased that the Minister for Veterans is about to announce a 46 per cent increase in the funding that he is to provide for remedial treatment which will help us to a large extent to increase the number of clinicians and skill mixes that we have in our treatment centres.

Q97 Willie Rennie: Do you think that the increase in referrals is due to the fact that people are more aware of your service or a change in the number of people who suffer from these conditions?

Commodore Elliott: All I can say is that there are far more people out there than we know about. Far more of them and their families are more aware of the issue and understand it. Quite often it is the wife or carer who brings Fred to our front door and says, “Take this man; otherwise, I am going to walk out on him.” It may sound amusing but it is not; it is very sad, and it is good that we have found him. From where do referrals come? About 10 per cent come from the National Health Service and social services; about 30 per cent come from our fellow ex-service organisations, for example The Royal British Legion, SSAFA and regimental associations working with us in partnership, which is very important. We are increasing our capability to work
in partnership, not only in terms of finding partners but also in terms of the services that we can provide to them. The remaining 50 to 60 per cent come by way of self-referral. We are not exactly certain whether the guy has called a helpline and been told to go to Combat Stress or he has found us on the Internet, or his mates, carer or whatever have told him about us, but that is a group which is really growing. We convert about 65 per cent of these people to active clients, as we call them, so each year we have about 600 new cases where we provide treatment and welfare support. As to funding, we rely heavily on income from the veterans agency and the war pension treatment and travel allowance that we get for providing treatment for up to six weeks a year to war pensioners, but only two per cent of last year’s intake who arrived at our front door because of mental health issues had a war pension. We do not turn them away; we worry about them first and how the hell we are to fund what we are doing for them comes second. In that area we are working very hard with the minister and the secretary of state who understand our problem, which is our need to find funding for that 40 per cent of the work we do. As to the clinical priority, far more of the newer guys than the older veterans need to come in and get what we can provide. The challenge we have at the moment is that we cannot afford to open up the beds for them because we need the money to keep all the beds open. We need to have a clinical priority for admission rather than the funny balance that we have at the moment.

Ms Freeth: One of the difficulties we have is that not everyone can be referred to the services that Combat Stress can provide. The charities support other people who perhaps do not have direct or provable combat-related needs but still are veterans with health needs. There are two groups, one of which we want to provide for and direct to local services that we cannot access; the other are people with other difficulties, for example problems with addiction. Commodore Elliott’s service is not able to take those people. These are people in very extreme circumstances. For these people there is a shortage of service provision. In our case the problem is particularly alcohol abuse. We have small numbers of people who are drug addicts. This is a group of people—I am sure SSAFA would say the same thing—for whom we need new services. At the moment, those services really exist only in London and are not in adequate supply.

Q98 Willie Rennie: Why is it necessary for those to be military-based services or services related to each Service? Why cannot the community not fund them? I know that mental health and addiction services are pretty poor relations, but why does it have to be in the military?

Commodore Elliott: If I may answer that, this is my specialist area. The truth of the matter is that the National Health Service tries to provide for these people. Veterans go to the NHS and get a very good service. They are happy with that and we do not see them, but the veterans we see say that when they go to the NHS they will be referred to, say, a PTSD support group. They will sit in the group with people who have had terrible car accidents, traumatic child births and all the rest of it. He will be one soldier who has worn his best mate’s brains down the front of his uniform and seen terrible things in Kosovo and so on. When it comes for him to talk about his experience, which is part of the process, either he bottles out and leaves the group straight away or reduces the group, including the therapist, to tears. He traumatises the group. They just do not fit in. The worst thing is that they feel they cannot say anything and so they get no benefit whatsoever from it and leave treatment.

Ms Freeth: There are two groups: there are people who want to receive therapy as a group of veterans and individuals who do not want to do that. We need services for both categories but there simply are not enough in the community generally for people who need drug and alcohol treatment. We need more of them. Our community seems to need a greater supply of that than perhaps other parts of society.

Q99 Willie Rennie: We return to Mr Jenkin’s earlier point about the responsibility of the MoD for ex-servicemen. If there is such a difference in their needs the ministry should have a greater responsibility. I am pleased that you will be getting extra funding, but do you think there is sufficient funding for addiction as well as all the other services?

Commodore Elliott: The answer is no. It is very difficult to deal with drug and alcohol addiction. Seventy-five per cent of the chaps on our books have major alcohol and drug problems. We do all we can to encourage them to detox and all the rest of it. We manage to get some of them to sign a no alcohol contract so that whilst they are with us they can benefit from the treatment we provide which includes working on alcohol problems. This is a really difficult group. I am sure that you have all heard of Dr Alan Jones and T Guinn. There are some really hard cases. They want to help half of the time; for the other half they want to do their own thing. They are incredibly difficult to deal with. At the moment we have a committee on which sits some ex-service rough-sleeping units. That is looking at the issue of whether or not it is possible to contain and provide these men with what they need in the sort of environment that many of us want to sustain. They can become very difficult to cope with; they can disrupt the whole unit, destroy the therapeutic environment that we need to do our work and be very dangerous both to themselves and the staff. That is not to say we do not try to identify how we may do this, but the sad thing is that for a lot of them the only time they get what they need is when they are in prison, and even then they do not get it all.

Q100 Chairman: I want to draw this session to a close because it has been going on for a long time this morning. Commodore Elliott, we are very much looking forward to seeing you in Combat Stress. You may not be aware of this.
**Commodore Elliott:** We were waiting to hear whether you would come.

**Q101 Chairman:** We would very much like to see you after visiting Headley Court on Thursday. When we visit can you possibly have considered the point that apparently some research was published in the *Lancet* that it is not necessarily a good thing to leap in very early when somebody suffers psychological stress; sometimes it is best to leave the individual for a period of time to allow his or her own resilience and curing mechanisms to kick in. Perhaps we can ask you about that on Thursday.

**Commodore Elliott:** With pleasure.

**Q102 Chairman:** I should like a quick yes or no answer to the final question which is to do with the role of the voluntary sector as a whole. My impression from what you have been saying this morning is that you believe the voluntary sector has a very important role to play in these areas; that you very much appreciated Lord Moonie’s comment that you had a huge role as ex-service organisations and government wanted you to go on doing it; that you could be more agile as organisations than the vast Ministry of Defence could ever be but that you need to be properly funded for the work that you do. Is that a fair summary of your views on the role of the voluntary sector?

**Mrs Sheldon:** Absolutely.

**Ms Freeth:** Yes.

**Air Commodore Jarron:** Yes.

**Commodore Elliott:** Yes.

**Ms Crane:** You are looking at me but I am not ex-service.

**Q103 Chairman:** But from your experience do you agree with that?

**Ms Crane:** Yes, most definitely. Often people want something that is not part of the system to be available in garrisons around the world, so I do support it.

**Q104 Chairman:** And not part of the Chain of Command?

**Ms Crane:** No.

**Commodore Elliott:** There is a nice mix. We want to work with the Chain of Command. We have been to 3 Para, the padre you talked about and the commanding officer. We already have a very good relationship. It is not so much for their benefit although talking to them helps them; it is to ensure that those soldiers who discharge themselves early post the amazing tour they have just had in Afghanistan know about us and will come to us.

**Ms Freeth:** There are some good services that we would like to see extended. We have been pressing for the Chilwell reservist programme to be extended. Those are things that could be provided within the resources of the MoD.

**Mrs Sheldon:** We would give a definite “yes” to that, but we also need to make sure that this includes in service. Charities have a huge part to play in partnership with the MoD in service. I have found a huge amount of willingness and interest in setting up family accommodation at Headley Court and Selly Oak, but I think there is a certain amount of embarrassment among people in the MoD that this is not publicly funded. They feel perhaps a little awkward sometimes when they work with charities and know that they can move and help people much more quickly. For us and the MoD it is important to encourage that maturity in partnership working. We would like the MoD to see all of us as very much part of the fabric by which services are delivered.

**Chairman:** I thank all of you for this very valuable session.

**Mr Jenkin:** Chairman, can we record the thanks of Members of the Committee for the work done by all of these organisations? That work is of tremendous value. The fact that the quality of your evidence this morning has been of such high value to us underlines what an immensely important role you play in the welfare of our armed servicemen and women, veterans and their families.

**Chairman:** That is entirely right.
Thursday 21 June 2007

Members present:

Mr James Arbuthnot, in the Chair

Mr David Crausby
Linda Gilroy
Mr Dai Havard

Mr Brian Jenkins
Mr Kevan Jones

Witnesses: Ms Julie Moore, Chief Executive, and Dr David Rosser, Medical Director, University Hospital Birmingham NHS Foundation Trust, gave evidence.

Q105 Chairman: Welcome to the evidence session here in Birmingham on the medical care that is given to the Armed Forces of our country. Welcome to Julie Moore and Dr Rosser. Thank you for showing us round Selly Oak this morning. As we take evidence from you this afternoon I would ask you, please, to remember that the microphone in front of you needs to be activated when you speak. It would be helpful, probably in order to avoid feedback and all that sort of stuff, if you could switch it off when you stop speaking. Could I ask you, please, to introduce yourselves and say what your role is. Julie Moore, would you like to begin?

Ms Moore: My name is Julie Moore, I am Chief Executive of University Hospital Birmingham which covers the Queen Elizabeth and Selly Oak Hospitals.

Dr Rosser: Dave Rosser, I am currently a consultant in intensive care at University Hospital but I am also the Medical Director.

Q106 Chairman: Can I ask that people switch your phones off otherwise it will cause all sorts of problems. Can I begin with a rather important issue. Do you think the decision to site the Royal Centre for Defence Medicine, the Centre for Defence Medicine as it was then, at a large National Health Service teaching hospital was the right one when it was taken? That is a sort of yes or no question. Do you think it is the right way for it to be run now?

Ms Moore: Thank you, Chairman. Thank you for inviting us today to talk about this. I think it was the right decision. Healthcare has evolved greatly now and increasing sub-specialisation in medicine means you do need a large acute teaching trust to have available all the specialties required to treat what are pretty complex injuries. Some of the soldiers we have had coming back from abroad have had upwards of ten, 11, specialties working on them at one time and I think only an acute teaching trust can provide that complex level of care. How it is run at the moment, I think it is the right way to do it, we are integrating military and NHS and both sides learn from each other. I think we are providing an excellent standard of care.

Q107 Chairman: Dr Rosser, do you have anything to add?

Dr Rosser: I would just like to emphasise the training role at the RCDM. One of the key functions is not just about looking after the military patients when they are evacuated to us; it is about making sure that staff who need to go out to the frontline and provide clinical care in theatre are adequately trained. As Julie says, if you are going to acquire and keep those skills up-to-date you need a significant workload and there is compelling evidence across a whole range of clinical specialties that people who do more of the procedure get better results. If you look at the workload, the complex surgery that comes purely from the military, there simply is not enough work to train and keep skilled a range of specialists.

Q108 Chairman: You have both given very medically-based answers. We will come on to the military ethos questions that all of this raises in a few minutes. Thank you for those answers. Why Birmingham? What makes Birmingham the right place, if it is the right place? Is it the right place?

Ms Moore: Birmingham is one of seven major trauma centres throughout the country but in terms of its central location, located near to a big airport and its good road networks, I think that was one of the major factors in choosing it so that patients can be easily transported when they are aeromedically evacuated back to Birmingham. In addition, it has got very strong partnerships with local universities, again feeding the training environment at the Royal Centre for Defence Medicine.

Q109 Chairman: By the way, you do not have to add anything if you do not want to.

Dr Rosser: I was just weighing up whether it adds value and I think it probably does. The other thing is the range of clinical specialties we have is very extensive. The only major specialties we do not provide are paediatrics and obstetrics and gynaecology. If one is injured in any form of major trauma any part of the body can be affected and we have surgical specialists particularly skilled in dealing with virtually every part of the body.

Q110 Chairman: Can you tell us please, how you are funded?

Ms Moore: We are funded on a very similar basis to the NHS in that we get paid per patient that we treat. In addition, there are some overhead costs put in to support the aeromedical evacuation service based at the Trust.

Chairman: Moving on to the treatment of casualties, David Crausby, the Vice-Chairman.
Q111 Mr Crausby: Thank you, Chairman. Could you explain to us first of all, briefly, the patient pathway for casualties from the frontline?

Dr Rosser: It depends on the severity of the injury and the nature of the injury to an extent. Essentially the evacuation is organised by aeromed, which is closely allied to the RCDM, so from a clinical perspective we receive a phone call from aeromed saying, “We have a casualty or a number of casualties” and a description of the injuries. Together with the aeromed team we make a judgment on whether they need to come to critical care or should go straight to a ward and which specialist ward they should go to. Aeromed decide which is the most appropriate airport, they are flown to that airport, brought to us by land ambulance and managed by the relevant clinical teams when they hit our institution.

Q112 Mr Crausby: Could you tell us what arrangements you have for the treatment of service patients with mental health issues?

Dr Rosser: We do not provide mental health care specifically. On the Queen Elizabeth site there is the mental health trust but that is an entirely separate trust, so we are not involved in the care of people with purely psychiatric problems.

Q113 Mr Havard: But the co-ordination of all of that is done through you, is it not, or done at your site?

Dr Rosser: If a patient comes back with physical injuries and psychological problems then we will import the relevant psychiatric and psychological support, usually via the RCDM because, as you are aware, they are quite specialist and not necessarily able to be dealt with by civilian psychiatric services.

Chairman: I do think you need to use the microphone for recording purposes.

Q114 Mr Havard: Technology and children, never work with either! The question is you are assessing that individual in the round, are you not, you are not just mending their broken leg or wound they have had from a bullet? That assessment is done at your location, is it not, and then that is the centre of the process?

Ms Moore: That is right.

Q115 Mr Havard: That gives the pathway for the individual, is that not right? If it is not right then it should be.

Dr Rosser: Yes, it is right.

Q116 Mr Jones: Some of the patients we saw this morning had some very severe and traumatic injuries but, in terms of their rehabilitation, what is the pathway when possibly they leave Selly Oak and perhaps go into the NHS, especially those people who are perhaps leaving the Armed Forces because of their injuries? What is the pathway for them to ensure that the care that you give is continued on, possibly from their local GP or local primary care trust?

Ms Moore: The RCDM have put in place a senior officer who is responsible for the whole pathway. Once a patient is fit to be discharged from our organisation, he will take over co-ordinating that care, whether it is to another hospital, to the military, to the GP or back to the unit to make sure that is as seamless as possible. That is all co-ordinated by a senior officer.

Q117 Mr Jones: That is on a case-by-case basis?

Ms Moore: Yes.

Q118 Mr Jenkins: Can I take you back six years because originally when the Government set this system up it was set up merely to be a contract with the MoD, so you treat it like that: twisted ankles playing football, dislocated shoulders, maybe some medical conditions amongst the personnel of the Armed Forces. It was never set up to expect you as a single unit to take the war casualties. In fact, there are arrangements in place with other hospitals which were funded with equipment so that we could put these war casualties across a wide range. You have ended up with a role that you did not envisage to start with. What impact has this had on the ability to run the hospital normally?

Ms Moore: You are absolutely right in what you say but what happened was with training the doctors and nurses to go out to the frontline and the degree of expertise and knowledge of the situation at Selly Oak and the frontline, that led to casualties increasingly being sent back to Selly Oak by the doctors on the frontline. At the same time, at Selly Oak we started developing a degree of expertise in trauma injuries that had not been seen in this country for decades. There was a sense of pride in the stuff that what we were doing was really quite groundbreaking in some of the surgeries and things we were doing to preserve life, preserve limb and the results coming back that the military have had show that the clinical results are excellent and better than would be expected. What we have done to make sure that there is no impact on our local population is gear up to meet that. We have put in additional facilities and expanded our services to do that. I am pleased to say that our waiting times for NHS patients are still amongst the lowest in the country. We have still delivered all our targets for all our commissioners; we have still got very high Healthcare Commission ratings, and have done so for the past four or five years.

Q119 Mr Jenkins: Thank you. I expect you to say the hospital is quite good, and I expect you to say it is improving and it is the centre of excellence, but would you agree—I am sure you will but I want to put this on the record—that the reason they are sent back to Birmingham is because the medical doctors in Afghanistan and Iraq recognise this as the place they want to send their patients, they are quite happy with it, in fact they are more than happy, so they see that as the centre of excellence. It is through their recommendation rather than your recommendation, and I tell you now I would rather take their recommendation about the state of the
hospital rather than yours because you are paid to say how good you are and they are not, they are there to look after the interests of our Service personnel. Given that, their recommendation raises your status, I am quite pleased to say, but the Reception Arrangements of Military Personnel have been ignored basically in as far as we are not sending them to any other hospitals, just yours. Do you think we have to rethink the procedure or do you think that procedure should still be in place because how many casualties can you accept and when do you have to start sending them to other reception centres?

**Ms Moore:** We are planning with the MoD how we take forward the contract for the future because we have seen an escalation in the number of casualties coming back and at the moment I am very proud to pay tribute to our staff who have come in on days off and who have worked tirelessly to make sure we have always accommodated casualties. The last time casualties were diverted was in 2003 and that was the only time. Since then we have always managed to accommodate any military casualties being aeromedically evacuated. What would be helpful for the Trust would be to have certainty as to whether we are to continue doing this for the future or, indeed, if the national plan is to be brought into place. We are having discussions at the moment about that.

**Chairman:** There are several of us who want to come in on this question, so if you can stick to this question.

**Q120 Mr Jenkins:** I am going to stick to this question. I would like to know, do I send a message to the Taliban asking them just how big and ferocious their attacks are going to be in Afghanistan because then we would have a degree of certainty. I asked you the simple question of what is the cut-off point where you would have to say, “We can handle no more, they must be diverted somewhere else”. Have you worked out or thought of a number?

**Ms Moore:** If we know with certainty what the number is we can plan for that. If we were told that the numbers are going to continuously go up, can we continue, yes, if they were to increase 20 per cent, 50 per cent, yes, but what I do not know is whether that is the plan to continue, that we will be the sole receiving hospital at the moment. If we were told, “You are going to be it”, then we would like to build in capacity to flex up and down which, indeed, we are doing at the moment. We could take, and have taken, anything we have been asked to take by the military and the MoD and we will continue to do so. A degree of certainty that they are going to continue to do that would just be helpful.

**Q121 Chairman:** Would you expect there to be any change in these arrangements when super garrisons come on-stream? For example, if there were large numbers of personnel based around Colchester, and hospitals are therefore used to dealing with military personnel there, would you expect any change in these arrangements as a result of that?

**Ms Moore:** Not in aeromedically evacuated patients. Prior to the recent conflicts we were seeing very, very small numbers of inpatients, sometimes none and the maximum we ever got up to was about four, six or eight before that, so very small numbers in a 1,200 bedded hospital. The real difference that has been made is soldiers posted overseas in conflict.

**Q122 Mr Jones:** Can I ask a question of Dr Rosser. We were in Afghanistan two months ago and we met the medical personnel at Kandahar and were very impressed by not only their dedication but also the change of emphasis in putting doctors on the frontline, for example, rather than after med evacuation. What feedback or professional contact do you actually have with the people on the frontline who are treating these young Servicemen as they are actually wounded? Is there an exchange of professional expertise or any lessons you could learn or vice versa?

**Dr Rosser:** A number of the people who go out are actually based with us so the contact we have with them is great because they are colleagues when they are back in the UK. We have learned a number of lessons about communication essentially and how important it is that there is personal conversation between doctors on the frontline, particularly for the major injuries, particularly chest, head and neck injuries that surgically are very complicated. We have done quite a lot of work with General Lillywhite and have arranged a number of different communication channels and regular telephone conferences to discuss issues in principle: maybe we are not using the right dressings, maybe we should approach something slightly differently. The surgery at the front end is about saving life, as I sure you know, really stopgap surgery, and reconstructive surgery is what we do when people get back here but clearly you cannot entirely separate those. There has been a lot of communication really fine tuning that interaction: “Perhaps if you did it a little bit differently the reconstruction results would be better”. We have also done a lot of work on opening up communication channels so there can be direct communication about individual patients on the way back because theoretically one should be able to put the necessary details on a handover sheet. To quote one of my surgical colleagues, “If you are going to have to put both hands inside somebody’s chest it is very reassuring to know exactly what your predecessor did and found”. We have recognised the importance of that and opened up better channels.

**Ms Moore:** The Army are looking at putting digital links in so that images are being fed directly back to our consultants for views as well, and also to have web cams to look at wounds. That is something that 24 hours a day will give access to surgeons that they have not got on the frontline.

**Chairman:** We saw something pretty similar to that in the Shaibah base in Iraq last year.

**Q123 Mr Havard:** As I understand it, that process is going to be extended further in the new hospital arrangements that are coming along.

**Ms Moore:** That is right.
Q124 Mr Havard: Therefore, a lot of this stuff is being planned to be developed in that. This comes back to a point that you made earlier about certainty and planning and the question that we asked about financing and contract arrangements and so on and the certainty of something remaining here and developing here. As I understand it, you, the NHS Trust, contract with the MoD to provide certain things. That is a commercially competitive arrangement, what, a 12 monthly process. Can you explain to us whether or not there is a 12 monthly contract between you and the MoD that deals with the current process as is described and running, and how the contracting arrangement is being negotiated about future development and your point about certainty and planning?

Ms Moore: The contract is negotiated 12 monthly. At the moment there are two processes going on, there is a routine 12 month contract and there are two contracts, one for treatment and one for the training and personnel placement and, secondly, we are having discussions with the MoD about what facilities they want exactly in the new build. We have got capacity to expand the military presence in there but we do need to know about that fairly soon. With a PFI build there is a timescale you have to meet, so the deadline that I have asked for is that they will let us know by August about what they want in the new hospital.

Q125 Mr Havard: So the new hospital is a PFI build.

Ms Moore: Yes.

Q126 Mr Havard: And you are in the process of contract negotiations now?

Ms Moore: Yes.

Q127 Mr Havard: So when you say the near future, are we talking about 18 months, 12 months, six months?

Ms Moore: No, six weeks.

Q128 Chairman: The new hospital is to be finished in 2011?

Ms Moore: We start moving in in 2010 and we finish the whole process in 2012. We have got an 18 month moving in process so you were right, somewhere in the middle.

Q129 Mr Jenkins: If I can take you back once again, because I like to learn from our mistakes if possible. There was a time when we first started out when we did have some problems in the treatment of injured personnel, and I think you would accept that as a justified criticism. As you put it, there were some “inevitable teething problems”. Did you log those teething problems? Did you in any way keep a profile of how you overcame those teething problems? If we need it I want to be sure that we can pass that on to another trust so we do not undergo the same problems in the future. Did you do that?

Ms Moore: We did do that. We have regular meetings with the military where we go over issues that are learning points. Some of those have been clinical issues because some of the injuries we have not seen and people have not been trained in for some time and a lot of that expertise has been shared. Others were some organisational issues but they were minor compared to some of the clinical elements at play.

Q130 Mr Jenkins: It is the clinical side that I am interested in. I think anyone who has spent any time looking at this problem will realise that there are men and women now alive today because they have come to Selly Oak. It would have been extremely challenging for our military medical teams to have shown the same degree and level of skill. Will you take it from me back to your staff and say thank you for all the work you have done, all of the hardships you have overcome, all of the teething problems you have overcome and everything else to provide that service.

Ms Moore: I will be very glad to do so. Thank you.

Q131 Mr Jones: Would you recognise one of our witnesses last week described the situation in Selly Oak in the early days as—the actual words used were—“confused and shameful”? Do you recognise that as a fair criticism?

Ms Moore: No, I would not. The focus has always been on providing the utmost clinical care. I think those words may have been applied to some other aspect but certainly not to the clinical care that was given then. I would be on record as saying that the staff of the Trust take a very, very high degree of pride in the care that they provide to the military. They are distressing injuries, the staff have a degree of empathy with the military casualties coming back, and I have no problem at all when we have an aeroplane landing that has got six coming into critical care that staff will come in at a moment’s notice on their day off to look after the soldiers. Around clinical issues, no, I would not recognise that at all.

Q132 Chairman: Clinically, clearly, you are quite excellent, and if I may take this opportunity, on behalf of the Committee, I would like to thank you for that because I think the care that you give is outstanding.

Ms Moore: Thank you.

Q133 Chairman: I suspect we all think that. When you say that around clinical issues you would not recognise that phrase, would you recognise it about any other aspect of the care which was provided by Selly Oak in the early stages? We have clearly moved on now but in the early stages would you recognise that?

Ms Moore: I think in the early stages where casualties were coming back people were not so used to casualties arriving back in the middle of the night or whenever and there may have been some organisational issues. There was never anything that we investigated from the Trust’s perspective that gave great cause for concern as far as we are aware. There were some complaints that came through about some of the follow-on care afterwards once people had gone.
Q134 Mr Jones: I just have a follow-up to that in terms of complaints, either about medical care or the way people dealt with it. How many complaints have you received from Armed Forces personnel who have been through Selly Oak, or their families in, say, the last 12 months? What type of complaints have they been?

Ms Moore: Since we have had the military there we have treated nearly 40,000 patients and we have had seven complaints; two last year and there have been five this year.

Q135 Mr Jenkins: What was the nature of those complaints? Were they about medical care or welfare care?

Ms Moore: There were a variety of issues. One issue we could say was about clinical care but the rest of the issues were more peripheral issues, if you like. The one medical issue Dave is familiar with so I will ask him to answer that.

Dr Rosser: The one which you could say is a half clinical thing which we picked up in one of the complaints was around a drug error when a short acting version of a painkiller was given instead of a long acting painkiller. That in itself poses no major risk but clearly it is not acceptable for drug errors to happen. Having said that, to put it in context, we administer 147,000 drug administration events per week in our organisations, so realistically, however hard you try and however hard your policies are for dealing with drug errors they will happen, when you are dealing with that many events it is inevitable.

Q136 Chairman: Do you know how those sorts of statistics compare to other NHS trusts in the United Kingdom?

Dr Rosser: The complaints statistics or drug error statistics?

Q137 Chairman: The complaints statistics I was asking about, but the drug error statistics as well.

Dr Rosser: The drug error statistics I do not really know how it relates because we are running a very advanced electronic prescribing administration system in our organisation which is unique to us. I can trot out those figures because I get weekly reports from that system, I suspect most of my medical director colleagues around the country would not have those figures. I think Julie knows the figures on complaints better than I do.

Ms Moore: In terms of general NHS complaints 0.1 per cent of patients in the NHS complain, the statistics for the military is 0.02 per cent, so five times lower.

Q138 Chairman: A final question on this and then I will turn over to Kevan Jones again. If this system is so good at administering drugs, why is it unique to you?

Dr Rosser: It was developed by us in partnership with the university and it has not spread throughout the NHS largely, I guess, because the NHS is waiting for similar products to be devolved through Connecting for Health.

Ms Moore: We will be looking to sell it in the near future!

Q139 Mr Jones: One of the debates, certainly in Parliament, has been about the idea, and one of the arguments is, we should have separate hospitals altogether for military personnel. Obviously even the Opposition have now conceded that is not clinically advisable. The emphasis now is on the creation of military-managed wards and we saw this morning when we visited it is perhaps the best way of treating military, not just in terms of the care but also people being together with a military ethos. Where are we at with that at Selly Oak and also what challenges does it set you as the Trust in terms of managing the military unit with all the other responsibilities clearly for the provision of care for the people of Birmingham?

Ms Moore: I think you are right; it provides the best of both worlds. We have got the skilled NHS staff who are able to teach the military staff and it also provides a high degree of military staffing for the wards so that the soldiers are nursed by large numbers of military nurses on the ward, which you saw this morning. The challenges it presents are that military nurses are not trained in running NHS wards so they have to get familiar with whole new jargon and I think the NHS have to get used to whole new jargon from the military as well. Both sides use acronyms like there is no tomorrow. In bringing the teams together there has been a positive benefit for both sides to learn from each other. There are not great challenges in that there are problems with it, they are all nurses, they are all doctors and they are all looking after very sick patients. We do recognise that the military environment is a different environment and having military people looking after you is good.

Q140 Mr Jones: So as a Trust you welcome it?

Ms Moore: We have always welcomed it. We did have a military-managed ward up until the deployment at first conflict. The problem with that was in times of conflict the military clinical staff are needed so they were deployed and we were given 24 hours’ notice of the ward staff being removed. We have to be quite careful, we have got contingency plans because obviously when there is conflict the military clinical staff are busy elsewhere rather than in Britain.

Q141 Mr Jones: That gives you flexibility, does it, in terms of if staff are then deployed on operations you can still cover a military-managed ward with your NHS staff?

Ms Moore: We make sure we have a core of NHS staff on the ward as well, yes.

Q142 Chairman: This issue has been put very strongly in certain quarters, so strongly, in fact, that some people say it is a breach of the military covenant to have a young man just serving in the military next to an elderly lady who has just had a
stroke. How do you answer those criticisms that this is going on and that it is a breach of the military covenant?

**Ms Moore:** I would say the overriding factor that is most important is getting the soldiers to be in the most clinically appropriate place with staff who are skilled at saving lives and saving limbs. Occasionally soldiers have been nursed alongside patients of the same sex—we do not mix patients of different sex inside the bays, we have entirely single sex bays—in other bays. I do not believe that is the most important factor. I believe the most important in all of this is the skilled care given by the doctors and nurses who are skilled to look after those patients. Whenever possible we put military patients together but if you have a head injury you want a neurosurgeon looking after you and if you have got a chest injury you want a cardiothoracic surgeon. Those injuries are very, very few in number, so we are not ever going to have enough to fill a ward or even a bay with single patients on there.

**Q143 Mr Havard:** My understanding of this is the Military Services Department have said that they would like to have a situation where a trauma ward could be established. From the business of managing it, it would appear there are not military nurses with the relevant qualifications to actually manage a ward and the idea is to get up to 70 per cent military nurses as the component in such a ward. We have not got to that situation yet. As I understand it, there are training activities and plans to try to get to that position, that is the idea. Currently, the situation is presumably managed by one of your NHS, I do not know what they are—

**Ms Moore:** Ward sisters.

**Mr Havard:** This is England and I come from Wales, so there is a different set of problems down here.

**Q144 Chairman:** You would never have been able to tell!

**Dr Rosser:** I had not noticed, no.

**Q145 Mr Havard:** It is that Grand Slam tie you have got on! It is 2005, by the way. How do we get to that situation? Is that what you are trying to move towards? I am concerned about the contractual arrangements from the point of view of knowing what the timetable is to advance this programme if this is what the programme is going to be. Is that where we are going to get to? As I understand it, you are not going to be in that position next month and next month was the original target date. Where are we?

**Ms Moore:** The military did have some ward managers but, as I explained before, a lot of them have been deployed and it does take time to skill somebody up for that. We do have a military nurse as part of the leadership team on the ward. There is a senior sister and there are junior sisters on the ward. There is a senior military nursing presence on the ward and that has been proved to be beneficial both to the casualties and the rest of the nursing team. The military nurses do require training up to be able to take full control of the ward. Some of them have been outside the NHS environment for a long time, have been out in the frontline in Afghanistan and Iraq, and they do take time to pick up their skills. I do not believe that the lack of that is causing any detriment to the people on the wards whatsoever.

**Q146 Mr Havard:** I was not suggesting that at all.

**Ms Moore:** No.

**Mr Havard:** I was asking if these are the parameters we are trying to get to, where are we getting in terms of progress towards it.

**Q147 Mr Jenkins:** With regard to our military ward and the military nurses because of deployment, and when they are on a six month deployment they are entitled to so much leave, they do not come back for a while, what difficulty is there in being able to rotate your staff to a level where they can get their training? You have to mix these with your NHS nurses but what problems have you had to overcome? I know it is necessary to train them because they have to go out to theatre and then come back home but have there been any major problems in these rotas for nurses?

**Ms Moore:** We are very fortunate to have some very skilled nurse managers who are used to managing rotas that you could only describe as 3-D rotas at times. I would pay tribute to the head of nursing in the division of the senior nurses who has done an absolutely fantastic job in managing the nursing situation.

**Chairman:** Moving on to welfare issues, David Crausby, the Vice-Chairman.

**Q148 Mr Crausby:** Thank you, Chairman. In our evidence session last week with representatives of families, there was a general acceptance about clinical excellence and the British Legion, for instance, said: “at the moment healthcare is extremely good”. One of the criticisms which the British Legion made to us was that you were better at looking after patients’ clinical needs than dealing with wider welfare issues. They made the point that charities are having to step in to provide basic essentials like clothes and toiletries when people are separated from their possessions. How do you respond to that? Is it appropriate that Service personnel and their families in these circumstances should depend on a charitable organisation?

**Ms Moore:** I am very glad of that comment because we are aiming to be excellent clinically and the comment did say that. The welfare of the military patients is purely provided for by the military but I would say I thought the comment was referring more to visitors than to patients. We have a full range of toiletries, pyjamas, slippers, towels, anything anybody might want when they come into hospital, because it does not just apply to the military who arrive without their things. We have a charitable organisation to support those families who are not ever going to be in that position next month and we are not going to be in that position by the end of this year, so there is a difference.

**Q149 Mr Crausby:** She said there were essential things like toiletries and clothing for people who have been separated from their possessions. I think it was aimed more at families but, even so, is it appropriate in these circumstances that charities...
should deliver this need? After all, people are sometimes quite proud about having to make appeals to charities. In circumstances like this should they be put under even more stress by having to ask for assistance with travel, for example?

Dr Rosser: We would answer no, it is not appropriate. We have very clear responsibilities as part of providing a high quality of clinical care to ensure that families understand what is happening clinically with their loved ones. The provision of welfare, travel, support and accommodation is not provided through us as the NHS, it is provided through the RCDM, so it would be unfair of me to comment too deeply on how that is provided.

Q150 Mr Jones: This morning we visited some of the flats that are made available for families to stay on site when they are visiting very seriously ill relatives. Can you just talk us through what actual support is given on site for relatives and also what the interface is? You say it is the military but one of the key things is what is the interface between yourselves as the clinicians and the actual next of kin? This morning we saw some very difficult examples where there were divided families and other things and who do you deal with as the next of kin, so I can accept it is not easy in some cases. Can you talk us through what is the impact and interface with the next of kin and what support is given to them?

Dr Rosser: As I said, from our perspective the interface with the next of kin is around communicating clinical progress, progression, making sure people are aware of what the plans are, trying to keep people up to speed as clinical plans change because in difficult complex injuries clinical plans do change as things evolve. As I said, provision of accommodation and the other aspects of welfare are not provided through us. That accommodation is on our site but it is provided by the RCDM.

Q151 Mr Havard: As I understand it, that is then partly delivered by the Defence Medical Welfare Service—another set of initials!

Dr Rosser: Yes.

Q152 Mr Havard: They are contracted to the MoD to do that.

Dr Rosser: Correct.

Q153 Mr Havard: So it is not just the charitable sector that gets involved in that activity.

Dr Rosser: No.

Q154 Mr Crausby: As Kevan said, we saw some good facilities this morning, we did not see them all of course, but the real issue is, is there more you could do or more you would like to do?

Ms Moore: I think Selly Oak is two pints in a one pint pot and there is very limited life left in the site and in three years’ time we will not be using it any more. In order to make sure that there is suitable accommodation nearby the RCDM have taken over some local flats to rent for relatives coming in. It is sub-optimal; we would like people to be on site, but in trying to make sure that there is accommodation available they have really tried hard to get accommodation nearby.

Chairman: I want to move on now to media coverage of the issues that we have been discussing.

Q155 Linda Gilroy: In your memorandum you are very critical of the effect of negative media coverage, and I will ask you in a moment about the effects of that. First of all, can you say how you think it came about?

Ms Moore: I am afraid I have thought long and hard about that and I do not know why the negative stories were picked up in the way that they were. We have given very good news stories that some of the media have run with and we have done some world first type surgery at the hospital and we were very proud to publicise that but it was not picked up so much as some of the stories that did do the rounds.

Q156 Linda Gilroy: We have your written evidence, of course, but for the purpose of this evidence session can you tell us what effect the media coverage has had and how you and the hospital as a whole, but particularly the staff involved in the wards, have been affected by it and reacted?

Ms Moore: Perhaps if I tell you a comment from one of the nurses on the ward who looks after the military casualties. She said: “I don’t like coming to work on Sunday morning any more because I never know what I might be going to read” as they are looking after the soldiers and what the soldiers might open up in the newspapers. We went through a period when there were a lot of sudden stories that we had no warning were coming arising in the press that staff found quite puzzling because the work they were doing and the feedback they were getting from soldiers and their families was not reflected in the articles they were reading.

Q157 Linda Gilroy: So it had an impact on the staff. It was quite a sustained period that it happened over. Have you had to offer support to the staff to try and cope with that?

Ms Moore: We have offered support to staff. We have offered them additional support to go in and talk to them about their experiences and I am pleased to say that the staff are so dedicated and pleased that they are looking after the military that they are still there, they are still wishing to provide the high level of service, and are viewing it as a nasty period in their lives that now, hopefully, is over. I think they are glad today that we have got the opportunity to tell you and put on record the kind of care that they have been giving.

Q158 Linda Gilroy: I think my colleague is going to come on to some of the urban myths in a moment but, before we move on to that, we have received a submission from the four Birmingham MPs expressing concern because they have had good contact with you over the period that the media coverage has led to measures being taken that were driven by motives other than clinical need. They are
also concerned that the desire for a military-managed ward might override proper clinical considerations. How would you respond to their concerns?

**Ms Moore:** The most important point is the last one and I think I would say that we retain clinical responsibility for that ward and would not let anything get in the way of providing excellence of care. Our main focus has solely been to provide clinical care that saves lives, saves limbs and rebuilds and preserves as much function as possible. Neither I nor Dave, as Medical Director, would let anything get in the way of that. The MPs have been exceptionally supportive, they have visited, they have been round the wards, talked to the casualties, they do know what is going on there and they have been as puzzled as we have—as MPs you probably deal a lot more with the press than we do anyway—as to why these things happen.

**Q159 Linda Gilroy:** Before passing over to my colleague to deal with the myths issue, can I say that we are hardened as far as media flak is concerned. Finally, can you tell us the scale of activity you had to put in place to respond to what has emerged from the media interest? Even though we are battle-hardened to these things, I must admit I was quite shocked at what you described in your memorandum.

**Ms Moore:** Some of the things that caused most concern were people posing as relatives, posing as visitors, taking photographs on phones, phoning the critical intensive care unit saying, “This is the on-call manager, just run down the military patients”. The staff have had to have their senses heightened to be aware of what is going on. We have got additional security around the place, and I do not think I should go into all that we do at the moment, but we have had to become extra-vigilant to watch out for this. We have had some excellent reporting and some excellent news stories as well, and some people have reported extremely well. I must say it is a small minority and it is disproportionate in how the press has represented it in that way. The small stories, the urban myths, have spread whereas the good stories have not been as puzzled as we have. We have interviewed every soldier who was a patient at the time and we looked into this and the RCDM managed ward might override proper clinical considerations. How would you respond to their concerns?

**Q160 Linda Gilroy:** In terms of press time to cope with that and arranging the visits that have flowed from all of that coverage, what would you describe that as?

**Ms Moore:** The time taken to deal with this has been quite considerable. The senior nurse in charge of the ward at one time said she felt she was doing organised visits round the ward instead of looking after patients, and that cannot be right.

**Linda Gilroy:** Absolutely scandalous.

**Q161 Mr Jones:** Can I just put some specific examples to you and I would value your comments. One is from last year and two from this year in national newspapers. The first one is the Daily Telegraph, 2 October 2006, headline, “Muslim accosts injured Para in hospital”. From this year, the Daily Star, 5 March, “Hero squaddie told by British hospital to strip uniform as offensive to Muslims”. The last one, quite recently, Mail on Sunday, 10 June 2007, “Muslim women abuse soldiers at troops’ hospital”. Can you just tell us what the background to any of these stories is and what you have done to look into what actually happened?

**Ms Moore:** I certainly can. The first one, the Muslim nurse, we looked into this and the RCDM interviewed every soldier who was a patient at the time and we looked at the nurses, we have no Muslim nurses on that ward, we have no Muslim nurses on that wing. No soldier said anything had happened to him at all in that time. The RCDM could find nothing and we could find nothing. The second one, soldier told to remove uniform because it was offensive, the soldier may have been told to remove his uniform but it is not unheard of for people in hospital to be asked to get out of their clothes and get into bed. As you will have seen from going round the hospital today, we have lots of staff in full military uniform, not just clinical uniform but full combat uniform, big boots, the lot. We have never told anyone to get out of their uniform because it is offensive, they are all over the place. On the last one, my understanding of this from talking to the soldiers is that the person concerned entered into some banter with three Asian people in the street, did not report it, somebody else saw and raised it. When the individual was asked about it himself he did not want to make an issue of this. I am told amongst young people, and it is a long time since I can remember this, that quite often banter will take place in the street between people. A lot of the soldiers say wherever they are, or the sailors in Plymouth, wherever, quite often young people will say something and most people thought it was meant in that vein.

**Q162 Mr Jones:** Clearly, as my colleague referred to, these are urban myths but we have even had Members of Parliament standing up repeating these as though this is the reason why we should have military-only wards, for example. Have you received any direct complaints to the Trust either from patients or member of families about any of the incidents that have been highlighted in those three examples of national newspaper stories I have got here?

**Ms Moore:** No. **Dr Rosser:** No.

**Q163 Mr Jones:** None at all?

**Ms Moore:** No.

**Q164 Mr Jones:** Have the national newspapers contacted you to actually ask you before they print these?

**Ms Moore:** For those that were printed, no. For one of the stories one of the newspapers did contact us, we told them it was not true and they did not run it. Another newspaper, despite being told so, continued
to run it. When we have been asked for comments we have strongly denied them. In relation to some of the stories I wrote letters to the editors and they were quite long and they published a paragraph or two. In most instances we were not asked to comment.

Chairman: We expect, therefore, on the front pages of these newspapers no doubt the headlines will be, “Julie Moore debunks urban myths”.

Linda Gilroy: Scandal!

Mr Havard: Do not hold your breath!

Q165 Chairman: May I say to both of you thank you very much indeed for coming to give us evidence, it has been most helpful. Once again from the Committee, representing a broad range of opinion across the country, thank you enormously for the work that you and your staff do. We would be grateful if you could pass on our thanks.

Ms Moore: We would be very pleased to do so. Thank you all.

Chairman: Thank you.

Witnesses: Mr Terence Lewis, Medical Director, Plymouth Hospitals NHS Trust, Mr Andrew Morris, Chief Executive, Frimley Park Hospital NHS Foundation Trust, Mr Neil Permain, Director of Operational Services, South Tees Hospitals NHS Trust, and Mrs Chris Wilkinson, Director of Nursing, Peterborough and Stamford Hospitals NHS Foundation Trust, gave evidence.

Q166 Chairman: Gentlemen, and lady, welcome. If I may begin by asking you to introduce yourselves and say where you are from and what you do.

Mr Lewis: My name is Terence Lewis. I am a consultant cardiothoracic surgeon and I am Medical Director of Plymouth Hospitals. I am here representing, I suppose, the opinion of Plymouth Hospitals. I separately submitted written evidence in my own right because I am a civilian consultant adviser and I sit on ASCAB. I have been involved with military medicine for a very long time.

Mr Morris: Andrew Morris, Chief Exec, Frimley Park Hospital. Frimley is about five miles from Aldershot, just in case you are not familiar with the geography.

Q167 Chairman: And you gave some very good care to my own family recently.

Mr Morris: Thank you.

Mr Permain: I am Neil Permain. I am the Operational Services Director for South Tees Trust, which is the James Cook University Hospital in Middlesbrough but also the Friarage Hospital in Northallerton. The Friarage Hospital is very close to Catterick Garrison. My responsibility in terms of military healthcare is the senior board lead for the contract with the military both on treatment and hosting of personnel.

Mrs Wilkinson: Mrs Chris Wilkinson, Director of Nursing from Peterborough and Stamford Hospitals.

Q168 Chairman: I wonder if you could explain briefly what sort of services you provide to Forces personnel. You do not all have to come in on this because you probably provide fairly similar services.

Mr Morris: Frimley Park Hospital provides a broad range of what I would call district general hospital services to MoD personnel. We treat around 14,000 outpatient attendances for Service personnel and around 2,500 inpatients and day cases. It could be a dermatological problem, it could be someone needing a hernia operation or an orthopaedic procedure. It is a broad range of activities that you would expect to find in that group of population.

Q169 Chairman: That is very interesting. Mrs Wilkinson, would you like to add anything?

Mrs Wilkinson: We provide district general hospital services similar to that of my colleagues.

Q170 Mr Jenkins: Mr Permain, you mentioned a “fast track service”. Last week one of our witnesses made the claim that we have thousands of Servicemen languishing on NHS waiting lists, yet
when we followed this up we found it not to be the case. Can you explain what you mean by a “fast track service”?

**Mr Permain:** If I could talk about the fast track service but also the waiting time issue in general because I think it is maybe of some interest. This is a service by referral within musculoskeletal services where there is a defined period of time within which a referral would be expected and further treatment. Predominantly two military consultants in orthopaedics deal with these patients. To be honest, I would not want to be quoted on exactly what the timescales are but they are pretty short run-through timescales to be referred and then to be treated as an inpatient. There is also a system within the contract of financial recognition for accelerated treatment for Service personnel across all of the different specialties, so we track and monitor waiting times for access to first outpatient appointment and also subsequent inpatient appointment. It is a particular part of the contract that we try to accelerate that treatment as fast as possible and our times are improving.

**Q171 Mr Jenkins:** Would you recognise what we were given as a waiting time of ten days?

**Mr Permain:** Would I recognise that as a waiting time of ten days for inpatients or outpatients?

**Q172 Mr Jenkins:** Inpatients.

**Mr Permain:** I think that would not be usual. The military would like us to aim for referral within 42 days and subsequent treatment within the same time period as an inpatient. Some patients will access within ten days but that would not be the norm, no. I would say at the moment the waiting times are probably slightly shorter than NHS waiting times, although they are reducing all the time as well.

**Q173 Mr Jones:** Can you explain what the procedure is for people accessing that service? How does that actually work in terms of the connection between the military and yourself in terms of, say, a squaddie at Catterick who needs an orthopaedic operation, for example? How does it work?

**Mr Permain:** Service personnel will be seen by military GPs within Catterick, there is a primary care centre there, and, as I mentioned, on a wider geographical patch there are the Regional Rehabilitation Units which are run by the military. It would be a referral from a military doctor from either of those two sources. There is an administration centre run by military personnel on site at Friarage Hospital in Northallerton who will then make the administrative arrangements directly into our booking and outpatient services and inpatient services to agree a date and communicate that to Service personnel to inform them of the date and subsequent communications from the hospital in the normal way about their clinical care.

**Q174 Mr Jones:** Is that dealt with separately from, for example, someone living in Northallerton who went to a GP? Is it a separate track or Chain of Command that it goes through? Are they dealt with differently?

**Mr Permain:** It is separate up until the point where your appointment is made within an outpatient department and then the system is essentially through our staff within the outpatient department to when they see the patient and then subsequent inpatient correspondence will eventually fit into the same system. The initial referral and dealing with that referral and some of the administration has a dedicated service for military personnel.

**Q175 Chairman:** Mr Lewis, can I pursue a point that you raised about somebody being inappropriately treated here when you have the speciality and the skills where you are to treat him in your MDHU. What happens if you ask Selly Oak for your patient back, as it were, and that patient asks, “Can I go to be treated by Mr Lewis, please?” and his family asks? Does any of that sort of communication take place?

**Mr Lewis:** We do get involved in the longer term care of our local Service personnel who have been repatriated back home and have got continuing problems, and that is completely appropriate. If we were to be approached by people wanting to be transferred to us then that would be fine, we would have absolutely no problem with that. The problem is that we have a relationship now developing between the military whereby the contracting basis for work is completely separate from the business of educating and training military doctors. We have 260 Regular staff in our organisation, 250 of whom departed to Iraq with virtually no notice. If you read the Ministry of Defence briefing document that has been released today for the first time it does not even mention the fact that Plymouth exists, which is entirely inappropriate. It does not mean that our staff within the organisation, who are highly trained and very senior and carry considerable roles and responsibility within military defence services, are not exposed to any of the trauma battlefield training at all and in the long-term it will become a real difficulty for them keeping their skills alive, and it is not necessary. The way that the NHS is developing—the NHS is changing very fast—I believe that we will end up with a small number of complex multi-specialists in very large organisations and a series of district general hospitals, some of which will do surgery and have A&E departments and some of which will not. The kinds of things that trauma patients need, and we do an awful lot of trauma as the tertiary services centre for the South West Peninsula, will have to more and more be concentrated in large organisations. My feeling is that the large organisations are suitable for the care of military trauma patients and that the expertise needs to be gained by the military staff who are being trained by those organisations. *Pari passu* with that, I think it is inappropriate for the routine work, which is the incentive, the carrot, for organisations such as my own to want to carry on training military personnel, the work should and must go with them.
In the past there has been a penalty in terms of funding but now with tariff and PDR that is not necessary, it should not be a financial risk to the Armed Forces and there needs to be concentration on Armed Forces' medicine within a smaller number of organisations which by and large are at the complex end of things. That does not mean to say that I think all services should be there. If, in fact, certain services can be entirely military as a proper critical mass in terms of people's careers and critical mass throughput, such as rehabilitation, mental health services, counselling, that kind of thing. I have no problem with that at all, but most of it is increasingly complex, it increasingly depends on interdigitating specialities and I think that services need to be rethought and fundamentally rethought.

Q176 Chairman: Should there then be a smaller number of MDHUs?

Mr Lewis: In my opinion, yes. I think that the MDHUs need to be concentrated, wherever possible, where there is an ethos of care and involvement in the military and where they are close to conurbations which provide those kind of people.

Mr Permain: Just to give the context because the debate is moving that way, I think it is worth pointing out that at South Tees Hospitals, which includes the James Cook as a major site, we have a cardiothoracic centre and a neurosciences centre and vascular services which are provided to the sub-regions, so as a hospital equally we have very high level complex services. In terms of the relationship the military have with the centre, we do have the services. When you asked me which services we provide, at the moment we are not a direct referral centre for the military for those complex needs but we do have that capability. I thought it was worth emphasising that. Particularly on the hosting side of staff as well, that does give opportunities for staff who are working within the unit to get experience in all of those specialities. Although the general services are provided to the personnel, staff are working in all areas. In fact, in our relationship with the MDHU staff locally we have continued to increase their presence in Accident & Emergency, in ITU and in other specialist services. I just wanted to emphasise that rather than just focus on where treatment is focused at the moment in our hospital, which is in the more general areas.

Q177 Chairman: Mr Morris, do you want to add anything?

Mr Morris: Nothing, apart from the fact that typically 95 per cent of the referrals are all looked after within the organisation, so very few people have to go on elsewhere to get a service. Clearly there is a balance to strike between proximity of MoD personnel and where people need to go for specialist care. The majority of Service personnel around Aldershot would look to Frimley for a service, and that is literally just down the road.

Q178 Chairman: Mrs Wilkinson, do you agree with Mr Lewis?

Mrs Wilkinson: I think that the specialist care is very important to go wherever the clinical outcomes are going to be the best for the patients. There are different issues around where MDHUs should be hosted for the training requirements of the staff who are going to go to places of conflict.

Q179 Mr Havard: Heaven forefend that I should interfere with this competition process in the health service, which I did not vote for! This is an interesting argument though because, as I understand it, in 1999 there was a competition held to have the host for the medical centre and this organisation—Birmingham—won that competition and that is why it is where it is. You seem to be suggesting in slightly different ways that that question about where the training is all concentrated in relation to this might be something that needs some form of re-evaluation and then the provision is perhaps a different level of discussion because people can be physically transferred after original assessment, as it were. What was said to us previously, as I understand it, was that Birmingham wants to be the reception centre and effectively has become that, by default or design that is what is happening, so they start by arriving in Birmingham. Mr Lewis, you seemed to be suggesting that some of them ought to arrive in Plymouth. There is a difference of opinion there, presumably, about that strategy of having the reception all in one place and the training in one place. Do I understand that correctly or are you just making a bid that you did not make in 1999?

Mr Lewis: No, this is not a fashion parade at all. We have got a very large civilian following in Plymouth and we have to respond to that. We are expected to do so and we are delighted to do so as part of our ethos. We want to look after our troops, many of whom come from that part of the world, particularly the Marines and the Navy, and we expect to be part of their long-term care as well and that is one of the advantages of being looked after from the very beginning to the very end in that the acute episode is just that, an acute episode, but too many of these episodes have very long-term follow-up requirements and we would want to be part of that. Where I am coming from, having been involved with the provision of Armed Forces' medicine for a very long time, is that there needs to be a radical rethink of the relationship between the Armed Forces' medicine and the NHS. The NHS is changing dramatically fast, it is not the same as it was before. My own organisation is not the same as it was in 1999. Our consultant numbers have gone up from 98 to 315 in seven years and we have become a tertiary services engine for the South West; we were not in 1999. Things are changing very rapidly. We need to play our role within Armed Forces' healthcare and we think that our role should be changed and different from what it has become, which is at the moment a trainer of a large number of Regular military forces and a provider of lots of Reservists who come and go with increasing regularity. We get contract work in terms of orthopaedics and various things like that in relatively large numbers, although
I cannot give them to you, but we are not involved in the major trauma side of things, which is an absolutely key part of what we provide to our local population. We are a very major trauma centre and we need to, and feel that we ought to, be part of that as well as just a trainer of Regular forces.

Q180 Mr Jones: What are you doing differently? I know the James Cook very well because most of my constituents go there for heart specialism. I think you are saying that personnel trainers have different specialisms but what prevents you, Mr Lewis, from allowing them to get experience in terms of trauma, which you are obviously a good centre of in the South West?

Mr Lewis: Nothing at all. I am not here to rubbish anybody else, not Birmingham, not any other healthcare organisation. I am here to state the situation as we perceive it in Plymouth.

Q181 Mr Jones: What stops you from using those people you are training to get expertise in trauma areas and other expertise?

Mr Lewis: We do not need the expertise, we have got every regional specialty that is provided except paediatric cardiac transplantation and liver transplantation.

Q182 Mr Jones: You are training people, are they getting experience in trauma medicine in your Trust?

Mr Lewis: They are getting a lot of experience in civilian trauma but there is a difference between civilian trauma and battle trauma.

Q183 Mr Jones: That is what I am trying to get at.

Mr Lewis: Our civilian consultants, and we have 80 doctors who work, the rest of the 260 or something are nursing staff, technical staff and the rest of it, our doctors are deprived from battle wound experience but they see an enormous amount of general trauma.

Chairman: We are falling behind quite badly now. Kevan Jones, can you move on, please?

Q184 Mr Jones: In terms of the requirements for Service medicine, can I ask you what are the challenges that Service populations put to you and what do you do to cater for them differently possibly than the ordinary civilian population?

Mr Morris: I think the key challenge is accessing treatment. Most people in the Services want to get back to the job they are doing, so there is enormous pressure on us to fast track soldiers so they can go back to their barracks and Service. The contract is structured such that there is a significant incentive for us to provide faster access to outpatient services and treatment services. A lot of us are hitting points where 75 per cent of people are seen within four weeks and 90 or 100 per cent are treated within 13 weeks if they need surgery, and I think that is the key concern along with welfare support and access to our sites. If you come into Frimley for an arthroscopy for a day, a knee procedure, and you are stationed in Maidstone, having the ability to stop overnight in Aldershot and just come down the road the following morning for your day procedure is quite important. That is where we work closely with colleagues in the MoD to make that pathway as smooth as possible. We do the procedure on a day case basis, it is cheaper for the MoD and the soldier is housed in an MoD environment before coming to Frimley if he has got difficulty in getting to Frimley.

Q185 Mr Havard: Given the time, we would have liked to have asked you a lot more questions but what is clear from what you have said is there are lots of questions about the benefits as well as the problems organisationally and the connections between the MoD and NHS, but that is a developing agenda. Can I ask you whether or not your Trusts, which are particular because of your relationship with the MoD, have considered becoming involved in the provision of healthcare overseas, Germany, wherever, because we have got people in a number of locations? You have not?

Mr Permain: No, we have not.

Mr Morris: No.

Mr Lewis: You mean providing to civilian overseas patients?

Q186 Mr Havard: Yes essentially at the first level.

Mr Lewis: Increasingly we now get patients from all over the South of England and abroad in terms of our cardiac surgical outfit which has got amazing results. We are running businesses now and our businesses have got to deliver a surplus in order to reinvest in our organisations. We would be very short-sighted in terms of marketing not to work out what our opportunities are. The opportunities for us in the South West are fairly considerable due to where we are and access to it. We would have no problems at all, particularly for our tertiary services. Secondary services are different, we have to concentrate and realise the core responsibility for us is to provide secondary services for the 450,000, 470,000 patients of the immediate Plymouth environment and for the 1.7 million patients in Devon and Cornwall. For tertiary and specialist services, which we have a complete range of, we must look wider where we have the spare capacity but not where we do not.

Mr Havard: Can I ask you a question about overseas in a different way. We are going to take some evidence from the BMA in a little while who are going to tell us there are all sorts of shortages in terms of the right sorts of people in the right place and so on, and we have TA personnel and there is a reliance on Reservists within the medical service. People get engaged in that process, we have got consultants flying on helicopters in Helmand going out and doing things, so people do get experience in all sorts of different ways for different reasons. The suggestion is that in some way or another if you get involved in this there are disincentives and you could be discriminated against or in some way be seen to be disadvantaged in terms of your medical career. What is your experience of trying to engage, because you have a lot of people involved in this way, presumably? What is your direct experience? Is that true?
Q187 Chairman: I wonder if we could ask Mrs Wilkinson to start off with that because we have been keeping you too quiet.

Mrs Wilkinson: Thank you. I think you are asking about military medical consultants.

Q188 Mr Havard: Yes, nurses and people going in formed units or whatever.

Mrs Wilkinson: The way we work with the MDHU in Peterborough is we work towards as full integration as we can so the opportunities that are available to our military colleagues are the same as those available to our NHS colleagues. We work very closely in all of the decision-making policy boards and so on, so I do not see disadvantage for opportunity within the NHS spectrum of experiences for my military colleagues.

Q189 Chairman: Would anybody like to add anything to that? Mr Lewis?

Mr Lewis: I do not want to be seen to be hogging this, I am sorry. I think there is a real threat there particularly in terms of the Reservist side of things. We are increasingly running ourselves as businesses and chief executives and medical directors, next or after next, are likely to be much more hard-nosed about the thing. Personally, in terms of a business I would not appoint a whole raft of Reservists if I knew they were more and more likely to disappear from our organisation. When we lost 250—not lost, but when they disappeared—into Iraq with zero notice, we have to bear in mind what these people were and they were absolutely crucial to the organisation: they were surgeons, anaesthetists, intensivists, high technology technicians, they are in A&E, they were in orthopaedics. Losing those in an organisation such as ours has a very major effect. In addition, if you are going to bleed your Reservists as well I think that is a real danger to their appointment and you could find them being negatively considered in years to come. Not now, we are absolutely committed to the whole manoeuvre, but I want to make sure that the critical mass of the military within my organisation is correct. It has stayed the same now for nine years and we have tripled in size, so it is becoming—

Q190 Mr Jones: Mr Lewis, what is the solution to that?

Mr Lewis: The solution is making a larger critical mass of military and spreading it through a smaller number of hospitals, particularly the extremely complex high-tech ones because that is the way that medicine is going to go. That does not mean to say that secondary care needs to be directed in the same direction. It would help as a financial carrot to trusts to carry on being involved in the military, but people need to be under no illusions as to how difficult is to have a very large military medical presence in a hospital because they do disappear all the time.

Q191 Mr Havard: Would you see that map of five, seven, or however many it is, coterminous with the future super garrison sort of map?

Mr Lewis: I do not see why not, it works perfectly well. That would allow long-term care of those patients as well. A lot of the R&D in terms of military medical care is not just about the acute episode, it is about what happens to these people in the middle and long-term. We have a very large population of such problems and we need to be in it at the beginning, the middle and the end.

Chairman: Thank you very much indeed to all of you for coming to Birmingham to see us and help us with our inquiry, it has been extremely helpful and also very interesting. Thank you very much.

Witness: Dr Brendan McKeating, Chairman, Armed Forces Committee, British Medical Association, gave evidence.

Q193 Chairman: Dr McKeating, could you tell us what your role is and why you do it?

Dr McKeating: Good afternoon. It is actually a voluntary role. My name is Dr Brendan McKeating. I am Chairman of the British Medical Association’s Armed Forces Committee. Just to give you a little bit of background on myself, I served for 16 years as a Regular in the Royal Navy as a medical officer, both at sea and ashore, both in the UK and overseas, and both in secondary and primary care both in the NHS side and military hospital side of the work as well. I am a Gulf War veteran. I have now served for the last seven years as a Reservist in the Naval Reserve and recently commanded my local Royal Naval Reserve unit. I am an NHS GP full-time and a GP trainer. I am Chair of this thing called the Armed Forces Committee of the BMA. We represent the views of members of the BMA who serve in the
Armed Forces, be they uniformed, Reservists or civilians as well working as CMPs, civilian medical practitioners, both GPs and consultants for the MoD. We represent their views both within the BMA itself and obviously to external bodies. Most of our work is based around providing evidence to the Armed Forces Pay Review Body and that is a lot of what we do throughout the year, but obviously we get involved in other work such as this as well.

Q194 Chairman: Thank you, that is helpful, Dr McKeating. You have given us a list of a number of shortfalls in DMSD manning levels in a number of medical specialties. For example, there is a shortfall of, I think, 32 per cent in orthopaedic surgeons, 69 per cent in pathologists and 100 per cent in neurosurgery. Where do you get these figures from and what is the evidence for your figures?

Dr McKeating: These figures are provided to us by the MoD, by the Defence Medical Services, so directly from the MoD themselves.

Q195 Chairman: What impact are the shortfalls having on an operational basis?

Dr McKeating: In terms of the operational basis, that is actually difficult to quantify. Certainly the guys who deploy around the world with the Armed Forces will give their all for their patients and they are part of the same organisation. They will look after their people to the best of their abilities, as I think we have heard. In terms of actual patient care, we have no evidence of any detriment that we are aware of to patient care on the frontline or coming back through the casualty evacuation process, but obviously what does happen is if you look at these shortfalls it is going to put a strain on certain pinch point crucial areas, such as surgeons, GPs, anaesthetists, because if you have got a small cadre of people who have been repeatedly deployed, if you look at the numbers here for deployable trained strength of general surgeons, we are looking at 12 and that puts a very heavy strain on those individuals. For a number of years we have been doing a cohort study looking at the attitudes and views of people as they move through their career with the Armed Forces and certainly this factor of turbulence and family separation is something that comes through all the time when we send out our questionnaires and I think that is where it is hitting people. The problem is as the group gets smaller the burden on these key groups who are going to repeatedly deploy gets heavier and I think that is the problem. We are asking a lot of these people. Not only do they have to meet all the requirements of their civilian colleagues, they have to be trained as GPs and consultants as per the NHS, they have to meet all the training requirements of the Royal Colleges and keep up-to-date and keep their standards going through appraisal just the same, and they also then have to be able to do that job in a military environment and they have to be safe and be able to function in the air, under the sea, on the sea and on the ground. These people are quite a national resource and the burden is falling on significant sub-groups of them repeatedly to meet the operational tempo at the moment.

Q196 Chairman: I was talking to one this morning who was regularly shot at, which is an additional burden to bear, I dare say.

Dr McKeating: It certainly is. As a Gulf War veteran a similar thing happened to me and it does focus the mind.

Q197 Chairman: How do these shortfalls compare with the National Health Service?

Dr McKeating: If the NHS was undermanned by 55 per cent for trained GPs and consultants in terms of their stated requirement it would be a very significant problem. Obviously the military have to have some flex in there, they have people doing staff jobs, people in training, various other posts, but we are looking at a very, very significant shortfall in terms of what goes on in the military. As far as I am aware, I do not think the shortfall in the NHS is anywhere near that and if you look at what has been going on recently in terms of the training of junior doctors, certainly the situation in the military is much more acute than in the NHS.

Q198 Linda Gilroy: Looking ahead, some commentators suggest that there may well be almost a surplus, unbelievably, of doctors in a few years’ time, domestic overproduction, so do you see this changing? Do you care to comment on the balance between having generalists available for deployment rather than specialists?

Dr McKeating: I will take that in two parts. First of all, yes, I understand that if you look at the people leaving the Armed Forces’ Medical Services, the doctors—these are MoD’s own figures—8.4 per cent was the resignation rate in 2004-05 and 3.8 per cent in 2005-06 and that is falling and we believe that may be lower this year. Why is that? Well, it may be due to turbulence on the outside, it may be that people are perhaps hedging their bets and waiting until things settle down in the NHS with the changes in training and structures within the NHS. In terms of the training pipeline, the military have always done relatively well. They can recruit people early on in their careers but traditionally their problem is keeping the trained product, the trained accredited GP, GP trainer and the trained accredited consultant, that has been the problem. In terms of deploying generalists, you could argue that all military surgeons have to be able to perform some general surgery and if you look at what has gone on in recent operations people are certainly extending their roles, but the way doctors have been taught and the way they are being trained, people are working in very specialist areas now. If we are going to continue to provide the high level of care that we do to people, our forces on the ground, then we are going to need to keep those specialists within the military.

Q199 Chairman: Okay, so that is the problem, what is the solution?
Dr McKeating: Certainly we see that there are a number of issues relating to why people go. One is turbulence and the problem is this becomes a vicious circle because if the cadre gets smaller then the burden falls more and more upon those who remain. That is one issue. Whenever we do our studies looking at how people feel and what the factors are that make them leave, it tends to come out that it is separation from family and turbulence, and also turbulence in terms of how it affects your clinical work as well being repeatedly deployed away. Certainly most hospital specialists are working within an NHS environment now, so they are working with their colleagues just the same as any other cardiologist or surgeon would do and that puts pressure on their workload. Pay is another issue. We still feel there is a differential between what people are being paid in the NHS and in the military. A few years ago we were not far off parity when a new pay scheme was brought through to military doctors, but not on the heels of that came the new GP and NHS consultant contracts which moved the goalposts for us. Certainly in terms of the consultant cadre we feel that over a career they are probably about four per cent behind their NHS colleagues looking at introducing a system of quality rewards, such as the local clinical excellence awards that NHS consultants get, and also some sort of out-of-hours supplement that the NHS consultants get, that will add another five per cent. In terms of the GPs, overall career-wise we think there is a career earnings differential of 4.8 per cent there, looking at our figures, but that differential in the early years of when you accredit is greater. If you are looking at the first one to 12 years you are looking at somewhere between an 11 and 14 per cent pay differential between what you would earn in the NHS and what you would do in the military. Pay is not everything and people do not serve in the Armed Forces, serve their country and put themselves through what they do when they join the military for the pay, but when you approach that time in your career and you are accredited as a GP or a consultant, you may then have a partner, may have children, you are looking for more stability in your life perhaps, if you then look and you perceive there to be a pay gap as well then that is going to have an effect. The third issue is around work issues, promotion, flexibility, flexible careers, career breaks, part-time working and that sort of thing. We know this is something that when we have spoken to the Defence Medical Services Department and also to the MoD about these issues they are looking at them, but these things are crucial. If you look at who go into medical school now, 50 per cent-plus and rising are female medical students. As time goes by they will want perhaps to manage their careers differently from the traditional role that the military have seen doctors working through in the past. There may be times when they want to take career breaks and may need flexibility in their working patterns and the hours that they work. These are all issues, I think, that come together to influence people to decide to go. As I say, we know that the PVR (requests for premature voluntary release from the Armed Forces) rates, the requests for premature release, are slowing but that may be due to changes and the turbulence in the NHS at the moment with what is happening with medicine rather than what is going on in the MoD itself.

Q200 Chairman: In relation to the pay thing that you have just raised, when we were in Iraq last we met a doctor who said if he left the following day he would be paid double what he was being paid in Iraq, with all the difficulties and danger there, if he went into the NHS. Is that about right? We put that figure to the Minister of State and he thought he recognised that.

Dr McKeating: There are certain instances where you could do that. If you were a newly accredited GP, for instance, depending on what practice you went into, you could go out and earn a lot more. To be quite honest, military doctors are quite a marketable commodity: they are well trained, they are going to turn up on time, do the job, do what they have to do. They are a very marketable commodity. You could envisage a situation where somebody could go outside, more so in secondary care perhaps with the inclusion of private practice.

Q201 Linda Gilroy: I think since that remark you have been successful in getting a reasonable settlement. It does not address everything but since a year ago there has been some improvement, even though it does not meet the whole gap.

Dr McKeating: Yes, certainly we managed to narrow the gap last year but, unfortunately, this year we got the standard public sector two per cent which effectively starts to chisel back the progress we made the previous year. Those figures I quoted initially are the differentials that we believe we are still looking at after the admittedly good pay rise that the Defence Medical Services achieved last year.

Q202 Mr Jenkins: They may have received a good pay rise but nothing like the GPs in the NHS got, did they, so how is a young GP going to explain to his family that he is prepared to go away and serve with the military and earn 40,000 or 50,000, but as a GP in the NHS he could bring home £120,000 a year? If you have done all the figures, can you tell us what the bill is to make sure that these people are compatible with the NHS because I would love to know so that we can pursue the MoD to see if we can bring them in line?

Dr McKeating: I am sorry, I do not quite understand. Do you mean the overall costing of such a pay rise?

Q203 Mr Jenkins: The bill that would bring them into line.

Dr McKeating: No, we do not produce such figures for the Government. We leave it up to the Government to do that.

Q204 Mr Havard: I find what you say very interesting. I was a trade union official for a number of years so I understand exactly what you are doing, you put all the factors in and you are bidding up the price, which is fair enough, that is part of your
activity, and it is part of the difficulty as well as part of the solution. In the limited time I have got available, in the evidence that you have given there are two elements, this question about terms and conditions issues, as it were, and whether or not people are discriminated against in their careers, either by the fact that their training fades or they cannot do the specialist they want to do and that side of it, discrimination in the sense of over-use of them in a particular way, but also direct discrimination, particularly in relation to Reservists. You seemed to suggest, and some of the trusts were suggesting earlier on, that because of more commercial arrangements within the NHS, if you like, it was said directly, “I would not employ them because they are a drag”, that sort of pressure. That was not directly what they said, I do not want to misrepresent their argument. Are people directly discriminated against and where is the evidence for that, or is the discrimination much more related to this complex complexion of different elements relating to training, pay, usage and so on? It is important. Is there a difference as well between the full-time personnel who you say are wanting to leave and the Reservists who increasingly are having to be retained and recruited to fill in the difference because of the gap?

Dr McKeating: In terms of Reservists, the figure we had to April 2006 was 770 and they got 380 doctors, so they are 50 per cent undermanned in the Reserved Medical Services. If you look at the people leaving the Armed Forces it is very interesting that the study that we did showed that only one in ten who were leaving the Regulars would consider joining the Reserve Forces. They will have some Reserve commitment on leaving the Regulars but in terms of joining the Reserve Forces and volunteering for Reserve Service, in other words joining the Royal Naval Reserve or the TA or the Royal Auxiliary Air Force, only one in ten said they would do that.

Q205 Mr Havard: But, as I understand your study, that was much more related to their family issues than it was any of these other issues about pay or training.

Dr McKeating: Coming on to the Reservists themselves, we are getting some evidence, and certainly I know of one senior Reservist Medical Officer who feels he was very much disadvantaged by the Reserve Forces in terms of every day that he took away to do his Reserve commitment he lost time out for his pension and towards seniority and towards clinical excellence awards while he was doing that. When we were coming up to TELIC 1, the invasion of Iraq, he was spending a lot of time being involved and feels he was very much penalised by his trust for that.

Q206 Chairman: Does that system remain the case?

Dr McKeating: It depends on the trust. Certainly from my own experience with my own Naval Reserve unit, we have one trust locally that is very supportive of Reservists and they effectively get two weeks' paid leave a year to go and do their training to keep themselves in-date for their Reserve commitment, but we know other trusts are much less supportive. It was very interesting to hear the gentleman from Plymouth's comments. These trusts are becoming much more commercially savvy and orientated and having a Reserve commitment in the future could become something that might go against you when competing for a job.

Q207 Mr Havard: So is the solution to bid up the price for the individual or is it to give a countervailing amount of money to the employer in order to avoid that problem?

Dr McKeating: If you are going to have Reserve Forces you need to look after the employer as well, especially if you are going to use them. You have to make it so that first of all the individual does not lose out by volunteering to serve their country and do these things. Certainly Reservists do not do it for the money but what they do not want to do is to lose out and when people approach them and say, “I have looked at the Naval Reserve” and then find out they may have to use their holiday to meet their training commitment or lose out financially or may find they are being disadvantaged in some way, we have to look after the employer as well and make sure the employer is on board. Trusts are like different employers: some employers are very supportive and other employers are not, unfortunately.

Q208 Linda Gilroy: We have heard some evidence from Service families that there can be difficulties with registering on coming back from overseas. From the point of view of your members, have you come across that at all?

Dr McKeating: Do you mean registering with an NHS GP?

Q209 Linda Gilroy: Yes.

Dr McKeating: That is something outwith our terms of reference, so I have no information on that. I have done it myself and not had a problem, but that is anecdotal.

Chairman: Dr McKeating, thank you very much indeed. Your session, as well as everybody else’s session, has been fascinating and very helpful indeed. Thank you very much.
Dr Christopher Freeman, Consultant Psychiatrist, Royal Edinburgh Hospital, gave evidence.

Q210 Chairman: I would like to say welcome to everyone. This is the third session of our inquiry into Medical Care for the Armed Forces. It is a particular pleasure for us to be able to come to Scotland to take evidence on this. We are grateful to our hosts at the Scottish Parliament for making these facilities available to us. We will be taking further evidence during the next few months from ministers at the Ministry of Defence, from ministers at the Department of Health and we expect, and hope, to publish a report some time in the New Year. This afternoon we have evidence from the Royal College of Psychiatrists, from the Board of the St John and Red Cross and also from officials from NHS Scotland. If I may begin by setting out the timetable for that. Dr Freeman, thank you very much indeed for coming. We will be hearing from you between now and about ten to two. We will then hear from the Red Cross and at about ten past two we will move on to NHS Scotland and the way that defence medical care interacts with them. We expect to finish at about 3.15, 3.20, so that gives us a timetable of how much we have got to get through in the time. With you, Dr Freeman, we have just over half an hour. I wonder if you could very briefly introduce yourself and say what you do and why you do it.

Dr Freeman: Yes, I am Dr Chris Freeman. I am a consultant psychiatrist and psychotherapist working in the Lothian Edinburgh area. I have been a general psychiatrist and more recently, over the last ten or 15 years, a specialist in the treatment of traumatic stress reactions. I run a traumatic stress treatment centre called the River Centre which offers a service for the whole of Scotland, but mainly for the south-east of Scotland, and we treat asylum seekers, refugees, civilian accident victims, Service personnel, Fire Service, Police, a wide range of traumatised people. I have been a consultant psychiatrist and psychotherapist working in the Lothian Edinburgh area. I have been a general psychiatrist and more recently, over the last ten or 15 years, a specialist in the treatment of traumatic stress reactions. I run a traumatic stress treatment centre called the River Centre which offers a service for the whole of Scotland, but mainly for the south-east of Scotland, and we treat asylum seekers, refugees, civilian accident victims, Service personnel, Fire Service, Police, a wide range of patients suffering from post-traumatic stress reactions. Just by chance, because most other services across the whole of the UK are very, very small, we are by far the biggest service anywhere in the UK with about ten or 12 full-time staff working in this area. It is a credit to Lothian Health Board and to the UK Trauma Group, which is a managed clinical network of all the trauma services in the UK, both in the independent sector and in the NHS sector, including Combat Stress and military psychiatrists and psychologists as well. We meet once or twice a year to exchange ideas, discuss policies, give advice, etc. That has been going on now for about ten years. I am really here with three different hats on, and if I give three different answers I apologise for that. I am here as a general psychiatrist to try and give you a picture of what it would be like in routine clinical practice were a veteran referred; I am here as a specialist in traumatic stress to say what could be done in specialist centres; and I am here representing the Royal College of Psychiatrists to give an overview of psychiatry. I have to say those are three quite different perspectives, there is not a single answer to most questions.

Q211 Chairman: Okay. Thank you very much. Can we look first at ex-Service personnel with mental health needs? Could you tell us briefly how well you think the NHS deals with ex-Service personnel?

Dr Freeman: It hardly deals with them at all. I speak now with my general psychiatry hat on, what it would be like if I was working in Fife or Argyll or Glasgow and a man, usually a man, with a Service history was referred to us. It would be no different there were he a postman, a painter, a squaddie in the Army, a colonel in the Army, in his history there would be a note that he was a soldier rather than a postman. It would be as basic as that. There is no specialist service. Most general psychiatrists would not be very much aware of the war pensions scheme, would not be aware of Combat Stress and the role it plays in Hollybush House, would have a vague idea that there had been a lot of debate around about Gulf War Syndrome, chronic fatigue, perhaps overemphasising the role of PTSD, but it would be no more than that. They would get treated for their depression, their alcohol or drug addiction, just like any other person. They would not be aware that a circular goes round to chief executives from the Health Department regularly saying that veterans should have priority because that would never filter down to your average general psychiatrist. They probably would not have any concept of what Army or Service life is like and what the particular stresses or strains of being a veteran would be. They would get the same treatment as anybody else, but not specialist tailored treatment if they were referred in that sort of way.

Q212 Chairman: Do you have a view about whether Ministry of Defence as opposed to the NHS should maintain some sort of responsibility for veterans after they leave the Service? Do you think the arrangements that we have got at the moment are satisfactory? From what you say it sounds as though you do not.
**Dr Freeman:** No, I do not think that. Things have improved. There was a time seven or eight years ago when if you referred a Serviceman you could hardly get access to his Service medical records, it was difficult to contact a doctor in the military to find out what had happened, but that has improved a lot. Of course, there was this very odd practice that the Army had of the man’s Commanding Officer writing him a letter of recommendation on his discharge saying, “This man is a credit to the Service. He would be fully well-employed in any job you would care to offer him”, without any mention of what difficulties he might have been through or what traumas he had had in Service practice. Men were discharged from the Services with, understandably, a big pat on the back for the service they had offered but were given a clear message: “You’re going to be okay. Go out there into civilian life and get on with things”. Of course, one of the big messages I want to get across is how difficult it is for these men to seek help. That is one of the really important things that we have to change. Even for Combat Stress it is many, many years before a lot of these people come forward for help. They are ashamed of having psychological problems, they use drink and alcohol to cover up their symptoms, and it is really hard for them to consider going to their GP and saying, “I’m breaking down. My marriage has gone wrong. I’m having dreams and nightmares”, etc. I do not know that the Ministry of Defence can do much about that. There could be an argument for saying that there should be some sort of post-discharge screening, that one or two years after discharge you should see someone and at least have your mental health checked out, but my guess is that many of these men would not go back for that, they would be avoidant of it. I think it has to be within the NHS and the primary target has to be alerting GPs to the particular problems of veterans and having them sensitive to doing that. These men do go with physical problems. The GP is the main point of contact and they do go with their excess drinking, etc. It is raising awareness amongst primary care teams that the NHS has to do.

Q213 Mr Jones: I agree with the need for perhaps more awareness among GPs of the general things you are talking about, but do you not think we could invent a system to at least track these people either through the NHS, the MoD or some veterans’ agency and at least we would know where they were? One of the things that comes over all the time, which is exactly what you are saying, Dr Freeman, is people do not know where they are and they only present when they have problems or perhaps they do not know they have problems?

**Dr Freeman:** As I am sure you will know, a lot of these arguments were argued out in what was called the PTSD case in the High Court a few years ago where several thousand soldiers were suing the MoD for not being looked after in terms of their psychological needs, both during their Service and post-Service. That was one of the areas that was debated and it was certainly something that the men put forward, that in some way a letter could go from the Army Medical Service to their GP on discharge simply saying, “This man served in Northern Ireland, two tours of service in Iraq” etc., flagging up that there would be certain people who would be at high risk, but that was rejected by the MoD at that stage. There are a few who fall through the net and drift around the country and do not register with GPs, but most of them do have a GP and when they go to their GP two years after discharge they do not say, “I am a soldier”, or “I’m an ex-soldier”, they just go in as someone who is working as a painter, a postman or whatever. So if the GP did have some little starred note saying, “Look, this man actually saw active service in three different theatres of war and was exposed to X, Y and Z” that would alert them, I think.

Q214 Mr Borrow: Moving on to serving personnel, to what extent do you think the MoD provides adequate support for the mental health services for serving personnel?

**Dr Freeman:** Again, it has waxed and waned. If you go back 20 years it was at a very low ebb. There was then a large number of community psychiatric nurses appointed in the Service and we had four or five working at Redford Barracks at one time. I happened to run a cognitive therapy, psychotherapy training course and those CPNs came on that course, so there was high quality psychological treatment for these people. Sadly, most of those personnel seem to have disappeared and Catterick has closed, which was a place that you could go for inpatient treatment. I think they do an okay job but not a great job. The psychiatric services are stretched. They do pretty good assessments and monitoring but getting high quality psychological treatment is certainly as difficult in the Army as it is in the NHS, given that these are a high risk group of people. The thing that the MoD has done over the last few years is there is a large research unit at King’s College run by Simon Wessely, they have put a lot of money and effort into that, and they are taking post-deployment screening seriously, they are following people up more during Service, but there is always this tension, you think of yourself as the soldier, “How much do I want to disclose about my mental health problems? Does that mean I am going to be gently eased out of the Army?” It is a very difficult tension. I feel that bit has not changed yet, there still needs to be more acceptance of psychological problems in serving Service personnel and the aim should be to treat and rehabilitate these people to keep them in the Services. They are often very, very good soldiers who are very, very loyal to the Army, particularly, and they want to stay. They are terrified of going to the medical officer and saying, “Look, I’m depressed, I’m having nightmares, I can’t sleep and my marriage is going wrong” in case that has an impact on their Service career.

Q215 Mr Borrow: You mentioned the closure of Catterick, but to what extent do you think the restructuring of mental health services has improved things or made them worse?
Dr Freeman: I am certainly concerned about the use of the Priory private independent hospitals for the inpatient services. I do not think when that was commissioned that the Priory were experts in this area. Many of these men say that what is important to them is being treated by someone who has some knowledge of the system in the Forces; they need to feel the person understands what life in the Army is like, so I am not sure that was a good idea. The problem with contracting to the private sector is that the private sector makes its money by keeping people in beds, the longer someone is in hospital, the more money they get, and that is a tension between the NHS and the private sector, I think.

Q216 Mr Borrow: To what extent is your view coloured by the actual work you do in the sense that within serving personnel there will be displayed a whole range of mental health difficulties, not simply those that are related to the trauma of being in theatre? Obviously that will be part of it but there will be the whole range of mental health needs that a civilian population would show as well.

Dr Freeman: I think that is a very fair point and something I would want to emphasise. Even if you take post-trauma psychological reactions we have slipped into a very easy way of thinking that horrible events happen to you, therefore the psychological reaction you get is post-traumatic stress disorder, and that is just not true. There are some good follow-up studies. If you take 100 people, military or civilian, who have been severely traumatised psychologically because of exposure to warfare, rape, torture or whatever, the commonest reaction they will get is depressive illness. The second commonest is some sort of anxiety disorder, panic disorder, agoraphobia, generalised anxiety disorder. The third is PTSD. Even in those who have been traumatised PTSD is not what you would expect to happen. I fully agree it is really important that we do not narrow this argument down to thinking of psychological trauma, therefore PTSD, therefore services for PTSD. Depression, alcohol and drug misuse, anxiety disorders, they get just the same range of psychological problems as people in the general population and, therefore, they need that range of treatments.

Q217 Mr Borrow: Is there anything the MoD could do to actually improve the preventative health services in the mental health area? In other words, what could be done to make it less likely that serving personnel have mental health problems either while they are serving or after they have left the Service?

Dr Freeman: Again, this was very fully debated in that MoD case and there were examples given of how we could screen entrants into the Services better. I think the answer is probably no, the evidence is that screening is not a sensitive enough tool and who would you actually screen out because sometimes someone who has had a very disadvantaged background, who may have had adolescent problems from the backstreets of Glasgow, becomes a really good soldier when they are embraced into the Army and supported and given an experience they never had in their civilian life, and you might screen out some very good soldiers. Apart from screening for very severe mental illness problems, which I think the Army would feel they already do—schizophrenia, bipolar disorder, excessive drug misuse—I do not think screening at the beginning would do. As you know, they have what is called the PULHEEMS System for rating people regularly during their Service and that does not pay enough attention to psychological and social factors. In-Service monitoring is something that I think could be done. The Israeli Army, as you will know, has very detailed pre-deployment preparation and there is this big debate about how do you prepare soldiers for warfare. Do you do traditionally what the British Army has done and said, “We’re a great fighting force, you should be proud to be a British soldier. We expect you to behave with valour and gallantry”, whereas the Israeli Army says, “You will be scared shitless. You will never feel fear like you will feel in the battle force and you need to know how your body responds to that. In training we are going to put you through that now so you are prepared for how you respond in very, very stressful situations”. It is quite a different message. They would claim they get lower rates of post-psychological breakdown but I think the evidence is not that strong, to be honest.

Q218 Willie Rennie: In general do you think that the mental health services within the Armed Forces are getting better or getting worse?

Dr Freeman: I think they are getting better. Although that big court case was “won” by the MoD rather than by the men, and many of the men were very disappointed in the outcome, it certainly focused the MoD on the fact that they had to do things better. There is some very good research going on. They are taking this seriously now. I am not sure it has been fully translated into treatment services but in terms of understanding what they can do in terms of post-deployment defusing and those sorts of things, the project that the Marines have, I think they are really trying hard.

Q219 Willie Rennie: Okay. Just going back to ex-Servicemen, do you think ex-Servicemen suffer a disproportionately higher level of mental health problems than the general population?

Dr Freeman: Yes. It is not uniform across the Services, the Air Force and the Navy have much lower rates than the Army. That may be about the nature of deployment and all sorts of factors may be involved in that. Of course, you have to say that the population that the Army recruits from is often a very disadvantaged population so they may have had problems anyway. The big issue is that for many of these men their time in the Army was the best time of their life. They had their needs met, the

1 The acronym “PULHEEMS” is derived from the first letters of the qualities assessed when a medical examination is carried out. The PULHEEMS qualities are P (Physical Capacity), U (Upper Limbs), L (Locomotion), H (Hearing), E (Eyesight), M (Mental Capacity), and S (Stability, reflecting the member’s psychiatric stability in the military environment).
comradeship, etc., and accommodating to civilian life after that can be very difficult for them and that is why many go in the TA and stay involved. I see many patients who are furious with what they regard as the bad deal they got in the Army in terms of medical care but if they could turn the clock back they would go back in and still serve.

Q220 Willie Rennie: Does the actual Armed Forces make them have more mental health problems or is it because they go in like that in the first place?

Dr Freeman: There is clear evidence that deployment in certain theatres of war causes a wide range of psychological problems and if you compare different theatres of war the rates are different. These are higher rates than those people who did not get deployed at all. There are some paradoxes in that, in that within those who were deployed, if you look at those who served on the frontline compared with those who were in support services, paradoxically those in the support services sometimes have higher rates of psychological breakdown. You cannot make a clear link between exposure to frontline warfare and psychological breakdown, but exposure to deployment overseas in certain theatres of war increases your risk.

Q221 Willie Rennie: I would just like to come to serving soldiers and other Armed Forces. You said they would benefit from having a separate service where they are treated together. Would that apply also to ex-Servicemen?

Dr Freeman: I certainly do not think we should go, and I do not think there are plans to, down the route of the Americans’ veteran system. There are all sorts of problems with that which we probably cannot go into. It is very expensive and it supports illness rather than getting well because people live in the VA system and feel secure there. I do not think we could possibly have a veterans system in the UK that separately treated people for depression, alcoholism, anxiety disorders, PTSD. We would need a whole new branch of the NHS. I think what we do need is a really good monitoring system, a central point of referral so that these men who find it very difficult to seek help can have walk-in shop front clinics where they can go, where they can see other veterans working as volunteers, where they can have an assessment triage for their appropriate treatment. After that stage, and they may well still link in with that shop front service for many years, they would go for their specialist treatment, getting psychotherapy or drug addiction treatment or whatever. It is the point of entry we need to manage better. It would cost hardly any money to have a triage system like that, an assessment service for veterans.

Mr Jenkins: I just want to labour a point with regard to ex-Servicemen and that they have more mental health problems. As you said correctly, the Army does but not the Air Force or the Navy, which is rather a funny way of putting it because they are ex-Servicemen. There must be a rational reason why they do not suffer the same problems. Then you said it is because of the recruitment base we take the Army from. I am suggesting that you might be right at some point because almost every weekend in this country three or four of our young people get killed in road accidents and these are the very adventurous, risk-taking group that we recruit from in the Army anyway. Probably if we did not recruit them there would be more dead in our country as civilians than there are Armed Forces, but that is not the problem. The problem is—

Chairman: What is the question?

Mr Jenkins: I am trying to make a statement here, Chairman. I think it is important we actually put this ground right.

Chairman: I know.

Q222 Mr Jenkins: The difficulty I have got is I have not got a control group to say, “This is what would happen to them if they did not join up” and “This is what would to them if they did join up”. We are in the realms of speculation, are we not, because we do not have enough records on these individuals to prove the result? We have not got any records on the probability of an individual suffering harm from his Service career.

Dr Freeman: I think that is partly true because, of course, even if you compare those who are deployed versus those who are not deployed the soldier has some choice in that. When they sign up, they sign up to be a cook or a technical officer rather than a frontline soldier and there is some choice in that. It would be a great disservice to our serving men to think that being exposed to frontline warfare has no effect on them. What would that say about humankind if that were so?

Chairman: Thank you. We have ten minutes more.

Q223 Robert Key: Dr Freeman, could you help me understand what I perceive to be mixed messages here. On the one hand, I think we are being told that psychiatry thinks it is better if people with mental health needs are treated in the community together in the round rather than singled out; on the other hand, the Chief Executive of Combat Stress said it could be damaging to put veterans into those circumstances with everybody else because they could disrupt everybody else with their terrible stories and it would not be a very helpful thing to do. Can you explain how I should reconcile those two statements?

Dr Freeman: I think the issue is that Combat Stress has a residential programme. As you know, it has three centres around the UK and there is no doubt that many men find that two week stay once a year extremely beneficial. It recreates for them something of what they get in their Service career and they meet colleagues and comrades. I have no problem with that. I think the issue is that most people can be treated on an outpatient basis. I would fully agree if I had a soldier with severe depression and was having nightmares and flashbacks and had a horrific trauma story and I felt they were so disrupted that they needed to be made safe and admitted somewhere I would rather they went to Hollybush in Ayr than they went into a general psychiatric ward, but that is a tiny proportion of the total. For each
one like that I would have 15 or 20 more I could treat
on an outpatient basis coming up once a week
offering them home-based assessment. I do not think
there is a tension really. I have no problem with the
inpatient services being around a particular
specialist area but you cannot travel to Hollybush
from Inverness once a week for your outpatient
treatment, you need to have distributed community-
based services for the majority of these men. We
need to work in partnership with Combat Stress, and
it needs to be something where the triage could be
done jointly between the NHS and Combat Stress,
most of the outpatient treatment could be done in
NHS services, because Combat Stress has difficulty
in treating people with drug and alcohol problems,
which is a big part of that, but if we wanted inpatient
treatment then a specialist unit would be fine.

Robert Key: Thank you.

Q224 Chairman: We seem to be giving you the
third degree.

Dr Freeman: It is okay, the sun is going down.

Q225 Mr Jones: Can I just follow up because you
made a point, Dr Freeman, about the Priory. I think
you just reinforced what we were told this morning,
that you are actually dealing with very small
numbers of people each year who do need inpatient
care. In Civvy Street that is the case as well. In my
PCT, for example, one hospital has closed and has
been replaced with a smaller unit because that is the
way the service has gone. It is not the fact that the
Priory care contract is not in the NHS, it is the fact
if they are keeping them in longer than they should
or they cannot provide what you say they should do,
that is actually about the contract rather than the
actual—

Dr Freeman: Yes. Obviously it is not something that
is unique to the veterans contract, it happens across
the UK with patients with eating disorders.

Q226 Mr Jones: So it does not make it wrong that is
in the private sector?

Dr Freeman: No.

Q227 Mr Jones: In terms of the Lancet evidence we
received recently, it said that it could be
counterproductive to intervene too quickly with
people who suffer from traumatic experiences, that
natural resilience would work in many cases. Can
you let us know what your view is of that?

Dr Freeman: There is very strong evidence now that
the vogue for psychological debriefing, ie doing
something early, 48 hours to ten days after a
traumatic event, be that to civilians or to soldiers,
can be harmful. The reason for that is by nature most
of us are very good at avoiding that, the best way of
coping in the short-term—

Q228 Mr Jones: Politicians better than most people!

Dr Freeman: —may well be to try not to think about
it. Some people can do that really well and if you sit
down in a psychological debriefing group and say,
“You’ve got to tell me your story, and not only
will you hear your story again but you are going to
hear five other stories from other people”, that can
be damaging.

Q229 Chairman: We have heard stories about there
being difficulties about the transfer of records from
the MoD to the NHS. Have you heard anything
like that?

Dr Freeman: Yes. Historically I have had great
difficulty but now I have to say it works extremely
smoothly with a phone call and you can often get
through to the Service GP or psychiatrist and get
details. That really has not been a problem recently
and I think that has been a big change.

Q230 Mr Hamilton: Combat Stress told us ten% of
the referrals they receive are from the National
Health Service and the vast majority from ex-Service
organisations are the ones who direct people to the
appropriate organisations. Does that mean that the
National Health Service is failing veterans in getting
that information forward?

Dr Freeman: Yes.

Q231 Mr Hamilton: It does?

Dr Freeman: The National Health Service in general
does not do well in getting young men into
treatment, and this is a problem across the board,
not just for Service personnel. We know that the
highest rate of complete suicide is in young men,
even though women have many more attempted
suicides. We need to be much more innovative in
how we get these men into treatments. The idea that
you have a clinic somewhere, that your GP refers
you up, you sit in a waiting room with ten other
people and you have a largely verbally based
psychological treatment is just a complete turn-off
for many men. There have been quite a lot of
experiments in Scotland about running clinics in
ASDA, running evening classes, having quite a
different approach to getting men with stress
problems into treatment.

Q232 Mr Hamilton: Could I follow up something
you said earlier on, and what you have just said. In
my constituency, which is Midlothian, just south of
here, there are six ex-Servicemen’s clubs. Could the
MoD not utilise the facilities they already have that
exist recognising the fact that many of the ex-Service
personnel will frequent these places because that is
where their comrades are and people who have been
through the Services would understand? Is there not
an argument that the MoD should utilise these
facilities far more than they are doing at the
present time?

Dr Freeman: Or do that in partnership with the
NHS. There is now a retired psychiatrist called
Dafydd Alan Jones who ran an infamous unit in
Wales called Ty Gwyn and he came up to Scotland
to run clinics, he did them in Boswell and Perth,
and he managed to get 60-80 men in an evening to come
to a church hall to discuss these issues. Clearly the
men valued that peer group relationship, valued
seeing a psychiatrist who knew about military
matters, and that is the sort of approach you need, I
Dr Paterson: I stress volunteers, in both St John and Red Cross origins. During the Second World War, volunteers, members of the Committee may be interested in its independent charitable company. I think the retirement I served for three years as Chief Medical honorary appointment. Immediately after Cross, initially as a Branch President, which is an retired in 1999. Completely apart from that, I have I was Director of Public Health in Aberdeen until I chair. I am a medical doctor, trained in Edinburgh. then the organisation which I have the honour to give evidence.

Q233 Mr Hamilton: You deal with Lothian NHS, it would be quite good if Lothian NHS, the MoD and the various legions all worked together to see if they could come up with a pilot.

Dr Freeman: The same with TA centres as well, we should have links there.

Q234 Mr Jenkins: Drug and alcohol addiction is high among ex-Servicemen. Should we treat this as a separate special group to try and tackle that for these veterans?

Dr Freeman: A cultural change needs to happen in the Services about the use of alcohol to relieve stress. It should be less tolerated than it is, but that is a social rather than a medical issue I think. In terms of special treatment services, I think there are probably enough ex-Servicemen with alcohol problems to set up some limited programme for Scotland, for example, one in Glasgow, one in Lothian, perhaps one in Tayside. There would be enough people where they could be treated on a group basis. As you know, the problem is the AA approach, which is very widely used in the non-statutory sector, does not go down well with most soldiers. They are not going to buy complete abstinence and they are not going to buy God.

Q235 Mr Jenkins: The other one is about our prison population, that there is a disproportionate number of ex-Army. Not ex-RAF or ex-Navy, ex-Army again. Because of the mental problems they have and because of the prison system, should they be treated separately as a priority within our prison system?

Dr Freeman: Yes, and it is one of the things we are just trying to plan in Scotland. We have had a very extensive programme of early intervention, guided self-help, all sorts of things for people in primary care with depression and anxiety, and I think we now need to transfer that to the Prison Service. Not the men who are banging their heads against the wall and are psychotic in prison, the severely mentally ill, but there is a significant morbidity of depression and anxiety, and these men are there, you could treat them, you have got a captive population.

Q236 Willie Rennie: Do you not think it is a disgrace that veterans have to rely on charity, organisations like Combat Stress?

Dr Freeman: I do not think it is a disgrace, no, because about half of Combat Stress’s money comes from central sources, so it is not all charity. I do think that it should not rely on charity alone. Conversely, there is something about the independence from the establishment which may be an advantage for some men. Some of these men feel very disenfranchised from the Army and from the NHS but can ally themselves to something that they see as independent. If you could maintain that independent streak but have secure funding that would be a good idea.

Q237 Chairman: Dr Freeman, I think we have got to draw this to an end now. May I thank you for what has been one of the best episodes of evidence I think this Committee has ever had. You have been extremely straightforward, clear, clipped, you have kept to time and we are most grateful.

Dr Freeman: Thank you.
recognised in our title, we are not part of either organisation. The Prior of the Order of St John and the Chairman of British Red Cross are the two members of our company, but other than that we are an independent organisation. We were awarded one short-term contract. The contract we have at present was won in competition with two other organisations and runs until March 2009. I think rather than my going on at length, Chairman, I would be more than happy in the limited time available to clarify anything in the written submission or to answer questions.

Q239 Mr Jones: I have read this and it is very useful background to how you came to be here but I am not actually clear what you do. It would be very helpful to me, and I am sure other members, if you could explain two things: one, what do you do in terms of this contract and, two, more importantly, what is it that you are asked to deliver that you are saying you are not delivering, because it is not quite clear?

Dr Paterson: It is a question I am often asked, usually in social gatherings, and I use two graphic examples. A Serviceman is wounded in Iraq today, he may well be hospitalised, have no equipment other than the clothing that he comes in with because it is all back with his unit. Obviously doctors and nurses are preoccupied with saving the man’s life and dealing with his injuries but there is a whole raft of things to be done in terms of literally providing some clean clothing, providing a DVD that he can watch in his hospital bed, supplementing the military communication channels back to home. In the most extreme situation, when a Service person is killed, our staff will accompany relatives from the airport to the mortuary to view their loved one. It is a combination of really quite soft welfare roles and some fairly hard and demanding emotional tasks.

Q240 Mr Jones: That is very helpful, but where does it fit in? For example, when we went to Selly Oak earlier this year and we saw accommodation being provided by SSAFA and other organisations, where do you fit in? Are there demarcation lines that one organisation does not do what you do, or what?

Dr Paterson: The building on the Selly Oak site is actually an NHS building. Our contract does not allow us, rather than my going on at length, Chairman, I would be more than happy in the limited time available to clarify anything in the written submission or to answer questions.

Q241 Chairman: What would you say that you do as an organisation that is different from what, for example, SSAFA does?

Dr Paterson: We are very much part of the clinical team. Some of our staff have healthcare backgrounds but we are not clinicians; we are definitely not clinicians. If you ask the medical commanders, and certainly if you ask Defence Medical Services staff, they would say that our personnel are integral members of the clinical team, they are there on day one when the casualty is hospitalised, and that is quite different from the other organisations.

Q242 Chairman: What do you think then should happen when the contract comes up for potential renewal in 2009 to resolve some of these issues?

Dr Paterson: I think two things. There should be a root and branch review of what it is that is managed by a hospital welfare service and is it really just an inpatient service. Many of the criticisms, some of them probably exaggerated, are that people get lost in the system. There is one specific issue. I am assured that the Joint Casualty Compassionate Cell, which is a Tri-Service organisation, does know the whereabouts of all personnel who are hospitalised, not just in the Ministry of Defence Hospital Units. Our submission would be that these are very often people with whom we have established a relationship when they have been in Selly Oak and I do not believe it would be breaching confidentiality rules if that organisation was willing to say to us, “This serving member of the forces, who you already know, has actually been hospitalised six miles down the road and maybe you would like to make contact with them”. We would not impose our service but the feedback we have had from Service personnel is that they would appreciate it.

Q243 Chairman: What would you say that you do as an organisation that is different from what, for example, SSAFA does?

Dr Paterson: We are very much part of the clinical team. Some of our staff have healthcare backgrounds but we are not clinicians; we are definitely not clinicians. If you ask the military commanders, and certainly if you ask Defence Medical Services staff, they would say that our personnel are integral members of the clinical team, they are there on day one when the casualty is hospitalised, and that is quite different from the other organisations.

Q244 Mr Jones: That last point is very useful. Do you really think what is needed here is that the MoD/NHS needs to clearly define—it is possibly because there have been some bad news stories, some true and some not about the way in which people are dealt with—the contract when it comes up for renewal and it needs to be a bit wider than what you
do or a series of organisations coming together to put together a welfare package around the individual which would be not just your side in terms of the clinical element but also, for example, how you deal with families, next of kin and things like that, so we do not possibly get duplication or a mismatch as you are describing where demarcation lines are drawn between you and another organisation?

**Dr Paterson:** There was a very unfortunate set of circumstances at the end of last year when, in fact, there were numerous individuals and organisations giving very mixed messages and I think a lot of Service personnel and families were very confused as to what was the right story. Can I stress that we are not in competition with these organisations.

**Q245 Mr Jones:** No, I am not suggesting you are. **Dr Paterson:** We work very well. I do take your point that clarity of what it is that is required and who can contribute what to that requirement would be very valued.

**Q246 Willie Rennie:** Is it confidentiality reasons that are stopping you contacting people in other circumstances?

**Dr Paterson:** It is very interesting because most of our staff in normal circumstances are deployed in Germany and it is not a problem. My experience, having worked with data protection for 40 years, is the Germans are much keener on data protection than we are, yet if any serving member of the British Armed Forces is hospitalised in Germany there is a free passage of information, so I do not understand it.

**Q247 Willie Rennie:** Is that the reason given in this country as to why you cannot go to the outpatients?

**Dr Paterson:** Yes.

**Q248 Mr Jones:** But you are under contract, are you not, from the MoD?

**Dr Paterson:** Yes.

**Q249 Mr Jones:** It is not as though it is like me, Joe Bloggs, or my organisations coming off the street and saying I want to have access to these people. Surely they are referring people to you, are they not? I cannot get my head round that one.

**Dr Paterson:** This is in stark contrast to the behaviours of the clinical staff because our staff sit in on multidisciplinary case meetings with the chaplain, the psychiatrist, the surgeon and the nurses.

**Q250 Mr Jones:** But the taxpayers are paying for your services, are they not?

**Dr Paterson:** Indeed.

**Q251 Mr Jones:** So why should that be any different from a taxpayer paying for the services anywhere else?

**Dr Paterson:** Lest I sound paranoid, you probably realise that this argument of confidentiality has been raised on a number of occasions when a number of Service families have said, “My son got lost in the system”. I was very encouraged by Dr Freeman’s comments about the fact that clinical information now passes quite quickly from the MoD to the NHS, but I do believe, and I think our staff feel slighted that we cannot be trusted with clinical information, we are bound by a code of confidence.

**Q252 Willie Rennie:** The fact that you have had to come before us to tell us this, does that indicate a breakdown of the relationship between you and your contractor?

**Dr Paterson:** Not at all. Can I say that we enjoy very good relationships with the MoD. They are aware we are here and were offered sight of our submission. They are very relaxed that we are here.

**Mr Jenkins:** If I can just say, Chairman, I sympathise with you on the Data Protection Act. In the past I have had to go to the Information Commissioner several times to get things clarified and to get him to send signals out, but jobsworths abide in this world and for some reason they just do not read legislation or understand. If it is for its primary purpose, and the primary purpose in this case is to trace, track and look after the welfare of an individual patient, they can release that information but, unfortunately, they do not read the small print, they just act as a jobsworth and stop people doing their job.

**Q253 Chairman:** In your submission you gave an example of someone who did not appear on bed state lists issued to DWMS and you heard about his visits to hospital only because his mother 160 miles away told you he was going to be in hospital.

**Dr Paterson:** Yes.

**Q254 Chairman:** When something like this happens presumably you make representations to the Ministry of Defence to say that there ought to be better communication with you under your contract.

**Dr Paterson:** Yes. We had a very productive meeting with the current Surgeon-General a few months ago and we made a strong plea that the regional model of working that we have in Cyprus and in Germany, which is basically anywhere there is a Serviceman or Servicewoman in hospital we visit, was extended to the UK. The Surgeon-General was very receptive but, sadly, nothing has happened.

**Q255 Chairman:** Looking at it for a moment from the Ministry of Defence’s point of view, what do you think their difficulty in relation to doing this has been?

**Dr Paterson:** I think there may be two explanations. One is the MoD themselves may not have known about Patient A, that he had moved from a military Ministry of Defence Hospital Unit, had gone home and had then been readmitted to an NHS hospital. They may not have known. I think my second point is had they known, at the moment the system would not have prompted them to tell us that the patient had been admitted to a nearby hospital, either because they did not want to tell us or they felt they should not tell us.
Q256 Mr Jones: The example you have just given, is that someone who has left the Armed Forces that you are talking about or somebody who is in it?

Dr Paterson: No, he was still serving.

Q257 Mr Jones: Surely the MoD would know about that individual.

Dr Paterson: They may not have done. If he had gone back to a private home as opposed to living in barracks it may have been a civilian GP who referred him into the local hospital.

Q258 Chairman: Surely his unit would be well aware that he was not turning up for work.

Dr Paterson: He was on sick leave.

Q259 Chairman: Ah, yes. Good point. You do not get involved in Headley Court, do you?

Dr Paterson: No, and that surprised the Surgeon-General because Headley Court has had a lot of publicity in the recent past around its hostel accommodation. The Surgeon-General was very surprised. In fact, I think he had assumed that we were because clearly the welfare needs of patients who are being rehabilitated and their families are quite substantial. Again, the Surgeon-General suggested that we ought to be involved; we are still waiting for an invitation.

Q260 Chairman: Is the Surgeon-General’s invitation not sufficient?

Dr Paterson: No. Unfortunately, we can only do what our contract says. That sounds like a jobsworth’s response, I do apologise. Certainly we cannot exceed our operational locations as described in the contract.

Q261 Chairman: How would you think that looking at the use of St John and the Red Cross things could be improved for Service personnel? What would be your overall approach to making things better?

Dr Paterson: I think the organisation is invisible. I suspect all the members of the Committee had never heard of us. Sadly, even in the higher ranks of the military many people have never heard of us. The people who really hear about us and sing our praises are the people in the hospital units and the Commanding Officers and the people who use the service. Our profile and awareness needs to be raised.

Q262 Chairman: That is a matter for you, is it not?

Dr Paterson: Well, it is, but I think there is a communication process within the military. I also think the artificial barriers to the passage of information should be broken down. We are willing to go anywhere that our services are required, whether it is in Germany, Cyprus or the UK. We have got two welfare officers in Iraq at the moment and two in Afghanistan who are fully respected members of the team. I just feel that the people who have been operating in that environment and come back to the UK do feel very frustrated that the skills they have exercised in the theatre of war are not used in a more civilian setting in the UK.

Chairman: Thank you. Willie Rennie, and then I think we ought to move on.

Q263 Willie Rennie: Who provides welfare support for those at Headley Court? I know you do not but do other organisations?

Dr Paterson: I have no idea.

Chairman: Dr Paterson, thank you very much indeed. We are most grateful to you for coming pretty much at the last moment actually. Thank you very much.

Witnesses: Mr Derek Feeley, Director of Healthcare Policy & Strategy Director, Mr Geoff Huggins, Head of Mental Health Division, Healthcare Policy & Strategy, and Dr Nadine Harrison, Medical Adviser, Primary & Community Care Directorate, Scottish Health and Wellbeing Directorate, gave evidence.

Q264 Chairman: Lady and gentlemen, thank you very much indeed for coming to help us with our inquiry. I wonder if I could ask you, please, to introduce yourselves and say what you do and why you do it? Derek Feeley, would you like to begin?

Mr Feeley: Derek Feeley. I am Director of Healthcare Policy & Strategy, the Scottish Government’s Health Department. That means essentially I am responsible for advising ministers on a range of healthcare policies that stretch from mental health all the way through to issues around hospital configuration, etc. One of my areas is around relations with Whitehall and, therefore, my interests are in defence matters.

Mr Huggins: I am the Deputy Director for Healthcare Policy & Strategy, Head of the Mental Health Division, and I have got responsibility for all matters in respect of mental health within Scotland. I am a member of the senior Civil Service and do liaison with Combat Stress.

Dr Harrison: I have a GP background. I work as a medical officer in the Primary Care Division in the Scottish Government Health Department giving advice to ministers on all sorts of aspects of policy and strategy.

Chairman: Thank you very much.

Q265 Mr Hamilton: Can you explain, briefly, the ways in which the National Health Service in Scotland work with the MoD to look after the healthcare needs of Service personnel and veterans?

Mr Feeley: I can kick off with that. I guess the first thing to mention is that there is a concordat, which the Committee may be aware of, between the Department of Health and the Ministry of Defence but signed up to by health ministers from the devolved administrations too. That helps set a framework, if you like, for the relationships between the departments. On the back of that concordat we,
in the Health Department, issue guidance to our NHS Boards and I can make the latest form of that guidance available to the Committee if that is of interest. The ongoing management of the relationship between the Health Departments and the MoD is done through what is called a Partnership Board. The Partnership Board meets about quarterly, certainly three times per year, to identify areas of common interest and opportunities for co-operation.

Q266 Mr Hamilton: What special provisions do you have to make for the needs of the Service communities within Scotland?

Mr Feeley: It works at a number of levels, I guess. We are responsible for healthcare for Service families and their veterans directly and working in partnership with Defence Medical Services to provide health services for the Armed Forces. The guidance to which I referred sets some of that out. Nadine can talk in some detail about primary care services. On secondary care, members of the Armed Forces based in the UK are entitled to the full use of NHS facilities on the same basis as civilians.

Q267 Mr Hamilton: So there are no special provisions?

Mr Feeley: There are provisions for access to high quality services through the NHS.

Q268 Robert Key: But no fast-track facilities, as in England?

Mr Feeley: No fast-track facilities. There will be a range of factors that a clinician will take into account in determining how quickly to see a patient, and one of those will be their occupation. We would not automatically see every Service person before every civilian, if that is what you are asking.

Q269 Mr Hamilton: That answer means there is no provision made other than a normal provision for ex-Service personnel if they go to see a doctor. If you listened to the first part of the evidence session, and I am sorry you were not here at the time, the doctor indicated the possibility of information passing when a person walks in off the street who is ex-Service personnel or, indeed, Service personnel on the sick, because many of the local doctors do not know the issues that affect them. In England that has been addressed by the fast-track system. What is the special provision agreed in Scotland?

Mr Feeley: Are you talking about ex-Service personnel?

Q270 Mr Hamilton: And Service personnel.

Mr Feeley: Geoff will be able to answer that. Most people are discharged without particular medical needs. Some have very specific medical needs and every effort is made to have those needs ready to be addressed in advance of their discharge. There is a good deal of collaboration and communication before the Service person is even discharged to enable them to get access to the NHS services that they need as quickly as they need them.

Chairman: We will come back to that in just a second.

Q271 Willie Rennie: Are you aware of the fast-track system?

Mr Feeley: In England?

Q272 Willie Rennie: Yes.

Mr Huggins: I think he means priority treatment.

Mr Feeley: Is that what you mean?

Q273 Willie Rennie: We understand it is called fast-track. Are you aware of that?

Mr Huggins: In Scotland we would call that priority treatment for war pensioners. It applies in Scotland and we—

Q274 Willie Rennie: This is for serving personnel, there is a fast track system. You can go down to the five MDHUs in England and get fast-tracked treatment.

Dr Harrison: There is not a specific place in Scotland where that happens but they would go to the English hospitals.

Q275 Willie Rennie: But you are aware of that system?

Dr Harrison: Yes.

Mr Feeley: Yes.

Dr Harrison: They would go to Northallerton probably.

Q276 Mr Jones: The MoD tell us that certainly in England in terms of war pensioners there is an entitlement to priority NHS treatment and obviously free prescriptions in certain circumstances. Is that the same in Scotland?

Mr Huggins: Yes.

Mr Feeley: Chairman, sorry if I misunderstood Mr Hamilton’s question, I thought he was talking about services in the NHS in Scotland.

Chairman: He was.

Q277 Mr Hamilton: I am specifically asking about Scotland. Naturally, being a Scottish MP, it is important from our point of view, and representing Glencorse Barracks we have an interest in what happens. How often do you meet with MoD officials and at what level do you meet them?

Mr Feeley: Our representative on the Partnership Board is one of the Deputy Chief Medical Officers, Professor Peter Donnelly, so at a very senior level. That Board meets three to four times per year.

Q278 Mr Hamilton: How many times?

Mr Feeley: Three to four times.

Mr Huggins: Because of the discussions that we have had in respect of Combat Stress we have been meeting with the MoD officials more regularly on particular issues around veterans and mental health. Most recently we met with them on Monday of this week in the context of the announcement made on, I think, Tuesday by the MoD in respect of fees for
Hollybush House and the other Combat Stress centres. We have a regular and ongoing dialogue at the moment around improving care for veterans.

**Q279 Chairman:** What triggered that increase in contact with the Ministry of Defence?

**Mr Huggins:** It was the HASCAS report. The Health and Social Care Advisory Service produced a report in 2005 into mental healthcare for veterans, largely at that time focusing on the services that were being provided by Combat Stress but also looking more widely at the range of service needs that veterans had in respect of mental health. That has generated both the consideration of the current fee base for Hollybush House but also the consideration of a wider set of policy and delivery measures around mental health for veterans.

**Q280 Mr Borrow:** There was a reference earlier to the Ministry of Defence Hospital Units in England, the five of them that exist in England and the fast-tracking system for serving personnel. We understand that at the time they were being designed there was no interest from the NHS in Scotland and, therefore, in the NHS in Scotland there was no unit up for consideration as far as Scotland is concerned. Is that something that you would like to see addressed? Do you think there would be a benefit in having such a unit in Scotland?

**Mr Feeley:** I think the existing system works well. There are very few complaints from Service personnel about the way in which they receive healthcare in Scotland. If there was a view that further MDHUs were required then it may well be that the Scottish boards would be interested in applying but we would need to look at all the circumstances at that time. As it stands just now there is no opportunity.

**Q281 Mr Borrow:** Following on from that, MDHUs do give an opportunity for military medical personnel to work alongside civilian NHS medical personnel. Are there any opportunities in Scotland for that to happen? Do you think it would be a good idea if there were more opportunities?

**Mr Feeley:** It would always be a good thing for there to be more opportunities but there are a number of opportunities that do exist, particularly in and around Edinburgh. We have some military staff working in general practice, we have a number working in a number of specialties, including psychiatry and orthopaedics at the Royal Infirmary of Edinburgh, and we have got one working in urology at the Western General Hospital in Edinburgh. There is the opportunity for that kind of exchange and I do agree that it is extremely valuable.

**Q282 Mr Jones:** You say it works satisfactorily but it would because you are exporting the patients to England, and I would not complain if I was in that system, but we were also told this morning that the MoD also then pay a premium for fast-tracking people through the Scottish system. How does that work?

**Mr Feeley:** I think it works through contractual arrangements between the MoD facility and the NHS Board.

**Q283 Chairman:** Mr Feeley, you said just now that there was an announcement about Combat Stress on Tuesday. I am very sorry, I am ignorant of it. Can you tell me what it was, please?

**Mr Feeley:** Mr Huggins can fill you in.

**Mr Huggins:** The MoD, the Scottish Government and Combat Stress have been discussing the basis on which to take forward aspects of the HASCAS report, which I referred to. One of the key elements of the HASCAS report was improving the clinical capability of Combat Stress as an organisation, in particular the proposition that they should have a medical director who is a consultant psychiatrist, but also to increase the range of professional nursing and psychology staff. To do that, Combat Stress were clear that the fee basis they worked on would need to change, and in practice what we have seen over a period of time has been a negotiation between the Ministry of Defence and Combat Stress about exactly the degree to which their fee base would need to change, which has effectively been resolved and was announced on Tuesday.

**Q284 Chairman:** Was this part of the Comprehensive Spending Review?

**Mr Huggins:** No. When I said Tuesday, I am clearly confused because what I meant was last Thursday, of course. As with you, I have been travelling somewhat and I am equally confused. The announcement was made last Thursday and effectively what it provides for is a phased uplift of fees with the uplift running across 2007-08 culminating in a final raise in January to a 45% increase, at which point Combat Stress should have significantly greater clinical capability. That was an announcement which was followed by the Scottish Government which funds the service which is provided within Scotland as, of course, veterans is a devolved matter in respect of healthcare services.

**Q285 Mr Jenkins:** Since you say veterans is a devolved matter, what exactly do you do with regard to the higher level of drink and drug dependency amongst veterans and the fact that we have got more veterans in prison as a percentage than the general population who suffer from mental problems as well? Are they just left within the prison system or do they get priority in the Scottish NHS?

**Mr Huggins:** At the moment we have a discussion with the Scottish Prison Service about how we can improve the general quality of access to healthcare services within prison because we found it quite challenging to offer mental health services within prison environments. At this stage we do not have a policy which provides differential treatment on the basis of military service or otherwise within the prison context or access to services. Certainly part of the discussion that we are having, and will be having, with Combat Stress and other organisations is around greater access to substance abuse and
alcohol services. This is a challenge we face not just with this population but across a range of populations.

Q286 Mr Jenkins: On drink and drugs and prison, the answer is you have done nothing yet but you are having meetings and talks on it?

Mr Huggins: There are programmes in place which offer assistance in respect of substance abuse and there are programmes in place in respect of alcohol within the prison context.

Q287 Mr Jenkins: For veterans?

Mr Huggins: For people within this context. There are not specific, separate programmes running in prison for veterans, no.

Q288 Chairman: Are you aware of the proportion of prisoners in Scottish prisons who have mental health problems?

Mr Huggins: It probably depends how you describe mental health problems. In terms of mental health we think of a spectrum of care needs from those who might have diagnosed mental illness, people with schizophrenia or bipolar disorder. That is around to 2 to 3, 3 to 4% of the general population and it is probably closer to 10% of the prison population. We then look at those who might have mild to moderate mental health problems, depression, stress, anxiety, which at any point in time is probably running at between 20 and 30% of the general population but is considerably higher within the prison population, it is going to be 50, 60, 70 per cent. For many it is a natural response to being incarcerated, probably locked up for extended periods of time, to be stressed and anxious being separated from loved ones. There are programmes that are run in terms of befriending programmes, listening programmes, activities which are intended to address those issues. When we talk about mental health problems we have to be quite careful in drawing those distinctions because those are mental health problems that were they in the community would be managed within the community by normal GP-style services.

Q289 Chairman: Dr Harrison, do please feel free to chip in whenever you feel that you would like.

Dr Harrison: Yes, thank you.

Q290 Mr Jones: You said that NHS services for veterans was a devolved responsibility and we have heard what you are doing in terms of looking at veterans in prison, for example. How is that actually dealt with by NHS Scotland? Is it looked at as a separate thing altogether? How is it managed?

Mr Huggins: The prison currently operates its own separate medical service which operates a medical service for prisoners. It is a challenging area and I think our collective view is we could offer a better medical service and we are in discussion with the prison medical service about how we would do that.

Q291 Mr Jones: What about veterans not in prison, the general veterans’ health, how do you manage that as the NHS in Scotland?

Mr Huggins: In terms of the veterans’ mental health we are in discussion with Combat Stress both about the service which is provided in Hollybush House, but we are also in discussion with the MoD in respect of the proposed pilots for community and primary services to veterans. We recognise that veterans are a distinct and different population who have a different background and who in many cases are looking for a different way in to access services. We recognise that there are organisations like Combat Stress which are clearly very acceptable and seen as good gatekeepers and good access points. At this stage, with the co-operation of the MoD and others, we are looking to develop approaches which are particular to veterans which enable us to improve those services. That is part of the outcome of the HASCAS report. I think we will shortly be seeing similar pilots announced in England and Wales. We have a developing programme of work to actually improve the quality of service at the moment. Other than that, at the moment veterans will receive services as other members of the public do. We are recognising that there is a distinction and a difference.

Q292 Mr Jones: So you have not actually got a separate policy for veterans in Scotland in the NHS?

Mr Feeley: They get priority treatment for the condition or disability for which their war pension is payable, if that is what you are referring to.

Q293 Mr Jones: No, I am asking, as the NHS, do you have a policy area to look at veterans? If you have been devolved the responsibility for it, it is an area where clearly you are looking at the mental health side of it but in terms of the care of veterans in general has any policy work or anything been done on looking at veterans as different types of customers from the rest of us?

Mr Feeley: We issued guidance to boards in 2006, the precise date eludes me at the minute, that reminded NHS Boards in Scotland of the entitlements of veterans.

Chairman: We will come on to further mental health issues in just a moment.

Q294 Willie Rennie: Often guidance that is issued by any organisation gathers dust on a shelf. Have you done any follow-up checks to see how well that guidance has been implemented? It was suggested earlier on by Dr Freeman, if I understood him correctly, that perhaps we should have a shop front for veterans so that they can go in, they do not know what is wrong with them perhaps but they could have access to a wide range of services. What would you think about that?

Mr Huggins: I can certainly pick up the latter point. That is a discussion that we have been having with Chris on the basis that what we are looking for here perhaps is a better door for people to go through, and a door which people find acceptable. We have certainly indicated a willingness to pilot that sort of idea.
Q295 Willie Rennie: What about the implementation of the guidance?
Mr Feeley: We have put guidance out roughly every two years and it is always followed up with a reminder to chief executives of NHS Boards that we expect the guidance to be applied and it is then for the management in the local boards to take whatever action is necessary to get this firmly on the—

Q296 Willie Rennie: Out of ten, how well is it implemented? Have you got a measure?
Mr Feeley: We have not got a measure that would enable us to do that. I guess our major measure of these kinds of issues would be are we getting a lot of complaints about them, and we are not.

Q297 Chairman: When you say you do not have a measure, do you monitor how well your guidance is followed?
Mr Feeley: Not specifically.

Q298 Chairman: Should you?
Mr Feeley: It is impossible to monitor how every bit of guidance that goes out is implemented. We have regular performance reviews with NHS Boards about every aspect of their performance but some of this is about the actual clinical interaction between a GP or a practice nurse or a frontline clinician and a veteran, and unless you are sitting on top of that interaction it is an extremely difficult thing to measure.

Q299 Mr Jones: Is this something that is different from the rest of the country where this has been a massive issue about how veterans are treated? Certainly my postbag and local newspaper in England have been inundated with various stories and criticisms of the Government and the NHS about how veterans are treated. Has it been completely different in Scotland?
Mr Feeley: It is difficult for me to compare since I do not know what it has been like in England.

Q300 Mr Jones: Wait a minute. You have got the campaign now being run by the British Legion and you have got newspaper headlines about the treatment of veterans, has that not even touched the Scottish newspapers or Scottish political scene at all?
Mr Feeley: I suspect your Scottish colleagues are different kind of postbag from mine. They will get a different kind of postbag from mine.

Q301 Chairman: There is a bit of a sense here of your issuing guidelines and seeing this ship sailing off into the mist and you saying, “Job well done” without contacting the home port to find out if it has come in or not.
Mr Feeley: The Partnership Board would pick up a lot of these kinds of things. There will also be interaction between the facilities and the local health boards. I am certainly aware of a good deal of regular and very positive discussion between Redford Barracks and NHS Lothian, for example, about the day-to-day issues around service delivery. That is the kind of level at which that would be done.

Q302 Robert Key: Could I ask if you have heard about the Help for Heroes campaign.
Mr Feeley: Yes, I am aware of it.

Q303 Robert Key: Good. I wonder if you could help me and tell me whether the new arrangement reached last Thursday with Combat Stress has covered a particular problem we were told about when we visited Leatherhead, and that is a lot of veterans do not present with mental health needs until an average of 14 years after they have left the Services and, therefore, they are not in receipt of a war pension and that presents an enormous funding problem for Combat Stress. Was that one of the issues that was addressed?
Mr Huggins: As I understand it, the figures that I have had from Combat Stress indicate that the majority of people come forward at about 12-13 years and they are eligible to receive war pensions. The difficulty is in establishing a case and establishing the linkage between the problem and the health problem, whether it is mental health or other problems. From what I have seen, the majority of the people who Combat Stress are offering help to have appeared significant periods of time after their time in Service. There is no barrier there.

Q304 Robert Key: There is a barrier because it is the difficulty in awarding the war pension, which is the funding mechanism. So nothing has changed in that respect as a result of last Thursday’s announcement?
Mr Huggins: They have not changed the regulations.

Robert Key: I am sorry to hear that.
Chairman: We may well come back to this again. We will move on now to the issue of healthcare of Service families.

Mr Hamilton: Before I get on to that, would it be possible for you to inform the Committee by a note about the number of people who are in prisons, in answer to Brian’s question, who have a history of being in the Armed Forces because you indicated that information is gathered. Could you get that information and send it to us and any other information that you think might be relevant because if certain matters are devolved to Scotland, as we are taking an evidence session in the UK, it is important the Scottish dimension is put into that. I know you have given us some information but some of the factual information about the Prison Service and the point that Brian raised, which I think is very relevant, I would like to see that coming forward.

Q305 Chairman: Are you clear of what you have been asked and will you be able to provide such a note?
Mr Huggins: I am clear of what has been asked. I did give information on our assessment of the mental health needs of those in prison. I do not know that
we have a figure for those who have had military service within the prison system but I can certainly make inquiries.

Q306 Mr Hamilton: You do not have a breakdown? 
Mr Huggins: Pardon?

Q307 Mr Hamilton: You do not have a breakdown? 
Mr Huggins: I personally do not but I can certainly answer the question. Corporate Scottish Government will provide that information if we have it.

Q308 Mr Hamilton: One problem raised during the course of the inquiry relates to Service personnel returning home from overseas postings and finding it extremely difficult to register with National Health Service GPs and dentists. What procedures do you have in place to help Service families coming back to Scotland from overseas? 
Dr Harrison: Any family coming into a community has an entitlement to register with a general practice in their area, so there is no difference there. I suppose it is the local intelligence of knowing where to go, if you like, when they arrive back. There should be no barrier to families registering with a local GP’s practice. We do not have problems like full lists in Scotland but I think there are some problems in some parts of England with that.

Q309 Mr Hamilton: And dentists? 
Dr Harrison: Some areas have more difficulties in providing NHS dental treatment and dentists for people to register with. There is an obligation on the health boards to provide a general medical practitioner for every citizen whereas there is not for an NHS dentist. I have no knowledge of whether Service families have particular difficulties over and above the rest of the population.

Q310 Mr Hamilton: So, effectively, as a family or an individual they have to fend for themselves in whichever area they go to, they have to find out for themselves? 
Dr Harrison: In dental terms that is more of a fending process. For general medical practitioners they can approach the health board and they will tell them who their local GP is and to go along to register.

Q311 Mr Hamilton: Could the MoD do more to make the transition easier? 
Dr Harrison: I suppose they could give them an information pack, and I suspect they might well already do so.

Q312 Mr Hamilton: I am thinking more along the lines that it is not just about the health services coming out, the MoD could help insofar as contacting local authorities about housing needs, for example. There is already a welfare officer who deals with personnel who are leaving the Armed Forces and they try to assist them. What I am trying to get to is if they are going to Lothian, Glasgow, Aberdeen, is there something rather than just a pack? Is there something where they can sit down and somebody will talk to them and say, “These are all the things you need to do”, which includes dental treatment, who you sign up to, what village or town you are going to, where the local GP is going to be in that area, and, indeed, if they can get on to the housing list? 
Mr Feeley: I think these are really matters for the MoD, but if the MoD wanted to develop those kinds of arrangements we would certainly be very happy to—

Q313 Mr Hamilton: They are not matters for the MoD if they are Scots coming back into Scotland and they are all issues which are being dealt with by a devolved government. At the end of the day these are matters that must affect individuals coming in. To put it across just to the MoD is absolutely outrageous. 
Mr Feeley: I am trying to explain. I assume that you would want—

Q314 Mr Hamilton: It sounds like there is a price tag at the end of it. 
Mr Feeley: No. There is lots of information that is available and it would not be a huge, onerous task. I assume you would want that material available to Service personnel before they are discharged.

Q315 Mr Hamilton: Yes, of course. 
Mr Feeley: Which is why I was trying to get over the message that I think principally, in terms of leading this work, the MoD would have to take a role. 
Mr Hamilton: Chairman, could I suggest at the next meeting of the three or four meetings they have a year that is one of the issues they raise for them to deal with it through a welfare officer and it is something they should tell the families coming out.

Q316 Chairman: I am concerned about this meeting that happens three or four times a year. Again, it is a bit like the ship sailing off into the mist. I have this impression that these three or four meetings a year that happen are considered to be the contact that you need to have with the Ministry of Defence and the notion of these veterans being heroes who fought for their country does not really stray outside the Ministry of Defence and it is the Ministry of Defence that is there to deal with these problems. If they have got education problems, health problems, that is the Ministry of Defence’s problem. This is the impression that I think this Committee is getting from the evidence you are giving us today.

Mr Feeley: I am not sure how you are getting that impression.

Q317 Mr Jones: You are doing a good job at it. 
Mr Feeley: As I have said, we believe that the healthcare services that personnel, their families and ex-Servicemen get in Scotland are extremely good.

Q318 Chairman: But no better than anybody else is getting? No recognition of some of the special needs that they may have from all we can hear.
Mr Feeley: Priority treatment for veterans for their condition. Priority treatment through the MDHUs if it is required.

Chairman: Those are English.

Mr Jones: We are paying for that. To be honest, I am very glad we have come here today to come to this session because I think it reinforces something which came out of our inquiry into education for children in Armed Forces' families, which is this complete disconnect between devolved administrations and the MoD. Mr Feeley, you sit there and say you have got policies but you have got no policies for dealing with veterans, you have told us. As I understand it, to be fair to Mr Huggins, you are going to look at mental health services because it has been upped on the agenda in terms of Combat Stress and you have amazingly said to one of your local Members of Parliament that basically Service families in his constituency have got no special treatment, you have got no priority on this, and all you are doing, as the Chairman says, is sending up paper to say, “This is what the policy is”. Go to Mr Keys' constituency and I am sure his local health authority has got a completely different attitude from that, and they have in mine as well and mine has not got huge Service families. If I was a Service family or a member of the Armed Forces from Scotland listening to you three I would be pretty appalled and depressed, frankly.

Chairman: I would feel that I was not high up the agenda.

Q319 Robert Key: Could I just ask Dr Harrison to clarify something about dentists. I think you told us that a Service family, perhaps coming back from Germany, would have to find out where their local NHS dentist was and there is no particular help available to anybody, is that right?

Dr Harrison: The local health board will have information on where NHS dentists and where general medical practitioners would be.

Q320 Robert Key: We have something in England called NHS Direct, which you can phone up and they will tell you where your nearest NHS dentist is to where you live. I think the equivalent is called NHS24 in Scotland.

Dr Harrison: Right.

Q321 Robert Key: Do they not provide that service?

Dr Harrison: They could do.

Q322 Robert Key: But do they?

Dr Harrison: Yes, indeed.

Q323 Robert Key: They do?

Dr Harrison: Yes, but the health board is a more direct approach.

Q324 Robert Key: That astonishes me because surely the health board is not something that I would ring up and say, “I've got a tummy ache, what should I do?”, that is something I ring up NHS24 for.

Dr Harrison: That is not the same question. You are asking about where they would find where they should register, and you would go to the health board for that because that is an administrative place. NHS24 will tell you—

Q325 Robert Key: I am sorry, in England it is not. Anyone can phone up NHS Direct and discover, “This is where I live, this is the number of my street, where is my nearest NHS dentist?” That is not available in Scotland?

Dr Harrison: They can phone NHS24 and ask those same questions and they will get an answer.

Q326 Robert Key: I thought you just told me they could not.

Dr Harrison: No, I did not.

Q327 Robert Key: That is for the NHS Board.

Dr Harrison: They could also phone NHS24 and get medical advice. They would probably be told where to go for family medical care.

Q328 Robert Key: Probably.

Dr Harrison: They would be, sorry. It depends. If it is out of hours they might be dealt with by NHS24.

Q329 Chairman: Records of Service personnel. We have heard that there has been a significant improvement in records being transferred from the MoD to the NHS. Is that your experience? Have you heard of any problems in transferring records?

Dr Harrison: There are two separate services. There is the military MoD Medical Services and the NHS Medical Services and the two do not, as far as I know, exchange records directly, they do not have a shared record. There would be a discharge note or some information given to somebody who was coming out of the Services. Is that what you are referring to, when someone comes out?

Q330 Chairman: Let us suppose an ex-Serviceman is discharged, perhaps he has been severely wounded in Afghanistan and he needs his treatment to continue under the NHS, somebody needs to know what has happened to him, what drugs he has had, what operations he has had. How does that get dealt with?

Mr Feeley: It would be contact between the MoD and the local NHS Board which will be responsible for that individual's care.

Q331 Chairman: Have you heard of any difficulties in transferring the records?

Mr Feeley: None whatsoever. Indeed, we asked all NHS Boards in preparation for this meeting whether they had experienced difficulties of that kind and all of them told us that they had not.

Dr Harrison: Could I just clarify, I was answering a question about transferring records which is, for instance, my GP records would be transferred somewhere else, but what you are talking about is transfer of information and I agree with the answer.
that has been given. When I answered and said that there was not a transfer of records, I was talking about the entire record not being transferred.

**Q332 Chairman:** We are not medical practitioners.
**Dr Harrison:** No, but it is different.

**Q333 Chairman:** There may be a serious difference in your mind but we would need that to be explained to us.
**Dr Harrison:** There is a distinction as well between what happens in a situation such as the one that you described and what happens in the ordinary situation of a Serviceman coming out of the Services and he has not really got anything particular wrong with him, he is quite fit, so he is being discharged, and that is just through the primary care service.

**Q334 Chairman:** If someone moves from Portsmouth to Edinburgh, would his records be transferred to Edinburgh?
**Dr Harrison:** Is this MoD or NHS?

**Q335 Chairman:** No, if a postman moves from—
**Dr Harrison:** NHS, yes, their records would be transferred.

**Q336 Chairman:** But if a soldier moves from Portsmouth to Edinburgh—
**Dr Harrison:** This is primary care records you are talking about?

**Q337 Chairman:** Yes. Would they be transferred?
**Dr Harrison:** From the MoD to the MoD in Edinburgh?

**Q338 Chairman:** Yes.
**Dr Harrison:** Yes.

**Q339 Mr Jones:** No.
**Dr Harrison:** As far as I know, this is an MoD matter obviously from Portsmouth MoD to Edinburgh.
**Chairman:** Anyway, Mr Feeley told us that none of the NHS Boards had suggested there was any problem over this.
**Mr Jones:** That is not the question you are asking, Chairman. The question you are asking is if you were a serving member of the Armed Forces in Portsmouth and you were discharged but you actually came to live in Edinburgh, would your MoD records be transferred to the local NHS. That is the question you were trying to get at.

**Q340 Chairman:** It was.
**Dr Harrison:** The two sets of records are separate. There would have to be some communication if there was an ongoing medical condition.

**Q341 Mr Jones:** But what is the procedure for doing it?
**Dr Harrison:** There is not a procedure, they are separate records.

**Q342 Mr Jones:** No.
**Dr Harrison:** It is the same as the Scottish Prison Service has their own medical services.

**Q343 Mr Jones:** No. If I move from Durham to Edinburgh you have just told me when I register with a GP in Edinburgh my records will come with me because I am a civilian.
**Dr Harrison:** NHS records.

**Q344 Mr Jones:** Exactly. If I am Army, Air Force or Navy personnel and I retire or finish up in Edinburgh, you are saying you are not aware of a system that allows my medical records then to transfer to my local GP.
**Dr Harrison:** From the MoD to the NHS?

**Q345 Mr Jones:** Yes.
**Dr Harrison:** That is correct.

**Q346 Chairman:** Do you think there should be?
**Dr Harrison:** I think it is very helpful to have a lifelong medical record.

**Q347 Robert Key:** This is very serious indeed. I wonder if we could clarify this by asking for a note of exactly what the situation is.
**Dr Harrison:** This is not a Scottish thing, this is NHS. This is not exclusive to Scotland. If you move from Portsmouth to York the same thing would happen.

**Q348 Willie Rennie:** We were told this morning about the process that is involved in transferring records from the MoD to the NHS and it is not automatic that the records do get transferred. Do you think it would be beneficial if it was automatic that they do get transferred between the two organisations so the NHS fully understands the medical problems that an individual has faced? Would that be of benefit?
**Dr Harrison:** Yes. Having a continuous medical record, particularly at a primary care level, is very, very beneficial, yes.

**Chairman:** That is something that we can ask for a note on. Maybe not from you, maybe from the NHS in general, but health being a devolved responsibility in Scotland it affects you. If you were able to tell us what your views are of it, it would be helpful.
**Mr Borrow:** Just following on that point, Chairman. My understanding of the situation is that if someone leaves the Services and goes into civilian life and signs up with a GP, a good GP would contact the MoD and seek the medical records held by the MoD, but there is no requirement on the GP to actually secure those records. The question is, does the absence of a requirement on a GP to do what seems sensible and proper cause a problem? Is there any evidence that causes a problem or should we, as a Committee, be recommending that there is a procedure put in place to make sure that those records are transferred? I think that is where the Committee is.
Q349 Chairman: I think that is very well put, thank you. We are content now to move on. Did you hear the evidence of Dr Freeman at the beginning? I do not think you were in for that. Is there anything else you would like to ask about mental health, Robert? One thing that he said was that psychiatrists generally on receiving patients who have had a history of being in, say, two or three combat zones may have no experience of, or understanding of, the sorts of stresses that those people have been under. Do you recognise that as a problem or as a fact?

Mr Huggins: I think that is entirely likely to be true.

Q350 Chairman: Given that these people are doing this for us, do you think it is a problem which requires to be dealt with?

Mr Huggins: Generally, where we are now in 2007 is that we have a model of care which is not about the single clinician. It is not about the single doctor relating to the single patient. We work with social workers, nurses, psychologists and psychiatrists, so generally, if there is a particular need in respect of the care of a particular patient, what we will look for is to ensure that need is met somewhere within the team. In the discussions that we are having in respect of provision of services for veterans in respect of mental health, that is where we see the particular value that an organisation such as Combat Stress, which involves volunteers and others with experience, can actually bring to the process. The difficulty would be if we expected everybody in every clinical team to have every experience, we simply would not be able to deliver that. Increasingly, care is team based rather than individual based and we think that gives access to a wider range of skills, talents and experience.

Q351 Chairman: Okay. The suggestion that Dr Freeman made was that since many of these veterans will never consider going anywhere near psychiatric nurses or psychiatrists of any sort, but they are quite likely to approach GPs for physical ills, it would be helpful if GPs had some training in recognising the need for mental health treatment. Is that something that you would feel able to respond to?

Mr Huggins: It is, again, a more general issue in that I would say there are many people who are reluctant to present themselves to psychiatrists or mental health services. What we have seen both in work environments and in public health environments is that people manifest with lower back pain, “I feel a bit low”, they respond through taking more excess alcohol and substance abuse, they do other things. GPs are increasingly aware of the range of reasons why people might be showing particular symptoms which might be linked back to traumatic stress of different kinds. Certainly we are doing work in Scotland about the range of factors that might cause people to present in GPs’ surgeries with different forms of problems: issues around child sex abuse; issues around trauma in early life. These are similar issues that require GPs to have that understanding of the wider reasons why people might turn up in their surgeries. I think my answer is therefore yes and it is certainly something that we are working on.

Q352 Mr Jones: Can I try and understand the system in Scotland. You have clearly got this now on your radar screen and the reaction you had to some of our questions was you devolved this to the local boards. What powers have you got to ensure that these things you are going to try and do are carried out? In terms of at a political level in Scotland, how high do you think health for veterans and Armed Forces’ families is? Has it ever been discussed in terms of a report in this place or anything else?

Mr Huggins: It certainly has been discussed in the Chamber on occasions.

Q353 Mr Jones: By who though?

Mr Huggins: I recall the First Minister discussing it.

Q354 Mr Jones: This one or the last one?

Mr Huggins: It would be the last one, this one has not had much time yet, and he certainly identified it as an area of funding. The Scottish Executive, as was, committed a certain amount of funding towards the redesign and redevelopment of Hollybush House because of the priority veterans had for the organisation. It is an issue which has political and service delivery profile.

Q355 Mr Jenkins: What was the money spent on?

Mr Huggins: What was the money that was allocated to Hollybush House spent on?

Q356 Mr Jones: Yes.

Mr Huggins: The Hollybush House unit has been significantly redeveloped in the last two to three years and is about to be reopened on Monday.

Q357 Chairman: On Monday.

Mr Huggins: Yes.

Q358 Mr Jones: The other side of the question is what powers have you got to ensure that the health boards do get this on their radar screen or carry out what they are doing?

Mr Feeley: Health boards are subject to regular performance review. There is a monthly meeting between the minister and the chairs of all the health boards. There are regular meetings between the chief executive of the NHS in Scotland and the chief executives of the health boards. We are in regular contact with our counterparts on boards to make sure that policies are turned into action on the ground. There was a recent report carried out about scrutiny of public services which reported that the Health Service was over-scrutinised, but we believe it is appropriately scrutinised to make sure that policies are turned into good services for patients, including veterans.

Q359 Willie Rennie: My understanding is that the difference between Scotland and England in the NHS is that it is more advisory and health boards have got slightly more independence and can take clinical guidance and other guidance and can implement it in their own ways with their own priorities. Is that your understanding of it?
Mr Feeley: One of the key differences between the NHS in Scotland and the NHS in England is that we do not have the kind of purchaser/provider split that you have in England. The boards have responsibility for both planning and commissioning the services and providing, and the boards have responsibility for secondary care, primary care, mental health services, public health services, so they can provide the whole range of services to Servicemen, their families and veterans, ordinary members of the public. It is perhaps easier to get a handle on who is doing what when you are only holding 14 organisations to account.

Chairman: We will move on to personnel issues.

Q360 Willie Rennie: This question is about Reservists. Do you know how many Reservists work within the NHS? Have you got a figure for that at all?
Mr Feeley: I do not have that. We could provide you with a note.

Q361 Willie Rennie: We have heard from the British Medical Association that it is a disincentive to work in the Reservists in terms of your career, that it has a detrimental effect on your career. They said specifically: “given the choice of two equal candidates for a consultant post [an employer is likely] to appoint the candidate with no reserve liability”. They went on to say: “reserve liability . . . will often be considered a handicap and a disincentive to recruit”. Is that your understanding within the NHS? Do you think there is a problem with recruiting Reservists from the NHS?
Mr Feeley: I have not had that issue put to me as a problem previously.

Q362 Chairman: But if you were in charge of appointing a consultant, would it not be your natural inclination to choose someone who is able to give you more time for their appointment and who was not likely to be whisked away to Afghanistan or Iraq?
Mr Feeley: We would expect that appointment to be made purely on the merits of the candidate.
Willie Rennie: I find this absolutely astonishing. I feel embarrassed, in fact, that we have come here, I have dragged my colleagues from down South—I did not have to drag them up, they wanted to come up really—and there are so many questions we have asked you that you do not know the answers to. If you are not the right guys perhaps we could get the right guys in London in front of us. There are so many questions that are obviously important questions that you have been unable to answer. Some of them you have been able to answer but this last one on Reservists, the bit about dentists and Service families, so much you have been unable to answer and, honestly, I feel embarrassed that you do not seem to have a handle on it. If you do not have a handle on it, does someone else have a handle on it, and if they do not, what is being done about it?
Chairman: Do you want to answer that? Kevan Jones?

Q363 Mr Jones: Can I ask you in this way: have you given any guidance or strategy to health boards about their policy on employing Reservists?
Mr Feeley: No.
Mr Huggins: To be clear, were we to say to health boards that they should offer an advantage—
Mr Jones: I am not saying that. I am just saying, have you given any guidance about how they should treat people who are in the Reservists, for example, whether they be nurses or anyone else? For example, I know if you go to my local strategic health authority, you have the Reservist unit in Newcastle which is completely staffed by local NHS people and they have a very positive attitude towards it and have a policy on it about time off, training and career development.

Q364 Chairman: Would you like to answer that question? Have you given any guidance?
Mr Huggins: I am not aware that we operate a separate policy which is different from any other policy which applies to Reservists in public life.

Q365 Chairman: Do you actually have a view as to whether it is a good thing to employ Reservists?
Mr Huggins: Certainly we have a strong view that it is good to employ people from a diversity of experience and background and Reservists is one of those. It is valuable to us and it is valuable to the wider public good. That certainly would be our view.

Q366 Chairman: But that view would be based on diversity rather than on the need to support our Armed Forces.
Mr Huggins: No. I certainly said also that there was a wider public good in supporting the Armed Forces as well as the value that we take. There is a value that we take as an organisation and the wider state takes in terms of the commitment that our organisations can give.

Q367 Chairman: But this is a view that you have not promulgated to the NHS Boards?
Mr Feeley: I referred earlier to guidance that we issued to boards about relations with the Armed Forces. The guidance was issued in March 2006 and it says in that guidance: “In support of the twin health goals required by defence, ie a trained and deployable healthcare capability and the maintenance of a fit and health Service population” etc., that the “DMS will benefit from a range of things which include assistance with loan or secondment to the DMS of NHS personnel to fill civilian medical appointments, NHS expertise to assist in the development overall of defence-wide health needs, encouraging and supporting NHS staff to become members of the volunteer Reserve Forces enabling them to develop new skills, both professional and personal”, so in our guidance to boards there is that kind of encouragement and support.

Q368 Chairman: That is very good to hear but you were not aware of it.
Mr Feeley: I perhaps misunderstood your question which seemed to me to be about do we give boards guidance about how they should use Reservists.

Q369 Chairman: Mr Feeley, if you were not aware of it when you gave your answer a few minutes ago to Kevan Jones, how can you expect the NHS Boards to be aware of it and how can you expect the employers of people who are actually deciding whether to choose a consultant or somebody else to be aware of this encouragement for Reservists? It seems to me that there has been no concentration on this issue at all.

Mr Feeley: Other than, as I said, we have given boards guidance.

Mr Jones: One line.

Chairman: But you do not monitor how it is followed through.

Q370 Robert Key: Chairman, we have already asked for a note on how many of your clinicians serve in the Reserve Forces. I wonder if you could also include the statistic for the number of consultants and other clinicians in hospitals in Scotland whose salary is paid for by the Ministry of Defence. This is quite a common arrangement. My own foundation hospital in Salisbury has at any one time between five and eight clinicians, including consultants, who are Reservists, and indeed I met three of them yesterday at Strensall in Yorkshire who are about to deploy to Afghanistan and one from Ninewells in Dundee. It is seen as a huge benefit to the hospitals concerned that they have men and women with this expertise. If nothing else, they have an extra dimension to trauma service that they can provide. They are the only people who are likely to have had to cope on a daily basis with blast wounds, shooting and so on. Perhaps if we could ask for the statistics it would act as a stimulant in Scotland to encouraging a higher profile for the work of Reservist clinicians.

Mr Feeley: We will provide such a note.²

Chairman: That would be very helpful. Thank you.

Q371 Mr Jenkins: The MoD says, and this might appear to be a sick joke after this hearing but it is not, in future it wants to work more closely with the NHS in providing healthcare for Service personnel. What advantage or disadvantage would you consider would arise if the MoD came to you and said, “We would like to work more closely with you in providing healthcare for our Service personnel”? Mr Feeley: There are a range of areas that we could build on. We could do more around information sharing. There is a deal of work that could be done around prevention and anticipation of health need, which I think touches on some of the points that were made earlier about alcohol and substance misuse. I take the Committee’s point that we could do more around the promotion of the joint benefits of particular skill sets of clinicians. I would welcome such an overture.

Chairman: I think it would be good also if you did not rely on these four meetings a year to form your sole relationship with the Ministry of Defence because what the Ministry of Defence does and what you do ought to be completely integrated for the good of our Armed Forces. If there are no further questions then I would like to thank our witnesses and declare the meeting closed.

² See Ev 149.
Tuesday 27 November 2007

Members present

Mr James Arbuthnot, in the Chair

Mr David Crausby
Linda Gilroy
Mr David Hamilton
Mr Mike Hancock
Mr Adam Holloway

Mr Brian Jenkins
Mr Kevan Jones
Robert Key
Willie Rennie
John Smith

Witnesses: Derek Twigg MP, Parliamentary Under Secretary of State for Defence, Lieutenant-General Robert Baxter CBE, Deputy Chief of the Defence Staff (Health), and Lieutenant-General Louis Lillywhite MBE QHS, Surgeon-General, Ministry of Defence, and Mr Ben Bradshaw MP, Minister of State for Health Services, Professor Louis Appleby, Mental Health Clinical Director, and Mr Andrew Cash, Co-Chair, DH/MoD Partnership Board, Department of Health, gave evidence.

Q372 Chairman: Welcome. This is our fourth evidence session on the medical care for the Armed Forces and it is our final evidence session. We are taking evidence today and we are most grateful to both of the Ministers in front of us from the Ministry of Defence and the Department of Health. I think this is a first. No, it is not a first in this parliament—we had the Secretary of State for Defence and the Foreign Secretary as well—but we are most grateful to you for coming with your teams. We have done a second stage of the web forum we have been running and we have decided to extend that by one further week, and I will take this opportunity for advertising the address, which is www.parliament.uk/defcom, so I hope people will get on to it and start telling us their experiences, bad and good, of the medical care available to the Armed Forces. Ministers, normally we do not have an opening statement but, in view of the announcements that you made on Friday, we think it would be extremely helpful if you could just summarise what it was that was set out then because I am sure that those questions and those issues will run through the whole of this morning’s evidence session. Which of you would like to begin?

Derek Twigg: If I could say briefly, I announced on Friday the pilot schemes for mental health for veterans and these will be at six places in the country. We announced both Camden and Stafford, which are just about to get off the ground, but there will also be pilots at St Austell, Newcastle, Cardiff and at a place in Scotland as well. We are spending around £500,000 on this project in the initial stages. The pilot will last for two years. Basically, the Ministry of Defence, with our expertise through defence mental health, will be working via the veterans units as well as with the NHS providers of mental health in these locations and that will be really to enable clinicians in the Health Service to gain a better understanding of the issues around those who have served in the Armed Forces and the issues that might arise, which often impact upon their mental health. Of course, in a number of cases there will be a number of people working in the pilot areas who have served in the Forces themselves, but really to build an expertise in centres of excellence around the country in managing those with mental health who have served in the Armed Forces. As I say, this will run for about two years. I went to Camden on Friday and Stafford yesterday. There is great enthusiasm at those pilots for that and I think a very exciting project is in place there. In terms of Scotland, I am not able to say at this time exactly where that will be, but what I can say to the Committee is that discussions are ongoing with the Scottish Executive. We will, of course, ensure the same funding that applies to the English and Welsh schemes as well and we look forward to getting that pilot up and running as quickly as possible.

Q373 Chairman: Minister, do you want to add anything to that?

Mr Bradshaw: It may be helpful if I outlined the other part of the announcement that we made on Friday, which was around extending the priority treatment to veterans. Priority treatment has existed since 1948 to those veterans who are pensioned out of the Service because of an injury or a condition that is service-related, to all veterans for any service-related condition. This was based on a system that has been up and running in the constituency of the Secretary of State for Health in Hull for some time and it will extend the priority from currently 170,000 to potentially five million veterans in the country. Would it also be helpful if I introduced my supporters?

Q374 Chairman: I was going to say, now that you have set those out, would you mind very much introducing your teams?

Mr Bradshaw: Not at all. On my left is Professor Louis Appleby, who is the Mental Health Clinical Director for the Department of Health, and on his left is Andrew Cash, who is the joint Chairman of the DH/MoD Partnership Board. Derek Twigg: On my right we have got General Louis Lillywhite, who is the Surgeon General, and General Robert Baxter, who heads our health services.

Chairman: Thank you very much. There will be plenty of questions arising out of that, and we will go during the course of the morning into the detail of what have you said. Willie Rennie.
Q375 Willie Rennie: If five million veterans suddenly came forward and demanded priority treatment, that would obviously create chaos in the system. How many people do you actually envisage coming forward and taking advantage of this service?

Mr Bradshaw: The experience in Hull has not been that it has created chaos in the system. I think it will depend to start with on how well informed both the individual patients themselves are of their right but also the response of the local health communities, and we do not expect that five million people are suddenly going to come forward and that will create chaos. In fact, I believe that part of the problem that we have at the moment is not enough veterans are aware of their right to priority treatment and not enough Health Service professionals are aware that veterans have those rights. It is something that we remind the Service of on a regular basis. We do so annually, both through our operating framework and through the guidance we put out, but we would encourage veterans who think they have a condition and a right to priority service to demand that right and, if they do not get it, to complain and we believe there will be fewer problems than there might have been in the past, Mr Rennie, because, of course, waiting times for the general public have been dropping dramatically and will be 18 weeks maximum by the end of next year.

Chairman: Hold on. We run the risk of getting seriously derailed onto this issue. I have Kevan Jones, Mike Hancock and Robert Key all wanting to catch my eye, but I just wonder whether it might be better for us to delay these questions on priority treatment. I am in the hands of the Committee.

Mr Hancock: We need to follow it up.

Chairman: We will follow it up.

Robert Key: It does come later.

Chairman: I have a sense from the Committee that actually you would prefer to get on with it now.

Willie Rennie: I think we had better deal with it now.

Chairman: Okay, Willie Rennie.

Q376 Willie Rennie: From the Hull experience, how many more people came forward and, therefore, if the same as happened in Hull happened all over the country, how many people would come forward?

Mr Bradshaw: I am not aware that there are any concrete figures in Hull, but I am aware that it has not caused any significant problems and it has been a very popular initiative.

Q377 Mr Jones: I am concerned with what you say about Scotland, because we had a very unsatisfactory evidence session in the Scottish Parliament with the Scottish NHS who, I have to say, I think Willie Rennie, as a Scottish Member, described as embarrassing. There was no real comprehension at the head of the NHS in Scotland that veterans came anywhere special. So, one of the concerns is that that has not been pinned down, which perhaps explains how the needs of veterans and also the needs of service families is going to be more reinforced with the Scottish NHS because, I have to say, we were not impressed by what we heard.

Mr Bradshaw: I am not responsible for the Health Service in Scotland.

Q378 Chairman: Neither of you is.

Mr Bradshaw: I am sorry; I thought that question was directed towards me.

Q379 Chairman: That is the problem.

Mr Bradshaw: Can I clarify? The NHS is responsible for the health services that are provided to veterans; I am responsible for the NHS in England. I understand that my Scottish counterpart has also announced that they will be giving priority treatment to all veterans. They have a different system—they do not have the 18 week target, for example—but she has announced, I believe, that they will offer priority treatment, but that is a matter for her, Chairman.

Q380 Mr Jones: I was not asking you that. I was asking him.

Derek Twigg: I think the evidence given already, in terms of partnership boards, exists and at different levels amongst our medical community meetings take place and this is discussed. In fact, if I can just say to you, even as recently as June this year---. I chair a veterans forum, and this issue was discussed and the Scottish Executive representative was very clear that this was an active issue on health, it was a devolved issue, and essential to ensure a consistent approach in delivery, and the advice was issued every year and disseminated by IT systems. So, we have had discussions with our colleagues in Scotland, as I say, both in terms of our medical people in the partnership boards and at other levels, but, of course, at ministerial level the Veterans’ Forum will discuss all these issues around veterans’ health, and veterans’ priority treatment was raised during the last Veterans’ Forum meeting.

Q381 Chairman: Could I ask you before you pursue your further discussion with Scotland to read our evidence session on what happened in Edinburgh, because Kevan Jones is right, it was unsatisfactory.

Derek Twigg: Yes. We are not being in any way complacent. As I say, we will continue to have further discussions to take up the issues, and I have read the evidence session and I have also talked to a number of the members of the Committee, who expressed their concerns to me.

Q382 Mr Jones: I am not saying the problem was with you, it was actually with the Scottish NHS?

Derek Twigg: I think what I am trying to say is that from the defence point of view we are actively engaged and we will certainly continue to do as much as we can to ensure the subject is given a profile, but, as I say, it is a devolved matter in terms
of the Scottish Health Service, but you can rest assured as a Committee that we will continue to do all that we can.

Chairman: Thank you. Mike Hancock.

Mr Hancock: Whilst everybody would accept that veterans should have this degree of priority, I cannot understand why Hull was chosen as a place for the trial to take place. In an area like South Hampshire, where there is a high disposition of service personnel returning, tens of thousands, that sort of priority will place real issues for the trusts running the hospitals in that area, particularly the big one in QA Portsmouth. What are you going to do about making sure there are resources available if there is a huge take-up of this priority for veterans in areas where there is a high predominance of retired service personnel? In Portsmouth, Colchester, Aldershot, Tidworth, round the Salisbury area, many of them have high concentrations and they would have been, surely, the places to trial something like this.

Q383 Chairman: I would normally say Minister, but I am going to find it very difficult to keep calling both of you minister, so I will say, Ben Bradshaw.

Mr Bradshaw: With A&E, Chairman, there would not be any question because A&E patients are treated within four hours because they gave got an urgent need. With general veterans presenting themselves at GPs surgeries, when they leave the Services, if they leave for medical reasons, there is a package that is arranged between the military medical system and the NHS and the local PCT or GP. They are entitled within a year, if they do not leave on medical grounds, to a GP referral, but we do rely on veterans themselves to identify themselves and to seek this priority treatment as their right and, as I said earlier, one of the difficulties is that not enough do. We remind the Health Service of its responsibilities and the Chief Medical Officer is writing out again to GPs to remind them of the priority treatment scheme and the fact that that has now been extended to all veterans.

Robert Key: I am not satisfied with that, Chairman. There must surely be a system in place where immediately a doctor’s receptionist can identify; this is a veteran, and there is not such a system. It depends at the moment upon the veteran saying “I am a veteran”, and then the receptionist will not even know what questions to ask, and it does matter surely?

Q385 Chairman: Mr Cash, do you want to add anything to that? I just gleaned from your body language that you might.

Mr Cash: Obviously, if they are veterans, in two ways really: first of all, they will be informed of this when they are in the Services and then become a veteran, so the individual will know; secondly, it will be in the operating framework, it will go out to each PCT and then out to each GP, so it is that way, but essentially, at the moment, the more complicated packages of treatment that the Minister has talked about are arranged between the military and the PCTs, the GP direct or a mental health trust or an acute trust.

Q386 Chairman: Surgeon General, do you want to say anything?

Lieutenant-General Lillywhite: No, because, of course, you are dealing with veterans, which I am not responsible for, but I would just confirm that when somebody with a health condition is actually discharged from the Forces, we do actually ensure that the care is actually passed over in as seamless a way as possible.

Robert Key: But there is still no process that identifies the individual person. We have heard from Combat Stress, for example, that it is typically 12 to 14 years before a mental condition manifests itself to a Serviceman. Twelve to 14 years later, if there is no method of identifying an individual person as a veteran, no-one is going to believe them if they walk
in off the street and say, "I am a veteran and I left 14 years ago." "Pull the other one", will be the reaction. Surely a system can be set up.

Chairman: It seems to me that we have alighted on a rather important point here. Kevan Jones is next.

Q387 Mr Jones: What you told us is complete nonsense, is it not, because you actually do not track veterans? The big problem is—Mr Key is exactly right—that once people leave the Services they go into the NHS system where there is no way possible of actually tracking where they go to and, 14 years later, as has just been said, you can take their word for it. Should there not be a system whereby we could really keep the promises? It is all right promising these things for veterans but we should actually have some marker or record that they have actually been a veteran. As for talks with the PCT, it is complete nonsense: because I actually spoke to my Chief Executive of the PCT the other week and asked her how many times or what correspondence or contact she has with the MoD. Nothing. So this idea that PCTs are actually on top of all this is just not the case.

Mr Bradshaw: Can I respond to that particular point. She is under an obligation to read the annual operating framework and the guidance that we issue to PCTs which draw attention to the Concordat, the special arrangements that apply to veterans; but on the point about records, my understanding is that when a Service personnel leaves the Armed Services, they are given a summary record of their medical records which they then take to their GP and when the two computer systems are integrated, which they will be as part of the National Computing for Health national IT network, this will, as I understand it, be automatically transferred. So there is a record that they are a veteran, they have it, and we do rely on them to then take it to their GP when they register with the GP. If they are pensioned out for a medical reason, this is all managed for them by the military support medical teams.

Chairman: Thank you, Mike Hancock.

Q388 Mr Hancock: I was just going to say, when I visited the medical facilities at QA along with our clerk a week or so ago, I raised the point that GPs had questioned the ability of themselves to get medical records which were comprehensive and clear about what had actually happened to service veterans when they came to them, and I was assured that that was not the case because they did not get a summary, they actually got a fairly detailed paper. It is a summary?

Mr Bradshaw: Yes.

Q389 Mr Hancock: That summary does not include, in some instances, the sorts of injections that personnel would have had. Certainly veterans who in the last ten years, maybe in the last five years it might have changed, but certainly anybody who left the Armed Forces before that period of time, their GPs will tell you time and time again the very real difficulty in achieving accurate medical records from the MoD. I think the point is valid. How easy is it for you now to make those medical records readily available to a GP on request when a service person signs up at that new GP’s surgery? It ought to be an automatic process, did it not? The GP immediately alerts the MoD: “I have got a new veteran on my list. I want his comprehensive medical records in my hands.”

Derek Twigg: Can I just say (and General Baxter will come in and correct me if I am incorrect here), people leaving the Services get a summary record, as you quite rightly say. If the doctor so wishes, they can then request the actual detailed medical record. Obviously, when the new IT system is up and running, it will provide a lot more information in terms of accessibility. In terms of war pensioners, they also get given a letter from the Service Personnel and Veterans Agency. I am not sure if it has some historical context in that it has never been a sort of systematic system going back to the Second World War. This is a system which, clearly, as I accept, we have got to see what more we can do, but I think the fact that they do get a summary record and they do get a letter from War Pensions is a very important point to make in the context of this debate.

Q390 Chairman: I will call on Surgeon General, then Adam Holloway, then John Smith, then I want to get back on track and I will make a comment after John Smith.

Lieutenant-General Lillywhite: Can I make a couple of points. First of all, as far as medical records are concerned, we keep for 100 years the medical records of all people who are actually in the Armed Forces. They are kept somewhere on the estate, they are comprehensive and they can be obtained easily on request. I only visited there about a month ago. There did not appear to be a waiting list in terms of responding to anybody’s request for records. They can be provided, but it is incumbent upon the GP to request them. I think there is another issue that we do need to bear in mind, and that is not all veterans want it to be known that they are veterans, so we just need to be careful about being too proactive in some cases. An individual who has left the Armed Forces, wants to sever connection with the Armed Forces, in some cases, not many but in some cases, may wish that severance to be complete, and we need to be very careful about being too proactive and overriding an individual’s wish.

Q391 Mr Holloway: Notwithstanding General Lillywhite’s point, I wonder what General Baxter thinks. How much can you rely on ex-Servicemen to flag themselves up? I have been to a GP a few times in the last 16 years, leaving the military with an injury from parachuting. I do not think I have ever mentioned that I was in the military; it did not really occur to me to do so. So if I, who am fairly pushy, have never done that, how do we expect some guy who is less so to do so?
**Lieutenant-General Baxter:** I think you go back to General Louis’ point. People have a right to their privacy and if we were to put a little ink mark on their foreheads, it would be getting in the way of what they wanted to do. The point about the medical records: the summary is there so the GP knows if there is something there that might worry the GP; he then has to request the record with the patient’s permission. You have to balance, if you like, identifying people versus people’s right to privacy and information about them; so a little more thought there before doing this on the hoof.

**Derek Twigg:** I think it is a very important point that you make, and it is true to say there are differences of opinion. Unless I have been somewhere else in the last 12 months I have been doing this job, I think health has had a pretty high profile in the media and the issue around priority treatment has probably never had such a high profile in terms of the media generally. Taking into account whether it is through the partnership boards, the various notes that go through PCTs and information that is coming around the system in terms of priority, and obviously your investigation, I think there is much better understanding. Even in terms of mental health, in terms of the stigma attached, it is very difficult for a lot of service people to deal with. It is, I believe, improving. Yes, there is a lot more that we can do and it is important that we look at that, but I think to suggest that a lot is not happening and the fact that the publicity around this has not been much greater in recent months, certainly the last 12 months, I think is something we should not overlook.

**Mr Bradshaw:** An illustration of the cultural problem to which Mr Holloway refers is that we are only aware of one complaint ever from a veteran about not getting the priority treatment.

**Mr Holloway:** They just do not complain.

**Q392 John Smith:** You will have to forgive me, but I do not quite understand how this priority treatment will work in practice when a constituent of mine presents himself to the GP. The highest proportion of veterans in the population is actually in Wales and we do not enjoy, unfortunately, the shorter waiting times for treatment and referral; so I suspect in Wales this is going to be an issue, with much longer waiting times. What will actually happen when my constituents present themselves to the GP which means they will get priority when we have got long waiting times? How will it work in practice?

**Mr Bradshaw:** As long as the clinician could satisfy the GP which means they will get priority when a constituent presents himself to the GP with the same clinical problems, they are clinically equal, or 200 people present themselves to the medical services and they are clinically equal, then a veteran will get priority over the other 199. Is that what you are saying?

**Mr Bradshaw:** As long as the clinician could satisfy him or herself that the problem was related to the service, yes.

**Chairman:** I do apologise to Brian Jenkins because he did catch my eye a lot earlier and then I got distracted.

**Q394 Mr Jenkins:** Minister for Veterans, in relation to the response you gave to Mr Jones with regard to the unfortunate evidence session we did in Scotland, would you take this opportunity to state now that if any agency, be it in Wales, Scotland or in England, fails to meet the standard we require for servicing veterans you will do what? What exactly will you do rather than, “We will try and talk to them. We will work to them”? If they are failing to meet the obligations, what are you prepared to do?

**Derek Twigg:** Clearly, the National Health Service knows, but it is the health departments in each study in Scotland and Wales. I cannot tell them what they should and should not do, but as the veterans’ minister I am the advocate for the veterans and I am certainly, if you ask people, not shy in coming forward in terms of advocating veterans’ issues and these are discussed at various forums. I mentioned one example, the Veterans’ Forum. Also I have got a meeting coming up shortly with members of the Scottish Executive. I will meet my fellow ministers; I have got health ministers on occasions during the last year to raise these issues, so I continue to press for improvement. The thing about veterans, very clearly, is it is not just the Ministry of Defence, it is a cross-government approach which is very important to all this. So, I will continue to advocate and to speak and discuss these things with my colleagues and other government departments on devolved administration and about how we can continue to improve that. I sensed a great deal of willingness, and I was not at the evidence session, and clearly understood how it went, to actually improve these things and take these things forward and I can guarantee that will be top of my agenda.

**Q393 John Smith:** I think this is very, very important for veterans to understand clearly. What the ministry is saying is that if two of my constituents present themselves to the GP with the same clinical problems, they are clinically equal, or 200 people present themselves to the medical services and they are clinically equal, then a veteran will get priority over the other 199. Is that what you are saying?

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**Q396 Mr Jenkins:** So you have got the power to do that?
**Derek Twigg:** If we have got a contractual position with an organisation, that is absolutely true.

**Q397 Mr Jenkins:** You have got the willingness to do it as well?

**Derek Twigg:** Absolutely, because at the end of the day what matters most is how our veterans and Service personnel get treated. That is our absolute priority.

**Q398 Mr Jenkins:** You have got the willingness to sort out an agency in England. Why have you not got the willingness to sort out an agency outside England which you have responsibility for? It is not devolved to you.

**Derek Twigg:** Can you be more specific? In terms of the Scottish situation?

**Q399 Mr Jenkins:** Scotland, Wales, yes.

**Derek Twigg:** Which agency in particular in Scotland?

**Q400 Mr Jenkins:** Any one of the devolved authorities who gets money allocated from the Treasury.

**Derek Twigg:** We do not have a contract with the health administrations for veterans *per se* because, as we say, there is a general administration that says how veterans should be given priority, but again that comes back to my earlier point. We have a dialogue and continue to press for improvements. I read out what the Scottish Executive said at the Veterans’ Forum. I was not at the meeting, but I have clearly read and heard about it and I am sure, I am quite convinced, that within Scotland there is a real willingness to see improvement and to see a commitment to veterans.

**Q401 Mr Jenkins:** A bit more push really.

**Derek Twigg:** I can assure you that will be done.

**Mr Bradshaw:** I hope you do not mind me saying, Chairman, I do think it is a little bit unreasonable to expect us to defend the behaviour of our Scottish colleagues. I regret deeply the decision by Scottish ministers not to bother to turn up to your hearing. I think that was inexcusable.

**Q402 Chairman:** If you are under the impression that we were expecting you to defend the Scottish Executive, please correct that, we are not. We are expressing our frustration with the way that that meeting went.

**Mr Bradshaw:** Which we share.

**Q403 Chairman:** Which we fully accept that you share, but the fact that all of this has to be delivered through that Scottish Executive means that we have to ask you questions of how you expect this to be delivered. It seems to me most likely that in our report we will comment on this difficulty, particularly about identifying veterans. Quite how we will comment on it will be a matter for us to discuss and consider, but when we do we hope you will be responsive and flexible in the way that the Government responds to our report because we think we have hit on a quite important difficulty here with what you are announcing.

**Mr Bradshaw:** I think that would be very helpful, because one of the three work streams that the joint partnership board is currently working on is this whole issue of transition from military to veteran status, and anything you say I think will be very useful.

**Lieutenant-General Lillywhite:** You have mentioned Scotland. I would just like to correct what I think may be a misapprehension from the minutes of that meeting. We actually have quite close relationships with Scotland at a variety of levels for serving personnel. For example, I meet with the Chief Medical Officer for Scotland, as I have done, along with the other chief medical officers. Our primary healthcare headquarters, for example, in Edinburgh has regular meetings with officials from the Scottish Executive. I do not think that actually came across in your evidence session, but there are, for serving personnel certainly and for their families, regular meetings between the Ministry of Defence and their officials and the people on the ground in the Armed Forces and the Scottish Executive. I would just like to correct the impression that I got from the transcript that there was no meeting of minds at all.

**Q404 Chairman:** I am relieved to hear it, as we will all be. I would like to get this evidence session back on track. Let us begin! Last week we had a briefing from the Army presentation team and we heard there that the Chief of General Staff had a briefing team report 2007 which referred to feedback that the CGS was getting from the Army. It would be most helpful to us if you, Minister, could see if you can find out from that report if there are any defence medical issues that it would be helpful to bring to the attention of this Committee before we finalise our report, please?

**Derek Twigg:** Can I apologise that the Committee did not actually see that report and can I give you an absolute assurance that you will have a copy. In fact, I have a copy here today with me which I will make sure that you will have and any other copies of the services that may be relevant in terms of this Committee.

**Q405 Chairman:** That would be very helpful, but if you have already identified any medical issues that arise out of that, if you could flag those up to us, that would save us a lot of time.

**Derek Twigg:** We will do that.

**Q406 Chairman:** We would like to get this report done quickly. We visited Selly Oak in June. I have to say that we were highly impressed by the quality of the people there, by the work that they were doing and the standards of care that they were producing, and we said that at the time and I want to repeat that today, and there are a lot of good stories coming out of defence medical care. What we will be doing
during the course of the morning is asking questions which might imply from the general tone of the way that we ask questions that we think the whole lot is rubbish. We do not think that. We ask questions because that is our duty. We, nevertheless, think that medical care in general is being produced well for the Armed Forces. I do not want to pre-empt our report, but can you explain briefly the plans that you have for developing the defence medical services facilities at Birmingham, how it ties in with Whittington Barracks in Lichfield and how definite those plans are?

Derek Twigg: Shall I take our development in terms of Selly Oak and I will hand over Lichfield to General Baxter. First of all, can I welcome your comments about Selly Oak. I visited Selly Oak on a regular basis and I think it was most unfortunate this time last year when there seemed to be a malaise in terms of the press comment on Selly Oak, and I think that was hugely damaging to morale, not least to the people who work at Selly Oak. Like any other large trust, there are always issues and things that do not always go right but we are absolutely committed to making sure that that happens. The overwhelming tone that I have had is the absolute amazing care and treatment that goes on in Selly Oak, not just for the military people but the NHS staff there. The true story about Selly Oak is the long operations to save limbs where surgeons carry out, in some cases, world leading operations and come in on their days off to make sure people are okay. The civilian NHS nurse who, a soldier told me, sat up all night with him to comfort him. They are the real stories about Selly Oak and, as I say, I am glad to see you confirm that your opinion is that of ours, but, of course, we always watch to see how we can do better. One of the issues we are watching of Selly Oak is in terms of this issue of the military ward and how that is approached. We currently have a Military Managed Ward, as you are aware, where we have around 39 military nurses, we have got two liaison officers who link in with units of the injured Service personnel, we have got a military ward manager, welfare officers and psychiatric nurses and there is obviously a much greater feel in terms of a military environment than a workplace. It is a very important partnership with the NHS. In terms of the new hospital building which is taking place at Selly Oak, we very much welcome the partnership and we intend to have a ward of up to 32 beds for our needs which are both for those who are injured in service and some elective cases as well. The idea behind this ward will be that it can be broken down into individual units of four beds or, of course, side rooms as well, and that, of course, will have a majority of military staff in but it will also have NHS staff. Again, it is very important that that partnership continues on the ward. Then, of course, it will have all the facilities of what would be, I believe, the leading trauma unit in this country, if not in Europe—an acute hospital with all the facilities that that provides for our people—but, of course, also enabling both our people and the NHS clinicians to develop a range of skills and training expertise. This is some of our early thinking. There has been an issue around civilians being in the same ward as military personnel. The intention in terms of this ward would be that we would be able to manage the ward in a much more defined military way because of the design the ward will have in place at beginning. That is not, of course, to rule out at any point, if there is a real need for it, God forbid, a major incident somewhere, using beds for civilians or other specific circumstances, but the general view that we have is that we will be able to make that a much more defined military ward than is currently the case now, but that does not in any way undermine—. I am sorry, you are underpinning the fact here that we want the best possible treatment for our Armed Force personnel who have been wounded in operations and elsewhere, and it has been Selly Oak that provides that for us.

Lieutenant-General Baxter: There are a number of ingredients when it comes to, if you like, the Birmingham/Lichfield, the dumb-bell, a lot of words have been used there. There is the military ward that the Minister has talked about; there is also the training and centre of excellence that has been built at Birmingham. Where there is the feedback from operational theatres, just producing that fissionable mass of expertise to look after battle casualties that is growing, and that is very important and feeds into the training which goes on there. So there is a training ingredient, a centre of intellectual excellence. And you may have come across the Ministry of Defence Technology Centre for Human Factors that is also based at the University of Birmingham. So there are a number of ingredients coming together in the centre of Birmingham; so that is part of it. The other piece that we are looking to do is to continue on that, if you like, the training and centre of excellence that has been built at Birmingham. Where there is the feedback from operational theatres, just producing that fissionable mass, bringing the various components together, making sure the thinking piece goes into the training and the education and to look at concentrating other bits of training. Our eyes are on taking Whittington Barracks and converting that into a satellite to the main Birmingham piece. We are looking at plans now, we are looking at budgets and we are looking to what we call a Main Gate submission, the investment decision, early in the New Year.

Lieutenant-General Lillywhite: Could I thank you very much for your comments on Birmingham and just reiterate that it has actually had a major adverse impact upon morale, the comments that we had at the beginning of the year. I literally had staff, military and civilian, in tears, as they felt that they were being got at and their quality of care was being undermined, but I would like to say, though, that the quality of care that Birmingham has provided has gone beyond that which is actually seen. They are making a significant contribution to the quality of care on operations. For example, the weekly conferences that we have between Afghanistan, Iraq and Birmingham, where casualties’ care is actually reviewed in theatre and back in Birmingham, allows us to actually improve by learning from the lessons
of casualties we have already treated. They are also actually assisting us in identifying research that we might want to undertake to improve the quality of care that we are being provided and, for example, to further that, the Professor of Traumatology at Birmingham came with me to visit Afghanistan to look at how it physically paid, there are within the Armed Forces. I regularly meet with the Medical Director at Birmingham to discuss, again, quality issues. So, Birmingham is contributing to the quality of care, both directly in the way that you saw it, but indirectly they are actually contributing in many other ways as well.

Mr Bradshaw: Briefly, Chairman, the NHS is also benefiting enormously from this collaboration in terms of expertise and skills and culture, and to confirm what Derek said, the new hospital will be the biggest critical care unit in the whole of Europe and it is the second biggest hospital building programme in Britain.

Chairman: However, we have had evidence to suggest that a lot of people are unhappy with the concentration of defence medical facilities in Birmingham, that it is not necessarily the best solution. On Friday I briefly visited Haslar, where, obviously, the support for the retention of an excellent facility is very high indeed. Plymouth—Linda Gilroy, you have your own views about that.

Q407 Linda Gilroy: I think the issues at Haslar and Plymouth are very different. I do not think that Plymouth would say that they were unhappy with what is happening at Selly Oak, and I would concur with everything my colleagues have said about the quality of care that we observed at Selly Oak. I think the points that have been given to us in evidence are more about the long-term development of the quality of care in traumatic services and whether, with the concept that there now is in the National Health Service and the concentration of defence medical facilities in Birmingham, that it is not necessarily the best solution. On Friday I briefly visited Haslar, where, obviously, the support for the retention of an excellent facility is very high indeed. Plymouth—Linda Gilroy, you have your own views about that.

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expertise. Our Minister has talked about bringing military casualties together—and I think CGS has been pretty strong on this one—so they support each other in the healing process, typically 15 at any one time, I think, in the ward, there or thereabouts. The general statistics are there but around about 15. If we were then to scatter them in too many places, we would destroy that mutual support. So there is always a complex balancing, of not creating an issue for the NHS and allowing ourselves to bring those patients together. General Louis talked about that feedback loop into operational theatre. If we started scattering patients around the place, that again would create an issue. I do not know if you want to talk about your initiatives in military medicine.

**Lieutenant-General Lillywhite:** I think, first of all, it is worth remembering two of the important criteria as to why we chose Birmingham. Those two criteria were that there was a strong relationship between a hospital and a university, and at the time, of course, the Peninsular University did not exist. The second criterion was that it ought to be in a conurbation because that would give us the opportunity to spread out in a local way should the number of casualties exceed the capability of whatever it was that we chose. It was also a competitive process, and the three that actually arrived on the short-list were Newcastle, Birmingham and Guy’s and St Thomas—all from conurbations—and Birmingham won and won actually by a significant margin. That is the first point I would make. Those are the reasons why we have chosen Birmingham. The second thing is, in terms of concentrating casualties, although the number of casualties is significant, we actually need that number in one place to actually improve the quality. We are learning all the time from the casualties, just as in the Royal Victoria in the early seventies we were learning as the result of the new type of injuries we were seeing at that time. The type of injuries we are seeing in Birmingham are not seen anywhere else Europe at all or, steadfast Landstuhl in Germany that the Americans have. These are different from every other casualty. They are casualties that do not survive in civilian life. We need to actually build up our expertise in continuing that survival and the quality of the subsequent outcome, and we need to concentrate that in one area to actually help develop that. So, that is why Birmingham.

**Mr Bradshaw:** May I add two other things. Chairman, the proximity of Brize Norton, the relative ease with Birmingham being central so that it is easier for relatives to visit. It is no disrespect at all to the excellent services provided at Derriford and its hospital, I know very well, but all chief executives want to increase the number of patients they treat because they are now paid to do so by Payment by Results.

**Q408 Linda Gilroy:** Can I make a further observation on that? That is that that decision was taken some time ago. There has been a report on trauma services in the National Health Service in recent days and a recommendation there that there is a need to significantly improve that under, I think it was, NCEPOD, who were looking at that for the Health Service. I just think it would be a pity not to consider the way in which the National Health Service is evolving. The point would be to do something for the sake of it but for the quality of traumatic services to benefit in the Armed Services as well as in the National Health Service.

**Derek Twigg:** We are not just saying that. You can rest assured we will always keep this thing under review. You know yourself in medicine and health things are always evolving and developing and I think, based on the current advice and situation that we have got, we believe that the current approach in terms of centring it at Birmingham is the one that is in the best interests of our injured Service personnel and their families.

**Lieutenant-General Lillywhite:** Could I add a different point. It is that I am sure right that those lessons that we are learning on operations should be taken account of in the civilian area. Myself and certainly my US colleagues both believe that the lessons we are learning are directly applicable to civilian trauma management. In fact, I had a meeting with the new Chief Executive of the Medical Research Council only two weeks ago, and I am due to meet with him in a small group in the near future to actually identify how we can exploit the lessons we are learning on operations for the civilian environment.

**Chairman:** That is helpful, because that answers one of the other questions that we were going to come on to.

**Q409 Mr Jones:** Can I retrace the Chairman’s comments in terms of being impressed. Certainly when I went to Northallerton last week I was very impressed by the people there. One of the more lurid sides of the media campaign against Selly Oak has been about military managed wards. There is an urban myth to some of this, which to an extent concerns me, that even the British Legion in their submission to us are raising issues around lack of military environment and security of personnel. I hope in our report we do actually debunk some of these myths good and proper. Could you just say what approach has been made on the Military Managed Ward and how is it working in practice?

**Derek Twigg:** Our intention was to develop a much greater involvement from an ability point of view in terms of numbers and in terms of nurses and in terms of the welfare support. I am sure I explained before, we have got about 39 military nurses now, we have got an RSM ward manager in terms of managing the discipline and the Service side of things and we have got two liaison facilities who link in with the units. This is very important in terms of the units in Afghanistan wondering how their mate is getting on in hospital. It is a very important linkage they have there and they do a very important job, and, of course, they have got a number of welfare officers, which are not just for the injured service personnel.
but also very much so for the families. Can I say a word on the families? I think there has been significant improvement since this time last year in terms of the reception of families and management in terms of welfare, and accommodation is provided at Selly Oak for the families as well. You just walk around Selly Oak now, and it is like new. There are a lot more military people and uniforms. It is about managing---. The overall responsibility, as Ben will confirm, is with the NHS. The hope going to the new ward is that we can put in an actual ward manager who would have the responsibility on that ward for all the things that happen in that ward. That is our intention as far as I can tell you today.

**Lieutenant-General Baxter:** Just to add to that, one of issues is the nurse is there to give part of that military flavour, but there is also patient administration: the sort of command and control makes the patients, the battle casualties, feel part of the medical organisations that would previously have been called “the patient group”—the patient, families, relatives, friends—through a very difficult time. The appointment of a Standing Joint Commander Medical. Colonel Chris Parker, an experienced soldier is going in there, he knows the issue in the operational theatres, he knows what it is like looking after soldiers. He will make sure of the command and control, once they come into the hospital, and then go on in the care pathways, and ensure that is done in a joined-up way. So, yes, nursing, but there is also that piece which I call patient administration, patient command and control, which is probably equally important.

**Chairman:** We have 15 questions, many of them with subparts. We have just finished question one. This is a comment to the Committee and to the witness. It would be helpful if we could move in a very clipped way through our further questions, please.

**Q410 Mr Crausby:** Can you tell us how the injury profile of operational battlefield casualties has changed over the last five years? Have you seen more serious injuries, for example? I am sure that we all hope that this will not continue indefinitely, but what implications does this have for the provision generally of healthcare for Service personnel?

**Lieutenant-General Lillywhite:** To summarise, body armour, in particular, has actually changed the profile by making those casualties that would have previously died from wounds to the centre part of the body survive. So we are actually seeing very much more serious casualties with significant limb and abdominal injuries that would previously have died; more severe, more challenging, not only in terms of the anatomical injury but the physiology and the support that is required and the reconstruction that will be required subsequently; that is the main change. In terms of healthcare, we have spent considerable investment in the last two years in actually looking at what the Israelis and the US do, looking at our own research in places like Porton Down. We have taken the enhancements that other nations have done, we have applied what I call due diligence to them and, where appropriate, we have adopted them, hopefully improved upon them and, as a result of that, as I said, we can demonstrate that we are actually having significant additional survival. For example, we have introduced new what are called haemostatic bandages at the point of wounding, the Israeli bandage we have adopted at the point of wounding, the new tourniquet we have adopted at the point of wounding—we have changed the way that we teach them to apply it—and that has led to significant increased survival at the point of wounding. As far as treating subsequently, we have introduced completely new protocols for the way that we actually resuscitate them. We have moved away from clear fluids to new blood products. We are actually introducing into theatre platelets. Platelets have to be carried at a certain temperature and have to be shaken, not stirred, the whole way during the transport process. We are, in spite of those logistical challenges, successfully getting them into theatre and applying them. As of this month, we are looking at actually producing our own platelets in theatre. So, over the last period of time, we have responded to the increased severity of the casualty and we are seeing, as a result, significantly increased survival.

**Q411 Mr Holloway:** In terms of helicopter evacuation, are you trying to manage commanders in terms of the level of risk they take in terms of operations they conduct on a given day to assure that they have got sufficient cover to pick people up in a timely fashion?

**Lieutenant-General Lillywhite:** If you actually go to Afghanistan you will see marks on everybody’s maps, circles, that actually indicate when they are going beyond available medical care, and commanders, if they are going beyond available medical care, do take a very careful risk assessment; but, generally speaking, all military operations are occurring within the two hours there and back of helicopters in Afghanistan, and we have additionally reinforced those helicopters by putting on those helicopters consultant-led teams, so the additional distance that previously would have taken them outside the range of medical support we have actually mitigated by sending the team in to them. We have taken the mountain to the casualty.

**Q412 Mr Holloway:** That is a very positive change.

**Lieutenant-General Lillywhite:** And we are awaiting firm evidence, but the initial evidence is that that helicopter borne teams are additionally significantly contributing to survival. So survival in Afghanistan, where distances are significantly longer, where evacuation times are longer, is actually the same as in Iraq where distances are shorter.

**Q413 Mr Crausby:** I know that you briefed the Opposition front benches and the Chairman yesterday, but could you for the Committee briefly
tell us what work is being done in researching the possible incidence and effect of mild traumatic brain injury? Do you have any initial impression of how widespread the problem will be?

**Lieutenant-General Lillywhite:** I think it is important that the Committee first realise what we are talking about in terms of the public concern in the United States which is now transported to here. The public concern is that very minor head injuries, perhaps so minor that they do not report to medical services in the first place, are leading to unrecognised and undiagnosed long-term consequences. There is actually very little concrete evidence that this is the case, and it is the main effort of both the US and ourselves at the present time to seek to confirm that there is, indeed, an issue. In fact, even before the issue arose in the United Kingdom, we had already initiated some research. So DSTL (that is our in-house research organisation) with some of our clinicians in South Tees, as an example, are looking for blood markers that indicate that somebody who has been in a road traffic accident has indeed had trauma, because we might be able to use that to actually identify people with even more minor trauma. We have actually got work going on in Porton Down looking at whether or not blasts alone will cause an injury to the head. We know that blasts will cause an injury to the head if the head bounces around, but does blast per se cause an injury to the head other than by bouncing it around? So we are carrying out some experiments in Porton Down to identify whether or not that is the case. Working with King’s College that we are contracted with, we are seeking to join the US research programme to actually do a prospective study on soldiers that have actually been in Afghanistan and Iraq using imaging to see whether or not we can identify whether or not there is damage. I could go on, but I hope that gives a taste of what we are doing.

**Q414 Chairman:** Thank you very much. You will produce something more definitive towards the end of January.

**Lieutenant-General Lillywhite:** Yes. Again, as I briefed you yesterday, after discussions within the Ministry of Defence and with the Minister we set up a small project team in June of this year. It has given an internal interim report to us literally a couple of weeks ago. They are due to give a formal report on the way forward in March when they can also exploit some of the reports that we know are due just before then within the United States.

**Derek Twigg:** As I said last night, we hope to have a solution and will keep you informed of any developments and sensitivities.

**Q415 John Smith:** I want to go back to the last question and the very impressive evidence we received about improved survival rates. Does that, as a consequence, mean that there is greater reliance on aftercare and through-life support, both in the Service and after the Service? Is that generating a large requirement for resources and are those resources being met?

**Derek Twigg:** You are absolutely right to point out that clearly a number of people are surviving with very, very serious injuries that might not have survived a year or two ago, maybe longer. You are absolutely right. I think if you briefly go through the pathway, we have heard about what happens in the field, both in the reception of the casualty back to Selly Oak, we have heard about the standard of care there and, of course, Headley Court—which I am sure we will get into at some point today, but I am happy, if you want me to, to give you a brief on that—I think is recognised as world-class in terms of support for our injured Service personnel and the rehabilitation they get to there and the prosthetic limbs, which I think you have probably seen examples of, which are provided. I am pretty confident that the care pathway there is very good and excellent, but we always keep it under review and we always attempt to try and improve it. What is very important is that we have a care pathway, and we have now put in place a system which is set back in operations all the way back down to Headley Court and actually in some cases where people leave the service a whole care pathway has been put in place there now. The Services have the responsibility for managing this but I want an overview of that system, because we hear of cases where people have fallen through the net or not quite had the support they should have done—whether it is through the Welfare Service or the Regimental Association, the Government, we hear all sorts of arguments—so that is very critical. In October I think we sort of put that in place, if I remember rightly now. In addition to that, those most seriously injured will from now on be appointed with a case officer. Do not forget, a lot of people actually stay in service. That is the other thing I should mention. Quite a lot of people now stay in service and it is our intention, where that can be done, that people stay in service, but those who actually have to leave the Service because of their injury, there will be a case officer appointed for each individual and they will follow their progress and deal with all the issues that might come around, whether it is housing, welfare, support, healthcare, et cetera, for a two-year period after they leave and longer if that is deemed necessary. That has only just been put in place. I think that will give us extra support and comfort to try and stop some people falling through the net. In terms of the compensation scheme, I am not sure how much you are going to go into that, Chairman, but clearly we have a compensation scheme in place. It is different from the previous compensation scheme because it now pays compensation in service, it did not before, and, of course, you get a guaranteed income payment which for the more seriously injured people is several hundreds of thousands of pounds during a lifetime. There are always ways we can improve it. I think we have looked for where the weaknesses have been. That is why these care pathways are very important.
and why the case officer situation is very important, and also making sure that records actually follow people and people have the information to make the decisions at that time and at the right time.

Lieutenant-General Lillywhite: Again, briefly, we also have a responsibility to ensure that the quality of survival is improved. Now that we are quite clear that we are saving those people who can be saved, our main effort is starting to switch to see whether or not we can improve the quality of the outcome. That was one of the reasons for my visit that I mentioned before and my discussions with the Chief Executive of the Medical Research Council as to what other resources in the United Kingdom can be brought to bear on improving the quality of survival which will reduce the requirement for aftercare or reduced dependency.

Derek Twigg: In connection with that, Chairman, I did forget something. I think it is quite important. There might be an issue where you get these standard prosthetic limbs that are provided by Headley Court. What happens when they leave in terms of what might be provided by the NHS? We are currently working with a number of trusts around the country to see whether we can find a specialist to actually provide the same standard of limbs for the people who have been through Headley Court, and I think that would be a very important step forward.

Q416 Mr Hamilton: Chairman, first of all, can I apologise for being late. I was speaking in Westminster Hall. If we are taking consultants to the front, so to speak, most of the consultants are Territorial Army. Does that mean there is an increased amount of training required to take them to the front and does that balance have to be balanced out about the potential danger of coming forward?

Lieutenant-General Baxter: First of all, the decision on how you go forward is a tactical decision. Clearly, the situation on the ground will dictate how you go about it. In terms of training, the medical staff are given the essential military skills during their call-up, if they are reservists, but equally if they have been working in an NHS trust they are given the top-up training before they deploy. Part of the way we deploy and the way we use aircraft, particularly using the larger Chinook aircraft, when they go, depending on the commander’s decision, they will have a close protection team with them, they will have explosives ordnance disposal with them on the aircraft. They, the medical staff, will be busy looking at the patient. We want to take away any distraction for the medical staff, but they do get those essential survival skills.

Lieutenant-General Lillywhite: If I could add, talking about the risk, I was at a meeting last week where a lot of uniformed personnel were present that actually did this job and there was a discussion about the risk that they were actually subjected to. They all accepted that it was an appropriate and reasonable risk given the actual effect that they were having on the patient.

Q417 Mr Hancock: Minister, you raised the issue of Headley Court, and I think that anyone who has witnessed what they do and has spoken to people who have been there are mightily impressed with the facility and the outcomes and the terrific work they have done. What forward planning have you done in terms of the anticipated workload falling on Headley Court, with the possibility that we will maintain the high tempo of activity that we have at the present time?

Derek Twigg: We have roughly about 40 in-patients at Headley Court at any one time in the current circumstances. We could actually go to around 60. We do have a surge capacity in terms of the Regional Rehabilitation Units and a possibility with one or two hospital trusts around the country as well, so we are looking at that planning. We are currently undergoing a review, both in terms of the future needs that we see at Headley Court, which will be very important in terms of the development of it for the future, and we have been in discussions with Mole Valley Council about that process, because obviously it is an old building, and we have also had discussions about the facilities we provide. As you know, we spent about £1.7 million recently on a new extension, which is not the prettiest extension in terms of building but it is very fit for purpose in terms of the facilities and the capacity it gives us now. So there is lot of planning work, on which we will report earlier next year, in terms of the future on that. At this stage we anticipate being able to deal with any demands, but we do want to look at the longer, short to medium term future in terms of any developments that need to take place at Headley Court.

Q418 Mr Hancock: Are you looking at a rearrangement of the finances of Headley Court from the MoD and charitable funding to support it?

Derek Twigg: No, we are not looking at any rearrangement. I suspect you are getting at this issue around the swimming pools and other issues. I am glad you have raised that. The issue around Headley Court, because, do not forget, we do not actually own it, it is owned by a trust, which I think is lost on the press quite a lot, and it is a very important partnership that we have with the trust there. In terms of medical facilities—the people, the clinicians—that is paid for by the MoD. There has always been a history within the Ministry of Defence, and it goes across health generally and education in terms of charitable involvement. It has always been the case in terms of health generally, and I do not think there is anything wrong where someone says to you, “Can we do something that would be good to help improve or provide additional facilities?”, and that is exactly what has happened in terms of this issue around the swimming pool. As you know, we already have a
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rehab pool and that is used well and is very important; so we welcome the partnership with the charitable sector. All the Service charities are very important to us and we have a very good partnership, and, no, there is no move to change our priority and commitment to providing the best possible clinical and medical services for our injured services personnel.

Q419 Mr Hancock: Are we going to put more resources in to improve the hydro-facilities there? We have been told that some of the personnel there have to go outside of the centre for that facility because there is not the capacity there.

Derek Twigg: First of all, there is not an issue of a waiting list to go into that pool. There is not. It is obviously a very heated pool, as you know, and it is not necessarily the right one for those with cardiovascular type issues, and that is why sometimes we take people out to the pool in Leatherhead. As part of the review that is taking place all these issues will be looked at in terms of what our future needs are at Headley Court, and clearly I cannot predict what the actual costs will be at this point in time, we need to wait and see what the report is, but we are absolutely committed to providing the best possible service.

Q420 Mr Hancock: Are the Ministry of Defence prepared to spend what is needed to bring Headley Court up to a facility where it would have on site the right facilities for these people?

Derek Twigg: We are absolutely committed to providing the best possible treatment and service and care for our people. As I said, the report is going on at the moment. I do not want to pre-empt what that will say, but we are absolutely committed to doing that.

Mr Bradshaw: I think there has been a slight misunderstanding about the role of the hydrotherapy pool at Headley Court. It is different from the role of a swimming pool. The temperature is different. The hydrotherapy pool is used for different sorts of complaints at different stages of complaints. It is not a question of it not being big enough or of there being too much demand, as Derek has already said. Ideally you need the use of both a hydrotherapy pool and a swimming pool. Whether you could justify having a full-time swimming pool is a matter for Headley Court.

Lieutenant-General Lillywhite: When Headley Court told us that they had difficulties with capacity we immediately provided the additional ward. They have never said to me that the arrangement they currently have with the local authority for the use of the swimming pool is inappropriate or is causing them any difficulties. Were they to do so I would, of course, consider whether or not we ought to provide one on site, but to date they have not come forward and said that the arrangements they have are sub-optimal.

Q421 Chairman: With regard to the recent news of behaviour at the Leatherhead swimming pool by the local community, which I am sure we all consider to be simply disgraceful, has it ever happened before?

Derek Twigg: I am personally not aware it has happened before. Clearly, we were extremely disappointed that that happened. Mole Valley Council’s reaction has been absolutely superb and I think they are now up to offering free use for visiting families as well of the wounded, which I think is excellent.

Q422 Chairman: Can I ask one final question on funding? Are the increased use of Headley Court, the increased demands on Headley Court and on Selly Oak and on general healthcare covered by the contingency reserve?

Derek Twigg: Yes.

Q423 Chairman: They are?

Derek Twigg: Yes.

Q424 Chairman: Thank you. We have been very impressed by the MDHUs we have visited. Would you accept that they are primarily places in which medical and nursing staff from the Defence Medical Services can be trained alongside NHS staff rather than providing secondary care for military personnel?

Derek Twigg: I think the answer is both.

Q425 Chairman: Are they single Service? They seem to have a strong single-Service ethos. That is what I found when I went to Frimley Park anyway, that some of the MDHUs --

Derek Twigg: I will ask the Army to answer that.

Lieutenant-General Baxter: Of course, the MDHUs have a historic connection. At Derriford, with the large naval presence, you would be a bit surprised if there were lots of people in khaki round there. At Peterborough again there is the legacy of the cold-war air bases, in the past Ely Hospital, and so an RAF connection. At Frimley Park, around Aldershot and up around the far reaches of South Tees there will be a natural centripetal effect to pull the khaki. However, all of them have a joint flavour to them. I am trying to think: is there one Ministry of Defence Hospital Unit that does not have a Tri-Service mix? I do not think so.

Q426 Chairman: I am sure. It was just that they were positively labelled. “This one is an RAF one, these three are Army ones, this one is a Naval one”.

Lieutenant-General Baxter: Chairman, you know how proud we are of our tribes and our tribal markings.

Chairman: Indeed so.

Q427 Willie Rennie: Why are there no MDHUs in Scotland, Northern Ireland or Wales, and does it not have a detrimental effect on the operational forces in those areas?
Derek Twigg: I asked this question and it is basically for historic reasons. I think a lot of the MDHU/s have grown up near to the military hospitals. It does not stop our Service people from getting fast-track treatment at other trusts or getting the same standard of care as someone in England, for instance; it does not affect that, but historically it has been the case. It does not mean, for instance, that Scotland will not have one. The honest answer is that we are keeping that under review, but that is the reason for it.

Q428 Willie Rennie: When we visited Edinburgh some of the people were being shipped out, I think to Northallerton, to get the treatment they needed, which seemed an awful distance to travel when Edinburgh has got some excellent medical facilities.

Lieutenant-General Lillywhite: Quite a lot of our military people in Scotland get treated in Scotland and all the practices have relationships with their local NHS and they use them. Clearly, if there is an advantage in going down to Northallerton they will take advantage of that advantage, so that, if I may say so, deals with Scotland. Just to clarify Northern Ireland, we still have our Musgrave Park military wing in Northern Ireland. That works in conjunction with a local hospital—it is not a trust there—and clearly, as the reorganisation in Ireland goes forward, we will keep under review how we deploy our secondary care personnel there.

Q429 Mr Hamilton: Just to follow up that point, if a person goes down south for a long time are arrangements for their family to be able to come down? The second thing I want to say is that in the literature you indicate that they do receive medical attention in Scotland, and all the practices have relationships with their local NHS and they use them. Clearly, if there is an advantage in going down to Northallerton they will take advantage of that advantage, so that, if I may say so, deals with Scotland. Just to clarify Northern Ireland, we still have our Musgrave Park military wing in Northern Ireland. That works in conjunction with a local hospital—it is not a trust there—and clearly, as the reorganisation in Ireland goes forward, we will keep under review how we deploy our secondary care personnel there.

Derek Twigg: They should not in any way be unfairly treated compared to people in England. If there are any cases I would be happy to look into them, Mr Hamilton.

Mr Hamilton: I read in the paper, Chairman, that the minister responsible for health in Scotland indicates quite clearly that there is a good relationship with the Lothian health board but there is a need to improve the relationships in other places, so I will bring it to the attention of the minister.

Derek Twigg: That works in Northern Ireland. That works in conjunction with a local hospital—it is not a trust there—and clearly, as the reorganisation in Ireland goes forward, we will keep under review how we deploy our secondary care personnel there.

Q430 Mr Jenkins: How many of our Service personnel who are admitted for medical treatment go into a military hospital and how many go into the NHS when it is elective treatment? What is the breakdown exactly?

Mr Bradshaw: We are not satisfied that these are completely accurate, but it is about 65% military to 35% not.

Q431 Chairman: Given that you had no notice of that we are impressed.

Mr Bradshaw: I have done my homework, Chairman.

Q432 Mr Holloway: It strikes me from the stuff this morning that if we are going to continue with this level of operational tempo perhaps the Committee should do an inquiry into the wider issue of veterans and perhaps look to the United States which might have some lessons for us. Whilst Selly Oak is much more focused now it took time to react to the criticism and it strikes me that the MoD, whenever there are problems, tends to justify and defend. I know of at least one general who thinks that you guys could be a little bit more proactive and should we not look at ourselves a bit more in order to pre-empt the criticisms that you are bound to get in the future in terms of treatment of veterans? It is a cultural thing almost.

Derek Twigg: First of all, I spend a great deal of my time defending the Government’s position in various parts of the press because I think there is a very good story to tell, quite frankly, and Selly Oak was one example of that, or whether it is Headley Court or our regional rehabilitation centres or the type of treatment that we have out in operations. I think we have been proactive but I think the fact that the Secretary of State has announced his Command Paper, which will look at the whole issue about what we now currently provide in terms of our Service personnel and veterans, the whole range of healthcare, welfare, accommodation, will be a really good way of setting out the arguments for what is happening on the ground, what more needs to be done and what we can do to improve that further. I think that is going to be a very good way of doing that, but I can give you an assurance, Mr Holloway, that we do everything we possibly can to get out the positive messages.

Q433 Mr Holloway: It is not about messages; it is about delivery.

Derek Twigg: When I was talking about positive messages it is about the delivery that we provide. As I say, if you go round and talk to the individual wounded Service personnel at Selly Oak, like I do, the overwhelming view there is of a very positive message about how they and their families are being treated.

Q434 Mr Holloway: Forgive me, but I am saying that I think you should be far more proactive in seeking out things that are wrong and will be picked up. It is terrible that we do it if it comes down to negative publicity in the press.

Derek Twigg: I am sorry; I misunderstood the question. No; we do. That is why, for instance, I visit Headley Court and Selly Oak and other parts of the healthcare system, and obviously Iraq and Afghanistan, to talk to those delivering it and look at where the issues might be and where we can improve things, and that applies to other parts of my role in terms of veterans and healthcare.
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Q435 Mr Holloway: I wonder how Lieutenant-General Lillywhite feels about this idea of being more pre-emptive.

Lieutenant-General Lillywhite: We are.

Q436 Mr Holloway: You were not.

Lieutenant-General Lillywhite: We are. In terms of all the improvements that I described, that is the result of us being extremely proactive. The work that I am doing with the Medical Research Council I referred to before is us being proactive and seeking where we can improve quality of care.

Derek Twigg: Can I just give you an example? This does not seem to get much publicity, but, of course, we have a major contract with King’s College in which we are monitoring and assessing those people who served in Iraq and Afghanistan on a variety of issues. Mental health is one that comes straight to mind but there are lots of different issues we are having them working with us on and looking at issues and how they are affecting them in their service during their time in Iraq and Afghanistan. It is very proactive. We are not sitting waiting for problems to happen. We are going out there and trying to find out what is happening on the ground and how we can improve it.

Lieutenant-General Baxter: One of my jobs is to play the “daft laddie” and a customer and go and ask all the stupid questions about why do we do things. On the very question about MDHUs I asked, “Why have we got one here?” That is part of my role as a non-professional medical person.

Q437 Mr Holloway: In the interests of maintaining morale then perhaps you should put a tabloid newspaper head on sometimes when you do it.

Mr Bradshaw: The Concordat has existed since 2002, long before the negative publicity around Selly Oak, and the work programme has been dealing with a lot of stuff, like the role of Reservists in the NHS, what we can do to encourage more Reservists in the NHS, what happens to Service personnel’s families when it comes to moving and dropping off waiting lists. These are issues that have been work in progress; they have not just been done because of negative tabloid headlines around Selly Oak.

Lieutenant-General Lillywhite: Just talking about being proactive, a significant number of my staff spend a lot of time visiting places like the United States. Our pain consultant is about to go over to consult and see again those who served in Iraq and Afghanistan on a variety of issues. Mental health is one that comes straight to mind but there are lots of different issues we are having them working with us on and looking at issues and how they are affecting them in their service during their time in Iraq and Afghanistan. It is very proactive. We are not sitting waiting for problems to happen. We are going out there and trying to find out what is happening on the ground and how we can improve it.

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Q438 Robert Key: Can I just touch on one very brief point? A number of consultants and clinicians in my hospital in Salisbury are in the Reserves and serve regularly in, for example, Afghanistan and Iraq. They come back and are reviewed by their chief executive and told they are not doing enough trauma surgery in the hospital, when in fact they are the experts. I just wonder if the National Health realises how lucky it is to have Reservists who are clinicians getting real experience of trauma surgery and so on coming back.

Mr Bradshaw: I certainly do, Chairman, and I think good practice in the National Health Service does, but I fully acknowledge that that good practice is not as widespread as it should be. One of the things we are considering doing is putting more explicit advice in the annual operating framework about the need to encourage Reservists, not just for the reasons that Mr Key has outlined in terms of the expertise that it delivers to the National Health Service but also for the cross-fertilisation of cultures which I think is very important.

Chairman: I want to move on to mental health now, which is a major area that has come up a lot this morning already.

Q439 Willie Rennie: The MoD has said that the incidence of medical discharge from the Armed Forces due to psychological illness was extremely low, running at about 0.1% in January 2007, but Combat Stress in their evidence to us said that they have seen a massive increase in the number of people presenting to them with a 30% increase over the last year to round about 885 new referrals. There seems to be a bit of a contradiction between the two. Can the Minister explain that?

Derek Twigg: The figures—and we can probably provide them to you—are that roughly in terms of the number of Service leavers a year, round about 130 are discharged with mental health problems. I think around 25-30 with PTSD. That is not in any way belittling the fact that for those people that is a tremendous difficulty and is affecting their lives, so I just want to put that on record. One of the problems, of course, is that many people will not present with the symptoms for some years after they have left, often ten or 15 years, and I think that is maybe where the disparity is in terms of the figures. We are doing regular assessments, as I mentioned previously, with King’s College in terms of mental health and lots of other issues for those currently serving in Iraq and Afghanistan and that will obviously inform our future policies. If I could explain the approach that I have put in place in the last 12 months or so, we have done a number of things which are to do with the fact that when people leave it might be some years after before they present with symptoms. For instance, we have increased Combat Stress’s funding by up to 45% from January next year. As I announced on Friday and spoke briefly about at the start of this meeting, pilot schemes have been put in place so that we can improve how we treat and care for our veterans who may have left the Service some
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Q440 Willie Rennie: Turning to the issue of active Service personnel and the service that is provided for them, the Royal College of Psychiatrists have said that the service is “okay . . . but not great” and it is “stretched”. Can you respond to that and is it adequately staffed? If not, what are you going to do to address the problem?

Derek Twigg: I have seen no evidence to say that it is not and that we are not working there in the best possible way, and I will ask the medics to come in and say something in a minute. If you look at what is provided in terms of the pre- and post-deployment briefings for personnel who go into operations, the fact that we have a psychiatric nursing team and a consultant out there, often embedded with people so that they are visible, because this is a stigma issue we are dealing with, it is, I believe, working very well. I have seen no evidence to say that it

Q441 Linda Gilroy: On the Priory Group, can you tell the Committee why it was decided to put that responsibility for in-service patients out to private contract and how the contract is performing?

Derek Twigg: It is supposed to get our people quicker treatment for those who need that type of treatment. We have a liaison officer who goes there regularly and sits in on meetings and discussions, and we believe that is working well. We have no evidence that that is not the case.

Lieutenant-General Baxter: We wanted somebody who had a joined-up regional, across-the-UK footprint that could then tie in with the Departments of Community Mental Health that also have a regional footprint, and the key to making the Priory contract work is a very close relationship between the mental health nurse or whoever in the Department of Community Mental Health interacting with the local bit of the Priory to make sure that people do not just end up lurking in the Priory. What we do in the Priory is stabilise the patient and then get them back into the community where it can be sorted out in a rather better way.

Q442 Linda Gilroy: Those are fairly sound reasons but how do you respond to the criticisms that have been made that they are not experts or specialists in the field, or they have not been, and that it would be better to be able to refer it to people who have got military experience?

Lieutenant-General Baxter: The whole point is that the Department of Community Mental Health person has expertise and we have military psychiatrists there and the Priory produces an environment which is stabilising.

Q443 Linda Gilroy: So it is taking on the contract, they have developed the expertise or had people embedded with them who—

Lieutenant-General Lillywhite: Staying with the Priory contract, it was not put out to a private organisation. There was an invitation for people to bid for it and it was the Priory that won the contract. The treatment of our mentally ill in a hospital, any hospital, is the exception. The intention is only to put into hospitals the minority for as short a time as possible, and we keep (for want of a better term) control of that with the military in-reach team that comes from the community.

time ago. I have also extended the medical assessment programme across the way at St Thomas’s Hospital, so those veterans who since 1982 feel the need to have an assessment for mental health can go there free of charge and have an assessment by a former military psychiatrist, Dr Ian Palmer, and, of course, the Reservist mental health scheme came out of the study that King’s were doing, so that where there was an albeit small but statistically significant difference between those we deployed and did not deploy in terms of their mental health we put them in the Reservist mental health scheme. I think we have recognised that there is more we have to do and we have to deal with that, but in terms of the figures, because many people are saying it is later on, the question comes back to, “Therefore, what do you do for those people?”, and I think the initiatives I have just described are part of that road to doing more.
Q444 Linda Gilroy: So does that also deal with the other criticism that has been levelled, that there is a danger that the private sector has a financial incentive to keep someone in as an in-patient for as long as possible?

Derek Twigg: They have places around the country so we can try and get people as locally knitted as possible in terms of mental health.

Q447 Willie Rennie: But even so you are not creating a military environment which you were trying to do at Selly Oak.

Lieutenant-General Baxter: We do not want them to be in the Priory for a nanosecond longer than they have to be. The best place is to be alongside the regiment, the battalion, with the Department of Community Mental Health producing the expert support. That is the ideal, to treat them there. We make them feel as normal as possible as early as possible rather than keeping them together and they are all feeling bonkers together. I am sorry; I am not sure how that will translate down the line.

Q448 Chairman: It is a medical term.

Lieutenant-General Lillywhite: It is getting people into that military flavour and obviously it is a different dynamic from physically injured patients where for clinical reasons they have to be in a hospital environment.

Q449 Chairman: You have caused the Health Minister to wince.

Mr Bradshaw: It is so refreshing to know that political correctness is alive and well in the military.

Lieutenant-General Lillywhite: Could I incite the clinical difference? Both on operations and in peace for people with mental health you do not evacuate unless it is absolutely essential. You try and treat them in the environment which is supportive, which is normal. You want to normalise them, so sending them somewhere miles away is wrong. That is why we closed Catterick, because that is what we were doing. That is why the people on the ground in Germany have closed Wegberg because even the people on the ground think it is wrong to try and send people a long way. For your combat casualties you evacuate, and in the case of the combat casualties we are having at the moment they are different from any other casualty in the United Kingdom, so we need to centralise those to learn from it.

Q450 Linda Gilroy: Except, I really do think Mr Rennie is right, that there is a balance to be struck and it is really not quite as black and white as that because the battlefield casualties, where traumatic stress is being dealt with very well at Selly Oak, also have stress dimensions to them, and there is also the question of the families, and while I would not quarrel at all with the fact that people are not going to complain when you visit because they are receiving marvellous care, whether that is the very best that can be done in future I think is something worth keeping under review. Families do have issues travelling to Selly Oak from the extremities, from the far south west and from Scotland, where it may be possible to blend those two things together once Selly Oak is established on its course of excellence.
Mr Bradshaw: I think this mental health issue is the most complex issue that we face in this and you probably face in your investigation. Just to support what Derek has said, what they are doing in the military does reflect what is happening in the civilian treatment of mental health as well in that we are moving away from centralised institutional care. Yes, there needs to be centralised care for the kind of trauma that Linda has just spoken about but the ongoing mental health care is much better provided in the community.

Q451 Chairman: Professor Appleby, I saw you nodding there and you should be allowed to say something. Is there anything you would like to add to what has been said on this?

Professor Appleby: From an NHS perspective the model that is being described is very much in line with current service provision. The modern idea of providing mental health care is that it is primarily community-based, that small in-patient units provide back-up of a very specialist kind linked to what is then provided in the community. It seems to me from what I know of the MoD version of mental health care that it is very much in line with those NHS principles.

Q452 Chairman: But does not an issue arise here with the fact that the community as a whole has no experience of military service and therefore these people being treated in the community do not understand the community that is surrounding them in which they are being treated?

Professor Appleby: Do you mean once people are discharged back into NHS services?

Q453 Chairman: Or when they are getting out-patient Priory care.

Professor Appleby: I will have to talk about NHS services which are my remit. I think that is an issue, that absolutely is an issue. It is one that I think in the last few years the NHS has been much more aware of. I do not think we were having the kind of discussion a few years ago that we are having now about the military experience of mental health staff. It was not taking place in the way it is now, and the new pilots reflect that because the new pilots are an attempt to combine the best of what NHS mental health care provides with military experience and expertise.

Derek Twigg: I think it is very important to make the point because in terms of our Departments of Community Mental Health that was militarily divided and it is the Priory contract which obviously does not have --- actually, there will be a few people who work in Priory who have had some military experience. I could not give you the numbers on that, but it is our liaison with them to talk about that and that is again the key thing which Professor Appleby mentioned in terms of the new pilots giving a better understanding of the military ethos and the issues that arise from military service.

Q454 Mr Holloway: Thinking about the future, we have got Armed Forces that are now working way beyond the planning assumptions. We have got many thousands of people working in the private security industry for British citizens, normally ex-soldiers who are in these environments for a very long time and often at more risk than serving Servicemen. Is the NHS ready to be hit by a bow wave in ten, 15, 20 years’ time?

Mr Bradshaw: I think, as we have already acknowledged, that there is still work to be done on the culture and the receptiveness of mental health services in the NHS to the particular needs of the client groups that you have just described and that is why we are supporting these pilots and we will be very interested to see how they develop. In terms of capacity, there has been an enormous expansion of NHS mental health services since 2003, 31% in real terms, and the Secretary of State recently announced another £170 million for psychological therapies, so this is a rapidly expanding service which I think most fair-minded observers would accept has transformed the quality of mental health services in recent years, and that capacity will continue to increase.

Q455 Mr Holloway: What does Professor Appleby think on that specific point of a bow wave coming from these two different groups?

Professor Appleby: The answer is in the two things we were talking about, first of all improving the understanding of some of the experiences that ex-Servicemen will have faced so that the NHS as a whole has a greater capacity, a greater knowledge, which will help it provide better care, and the second thing is the psychological therapies work which Ben Bradshaw has just referred to. This is a major initiative for us in mental health care, probably the biggest and most ambitious change in mental health services of the last seven or eight years, maybe one or two of the biggest since the NHS was set up to run mental health services, and it is there to acknowledge that if you are going to improve the mental health needs of the community you have to provide better psychological therapies, you have to provide better primary care. Most of the conditions which are likely to affect people who have been servicemen and who report some years later are going to be depression, anxiety, sometimes PTSD, although that is not at all the most common diagnosis, and all of those things are primarily treated through psychological therapies. That capacity to treat people with psychological therapies has not previously been enough and this new initiative is an acknowledgement of that and a massive expansion of what we can achieve.

Q456 Mr Hancock: If I can just go back to the primary contract, is that cash limited, ie, are there people waiting for a place in the Priory because there is insufficient money to fund their places?

Lieutenant-General Baxter: Not to the best of my knowledge.
Derek Twigg: Not that I am aware of, no.

Q457 Mr Hancock: What is the success rate of the Priory for when Service personnel go there? Have you got information relating to the numbers who have returned to active service having completed their treatment?

Lieutenant-General Baxter: There is a crude figure, and I will get prodded in the back if I am saying the wrong thing early on, of a grand total of about 7,500 who present with some sort of symptom. We heard of about 150 being discharged, which implies that there is a large number of people being returned to productive, active military life.

Q458 Mr Hancock: It would be helpful if the Committee could have some information about the throughput in the Priory and the discharge numbers of Service personnel who have completed a course there but have not returned to Service duties and have left the Armed Forces.3

Lieutenant-General Lillywhite: It is important to recognise that only the most seriously ill go to the Priory.

Q459 Mr Hancock: Yes, I can understand that.

Lieutenant-General Lillywhite: What we do at the moment is certainly measure the outcome of the whole system, with the mainstay, of course, being the military DCMHs. They are the teams that are responsible for the care. The overall majority, a significant majority, all return to work but we can find out the proportion that have gone into the Priory that return to work. I do not have that immediately to hand.

Q460 Mr Hancock: Can I raise one issue about veterans, many of whom, sadly, end up homeless, and the statistics say that at any one time a thousand ex-Servicemen are on the streets of London homeless and a number in prison, many of them suffering from mental illness problems, and whether or not they are getting the right sort of treatment and assistance. Can you address those issues?

Derek Twigg: Yes, sure. In terms of the last study that was done a few years ago, there was a drop in the number of homeless on the streets of London. I have asked for some further work to be done on this in terms of the current numbers but there is no indication that that has increased but we do not know is the latest because the previous survey was a few years ago now. There are a number of projects around which are particularly important in terms of in North Yorkshire, at Colchester and at Catterick in terms of accommodation for single Service persons coming out of the Forces. There is also the Compass Project where the British Legion do a great job with us in terms of getting people who have been homeless back into the mainstream, giving them good accommodation and the potential to get back into work. There is a lot of work going on in a number of projects around the piece. In terms of the Prison Service, I think it is a very important point you make. There is a study taking place in Dartmoor at the moment, which clearly we will share with you when that is completed, in terms of the numbers of ex-Service personnel who are now prisoners. I have written to the Department of Justice to offer the help of Dr Ian Palmer, our person across there in St Thomas’s Hospital, because we have to be asked in because it is provision within the NHS and they might want to say something about this. If he can help either via the GPs or missions and also visiting prisoners if that is required, he would be available to do that. We are taking a number of initiatives around the Prison Service.

Q461 Mr Hancock: Are you given any information when a prisoner arrives into a prison that they have a veteran status and your department is informed?

Derek Twigg: Prison is within the NHS. I am not passing the buck but it is the NHS. They could have left the Service many years ago or recently or whatever.

Q462 Mr Hancock: Yes, I know, but as you are the Minister for Veterans I am interested to know whether there is a mechanism for the Department of Justice triggering the fact that there is another ex-Serviceman about to enter prison and is there a tracking mechanism to assist them in any way?

Derek Twigg: Not that I am aware of.

Q463 Mr Hamilton: In answer to Adam’s question about a bow wave coming, one of the problems may be, of course, that this will be dealt with in different ways depending which country you are living in because of the different health authorities. How would you deal with that, and could I suggest that one of the issues might be a greater use of the ex-Services clubs which are not just social clubs; they are far bigger organisations? I take the point that you made earlier on about many of the troops being macho in the sense that they do not want to admit they have a problem. My concern is that as they come out of the Armed Forces and move back into society in general they do not have the comradeship that they normally have. One of the places they do have that comradeship is in the Legions throughout the UK. It is a suggestion, Chairman, that we could utilise the Legions in a far greater way to assist us in that long-term mission.

Derek Twigg: We work very closely with the British Legion, as I say. I will just give you an example. In my own constituency the British Legion club has done some sterling work with veterans who have come out in recent conflicts.

Q464 Mr Holloway: There is a tiny comment here. The Data Protection Act is causing a real problem for these veterans’ organisations because whenever they want to get details of people, if they have not
signed the thing to join these organisations as they leave the military, these organisations have no way of finding them.

**Derek Twigg:** That is resolved now. They get information in the leavers' pack for the five main charities.

Q465 **Mr Holloway:** Yes, that is what I was alluding to, but if they do not do that it is very hard. 

**Derek Twigg:** That is what we have asked, but they seem to be content with that.

Q466 **Robert Key:** Could we focus specifically on Combat Stress? I know the Minister, Derek Twigg, has been to Combat Stress in Leatherhead and some of us have as well, and a very fine job they are doing, but Combat Stress tell us that the demands placed on their services are far outstripping their ability to meet them. It is the usual balance—voluntary sector, state funding. Could you tell us how much money Combat Stress is getting from the taxpayer and whether it is all coming from the Ministry of Defence or whether the Department of Health is also funding it?

**Derek Twigg:** No. We were funding Combat Stress to the tune last year of £2.5 million, I think, and we are just going to increase the overall amount in stages to 1 January next year by 45% on top of that. That will help them develop their clinical governance and the ability to deploy more clinicians and practitioners in terms of their general support to the veterans. It is very important that you understand that of course we have a very close relationship with Combat Stress, and you are right, I have been to see Tyrwhitt House but also up to Hollybush House in Scotland as well and hope to visit Shropshire some time in the near future. Actually, the Shropshire one is very important if I may pause there for a minute. The whole purpose of the new pilots is to look at the whole holistic approach here and they are key partners. It is not just between ourselves and the NHS; it is also Combat Stress, and they are working with us to set up a system whereby we can refer people there and they can refer people to the NHS, and I think that will set a very good grounding for the future provision of services for veterans in this area.

**Lieutenant-General Lillywhite:** I think it is important to recognise that Combat Stress, under some pressure from us, is actually reviewing how they are treating those of their clients. They have previously been a kind of respite home rather than a treatment centre. They have just appointed their medical director which they did not have before. They are working, as the Minister said, with us in terms of the pilots. I think there will be an issue in the longer term as to the balance between the community and how many go into the Combat Stress homes that may relieve the pressure on the homes that Combat Stress are saying they have.

**Chairman:** We will now move on to MoD funding and healthcare services overseas.

Q467 **Robert Key:** The funding the MoD provides for healthcare for Service families overseas simply has not kept pace with the increase in funding in the NHS. NHS spending has increased dramatically. Why has Defence Medical Services spending not matched that? Why is it lagging behind?

**Derek Twigg:** We recognise that is the case, that we have not matched it. As you know, our funding comes directly as part of our overall settlement. We provide health services and that is something we are working on at the moment and having discussions with the Department of Health on and how we can continue to improve that with initiatives that are being taken, but it is the case that we have not at this stage been able to keep pace with the National Health spending and that is something we are working on at the moment and having discussions about.

Q468 **Robert Key:** With the Treasury?

**Derek Twigg:** It is part of our bid. We will put the bid in for that.

Q469 **Robert Key:** Can you go on affording the Princess Mary Hospital in Cyprus and the Royal Naval Hospital in Gibraltar?

**Derek Twigg:** As you are aware, because I think the Committee visited Cyprus, we are looking at the whole issue in terms of the provision of health services in the likes of Gibraltar and Cyprus, and obstetrics and gynaecology of course have been looked at. We have had the Royal College look at that and they have endorsed our approach to looking at how we can provide through a local provider the services for our people out there, and that could be through the sort of contract we have currently with Guy’s and St Thomas’s. They have endorsed that approach and work is ongoing on that to bring about those improvements we want to see.

Q470 **Robert Key:** Can I ask very specifically about IVF services? The memorandum we have received from the Department of Health points out that now, if a soldier and his spouse are moved from one end of the country to the other, there is an arrangement between the primary care trust to pay for it, but if a Service family is moved from Britain to Cyprus or Germany there is still a break and it still depends on the PCT, on bargaining between the Ministry of Defence and PCTs, as to whether a course of IVF treatment can be continued or whether in fact it will just fizzle out, and that is causing great distress to some people.

**Derek Twigg:** You are right; there should be in terms of the UK no change in terms of the waiting list position and they should continue with the treatment. In terms of people moving elsewhere, I would very much hope and what should happen is that the regiment or the unit should be very sympathetic to not moving people while that treatment is ongoing. I cannot give you an absolute
guarantee that that is happening but that is certainly my view about what should happen and that generally is the picture as I understand it.

Q471 Robert Key: It is a reassuring view, Chairman, but the fact is that you cannot necessarily hold up the posting of Service personnel because their wife is receiving treatment.

Derek Twigg: We can. I would expect the Services to be very sympathetic to doing that. Clearly, there may be on some occasions a real practical reason why that would not happen and we would have to look at that in an individual case but certainly that is how I would expect the system to work.

Lieutenant-General Baxter: As a brigade commander, one of the things is a couple coming forward and saying, “This is our situation and we would like to do it”. The chain of command can be a bit scary sometimes, but certainly in my time as a brigade commander about two or three came up and we said, “Okay, stay put”. That is anecdotal.

Derek Twigg: We need to make sure that people actually do have the confidence to do that.

Chairman: We come to the final set of questions on Reserve personnel.

Q472 Willie Rennie: Do you not think that the MoD should be worried that the Defence Medical Services are so reliant on Reserve personnel? Is there any way of reducing this reliance?

Derek Twigg: As you know, we published a few months ago the new manning structure and we are round about 90% now in terms of our requirements, but of course we have used and we will continue to use Reservists. They play an absolutely essential part in that. While we continue to bring about and make improvements in terms of recruitment with all sorts of initiatives and retention mechanisms we will continue to rely on Reservists for some time into the future. Having said that, I think it is also very important from the Reservists’ point of view that they get the chance to go and practise what they joined up for in the first place. I know from having been out to the field hospitals in Iraq and Afghanistan that the expertise and challenge they have had there are something that they have widely welcomed, and, of course, as one Reservist said recently, “I have had more opportunity to practise my skills on trauma here than I have had in my whole career in the NHS”, and that will benefit the NHS as well. We recognise that we have got pressure points, we recognise that we are increasingly using Reservists, but I think there are many benefits to doing that as well.

Lieutenant-General Lillywhite: In terms of reducing reliance on the Reservists, it is important to stress that our manning position is significantly improving. Just to use one example, anaesthetists, in 2002 we only had 20 of them. We have got 45 today. Because they are in training now we know we are going to have 71 by 2012, against a requirement, admittedly, of 95, but manning is increasing. In some areas like orthopaedics by 2012 we will be slightly over our requirement. That, of course, will automatically reduce the reliance on the Reserves, if we are working within DPAs. Clearly we want the Reserves on operations with us for two reasons: one, when we are working in advance of DPAs. For anything other than—

Q473 Chairman: Do you mean planning assumptions?

Lieutenant-General Lillywhite: My apologies—defence planning assumptions, when we are working at the higher scale, when you need more forces, but it is important that we use the Reserves anyway because that is actually why they joined the Reserves. We are seeing an increasing number come into the Reserves in order that they may deploy and if we do not use them in a sense we will lose them.

Q474 Mr Hancock: One of the interesting things, visiting the MDHU in Portsmouth, was the non-show of any Reserve Forces for us now in the MDHUs, and that is the largest one in the country. I would have thought there was an advantage from time to time in that Reserve personnel would have been brought in to the MDHUs to help their problems of when a third of their staff might at any one time be on deployment or awaiting deployment to a theatre. Is that a conscious decision you make, not to call Reservists in to backfill?

Lieutenant-General Baxter: There is an interesting point in another set of disciplines. When Reservists were called up to man the Base end, I think it was in Marchwood, and the regulars went out. Reservists were called up and went to do the Base. That really was not quite as satisfying as going on operations. People, Reservists wanted to go to theatre, that is why they joined up, so it is a careful managing human expectation piece here, and I think if we said, “Join the Reserves and you will have a thrilling trip from Northallerton to Portsmouth”—

Mr Hancock: Oh, come on, General. They would love the opportunity.

Q475 Willie Rennie: How do you manage your workforce demands and needs for the various hospitals and local health services when there are perhaps large numbers of Reserve personnel going out to theatre? How do NHS managers manage that and is there central guidance?

Mr Bradshaw: There is guidance that the NHS should facilitate on the duties that Reservists have to undertake. Workforce planning is left to individual trusts under the Strategic Health Authorities, but one of the things that ought to help and may already have helped, in the case of anaesthetists, the military meet some of these capacity challenges is the fact that we are training more medical staff and doctors than ever before. We have expanded the number of medical training places, we have opened two new medical schools, so whereas in the past the NHS itself was short of quite a number of specialities that is now no longer the case and that should have a positive knock-on impact on the Defence Medical
Services as well. There is just one thing that Mr Key said. I would not want the Committee to go away with the impression that because the Health Service has had a good settlement in spending terms in recent years, perhaps an even better one than the MoD, that means that Armed Services personnel are receiving a worse service. He pointed to one particular example of IVF, which I think we all accept is a challenge for the Services, but for the vast majority of procedures waits are significantly less for Armed Service personnel than they are for ordinary civilians.

**Lieutenant-General Lillywhite:** Could I just assist in terms of the impact on the NHS? About four or five years ago we did actually do a proper study into looking at what would happen if we mobilised two Reserve field hospitals, and the impact upon the NHS is quite small. The proportion that we draw from the NHS is a very low percentage, one or two per cent of the Service. Remember the exact figure. Only with a couple of particular individuals where they were quite key to the trust did there appear to be a significant impact upon the NHS and it was felt by the NHS that they could manage that given a little bit of time and some leeway.

**Mr Cash:** In the six MDHUs there is a question of co-ordination to make sure that the Reserve medical hospital does not go out at the same time as MDHU staff and get deployed; that is an obvious point, but in the Partnership Board, which is the work between the MoD and DH, one of our three priority areas now is workforce and this whole issue and how we incentivise people, how we re-empower people, how we re-affirm the message about Reservists, that employers, NHS trusts and so on should give priority to these people, and we are pulling all the chief executives together across different regions to reiterate this issue of supporting people who want to be Reservists. That is one of our work stream areas.

**Q476 Willie Rennie:** That is my next point because I have suffered from discrimination against somebody who was in the Royal Naval Reserves in my constituency from the education authority which was refusing to let them go on training. We have heard from the BMA that there is discrimination against those who are Reservists within the NHS. You mentioned that there was only 1 to 2% reliance on Reservists and therefore the impact is small, but have you discovered discrimination against Reservists in the NHS?

**Mr Cash:** Not specifically. The issue, according to the needs of the Service, is to go away on the 15-day camp that is required, and normally what will happen, and we need to re-empower this, is that that will be absolutely supported, normally a week’s pay, the normal leave, and normally either annual leave or unpaid leave for the second week. We have not come across these cases. What we do need to do is to make sure the flow of workforce through to the Reserve units is maintained is to reiterate this with chief executives and medical directors all round the country and.

**Mr Bradshaw:** I would urge Reservists, Chairman, to use the complaints procedure if they feel that their rights are being infringed.

**Q477 Chairman:** You would be wholly supportive then of Reservists continuing to work in the NHS?

**Mr Bradshaw:** Absolutely.

**Q478 Chairman:** Surgeon-General, is there anything you want to add?

**Lieutenant-General Lillywhite:** No, I do not think so.

**Q479 Willie Rennie:** When the Reservists come back from deployment in theatre what kind of support is in place within the local hospital in the NHS to make sure they are able to acclimatise back into the normal NHS service, and what advice is given to other health professionals when dealing with those individuals themselves?

**Mr Cash:** They normally get a de-briefing with the occupational health department within the trust or the hospital to go through any issues they may have, and normal line management responsibilities with their immediate line manager to talk through any issues they may have, and there is a kind of open line through, of course, the human resource or the personnel director in the organisation.

**Q480 Willie Rennie:** And other health professionals, is there advice given to them? Are their work colleagues given advice about how to deal with them?

**Mr Cash:** Yes. People do a round of promoting this, so in most organisations, and again we need to re-emphasise this, you get heads of departments together to (a) say as an employer they encourage it, and (b) what do you do with people when they come back? Make sure you de-brief them, make sure that you do not perceive them to have any issues that have arisen from their service.

**Q481 Willie Rennie:** It sounds quite loose. Is there a need for more?

**Mr Cash:** I think there is room for more and I think that is why we have picked this up as an issue in our next phase of work, to really restate that we support this, so we are planning, as I say, to pull people together, probably the human resource directors of various organisations on a regional type basis, to re-emphasise what they need to do.

**Q482 Chairman:** I would agree with what Willie Rennie has just said about it sounding quite loose because when I visited Frimley Park people being de-briefed by people who had no experience of military service at all, who just did not understand the sorts of things that people had been through, was an issue and I hope it is something that you will seriously address.

**Derek Twigg:** Okay. Can I just say it is obviously our responsibility as well and I think it is in an area where we would look to do more.
Q483 Mr Holloway: I have found the answers to our questions highly relevant and it is very nice to see such grown-up people in key jobs in all this.

Derek Twigg: Do you mean all of us?

Q484 Mr Holloway: Of course, all of you. However, I cannot help feeling that yet again we have got the “everything is absolutely marvellous, wonderful, we have thought of everything” line. We spoke earlier about pre-emption. Obviously, with members of the press sitting around you are not going to give us the precise things that you are working on but there must be areas that you are quite worried about and you are probably quite relieved we have not touched upon. What are they?

Derek Twigg: To take your general point, I will give you an example—Selly Oak. There is no problem with clinical care or anything like that, but we looked at it and said, “What more can we do in terms of welfare support both for the Service personnel coming in and also for their families?” , so we have improved that tremendously. We have talked again about Headley Court and the review about what further we need to do. Everyone says it is excellent and, of course, it is excellent but we are not resting on our laurels but are looking at what further we can do. In terms of mental health, we clearly saw there were issues there. That is why we have introduced the medical assessment programme and why we have gone down the pilots. On the specific issue about Reservists we have just been talking about now coming back individually, and the effect on their mental health compared to the Regular Army, there is another example.

Q485 Mr Holloway: So we are not going to see headlines in six months’ time of the kind that we have had in the past that we have been letting these young men and women down? Is that what you are saying? Is it now broadly sorted? Is the chapter over?

Derek Twigg: If I could give you a sort of guarantee that there will never be anything go wrong or the press will not—

Q486 Mr Holloway: I was not asking for that.

Derek Twigg: I know, but that is what the point is. I think if you look at the way some of these things are reported you would expect there is a systematic breakdown. I think from your own investigations, and certainly our personal experience of some of those people who have to deliver services, that is not the case. Clearly, in terms of veterans, and not least in terms of mental health, there have been gaps and issues there in terms of how we can improve that, and there always will be areas where we can improve, but I do not want to give you a sense or complacency here. There is not, absolutely not.

Q487 Chairman: Before you move on, something prompted your statement on Friday. Did that statement on Friday imply that there is ongoing work, that it is not settled, that there are still things you will need to be addressing because you are not entirely satisfied that we are in the right place here?

Derek Twigg: You will know from statements I have made in the House in terms of the pilots and initiatives we are talking about that it is about—well, we announced it, we did it then. Yes, we are not completely satisfied because we want to ensure we get the best possible system. It is not a case of resting on our laurels or resting on the last initiative or the last announcement. It is about moving forward and looking all the time. As the Generals will tell you, there is an absolute commitment ministerially, the same in the Department of Health, to provide the best possible healthcare and support, and we are looking to make that change. I will just give you an example which we have not touched on today but we had it ready to give you, and I think we should do it at this point. One of the things I said to the Surgeon-General when he came to the job was, “How do we know that the health services we are providing are as good as we all think they are and that generally people tell us they are, given the gaps and problems, so how do we measure that?” . One of the things we are looking at is having an independent look at the services, to have the Healthcare Commission look at them. That is my answer back to you, that we are prepared to do that. I do not know what that will come out with. I hope it will come up with a very good report but the fact is that I want to make sure we have absolutely the best systems in place.

Q488 Chairman: David Hamilton has just asked if that is for the whole of the UK.

Derek Twigg: Yes, and abroad.

Q489 Mr Hamilton: The reason for asking is that you have the responsibility because Ben Bradshaw does not represent the UK; he represents England. He represents English health authorities; that therefore represents 87 per cent. Derek on the other hand does represent the UK. I raise that question quite genuinely because we have seen the discrepancy in education.

Derek Twigg: Our services are UK-wide as well.

Mr Bradshaw: DMS is UK and abroad and I think the Healthcare Commission has already indicated that they would be very happy to undertake a review.

Lieutenant-General Baxter: The Partnership Board are very keen to get the Chief Medical Officer of Scotland and appropriate people from Ireland and Wales so that when something does come up, and I like to think of myself as a fairly persuasive person, we can say, “Look: what are you going to do about it?”, and then if I get no satisfaction—

Lieutenant-General Lillywhite: I would just like to answer the question do we have any worries and perhaps correct a slight mis-impression that I might have given earlier. Manning still concerns us. We are significantly improving our Manning in many areas but we have a workforce that is very junior, that in many cases, particularly in the nursing area,
inexperienced. We still have some way to go to produce the number of specialist nurses, for example, that we want and, although consultants as a whole are improving significantly and have improved significantly over time, there are a couple of areas like general surgeons and general medical practitioners where we do not seem to be having the same improvement as we are having in other areas, so there are still one or two areas that we have not quite got right which we are looking at.

Q490 Chairman: So if there were any worry that you would put at the top of your list of worries manning would be the one, would it?
Lieutenant-General Lillywhite: No.

Q491 Chairman: Then what would?
Lieutenant-General Lillywhite: What would be top of my list would be to ensure that the quality of care we are producing is as good as we think it is and that is why the Healthcare Commission external audit is an important part of the work.
Lieutenant-General Baxter: Everything would flow from that.
Mr Bradshaw: In response to Mr Holloway’s question about this terrible phrase “horizon scanning”, I think the work programme at the board gives a good indication of where we think the main concerns are, but because of the rapid development of both medical treatment and technology and the rapid changes in military techniques and technology these things are constantly changing and our challenge is to try to stay abreast of the latest developments and deliver, as we have all said, the best healthcare possible.

Q492 Willie Rennie: Following on from Mr Hamilton’s point, will this Commission to check on the quality of the care follow the patient, and if it follows the patient will it make sure that it goes all the way through the system so that it goes from the GP and covers the secondary care, in which case full partnership with the Scottish Government and the Welsh Assembly will be absolutely essential to make sure that works, so that it is not just about your services within the military; it is also about the services across the board. Is that the case?
Lieutenant-General Lillywhite: I can give you an assurance that we are looking at the care of our casualties wherever they are treated. I expect the Healthcare Commission to assist me in being able to identify whether there is any sub-optimal treatment anywhere that our Servicemen are treated.

Q493 Mr Hancock: Is it possible as a veteran to get Mr Holloway some priority to have his Blackberry surgically removed as quickly as possible? It should be of some priority.
Derek Twigg: I shall make sure he gets a veteran’s badge.
Chairman: We are reaching the law of diminishing returns. I think we had better close this evidence session and say thank you very much indeed to both of you, Ministers, and to your teams for some very useful evidence on an exceedingly important subject.
Written evidence

Memorandum from the Board of the St John and Red Cross Defence Medical Welfare Service (DMWS)

INTRODUCTION

The Board of the Defence Medical Welfare Service is pleased to be asked by the Defence Committee to submit evidence to the inquiry into Medical Care for the Armed Forces. Members of the Board have significant experience in the Armed Forces and healthcare. In addition, the Chief Executive and Operations Manager have just returned from a visit to the Military Field Hospital in Basra (Op TELIC) and have first hand knowledge and experience of the provision of welfare support in Iraq as well as detailed knowledge of the support provided in Afghanistan (Op HERRICK) and in the Ministry of Defence Hospital Units (MDHU’s) in the UK, the designated provider hospitals in Germany (DGP’s), and the Princess Mary Hospital in Cyprus.

The Defence Medical Welfare Service is funded under contract by the Ministry of Defence. The current contract expires in March 2009. It is our understanding that a review of the current Service requirement is to be carried out and a competitive tendering process will determine which Organisation will provide the service, revised or otherwise, from April 2009.

BACKGROUND

For several decades the Order of St. John and The British Red Cross Society included a joint operational “welfare” component in support of military hospitals. Originally this was delivered by the Service Hospitals Welfare Service, which had its origins in the Second World War and was subsequently taken over by the Joint Committee to become the Service Hospitals Welfare Department (SHWD). This was funded by a combination of the Joint Committee’s funds and “grant in aid” support from the War Office/Ministry of Defence.

A change to these arrangements occurred in 2000 when the MoD indicated that it would no longer be acceptable to continue funding by way of “grant in aid” and that a formal contractual relationship with SHWD was to be established. The imperative to move to a more business-like contractual relationship with the MoD led to the decision to establish SHWD as a separate corporate entity, linked to the Joint Committee, but with distinct company and charitable status. The St. John and Red Cross Defence Medical Welfare Service was incorporated on 22 March 2001 and began its activities on 1 April 2001.

PRESENT POSITION

DMWS Welfare Officers provide a variety of welfare support ranging from routine day-to-day inputs through to highly complex support and interventions. These are provided in dispersed locations to:

— members of the Armed Forces of the Crown;
— dependent relatives; and
— certain civilians acting in support of the Armed Services.

Welfare Officers also provide support to Defence Medical Service personnel who work in hospitals in the UK and overseas. They deploy on operations and exercises, where they have a key role in support of Military Field Hospitals.

DMWS has a small headquarters staff based in London and led by a Chief Executive who is accountable to a Chairman and Board of Directors.

Operational service delivery is via a peacetime establishment of 17 Senior Welfare Officers and 24 Welfare Officers. They are primarily deployed in 7 Departments in the UK, including Northern Ireland, 5 Designated German Provider Hospitals (DGP’s) [managed by Guy’s and St Thomas’ NHS Foundation Trust in Germany], and 1 Department in Cyprus.

ACTIVITY DURING THE CONTRACTUAL PERIOD APRIL 2006–MARCH 2007

<table>
<thead>
<tr>
<th>UK/Germany/ Cyprus</th>
<th>Operations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients seen by DMWS Welfare Officers</td>
<td>12,596</td>
</tr>
<tr>
<td>Number of visits made (including grave visits)</td>
<td>30,421</td>
</tr>
<tr>
<td>Number of deaths for which Welfare Officers accompanied relatives to view deceased</td>
<td>43</td>
</tr>
<tr>
<td>Family Units/close friends supported</td>
<td>1,390</td>
</tr>
<tr>
<td>Out of hours telephone calls requiring attendance by Welfare Officers</td>
<td>1,011</td>
</tr>
</tbody>
</table>
DEPLOYED OPERATIONS

When deployed with mobilised Field Medical Units in times of tension or war, operational numbers are supplemented by additional recruitment from the static locations. Whilst Welfare Officers work in a military environment in a variety of hospitals in the UK and overseas, they are under DMWS authority and management and have civilian status. If deployed with mobilised Field Medical Units they come under military command.

The Chief Executive and Operations Manager of DMWS recently spent time in the military Field Hospital in Basra. During their visit the hospital came under regular mortar and rocket attack. As a Registered Nurse with accident and emergency experience, the Chief Executive was able to observe at first hand the high quality skills and commitment of the clinical staff caring for sick and injured servicemen and women and the facilities in which they were cared for. It is a tribute to their professionalism that they continue to work in such a highly charged and unpredictable environment. What is also apparent is the way in which DMWS welfare staff are completely integrated with the clinical staff as part of the whole health care team, working along side them in this high risk environment.

DEVELOPMENT

The Defence Medical Welfare Service works closely with the Armed Services. The Board and staff of DMWS recognise the importance of adapting to changing needs to ensure the most effective and appropriate responses within the available resources. Because, ideally, any changes in service must be evidence-based DMWS has committed resources from its own reserves to provide robust evidence to support change.

For example, in 2006 DMWS commissioned and funded the University of Stirling to review the provision of support to those members of the Armed Services and their dependent relatives posted or living in Germany who develop cancer. This work identified a number of issues, which DMWS and the Armed Services needed to address. Further detailed work has recently been commissioned.

This work on cancer care will continue during the course of the contract and Welfare staff have identified further areas of welfare provision and areas of concern for which DMWS will seek to fund further research

ISSUES

(a) Support in hospital

DMWS provides a 24 hour 365 day a year welfare service. Patients and dependent relatives in hospital are visited at least every day and, more often, depending on need. In Germany and Cyprus, Welfare Officers are based in a DGP (or The Princess Many Hospital, Cyprus) but operate on a regional basis covering hospitals over a large geographical area.

In the UK, welfare staff work and are based in an MDHU. They are often completely unaware of patients in other nearby hospitals and therefore these patients cannot access a medical welfare service. A recent example encountered by our staff working at MDHU Portsmouth concerned Patient A. Patient A underwent routine surgery at Queen Alexandra Hospital, part of the Portsmouth NHS Trust, and was discharged but readmitted with an apparent infection. He was subsequently diagnosed with a terminal illness and transferred to Southampton General where DMWS visited him until he was discharged. Patient A continues to be admitted for treatment to Southampton General on a regular basis but, because this is not part of Portsmouth NHS Trust he does not appear on bed-state lists issued to DMWS. We continue to visit and do so because we are notified in advance of his expected admission by Patient A’s mother. It should be noted that this lady lives approximately 160 miles from Southampton. Unfortunately this is not an isolated example. A fully comprehensive tri-service notification does not exist or if it does, there is a reluctance to share this information with DMWS. Despite our very best efforts to provide a medical welfare service to this group of people, our attempts have been frustrated.

(b) The Royal Centre for Defence Medicine, Birmingham (RCDM)

We are very concerned about the situation regarding welfare support to patients and dependent relatives at RCDM because roles and relationships lack clarity and definition and they are confused.

DMWS is contracted to provide the in-patient hospital welfare service, the service is well regarded but despite consistent excellent local feedback about the quality of this service, it was decided by the Chief of the General Staff to increase the number of individuals and organisations providing support. This has caused significant problems and, as a result, patients have been regularly visited by more than seven different people or organisations daily. In our view there is a real danger that if this confusion regarding roles, accountabilities and reporting relationships continues, patients and their relatives will fail to get the targeted and appropriate support they so desperately need and deserve.

We have no doubt that Ministers and senior military personnel regard welfare support to the Armed Services as a top priority. However, we believe that in an effort to counter the untoward publicity regarding inpatient treatment at RCDM there appears to have been a knee jerk reaction to solving problems but with
no strategic overview of how to manage them in the longer term. In our view this is evidenced by the decision to over provide welfare resources in Birmingham which has added to the problems and not solved them. We understand that an Army Colonel has now been tasked to co-ordinate support to patients in RCDM and we look forward to clarity of direction in the near future.

(c) The Defence Medical Rehabilitation Centre Headley Court, Surrey

DMWS does not currently provide medical welfare support to those patients transferred here from RCDM and other hospitals. We believe that this is an environment where patients could benefit from additional medical welfare support and we are exploring this potential.

(d) Support on discharge from hospital

The present contract with the MoD requires DMWS to provide an in-patient medical welfare service. The service does not extend to those patients attending out-patient follow up.

When a patient is admitted to or discharged from hospital, or transferred to a non-MDHU hospital it is very unlikely that they will have access to a medical welfare service for the reasons given above. This means that their immediate needs will not necessarily be assessed (something the DMWS welfare officers are trained to do) or solutions found to resolve worries. Sometimes these concerns are fairly routine and can be dealt with easily but often they involve complex liaison and communication with a variety of other individuals and organisations. Under the terms of our current contract DMWS is constrained from providing the much needed after care and would welcome the opportunity to continue supporting these patients following discharge from hospital if appropriate. This would not impact on the role of single Service welfare organisations whose work focuses on community based issues and not in the specialist medical welfare field.

DMWS believes that these issues represent a major gap in the provision of support and may be one of the reasons why so many people have said that they feel abandoned by the Armed Services particularly if they have served on deployed operations.

CONCLUSION

DMWS is proud to work closely with the MoD and with other welfare agencies including Army Welfare, SSAFA, WRVS and others to ensure the very best outcomes for members of the Armed Services and their families. We will continue to do our very best to enhance the ethos that prompted the creation of our predecessor, the original Service Hospital Welfare Service, to ensure that every serviceman and woman and their loved ones get the maximum support that DMWS can provide.

10 May 2007

Memorandum from South Tees Hospitals NHS Trust

Further to your email of 30 April 2007 I attach the following comments regarding the experiences of Northallerton Hospital, part of South Tees Acute Hospitals NHS Trust, in working with the Ministry of Defence Hospital Unit (MDHU) Northallerton.

I believe the MDHU has made a positive contribution to the Friarage Hospital, Northallerton in delivering healthcare to military and civilian patients and supporting the training and development of military staff for operational deployment. Military staff are integrated into many clinical areas at the Friarage Hospital, Northallerton and increasingly working in complex clinical settings on the James Cook University Hospital (Middlesbrough site).

Military personnel are fully integrated into a combined workforce in the main wards and Departments on the Friarage Hospital site and deliver high quality services as a single team. Effective relationships are maintained at all levels to ensure that the objectives of delivering high quality clinical care and supporting training for military clinical staff, to provide medical support for deployed operations, are consistently delivered.

At ward and Department level the military staff members of the whole squads that contribute to the NVSP are part of a single team integrated into all ward activities. Senior staff contribute to weekly Clinical Management meetings ensuring involvement in operational activities throughout the hospital.

The Commanding Officer, Medical Director, Senior Nurse and Business Manager regularly meet with the Hospital Manager and Clinical Divisional Managers to review and oversee all aspects of service delivery.

Military patients are treated in specialty based wards by the combined team of military and civilian personnel. Arrangements for admission and administration are coordinated by the military MPAC Unit with effective communication linking the clinical staff on the ward areas to military based pastoral support through dedicated Welfare Support Officers.
The majority of patients treated on the Friarage Hospital site are elective patients from the local catchment area and military Fast Track patients from a number of Regional Rehabilitation Units (RRU’s).

Contract arrangements for the treatment of military personnel are formally reviewed on a quarterly basis with DMETA where formal issues are identified, discussed and resolved. The majority of issues are discussed and resolved informally outside of the contract meetings by local military and civilian managers.

In response to the specific areas covered by the Defence Select Committee enquiry, we make the following comments:

(1) **Healthcare for Service Personnel, both at home and overseas, and arrangements for those returning from overseas postings.**

The Trust predominantly receives military personnel for treatment from the local area and designated RRU’s, through the orthopaedic Fast Track service. The Trust would welcome an increased role in medical care for Service Personnel returning from deployed operations who reside within the Catterick Garrison area.

(2) **Medical support for operations, including the treatment of injured personnel from immediate treatment in the theatre of operations to after-care in the UK and the faculties provided for them.**

The Trust and senior military management are committed to providing appropriate training for military clinical staff, both on the Friarage Hospital site, Northallerton and increasingly making use of complex clinical situations such as major trauma on the James Cook University Hospital (Middlesbrough) site. South Tees Trust has a whole offers excellent opportunities for flexible learning and rounded training provision allowing the key operational competencies to be developed and maintained for operational service personnel.

(3) **How medical services for the Armed Forces are delivered and in particular how the Ministry of Defence engages with the National Health Service to provide healthcare. The MoD has already entered into some arrangements with NHS providers, and extending these partnerships is one option for the future.**

The South Tees Hospitals Trust is keen to maintain an effective relationship with the MDHLJ supporting an increasing local military population through the expanding Catterick Garrison. Current arrangements work well and continue to improve as operational issues are identified and resolved by both parties in partnership. Collaborative working with local and national military agencies is seen as key and the Trust is committed to joint working in the current and future planning and delivery of services.

10 May 2007

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**Memorandum from the Royal National Institute for the Deaf (RNID)**

**Executive Summary**

1. RNID has concerns regarding the treatment available to those who have a hearing loss caused by their time in the Armed Forces. Since 1953, veterans have been offered priority treatment on the NHS, but we are unsure as to who is eligible for priority treatment. There are two reasons why this is particularly significant. First, digital hearing aids can radically transform the life of someone who has a hearing loss, but current waiting times for digital hearing aids are over two years in some parts of the country. Second, since 1993 veterans with noise-induced sensorineural hearing loss receive different treatment to veterans with other conditions, which has created ambiguity. RNID believes all members of the Armed Forces should receive a high level of treatment. We would like clarification as to which groups are eligible for priority treatment, and how this is promoted among medical staff and veterans.

**Introduction**

2. RNID is the largest charity representing the 9 million deaf and hard of hearing people in the UK. As a membership charity, we aim to achieve a radically better quality of life for deaf and hard of hearing people. We do this by campaigning and lobbying vigorously, by raising awareness of deafness and hearing loss, by providing services and through social and medical research.
How medical services for the Armed Forces are delivered, and in particular how the Ministry of Defence engages with the National Health Service to provide healthcare.

3. Since 1993, veterans with noise-induced sensorineural hearing loss assessed at 1–20% have typically been informed that their hearing loss is attributable to service, but that they are not eligible for a disablement pension or a one-off lump sum payment.

4. Current NHS guidance is based on HSG(97)31, a circular issued by the Department of Health in 1997, which states that “priority should be provided to people who receive a war pension for examination or treatment that relates to the condition for which they are receiving the pension, unless there is another case that requires clinical priority.”

5. During a meeting with the MoD in November 2006, RNID was told that all veterans assessed with a hearing loss attributable to service are eligible for priority treatment. However, the guidance appears to suggest that the veteran has to actually receive a war disablement pension or a gratuity in order to be eligible. At the very least, there is ambiguity around how the guidelines should be followed.

6. There are some gaps in the data, but since 1993—which is when the compensation threshold for veterans with sensorineural hearing loss was raised to 20%—the MoD estimates that over 88,000 veterans have been told their hearing loss is attributable to service, but have not received a gratuity or a war disablement pension. The actual number of those who could have been affected by ambiguity over prioritisation is likely to be over 100,000.

RECOMMENDATIONS FOR ACTION

7. New guidance should be issued by the Department for Health. This should make it clear that all veterans should have priority for examination or treatment that relates to their condition as long as this condition is attributable to service; and that, in the case of veterans with noise-induced sensorineural hearing loss attributable to service, this is regardless of whether a gratuity or a disablement pension is actually awarded.

8. The Department for Health should take steps to ensure that medical staff and veterans are aware of the new guidance and its implications.

14 May 2007

Memorandum from Deltex Medical

SUMMARY

— Deltex Medical is a small British company which produces an innovative medical device called the CardioQ which accurately monitors changes in blood flow in critical care and during surgery. Numerous independent clinical studies have shown that the CardioQ reduces the number and severity of post-operative complications leading to improved outcomes and reduced hospital stays.

— The CardioQ is an ideal tool for helping to stabilise injured patients and deal with the sorts of wounds commonly encountered in combat situations.

— The US Army has quickly recognised the potential of the CardioQ to save lives in military situations. The US Army first bought CardioQ in 2005 and is now assessing protocols for its use in Iraq to improve care given to wounded soldiers.

— Progress towards wide-scale adoption of the CardioQ by the US military is in marked contrast to the UK where the CardioQ is not available at all in combat situations.

— NICE’s Interventional Procedure Programme (IPP) has declared the CardioQ technology “standard clinical practice” yet this has done little if anything to encourage uptake in the UK military or wider NHS.

— The potential to develop Deltex Medical’s new wholly non-invasive SupraQ for wider use, including on the battlefield itself, has already been recognised by the US military; in the UK it has not been possible to find out who in the MoD might be responsible or even interested.

INTRODUCTION: ABOUT DELTEX MEDICAL AND CARDIOQ, AND ITS USE IN COMBAT SITUATIONS

1. Deltex Medical is a small innovative British healthcare company which has developed a device, the “CardioQ” Oesophageal Doppler monitor (ODM), to accurately monitor blood flow during surgery and in critical care. Reduced circulating blood volume is known as hypovolemia, which leads to insufficient oxygen being delivered to the organs, causing medical complications including peripheral and major organ failure
resulting in longer hospital stays and in some cases death. Using the CardioQ allows the clinical team to better manage the patient during this time (haemodynamic optimisation), reducing complications and mortality.

2. Clinical evidence has shown that there are approximately 1 million NHS patients each year who would derive a clear clinical benefit from haemodynamic optimisation. If lengths of hospital stay for these patients were reduced by two days each, the NHS would free up about 5,500 beds, with a saving of at least £350 million a year. Were NHS managers to embrace the CardioQ technology and work with their clinical colleagues towards implementing it effectively they would significantly improve the experience of hundreds of thousands of their patients undergoing operations. By freeing up hospital beds they could choose whether to treat more patients, close beds or redeploy resources to meet local priorities.

3. In August 2006 the British Journal of Surgery published the results of a major new randomised controlled clinical trial of the CardioQ during surgery. The study on bowel surgery patients at the Freeman hospital in Newcastle-Upon-Tyne was funded by the Royal College of Surgeons and was the seventh high quality CardioQ outcome study to be published in a leading peer-reviewed journal. It demonstrated that in those patients whose circulating blood volume was optimised using the CardioQ, serious post-operative complications, emergency post-operative admissions to critical care units and emergency readmissions to hospital were almost entirely eliminated. The study found that CardioQ patients were also fit to go home three days earlier than non-CardioQ patients.

4. Routine use of the CardioQ during surgery is now a core part of the Freeman hospital’s “enhanced recovery” or “fast-track” programme for major bowel surgery. This programme delivers amongst the lowest mortality rates, the lowest readmission rates and the shortest lengths of stay not just in the UK but in the whole of the developed world.

5. The effectiveness of the CardioQ and the quality of the scientific evidence behind it have been confirmed by the results of both an independent clinical meta-analysis and by a US Government funded Health Technology Assessment.

6. The benefits shown from using the CardioQ in emergency trauma surgery and critical care in NHS hospitals are particularly applicable to combat situations, where patients frequently suffer from hypovolemia due to blood loss and shock. Using the CardioQ would also enable medical staff to make an early identification of internal bleeding.

DELTEx MEDICAL’S EXPERIENCE OF UPTAKE IN THE UK AND THE US

7. Deltex Medical is a British company which has brought to market a British technology: the vast majority of the clinical and “real-world” evidence supporting the CardioQ comes from British hospitals. Yet the company has found its dealings with the Department of Health and the NHS consistently frustrating over many years. Our recent experiences with the equivalent bodies in the USA have been in marked contrast. In the USA the decision making process is more transparent, faster and considerably less bureaucratic with clearly defined roles for the various bodies and agencies involved.

8. The Centers for Medicare & Medicaid Services (CMS), the US Federal Government body responsible for determining coverage for the reimbursement of medical technologies in the US, recently (26 February 2007) published a favourable draft decision on ODM following an application originally submitted on 22 August 2006. If a technology is “covered” it is possible for hospitals to receive a payment (reimbursement) that covers the costs associated with the purchase and use of that technology.

9. In reaching its proposed decision, CMS had commissioned a Health Technology Assessment (HTA) on ODM from the US Government Agency for Healthcare Research and Quality (AHRQ). The AHRQ report was delivered to CMS on 16 January 2007 and published on CMS’s website on 14 March 2007. It grades evidence whether a technology does or does not work into four categories: “strong”, “moderate”, “weak” and “inconclusive”. Strong evidence is where “it is highly unlikely that new evidence will lead to a change in this conclusion”. The HTA concluded that in “patients undergoing surgical procedures with an expected substantial blood loss or fluid compartment shifts requiring fluid replacement” the clinical evidence for ODM was “strong” in respect of the following three statements:

(a) “Doppler-guided fluid replacement during surgery leads to a clinically significant reduction in major complications”;
(b) “Doppler-guided fluid replacement during surgery leads to a clinically significant reduction in the total number of complications”; and
(c) “Doppler-monitored fluid replacement leads to a reduction in hospital stay”.

10. The US Army first bought CardioQ in 2005. Following a satisfactory evaluation in the William Beaumont military hospital in Texas, the US Army has purchased a further six monitors for use in one of its mobile field hospital posted to Iraq. Amongst other applications, the CardioQ is being used to stabilise wounded patients before they are flown back to the USA for treatment. Doctors associated with using the device in Iraq have already indicated that they expect it to enable them to save servicemen and women’s lives.
RECOMMENDATIONS

11. The UK Armed Forces should be actively seeking to help develop and deploy innovative new medical technologies which will benefit its front line troops.

12. The MoD should apply equivalent development and procurement processes to technology aimed at caring for wounded personnel as it has long done for the development and procurement of weapons for the same personnel to use in combat.

14 May 2007

Memorandum from Peterborough and Stamford Hospitals

1. INTRODUCTION

1.1 This short submission has been made following a request from the Committee who have expressed interest in hearing about our Trust’s experiences in working with the Ministry of Defence Hospital Unit at Peterborough. This provides a brief overview, but the Trust would be pleased to provide more detail on any areas that the Committee would like to explore further.

1.2 This submission focuses on the third element identified for the inquiry in the operational note of the 28 March 2007 regarding “how the Ministry of defence engages with the National Health Service to provide healthcare.” The establishment of the Ministry of Defence Hospital Unit, the delivery of clinical care, the management of deployments and contractual arrangements will be covered.

1.3 The Trust considers that the advent of the Ministry of Defence Hospital Unit Peterborough has been a success and would like to ensure that the relationship continues to develop for the benefit of the NHS and MoD alike.

2. ESTABLISHMENT OF THE MINISTRY OF DEFENCE HOSPITAL UNIT

2.1 The Trust was pleased to be selected to be one of the first new Ministry of Defence Hospital Units in 1995. Local links with local air bases provided a strong foundation for the establishment of the MDHU, and close partnership working with project leads from the MDHU and the Trust ensured the successful opening of the MDHU on 29 February 1996.

2.2 The establishment of the MDHU saw a discrete headquarters function to support the commanding officer structure and command and control requirements including military medical records, finance, business planning, links directly to the MoD and specific military training, deployment and welfare support.

2.3 Direct links were established between the command and control structures of the MDHU and the Trust—for example the commanding officer of the MDHU and the Trust chief executive, the officer commanding nursing and the director of nursing. These links were complementary to the integration of the management arrangements with the commanding officer being a member of the Trust Executive which covers all the operational planning and delivery requirements of the Trust.

2.4 To ensure the success of this new partnership time was invested to ensure that existing NHS staff understood the rationale for the establishment of the MDHU, the roles that military clinical staff have when away from the Trust and the meanings of military ranks and terminology.

2.5 This is a necessary requirement for new staff, especially in clinical areas where military and NHS staff work together in teams. These ongoing updates are delivered jointly between the Trust and the MDHU and cover arrangements such as sickness notification and NHS and military training requirements.

2.6 There has also been the need to recognise and understand the different pressures and priorities that exist between NHS and military staff and NHS and military patients.

2.7 In contrast with the MDHU headquarters, the clinical delivery of services within our hospital wards and departments such as A&E, pharmacy and outpatients has always been integrated within the Trust’s service delivery structure as explored in section 3 below.

3. CLINICAL CARE DELIVERY

3.1 The delivery of clinical care to patients has been integrated within the structure of the Trust. The Trust has distinct clinical Service Units, covering medicine, surgery, woman and child and clinical and life support services.

3.2 Within these units the delivery of care has been integrated so that military staff provide services alongside their NHS colleagues. This allows for the development of an understanding of skills and expertise and also the cross-fertilisation of ideas and experience that help to develop services for patients. Examples
of these are the establishment of a surgical recovery unit for surgical cases requiring more intensive support prior to being placed on a general ward for aftercare, and the development of fast-track orthopaedic care in partnership with military health centres.

3.3 The overall management of the staff has been within the Trust’s service unit structure with the Service Unit General Managers accessing support from the MDHU headquarters staff if required, whilst ensuring that any performance issues are fed into the military command and control structure.

3.4 Clinical staff share the NHS and military patient workload, with the co-ordination of the military patients being handled jointly between the NHS and military administration staff. This has specific benefits in that the military staff can use their contacts with military health centres and knowledge of military requirements to review the attendance of military patients. Military support staff are also important when considering the welfare of military personnel who will have specific needs, especially if arriving direct from distant military units.

3.5 It is important to note that the Trust does not receive casualties directly from overseas deployments. This is because at the time of a deployment, the Trust will have military clinical staff deployed away from Peterborough and there is an agreement to ensure that a “double whammy” of losing clinical military staff and receiving military casualties does not occur.

3.6 It should be noted that this does not exclude the Trust from receiving local surgical or medical emergency admissions from military bases in the surrounding area. If required arrangements can be made for injured personnel who are based or live locally once entry back into the UK has been effected.

3.7 Waiting time performance targets has been an area of difference between the military and NHS. As NHS waiting times reduce these differences are becoming less relevant and these priorities are easier to manage.

3.8 To ensure the development of integrated working military clinical staff are involved throughout the Trust’s mechanisms for clinical and patient care quality development which includes attendance at the Nursing and Midwifery Advisory Group, the Clinical Management Board and Healthcare Governance Committee.

4. TRAINING

4.1 The training of staff has been of mutual benefit for the NHS and MoD. The different skills required have helped develop new ways of working and consideration of new models. As well as the examples in 3.2 above close working and problem solving through discussions at the Nursing and Midwifery Advisory Group have ensured that the different range of skill sets required by military staff on deployment can be recognised and supported. An example of this includes the specialist training for the infection control specialist nursing officer who whilst working as part of the integrated team has objectives that include military needs (such as community infection outbreak management) as well as secondary care NHS needs.

4.2 The placements for military staff are well managed with military support available for students who may be in training placements for the first time. It is worth noting that Peterborough is a very popular placement for pre-registration nursing students.

4.3 The Trust has also been able to work with military colleagues to develop a military Practice Development Nurse and Clinical Educator to integrate with the NHS team and support both military and NHS practice development.

4.4 The Trust has also adapted the in-house clinical leadership programme to provide a dedicated military clinical leadership programme which is run by the practice development team.

5. DEPLOYMENTS

5.1 The Trust has had a range of experiences of deployments. It is accepted that there will always be an underlying level of deployment and the management of this has been enhanced by the provision of as much notice as possible from the MoD to ensure that clinical commitments can be maintained.

5.2 There have also been significant deployments. It is important to manage major deployments well. If they are not managed successfully there is the potential for remaining staff to feel that they are being left to cope with reduced staffing and for the work of staff when on deployment not to be recognised on their return.

5.3 We have learned that the key to managing major deployments is to have commitment to clear project management arrangements—this has been successfully funded by the MoD and has enabled a strong relationship and commitment to ensure that deployments are managed smoothly both pre and post deployment. We would recommend that such project management is used in any future significant deployments.
6. CONTRACTUAL ARRANGEMENTS

6.1 The formal arrangements between the Trust and the MDHU operate through a contract that specifies the level of funding provided by the Trust for military staff and the level of funding received by the Trust for treating military patients and separate funding is provided for specific training, whilst the medical training of staff is integrated into deanery arrangements.

6.2 The Trust has seen changes in the way the contract mechanism works, with the contracts having been divided between the treatment of military patients and military staffing. This has reduced the previous flexibility that was available to negotiate across these areas.

6.3 It should be noted that the success of the contract is through maintaining good local relationships and understanding. Good communications are especially important considering that the MoD functions for negotiation, formal contracts and payment are based throughout the UK.

7. SUMMARY

7.1 In summary the Trust has welcomed the advent of the MDHU Peterborough. It is important to ensure that work continues to ensure that relationships are maintained and that services can be developed that meet the MoD requirements. The success at Peterborough would not have been successful without the clear commitment to partnership working from the NHS and MoD and we look forward to this continuing in the future.

15 May 2007

Memorandum from the Royal College of Physicians

We are pleased to submit evidence to the above Inquiry. The Royal College of Physicians (RCP) plays a leading role in the delivery of high quality patient care by setting standards of medical practice and promoting clinical excellence. We provide physicians in the United Kingdom and overseas with education, training and support throughout their careers. As an independent body representing over 20,000 Fellows and Members worldwide, we advise and work with government, the public, patients and other professions to improve health and healthcare.

The RCP has a number of members who work in defence medicine, and our evidence has involved some of their views.

BACKGROUND

Following the closure of military hospitals in the UK, Ministry of Defence Hospital Units (MDHUs) were integrated within NHS Trusts. The current situation sees consultants involved in defence medicine give 75% of their time to the trust, and 25% to the military. For deployable specialties, this time is mainly made up in time abroad.

In 1995, there were small-scale deployments of clinical defence staff to the Balkans. However, over more recent years, since the second Gulf war and other military activities, such as in Afghanistan, the increased commitment to providing medical services is greater than is accounted for by defence planning assumptions. This will inevitably have consequences for defence medicine, such as resourcing.

CURRENT HEALTHCARE FOR SERVICE PERSONNEL

Secondary care in the UK during peacetime has generally been good. Contracts with NHS Trusts which host MDHU encourage them to give priority to defence service personnel, where operationally necessary. The MoD pays for this “enhanced” service. If there is no MDHU available, service personnel can be sent to a non-MDHU NHS hospital.

Secondary care provision for UK personnel in Germany is provided by the MoD through a contract with Guys and St. Thomas’ hospital. Again, the provision of secondary care in Germany seems to be good.

MEDICAL SUPPORT FOR OPERATIONS AND FACILITIES PROVIDED FOR THEM

There are small deployed military hospitals in Basra and Afghanistan for service personnel. The capability of these hospitals is appropriate for addressing current need, which means that not all specialties are represented on the ground.

Provision includes the following:

— The vast majority of care is around Disease and Non Battle Injury (DNBI). Historically this has been the largest makeup of medical provision.
Medium scale deployment might consist of a consultant general surgeon, consultant orthopaedic surgeon, 3 anaesthetists, 1 SpR (for 3 months training) and 1 consultant physician. There are also SHO’s, nursing staff, radiographers, laboratory staff and physiotherapists. Psychiatric nurses are also deployed, but are not based within a hospital. No psychiatrists are deployed.

Tele-radiography and digital imaging are routinely available, and support the deployment of CT scanning. Scans can now be sent back to the relevant UK hospital in seconds, with consultant reporting thus available in a very short space of time. This facility has been available for approximately 3 years.

Medicine

Acute medicine has an increasingly important role in defence medical provision and needs further support in the future.

Historically, the MoD has tried to provide a range of specialties, with the emphasis on infectious disease, which has been the major issue for defence medicine. The norovirus outbreak in Afghanistan in 2002 is an example of this.

Provision around infectious disease includes the following:

- Funding is now available to send junior doctors to do Diploma in Tropical Medicine and Hygiene (DTM&H).
- 1 physician is accredited in infectious disease from the Centre for Control of Communicable disease (CCDC).
- 4 SpRs are trained in infectious diseases.

Despite advances and current provision, there is currently a lack of adequate deployed laboratory facilities. This is of particular concern because of the development of new diseases, the increased complexities of TB and the on-going threat of “deliberate release” (bio-terrorism).

Trauma

The management of trauma is constantly improving, and there is an on-going trauma audit being carried out. This is important work as expectations around timelines for dealing with and treating trauma have changed. Whereas delivering initial trauma care was once known as the “golden hour”, medical care is now expected to react within 10 minutes. However, military operations can be far away from hospital facilities, which raises questions about how to provide trauma care. If military operations are more than an hour’s helicopter flight to the base hospital, other medical provision needs to be delivered. This is largely around resuscitation, which A&E teams can deliver. By design, trauma and medical patients are sent to Birmingham for their on-going care.

The deployment of neurosurgical teams is now happening in Afghanistan, as head injuries are becoming more prominent with improvements to body armour. Currently, the UK is the only nation that has this capability.

Medical Service Delivery and MoD Engagement with NHS

As discussed above, military evacuees currently receive their care in Birmingham. The trust is in 2 locations, which are the Queen Elizabeth Hospital and Selly Oak hospital, where A&E, trauma and ICU are located.

Although there has been some call for a separate military hospital for service personnel, the generally accepted plan has always been that tertiary care be provided by NHS hospitals. In previous years, personnel arrived in Birmingham and NHS staff may not have appreciated the environment they have come from. However, the feeling now is that there is a better understanding of such issues, and staff are committed to the “cause”.

Welfare support

Although, as indicated above, many aspects of secondary and tertiary care are good, welfare support has not yet reached an acceptable standard. This includes issues such as the transfer of a patient to a hospital nearer to their family or unit or facilities enabling family to stay with the patient at the hospital. It is our understanding that the Centre for Defence Medicine is to review the process around these issues, and that there is now at least some accommodation for family members. In Birmingham, defence healthcare staff do make at least one visit each day to personnel. The Welfare Department look after other issues too, including use of library facilities and access to a phone.

It is important that both defence medicine staff and the individual military units take responsibility for ensuring that personnel get the appropriate welfare support they need.
CONCLUSION

Initial concern at the closure of military hospitals has abated. There was no way of knowing then about the EU working time directive and changes in training, for example, which would have had significant impact on military hospitals.

We believe in particular that trauma care is regarded as outstanding, considering the facilities available. New technology has allowed defence clinical services to take advice more readily on medical issues, such as with the deployment of CT scanners. Such developments are important for providing the best possible treatment for service personnel.

Welfare support has been highlighted as an area that needs improving, in order to ensure on-going care and support of service personnel.

RECOMMENDATIONS

— Physicians should maintain their skills in acute medicine, as this fits well with the current emphasis on infectious disease
— Defence planning assumptions must take into account current and future medical resourcing needed, if there are to continue to be on-going military operations of this scale
— Investment in appropriate facilities is essential, for example laboratory and CT scanning. It is important that the MoD support laboratory deployment, to help deal with emerging infections and deliberate outbreak
— Efforts to improve social care around medical care must continue
— Military nursing is experiencing similar shortages in specialist care as the NHS, such as in critical care. It is difficult to recruit nurses from the NHS, and efforts must be made to address this
— Hospital accommodation should be provided for soldiers in the UK which allows them to have access to en-suite facilities, welfare and other support
— There is a sense of entitlement that more should be provided for personnel in terms of medical, welfare and social support than the NHS can provide. Efforts must be made to ease tensions between civilian and military expectations regarding service provision and treatment.

15 May 2007

Memorandum from the Ministry of Defence

1. This Memorandum aims to provide the House of Commons Defence Committee (HCDC) with relevant background information to aid their inquiry into medical care in the Armed Forces.

INTRODUCTION

2. The strategic intent of the Defence Medical Services (DMS) is that every Serviceman and woman enjoys a level of health that is appropriate for the tasks they are required to perform by the Chain of Command. To that end, the DMS have two key measurable outputs: the provision of medical support to deployed operations (from theatre back to the UK); and the provision of healthcare to the Armed Forces to ensure that the maximum numbers possible are “fit for task”. The DMS also provide advice to commanders to support them in the discharge of their responsibility for the health of their personnel. There have been many significant developments in support of the DMS’ outputs since the HCDC last reported on the organisation in 1999. These are summarised within the sections below.

3. The DMS are headed jointly by the Deputy Chief of Defence Staff (Health) (DCDS(H)) and the Surgeon General (SG). DCDS(H) is accountable for the overall outputs of the DMS, and SG is the clinical head of the Department with responsibility for the professional performance and development of military medicine. They oversee the work of three separate organisations:

(a) Defence Medical Services Department (DMSD)—The Head Office for the DMS, which provides strategic direction to ensure coherent delivery of all medical outputs;
(b) Defence Medical Education and Training Agency (DMETA)—A tri-service organisation that provides secondary care personnel to meet requirements for operational deployments. It also

1 and other entitled personnel, eg MoD Civil Servants serving overseas and dependents accompanying Service personnel posted overseas.
underpins medical support to the UK’s Front Line forces by educating and training medical personnel. The Agency delivers annually over 300,000 man training days across 2,000 clinical courses to the single Services. DMETA has command and control over:

1. Ministry of Defence Hospital Units (MDHUs);
2. The Royal Centre for Defence Medicine (RCDM);
3. The Defence Medical Rehabilitation Centre (DMRC) at Headley Court;
4. The Defence Medical Services Training Centre (DMSTC) at Keogh Barracks;
5. The Defence Medical Postgraduate Deanery; and
6. Retained military tasks at the Royal Hospital Haslar, which is managed in partnership with Portsmouth Hospitals NHS Trust (due to close in late 2009).

c. Defence Dental Services (DDS)—a tri-service organisation employing both Armed Forces and civilian personnel, providing dental services in the UK at service establishments and to personnel on operations.

5. DCDS(H) and SG also produce medical policy for the three Single Services. The Royal Navy (RN), Army and Royal Air Force (RAF) Medical Services are responsible for delivering primary healthcare to their respective Service Commanders in Chief and for providing the requisite medical support on operations;

PROVISION OF MEDICAL SUPPORT TO DEPLOYED OPERATIONS

Meeting Operational Requirements

6. DMS personnel are currently deployed on operations in Iraq (TELIC), Afghanistan (HERRICK) and Bosnia and Kosovo (OCULUS), as well as supporting military training (eg in Sierra Leone) and other standing commitments worldwide. For example, the DMS provide uniformed personnel to meet some of the medical manpower requirements of the medical services provided by Commander Joint Operations (CJO) within the Permanent Joint Operating Bases (PJOBs) (Cyprus, Gibraltar, The Falkland Islands (FIs), Ascension Island (ASI) and the British Indian Ocean Territories (BIOT)). The majority of the manpower requirement lies within the PJOBs in Cyprus and Gibraltar, where both Primary and Secondary medical care is provided, as well as primary Dental care, Environmental Health and Community Mental Health services. Lesser requirements exist in FIs, ASI and BIOT, where DMS services are predominantly primary care based, utilising local Secondary Care facilities as appropriate.

7. The DMS' medical manpower commitments are met by utilising personnel from all three Services with RN, Army and RAF personnel serving along-side each other. Reservists continue to make a significant contribution to medical capability, most importantly for deployed hospital care and in niche specialisations. Close to 50% of the Army’s deployed Secondary Care capability has been found from the Territorial Army (TA). For example, four TA Field Hospitals are covering a 12 month period (HERRICK 6 & 7) in Afghanistan starting in April 2007. Early indications are that deployment as formed units is welcomed and strongly supported by TA volunteers. In addition, early engagement with NHS employers of TA volunteers has also had a positive impact on the TA deployment process.

8. To date, the DMS have met all the operational requirements placed on them (although harmony guidelines have been broken for some cadres). In addition, whilst some manpower shortfalls exist, the manning situation is improving and the standard of medical care provided to Service personnel remains high. Further details of the DMS manning situation can be found at Annex A.

Medical Operational Pathway

9. The DMS provision of medical support on deployed operations covers treatment and casualty evacuation from the deployed theatre back to the UK. This managed patient care pathway ensures that patients are assessed and treated in a timely fashion and that they receive high quality treatment and rehabilitation, aimed at maximising functional outcome and returning them to operational fitness, when this is clinically possible.

10. Pre-Deployment Training. Comprehensive military pre-deployment training of DMS personnel is conducted prior to deployment. Pre-deployment collective medical training is also essential as deployed field hospital manning is found from a wide range of donor units. Mission rehearsal for hospitals is conducted at the Army Medical Services Training Centre Strensall (2 Med Brigade). Experience in field medical units is also provided and personnel attend specific training courses, such as the Battlefield Advance Trauma Life Support (BATLS) course. Secondary Care personnel, both Regular and Reserve, are also routinely employed within the NHS to ensure the currency of their clinical skills (further details at paras 59–62).
11. Treatment in Theatre. The size of the deployed force, specific mission and prevalent threats, determines the capability and capacity of medical support provided in theatre. In-theatre medical staff provide assessment and immediate treatment for all casualties, whether as a result of hostile action or non-battle illness or injury. The medical element of Incident Response Teams (IRTs) provides the link between initial medical care and evacuation to a hospital facility. Our Concept of Operations for delivering the medical component of IRT is saving lives. For example, a recent innovation on Op HERRICK has been to deploy a hospital-based consultant forward on the IRT to recover severely injured casualties. This hospital physician led team has become known as the Medical Emergency Response Team (Enhanced) (MERT(E)), a step up from the Emergency Medicine Nurse/Paramedic lead Medical Emergency Response Team (MERT).

12. Deployed Rehabilitation Teams also contribute to force conservation by retaining and treating in Theatre those who would otherwise have to be evacuated. For example, the fielding of Deployed Rehabilitation Teams provides for the treatment and return to duty of some patients with musculo-skeletal injuries. The teams will also provide guidance on the most appropriate further course of treatment, if required. Similarly, Deployed Mental Health Teams will also treat in theatre and provide guidance on further courses of treatment for patients with mental health conditions.

13. More detailed information on the medical treatment facilities available to UK personnel on operations can be found at Annex B and in the section below on mental health.

14. Evacuation of Casualties. Where casualties have been seriously injured on operations, the usual care pathway is for our deployed medical support to treat and stabilise the patient’s condition and then aeromedically evacuate them back to the UK at an appropriate point in their treatment. UK strategic Aeromedical Evacuation (AE), provided by the RAF, is widely regarded as delivering an exceptional service. For example, the RAF are able to transfer critically injured and ventilated patients by using specialist teams capable of maintaining a patient’s condition when in transit. The UK has also agreed to provide strategic AE to some coalition partners. This has been activated, when required, as part of a multinational agreement.

15. Patients are evacuated on the basis of clinical need. From 1 Jan 2006 to 15 April 2007, 367 UK personnel from Afghanistan and 866 from Iraq were aeromedically evacuated back to the UK on medical grounds (not just battle casualties). Casualty statistics are updated regularly on the following MoD webpages:


   http://www.mod.uk/DefenceInternet/FactSheets/OperationsFactsheets/OperationsInIraqBritishCasualties.htm

16. Selly Oak Hospital. Since 2001, the Royal Centre for Defence Medicine (RCDM), based at the University Hospital Birmingham Foundation Trust (UHBFT), has been the main receiving unit for military casualties evacuated from an operational theatre. In the Birmingham area, military patients can benefit from the concentration of five specialist hospitals (including Selly Oak Hospital) to receive a very high standard of care. Indeed, Selly Oak is at the leading edge in the medical care of the most common types of injuries (eg polytrauma) our casualties sustain. The medical needs of the Armed Forces are best served through access to facilities and training in a busy acute care hospital that is managing severe trauma on a daily basis. By contrast, the last of our UK military hospitals, the Royal Hospital Haslar, had for many years nothing like the range of medical facilities and expertise that is found at a major trauma Trust hospital such as Selly Oak.

17. Wherever practicable, military patients are allocated to one of the military consultants who work at RCDM. However, by far the largest proportion of specialist care is provided by NHS consultant staff, which reflects the range and capabilities of the knowledge, skills and resources the NHS makes available to our patients. We do, of course, appreciate the importance of military casualties continuing to feel part of the military family, where practical. They will obviously benefit from being treated, where clinically feasible, in a predictable and understandable environment, with care delivered by staff who can empathise with patients. That is why at Selly Oak Hospital we have created a Military Managed Ward (MMW), located within the main orthopaedic/trauma ward at Selly Oak Hospital. The MMW reached Initial Operating Capability just before Christmas 2006. A combined team of military and civilian personnel provide care for military patients whose clinical condition allows them to be nursed in this ward. Military nursing managers work at all levels on the ward and military nursing staff, including military nurses and military health care assistants, are on duty on every shift. Full Operating Capability (FOC) for the MMW will be declared once the military presence on the ward has been assessed as having achieved sustainable increased staff numbers, together with the skills and experience levels required to take over fully the management of the ward from UHBFT and to have a predominantly military nursing presence on the ward. A works project also started on 14 May
2007 to change the layout of the ward to produce a separate area for some military patients whose condition allows them to be nursed together, utilising the two bays and isolation rooms at the far end of the main orthopaedic/trauma ward. FOC for the MMW will be achieved by summer 2007.\(^3\)

18. The new MMW is one of several improvements we have made to the treatment of military patients. Each military patient in the Birmingham area now has a named military nurse whom he or she can contact at any time on clinical and other issues. Community psychiatric support has also increased, with two full time Community Psychiatric Nurses now in post. A military nurse team member visits every military patient being treated at a Birmingham hospital three times a day. This is in addition to the welfare support we receive under contract from the Defence Medical Welfare Service (DMWS), which has four welfare officers based at UHBFT who visit our patients regularly.\(^4\)

19. Additional funding has been provided to help meet the travel and accommodation costs of patients’ families who need to travel to Selly Oak. Accommodation available includes seven flats, plus a number of family rooms. Some of the flats have benefited from recent refurbishment funded by the Soldiers, Sailors, Airmen and Families Association (SSAFA), which is helping to provide a more suitable environment for the families of the patients concerned. Additional transport for patients and families is also being provided from public funds.

20. Military staff at Selly Oak hospital are assisted by the staff of the Aeromedical Evacuation Cell, the Military Patient Administration Cell and the Defence Medical Welfare Services, which are all part of RCDM. The military chain of command also works to maintain links between the individual patient and their parent single Service unit.

21. Although Service patients are nursed with other Service patients when this is clinically feasible, the over-riding factor in the treatment of any patient must be their clinical condition and need. The patient must be placed in the most appropriate specialist environment, with associated equipment and trained personnel who have the necessary skill sets.

22. Defence Medical Rehabilitation Centre (DMRC) and Regional Rehabilitation Units (RRUs). MoD has made considerable investment in rehabilitation in recent years and now adopts a tiered approach. Selected primary care centres have been reinforced by physiotherapists. When necessary, patients are referred to one of 15 Regional Rehabilitation Units (RRUs) which focus on the assessment and treatment of musculoskeletal injuries and sports medicine and are staffed by specially trained Doctors, Physiotherapists and Rehabilitation Instructors. Further details on the benefits of RRUs can be found at Annex C.

23. Military patients requiring further rehabilitation care may be referred to the Defence Medical Rehabilitation Centre (DMRC) at Headley Court in Surrey, which is the principal medical rehabilitation centre run by the Armed Forces. DMRC also accepts direct admission from hospitals, and most combat casualties are referred directly to DMRC from Selly Oak. DMRC provides both physiotherapy and group rehabilitation for complex musculo-skeletal injuries, plus neuro-rehabilitation for brain-injured patients. The Complex Rehabilitation and Amputee Unit, based within DMRC, provides high quality prosthetics and adaptations, manufactured on site and individually tailored as necessary for the specific patient. Priority is given to the provision of prosthetics to enable Service personnel to resume service duties.

24. Deployed Rehabilitation Teams help to determine the most appropriate location for a patient and, in the UK, the Defence Rehabilitation Evaluation Coordination Cell is improving the management of operational patients with musculo-skeletal injuries or rehabilitation needs. This has led to improvements in clinical outcomes and more effective return to fitness and duty.

25. Mental Illness. It is our policy that mental health issues should be properly recognised and appropriately handled and that every effort should be made to reduce the stigma associated with them. Diagnosis and treatment of mental illness in the Armed Forces is performed by fully trained and accredited mental health personnel. The MoD recognises mental illness as a serious and disabling condition, but one that can be treated.

26. Measures are in place to increase awareness of mental health at all levels and to mitigate the development of operational stresses. These include pre-and post-deployment briefing and the availability of support, assessment and (if required) treatment, both during and after deployments. This is available to all personnel, whether Regular or mobilised Reservists.

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\(^3\) Military nursing staff allocated to the MMW at FOC will be:
* 11 Orthopaedic (specialist) nurses.
* 15 General nurses.
* Health Care Assistants.
TOTAL 39
These numbers include the military ward manager and her three deputies.

\(^4\) DMWS staff also provide welfare support in Germany, Cyprus and deployed field hospitals.
27. During a pre-deployment medical, whilst deployed, or during the post-deployment normalisation period, all personnel including reservists can identify themselves to any Medical Officers or their chain of command if they believe they are suffering from any mental health condition. The families of returning personnel are also offered a presentation and issued with leaflets to alert them to the possible after-effects of an operational deployment.

28. In the deployed operational arena, commanders and their medical staff can call upon mental health professionals that can provide assessment and care in theatre. Theatres are regularly visited by consultant psychiatrists who audit the service provided by the in-theatre mental health professionals. If personnel do need to leave the operational environment, then their care continues either on an out or inpatient basis in the UK.

29. Following the Medical Quinquennial Review, whose conclusions were published in 2002, our mental health services have been re-configured in line with national best practice, meeting the standards of the National Institute for Health and Clinical Excellence, to provide community-based mental health care. We do this primarily through our 15 military Departments of Community Mental Health (DCMH) across the UK (plus satellite centres overseas), which provide out-patient mental healthcare. The DCMH mental health teams comprise psychiatrists, mental health nurses, clinical psychologists and mental health social workers. The aim is to see referred individuals at their unit medical centre and, with the patient’s permission, to engage with general practitioners and their chain of command to help manage mental health problems identified in personnel. A wide range of psychiatric and psychological treatments are available, including psychological therapies, environmental adjustment and medication, where appropriate. The Defence Mental Health Services have particular expertise in psychological treatments for mental health problems in general and psychological injury in particular.

30. In-patient care, when necessary, is provided in psychiatric units belonging to the Priory Group of Hospitals, through a central contract with MoD. Close liaison is maintained between local DCMHs and the Priory units to ensure that all Service elements relating to inpatient care and management are addressed. The arrangement with the Priory Group means that the majority of patients can be treated much closer to their parent units than was the case when we maintained the last of our own psychiatric hospitals.

31. It should be noted that medical discharge from the UK Armed Forces due to psychological illness is low. As at Jan 2007, out of about 180,000 Regular Service personnel only about 150, or less than 0.1%, are discharged annually for mental health reasons, whatever the cause. Of these, only 20–25 meet the criteria to be diagnosed with PTSD at discharge.

32. Reservists. Any mobilised serviceman or woman injured when on operational deployment is entitled to and will receive the same level of medical treatment and support, irrespective of whether they are a member of the regular or reserve forces. If a medical officer in-theatre assesses that a member of the reserve forces requires treatment or rehabilitation back in the UK, they will be treated in exactly the same way as regular personnel. This may include treatment and rehabilitation at a military RRU or the DMRC at Headley Court, Surrey, or—if the problem is related to their mental health—treatment at a military Department of Community Mental Health (DCMH) or admission to the Priory Group.

33. When reserve personnel are demobilised, they are given a medical assessment. During this process, if it is identified that they are in need of hospital care they may be referred to NHS hospitals hosting Ministry of Defence Hospital Units (MDHUs) or the RCDM at Selly Oak Hospital. They will be treated within military timeframes which can in some cases offer faster access to treatment than is the case for NHS patients. Reserve personnel will receive treatment for injuries sustained on operation until they are deemed to have reached a steady state of fitness. They are then demobilised, and taken through a transition from military to NHS care, if they have continuing healthcare needs. The patient may express a preference for treatment in a hospital nearer to their home, which may be a non-MDHU hospital, and some reservists opt for this route. In accordance with NHS protocols, if they are referred on to a non-MDHU hospital, then access to treatment is according to clinical priority.

34. Once demobilised, it is a long established tradition that reserve forces’ medical care becomes the responsibility of their own local NHS primary care trust and the majority of Veterans’ physical and mental health needs are met by these provisions. However, the MoD recognises that it has an expertise to offer in certain specific circumstances, and in November 2006, it launched a new initiative—the Reserves Mental Health Programme (RMHP).

35. The RMHP is open to any current or former member of the UK Volunteer and Regular Reserves who has been demobilised since 1 January 2003 following an overseas operational deployment as a reservist, and who believes that the deployment may have adversely affected their mental health. Under the RMHP, we liaise with the individual’s GP and offer a mental health assessment at the Reserves Training and Mobilisation Centre in Chilwell, Nottinghamshire. If diagnosed to have a combat-related mental health condition, we then offer out-patient treatment via one of the MoD’s 15 DCMHs. If more acute cases present,
the DMS will assist access to NHS in-patient treatment. We are working with the UK health authorities to ensure that GPs across the UK are aware of the initiative. Full details of this programme, and how to access it, are published on the following web site: www.army.mod.uk/rtmc/rmhp.htm.

36. For the wider veteran population, MoD officials, the Health Departments, the NHS and the specialist mental health charity Combat Stress have been working together to develop a new community based mental health service for veterans. Advised by national clinical experts, this service will reflect NHS good practice and procedures and will be made up of clinical networks. This will allow civilian and military experts from the public and charitable sectors to work together, sharing experience and expertise and delivering appropriate evidence-based interventions in a culturally accessible and acceptable way. Plans are now well advanced for the model to be piloted at sites across the UK, including one each in Scotland and Wales. The pilots will run for two years and will be fully evaluated ahead of wider roll out.

37. We also have work in hand to ensure that Service leavers can recognise the signs of stress and know where to go for help, using suitable magazine-style material. In addition, the Government funds courses of care at Combat Stress facilities for those veterans whose condition is due to service and for whom this is an appropriate course. In 2005–06 this amounted to some £2.9 million.

Further Developments in Support to Operations

38. Details of further key developments in the provision of medical support to operations can be found at Annex D.

PROVISION OF HEALTHCARE TO THE ARMED FORCES—MAINTAINING HEALTH

39. Members of the regular Royal Navy, Royal Marines, Army and Royal Air Force have access to a wide range of medical and dental services at all times when they are not on operational deployment overseas. The range of services includes: Primary Medical Care; Dental Services (including dental hygiene); Secondary Medical Care in NHS hospitals; Overseas Healthcare; Rehabilitation Services provided by DMRC and the 15 RRU of the RCDM (see paras 22–24 above) and Community and Inpatient Mental Health Services (see paras 25–31 above).

Primary Medical Care

40. The MoD provides a range of Primary Care Services including medical centres located throughout the United Kingdom and Service base areas overseas. The size and “skill mix” of each medical centre varies depending on factors such as location and the size of the population served. The typical medical centre provides access to General Practitioners, Practice Nurses, Military Medical Assistants and Physiotherapists and Remedial Instructors. Some of these personnel will be uniformed DMS personnel and others will be civilian practitioners. The medical centres provide medical diagnostic and treatment services similar to those provided by a civilian medical practice, but they also provide occupational medical services, which is a major component of their activity. In the main, Service personnel have access to a medical centre on their unit or barracks but in some areas where the serving population is few in number, personnel will have access to the medical centre of another military unit.

Dental Services including Dental Hygiene

41. The DMS provide unit- and regionally-based dental centres in the UK and overseas base areas. These centres operate under the command of the Defence Dental Service (DDS). The DDS provides local access for serving personnel to Dentists, Dental Nurses and Dental Hygienists. These specialists provide routine diagnostic and treatment services, but also offer valuable occupational screening services ensuring that serving members of the Armed Forces are “dentally fit” to undertake their role.

Secondary Medical Care in the UK

42. Service personnel are entitled to secondary care from the NHS. In addition to local NHS access, the Ministry of Defence provides access to secondary care services at the NHS Trusts hosting MDHUs at UHBT where the RCDM is based. The MoD have agreements with the NHS Trusts (referred to as “Host Trusts”) in these areas, to provide accelerated access for elective referrals of Service personnel to meet operational requirements. The MDHUs are situated in areas with dense military populations so the trusts are ideally located to provide the required accelerated access.

43. The MoD has developed a specific musculo-skeletal fast track programme to meet the relatively high incidence of these disorders within the military environment. Unit-based General Practitioners and Physiotherapists can refer personnel to Multi Disciplinary Injury Assessment Clinics (MIAC) located at their local RRU to seek specialist opinion and treatment of musculo-skeletal injuries. This involves rapid

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6 Derriford, Frimley Park, Northallerton, Peterborough and Portsmouth.
access to assessment by multi-disciplinary teams, investigations (specifically MRI scan) and treatment, which includes physiotherapy, rehabilitation and orthopaedic surgery when clinically indicated. The latter has been very successful, enabling personnel to return speedily to operational fitness, thus reducing the burden on fit personnel, and enabling the MoD to meet its commitments. Further details on MDHUs are provided at paras 59–62.

44. The MoD also has contracts with some NHS Trusts and other organisations to provide specialist diagnostic, treatment and screening services in areas such as Cardiology and Cervical Cytology screening.

45. The Army is also responsible for the Duke of Connaught Unit in Belfast, a diagnostic and treatment facility providing access to secondary care services equivalent to those at MDHUs in mainland Great Britain.

Overseas Healthcare

46. Germany and Isolated Detachments (ISODETS). Medical support is provided by British Forces Germany Health Services (BFGHS) which comprises a partnership between MoD; Guys and St Thomas’s; DMWS and SSAFA; and the Defence Dental Service (DDS) who seek to provide seamless primary, community, secondary and tertiary care. Those aspects of primary and community care currently provided by SSAFA are in the process of being re-competed.

47. Hospital support is provided through Guys and St Thomas’s Hospital who subcontract with five German provider hospitals. These hospitals provide a service tailored to the requirements of UK patients and UK primary care (for example, providing an outpatient service, an additional evening meal, enhanced privacy and UK television). The Department of Health now funds tertiary care in Germany, obviating the need to return patients to the UK for this purpose.

48. BFG Health Services has also recently assumed responsibility for medical support to ISODETS and is currently scoping the local medical services being provided.

49. Permanent Joint Operating Bases (PJOBs). The Permanent Joint Headquarters (PJHQ) oversees the provision of primary, community, secondary and tertiary care for our Service population and their families in the PJOBs.

50. Primary Healthcare in all of the PJOBs is provided directly by PJHQ, using predominantly Service personnel.

51. Secondary Healthcare is provided locally, by the Princess Mary’s Hospital and the Royal Naval Hospital, in Cyprus and Gibraltar respectively. A variety of local civilian provider hospitals and UK-based NHS Hospitals are also used to access services that cannot be provided through MoD resources. The facilities are manned by a mixture of Service and civilian staff, the latter generally under UKBC contracts or as part of an arrangement with SSAFA. The DMWS also provides welfare support to patients in Cyprus.

52. For the remaining PJOBs (FIs, ASI and BIOT) there are no local MoD Secondary Healthcare facilities. Secondary Healthcare is therefore provided exclusively through either local civilian facilities or via UK-based NHS hospitals.

53. Land Overseas Bases. Primary and Secondary care is provided at LAND overseas bases through a variety of routes, depending on the location and size of the base. Primary care is provided by Medical Reception Stations, Medical Centres or local GPs. Dental Services are also provided for personnel locally. Secondary medical care is made available by local government hospitals, private clinics/hospitals or through referral overseas or back to the UK.

Veterans

54. When personnel leave military service their healthcare becomes the responsibility of the NHS. That has been the policy of successive governments since 1948.

55. War pensioners are entitled to priority NHS treatment for accepted disablements. This arrangement has been in place since 1953 when Ministry of Pensions hospitals were transferred to the NHS. Priority is decided by the clinician in charge and is based on clinical need. Regular reminders of the provision are sent out by the NHS Executive to Trusts and clinicians.

56. War pensioners are also entitled to free prescriptions for accepted conditions and are paid treatment allowance (ie reimbursement of lost earnings) and travel expenses for out-patient attendances in respect of accepted conditions. In addition, where there are patient costs under the NHS (eg dentistry, eye examinations or spectacles), war pensions funding is also appropriate.

57. There remains in war pensions legislation a discretion (Article 21 of the Service Pensions Order 2006) whereby any necessary expenses in respect of the medical surgical or rehabilitative treatment of accepted conditions, aids and adaptations for disabled living may be defrayed. However, no expenses can be defrayed where treatment, aids or appliances are provided for under other legislation of the UK. Essentially, this

7 Brunei, Nepal, Kenya, Canada and Belize.
discretion does not therefore apply to treatments which are the responsibility of the NHS. This power to meet the individual costs of war pensioners undergoing “remedial treatment” at homes run by Combat Stress is a long standing arrangement and predates clarification of the NHS responsibility.

Medical Discharges

58. Once personnel are identified as potential medical discharges, a comprehensive programme of resettlement assistance is given. That resettlement assistance lasts for the rest of the service leaver’s lifetime. The programme includes comprehensive advice on future employment and assistance in specific training for future employment. Advice can also be obtained on other regional matters such as schooling and housing.

Relationship with the NHS

Ministry of Defence Hospital Units (MDHUs)—Training DMS Personnel

59. The MoD took the decision in the mid 1990s to close military hospitals and open Ministry of Defence Hospital Units (MDHUs) within NHS hospitals after it had become clear that our existing military hospitals did not have sufficient patient volume or the range of military cases to develop and maintain the skills of our medical personnel. On average, the total number of military in-patients in hospitals across the UK is currently only about 60–75 for all illnesses and injuries, however sustained. Those kinds of numbers do not provide the kind of breadth of experience that our military doctors and nurses need to stay on the cutting edge of medical care. Neither does it make sense to bring together in one place such a small number of patients from all across the country.

60. At the MDHUs, Service medical personnel are integrated throughout the host NHS Trust, enabling them to maintain their clinical skills in an active, up-to-date environment, while also contributing to the NHS clinical capacity. This ensures that they retain their qualifications, allowing them to deploy quickly to areas of conflict, providing the essential medical support to frontline forces. Indeed, the vast majority of the Reserve medical personnel whom we deploy to operations are NHS employees. The training they gain in their NHS jobs is indispensable for ensuring the quality of the frontline care they help to provide. The role of the MDHU is to provide administrative, business and training functionality and they enable clinical staff to concentrate on honing their medical and military professional skills. It is precisely because of the success of the adopted model for training military medical personnel and providing care for our personnel in NHS hospitals, that we can deliver our excellent levels of medical care in the UK, overseas and on operations.

61. When the decision was taken to close military hospitals, it was originally intended to retain the Royal Hospital Haslar, primarily as a centre for training. But the required number and range of cases did not occur, and in December 1998 the Government announced its decision to phase out Haslar and consolidate training within the NHS, building on the establishment of the MDHUs. Since then, Haslar has undoubtedly continued to provide a first class service for the local community, but the medical needs of the Armed Forces are best served through access to facilities and training in a busy acute care hospital that is managing severe trauma on a daily basis. And the fact is that for many years Haslar has had nothing like the range of medical facilities and expertise that are found at a major trauma Trust hospital such as Selly Oak. In addition, Selly Oak offers much better links to the military airhead at Brize Norton, and a regional civilian airport that can handle our largest aircraft, within easy reach of the receiving hospital. That is why Selly Oak Hospital now acts as the primary receiver of overseas casualties.

62. Although it ceased to be a military unit on March 31, the Royal Hospital Haslar continues to be owned by the MoD and will continue to function, under a partnership arrangement with the Portsmouth Hospitals NHS Trust, until late 2009 when clinical services, along with both NHS and some military staff, will transfer to the redeveloped Queen Alexandra Hospital in Cosham, Portsmouth. Other military tasks currently retained at Haslar will be transferred to the RCDM and elsewhere. Until the hospital’s closure military doctors and nurses will continue to serve at Haslar, many of them as part of the Portsmouth MDHU. The MDHU will continue to play a major role for the foreseeable future in providing training for our medical people, as well as providing healthcare for both military and civilian patients. There will, therefore, continue to be a strong military medical presence in the Portsmouth area when Haslar eventually closes.

Royal Centre for Defence Medicine (RCDM)

63. RCDM opened in April 2001 as a centre of military medical excellence, with academic, teaching and clinical roles. RCDM, with its host UHBFT, provides a stimulating working environment for the DMS staff and an opportunity to develop academic ties with universities. Defence medical personnel gain valuable work experience primarily at UHBFT’s Queen Elizabeth and Selly Oak sites (although other hospitals in the Birmingham area are used for particular specialisms), and some work closely with the Universities of Birmingham and Central England and with other academic partners in research and teaching roles. Many of the DMS Nurses and Allied Health Professionals gain their professional qualifications through the academic courses provided at these universities. The Defence School of Health Care Studies is a unit of
RCDM. RCDM’s roles also include the provision of clinical feedback to operational areas, the development of clinical doctrine and the focus for curriculum design and development for clinical operational preparedness.

64. The Surgeon General’s vision for defence medicine in the 21st Century is for RCDM to develop into an internationally recognised centre of excellence for military medicine. This vision is being principally implemented through the Midland Medical Accommodation (MMA) project and the MoD’s close involvement in the Birmingham New Hospital Project.

65. The Midland Medical Accommodation (MMA) project is currently planned to bring together on one site the Headquarters of the Royal Centre for Defence Medicine (RCMD), the Headquarters of the Defence Medical Education and Training Agency (DMETA), the Defence Medical Services Training Centre, and 33 Field Hospital. The site will also provide living accommodation and facilities for military training and sports. Whittington Barracks, Lichfield has been selected as the preferred option to meet the requirement. The project is currently undergoing its Assessment phase which should be concluded around the end of this year. A “Main Gate” decision will then be taken on the major capital investment that would be involved. Assuming that the Lichfield site’s suitability is confirmed, redevelopment could be completed around the end of the decade.

66. The NHS Birmingham New Hospitals Project will replace the existing Queen Elizabeth and Selly Oak Hospitals, and will provide acute and mental health hospital services in South Birmingham. It is Birmingham’s first new hospital for nearly 70 years, and is scheduled for final completion in 2011. The main partners in the project are UHBFT and Birmingham and Solihull Mental Health Trust (BSMTH). Central to the development will be a 1,213-bed acute teaching hospital on the 50-acre Queen Elizabeth site. There will be 30 operating theatres, as well as specialist treatment units for angiography, CT scanners, ultrasound, MRI scanners, and fluoroscopy. The patient care and training elements of RCDM will form part of this main new hospital building under long term arrangements that have been concluded between the MoD and UHBFT. The new hospital will thus give the MoD access to some of the best medical “state of the art” facilities in Europe. We will take the Military Managed Ward (MMW) concept forward in our discussions with UHBFT to confirm our footprint in Birmingham’s new hospital. Options will be examined to see how we might resource an MMW of up to 32-bed capacity for the treatment of operational casualties and elective patients, where these can be brought together on clinical grounds. This would mean the ward would have military ward managers, and patients on this ward would be nursed by predominantly military personnel.

**Partnership Board**

67. The key outputs of the DMS are supported by a close working relationship with the NHS, supported by the MoD/Department of Health (DH) Partnership Board. A Concordat between the DH and the MoD has been in place since 2002, which sets out how the DMS and the NHS will work together to further their individual and mutual aims of delivering high quality healthcare to both the UK Armed Forces and NHS patients. The Concordat was extended in March 2005 to include the Health Departments of Scotland, Wales and Northern Ireland.

68. The MoD/DH Partnership Board meets three times a year to monitor the effectiveness of the Concordat and to explore mutual areas of co-operation. Its membership consists of representatives from MoD, the DH, the Health Departments of Scotland, Wales and Northern Ireland and NHS Trusts. Its work is supported by desk level liaison on a day to day basis to ensure the progress of Partnership board projects in between Partnership Board meetings.

**PROCESS/ORGANISATIONAL IMPROVEMENT**

**The Defence Health Programme**

69. The Defence Health Programme (DHP) is the performance management tool that enables the DMS to deliver the changes and improvements needed for it to continue to provide Service personnel with the level of health care support necessary to maintain their medical fitness for their operational role. The following key strands of work are being undertaken under the umbrella of the DHP:

(a) Director General Medical Operational Capability (DG Med Op Cap) Project. The principal achievement of the project to date has been the endorsement of the DMS regular uniformed manpower baseline (see Annex A) together with a number of recommendations for future work on manpower issues, including the Reserves. Additionally, a project report has now been produced which provides an assessment of the operational outputs (clinical, organisational and equipment) required of the DMS and their associated processes. During the same timeframe, a number of recommendations to further improve our capability in medical logistics have been identified. An integrated Implementation Programme is now in place to expedite the findings and recommendations of the DG Med Op Cap project and to take forward the recommendations of the uniformed medical manpower requirement work and the Medical Logistic End-to-End Review.

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8 Work carried out with Medical Stores Integrated Project Team on Medical Logistics.
(b) Leadership, Management And Governance Of The Defence Medical Services study. In parallel to the above project, DG Med Op Cap has also been tasked with reviewing the extent to which the DMS Top Structure is effective in delivering the two pathways of Medical Operational Capability and Healthcare. It has been decided that the Department will pursue the development of a “Joint Medical Service” manned by people recruited by the single Services to fill a joint medical manpower liability that is globally managed. A short study (the DMS Leadership, Management and Governance (LMG) study) is now taking place to determine how this restructuring will be delivered. The study will recommend the future functions, structure, leadership responsibilities and outputs of a Joint Medical Service, which builds on the currently agreed organisation of the DMS. The review is due to complete in summer 2007.

(c) Managed Military Health System. The MMHS Project was conceived within the Service Personnel plan to improve pan-DMS management and delivery of health and healthcare (medical and dental) to the Armed Forces and other entitled personnel. The project was concluded in Jul 06 and follow-on work to further develop the MMHS is now be undertaken as part of the Director General Healthcare’s routine work. The aims of the MMHS are to maximise the number of Armed Forces personnel Fit for Task; contribute to deployed Medical Operational Capability and improve morale in the DMS. The MMHS scope is limited to UK non-deployed personnel. However, many of the changes expected from it will beneficially impact on Health and Healthcare provision across the MoD including the overseas Commands. The project has already delivered a number of significant improvements through the development of the Fast-Track treatment regimes, rehabilitation and the provision of Mental Health Services (see above). Further work is now underway to:

1. Develop enhanced Primary Care services (General Practitioners with Special Interests and Advanced Nurse Practitioners)
2. Implement patient Care Pathway tracking across Defence Primary Health Care
3. Implement common processes and standards
4. Develop Performance Management processes and structures
5. Expand our Healthcare capabilities and capacities to meet need.
6. Develop relationships with the Department of Health and the NHS
7. Implement connectivity between the MoD and NHS ICT services
8. Put in place the MoD response to the Governments initiatives on Health.

(d) Defence Medical Information Capability Programme (DMICP). DMICP is a major IS-enabled business change programme. It will provide an integrated healthcare information system across the DMS, and will also link to the NHS’s major new National Programme for IT. The roll-out of the system to pilot UK sites started earlier this year. It should be available in all fixed medical and dental centres in the UK and Germany by mid-2008. DMICP will provide an integrated Health Record—including both medical and dental data—for all members of the Armed Forces. This will promote improved medical treatment by enabling medical staff worldwide to have immediate access to a complete, up to date Health Record at the point of treatment. The system will also link electronically with the NHS from 2010, which will bring benefits for Armed Forces patients receiving secondary care in NHS hospitals. The programme will bring improvements to patient management, enabling improved appointment booking for both primary and secondary care. A deployed version of the system will be available from late 2008 to medical staff on operations. The system will also improve information handling, and provide a range of data about health patterns in the Armed Forces, as well as health information on forces about to deploy. The system has been designed with confidentiality controls to ensure that only medical staff with a legitimate relationship with the patient have access to a health record.

Annex A

MANNING IN THE DEFENCE MEDICAL SERVICES

1. To date the Defence Medical Services have met all the operational requirements placed on them and while shortfalls exist they have never resulted in the Defence Medical Services being unable to meet its operational commitments. Overall, manning levels within the Defence Medical Services are rising (see figures below). However, we acknowledge that manpower shortages remain a problem, especially in some key specialties like Accident & Emergency, Anaesthetics and General Practice. We are taking active steps to address the shortfalls, through a range of pay and non-remunerative initiatives including:

(a) Working to ensure pay remains comparable with the NHS;
(b) Managing medical deployments on a tri-Service basis allowing the work load to be shared more evenly and maximising capabilities;
(c) Prioritising resources to support operations;
(d) Establishing alternative means of meeting operational commitments to reduce overstretch (eg use of Reserves and civilian agency contractors and working closely with Allies on operations).
(e) Payment of “Golden Hellos” to direct entrants into specialist areas where there is greatest shortfall.

(f) Payment of FRI to encourage nurses in operational pinch point specialties to return to and remain in specialty.

(g) Continued development of Military career pathways. For example, we are implementing the Defence Nursing Strategy to enhance the career pathway for military nurses. As part of this initiative, Defence Specialist Nursing Advisors have been appointed for each specialism, to plan and manage recruitment and retention in their own specialism.

(h) Encouraging personnel to train and remain in operational pinch point specialties.

2. On 27 March 2007, the Under Secretary of State announced the introduction of an improved military medical manning structure following a review of the DMS manpower requirement. The review analysed lessons learned from recent operations to establish a credible baseline on which the DMS can base its planning and ensure that the excellent level of healthcare which it provides both on operations and, in collaboration with the NHS, in peacetime, is sustained into the future.

3. One of the reasons for the changes is to reflect advances in military medicine that enable us to save more seriously injured battlefield casualties. They also reflect the changing roles of our Field Hospitals, which are now smaller but better equipped to stabilise patients before their return to the UK for further treatment. When the requirement was previously set, single-Services generally operated on their own. Increasingly, medical personnel are operationally deployed on a tri-Service basis, which shares the workload more evenly and maximises capabilities.

4. The overall result of this work is that the uniformed manning requirement for medics has now been set at 7,573 posts, supported by a training and manning margin of 678, giving a grand total requirement of 8,251. This compared to a previous requirement of 8,970, set by the Strategic Defence Review eight years ago, which did not separately specify a supporting training and manning margin.

MEDICAL TREATMENT FACILITIES ON OPERATIONS

1. The DMS plans to provide a seamless continuum of medical support encompassing preventative medicine, evacuation, primary, secondary and tertiary care. For UK personnel on deployed operations this is delivered via three echelons of medical treatment facility: Role 1, which is integral to the Force elements and provides primary health care and the initial management of combat casualties which might involve initial resuscitation and preparation for evacuation; Role 2 which will deliver reception and triage of casualties, damage control surgery when required and the care necessary to ensure survival to hospital; and deployed Field Hospitals (Role 2 (Enhanced) and Role 3) providing, among other things, emergency medical care, diagnostic support, primary surgery and hospitalisation.

2. In Iraq, facilities include the Battle Group Role 1 facilities, as well as two fixed Role 1 facilities supporting personnel in Basrah Palace and Contingent Operating Base (COB) and a Role 2 (Enhanced) deployed Field Hospital at the COB in Basrah. In addition to the Hospital Squadron, the UK Med Gp also includes elements of a Medical Regiment providing close medical and evacuation support to operations. RAF personnel provide Forward, Tactical and Strategic aeromedical evacuation. In Feb 2007 the Defence Medical Service were deploying some 372 staff in Iraq.

3. In Afghanistan the UK has: ten Role 1 facilities supporting fixed locations the Manoeuvre Operation Groups (MOG) and the Operational Mentoring and Liaison Teams (OMLT); and a Role 2 (Enhanced) Field Hospital at Camp BASTION in Helmand Province. Evacuation of casualties is supported by Medical Emergency Response Teams and RAF personnel delivering Forward, Tactical and Strategic Aeromed, including a theatre specific Critical Care Air Support Team and an Air Staging Unit. The Multi-National Headquarters of the ISAF Regional Command (South) in Kandahar (currently UK lead) maintains a Multi-National Role 3 Field Hospital, which provides hospital care for coalition personnel. In Feb 2007 the Defence Medical Service were deploying some 247 staff to support the operation in Afghanistan.

Collaboration

4. UK medical support continues to be augmented by coalition partners under a process of burden sharing utilising bilateral, trilateral and multi-national agreements. In both Iraq and Afghanistan, collaboration occurs in several ways: mutual use of treatment facilities, embedded staff and liaison officers, Multi-National Field Hospitals and sharing of evacuation assets to transfer patients from theatre. At Kandahar, the Field Hospital is currently led by the Canadians with the UK, Dutch and Danish in support.
In Kabul, UK personnel have access to either the Czech or Greek Role 2 facility. A Czech surgical team was embedded in the UK Field Hospital in Iraq for two years. In Iraq and Afghanistan, UK personnel also use United States’ facilities. The United States can also evacuate UK casualties to Ramstein in Germany, should it be required. However UK strategic aeromedical evacuation and the UK aeromedical Critical Care capability have proved reliable, resilient and responsive.

Defence Medical Welfare Service

5. The Defence Medical Welfare Service (DMWS) has provided hospital based welfare support to Service patients at home and overseas since 1943.\(^9\) It is currently based in the MDHUs, RCDM, Germany and Cyprus and is deployed on operations in Iraq and Afghanistan. Its prime purpose is to address the welfare needs of patients admitted to hospital and to refer on to appropriate agencies those who will need prolonged welfare support.

Annex C

REGIONAL REHABILITATION UNITS (RRU) END OF YEAR RESULTS:
1 APRIL 2006–31 MARCH 2007

1. The Table below shows the number of new cases that have actually attended the RRU assessment clinics in Year 3 and the accumulative total for year for the 3 years.

<table>
<thead>
<tr>
<th>Outcomes Year 3 (1 Apr 2006–31 Mar 2007)</th>
<th>Accumulated Total for 3 Years (1 Apr 2004–31 Mar 2007)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients Assessed</td>
<td>7,168</td>
</tr>
<tr>
<td>Physio/rehab only</td>
<td>5,766</td>
</tr>
<tr>
<td>Referral to Fast Track Ortho surgery</td>
<td>705</td>
</tr>
<tr>
<td>Number of these discharged from rehab</td>
<td>10,254</td>
</tr>
</tbody>
</table>

2. The following specific benefits of RRUs have been noted at the time of in the 2007 End of Year Results.

   (a) 80%+ of patients successfully treated by physio/rehab alone
   (b) 10% only required accelerated access to fast-track orthopaedic surgery.
   (c) In the past all of these patients would probably have been referred to orthopaedic surgeons and/or DMRC with long waiting times to be assessed and treated.
   (d) Over 10000 patients have been discharged, the vast majority fully fit for task. This figure will always lag behind those assessed as rehab takes time to complete successfully.
   (e) The development of the RRU Programme has permitted DMRC to focus on the more complex rehab cases, including amputees and neuro-rehab for brain injured patients.

Annex D

FURTHER DEVELOPMENTS IN MEDICAL SUPPORT TO OPERATIONS

Deployed Capability

1. The Maritime Role 3 Medical Capability (MR3MC), or Joint Casualty Treatment Ship (JCTS) is a proposed (2020 timeframe) replacement for the Primary Casualty Receiving Facility (PCRF)—a capability of RFA Argus, which delivers secondary healthcare and primary surgery in an afloat hospital environment. RFA Argus entered Service in 1990. It was upgraded substantially prior to the 2003 Iraq conflict, where it was deployed in support of operations afloat and ashore.

2. Work on Improving Medical Support to a Brigade (IMSB) will deliver, by 2011, a rebalanced Army Medical Service to provide support at Brigade rather than Divisional level in line with defence policy which requires the DMS to move routinely to a medium scale of effort. It will deliver five Medical Regiments each to support an Armoured or Mechanised Brigade, and two hybrid Medical Regiments (V) to provide to Logistics Brigades. One specialist Medical Regiment for 16 Air Assault Brigade and one Divisional Medical Regiment (V) will be retained. Deployed hospital care will be provided by a Force Support Hospital (FSH) or a number of Close Support Hospitals (CSH), depending on the scale of effort.

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\(^9\) The MoD’s current contract with the DMWS was awarded in 2001.
3. There have been major equipment enhancements to our deployed Field Hospitals. For example, a CT scanner has been deployed since 2004 in Iraq. A second scanner, deployed to Afghanistan, has reached initial operating capability and is due to be declared fully operational in May 2007 once a satellite link is established. It is considered that the deployment of CT scanners will be the norm for future enduring operations.

4. In the near future Role 1 and Role 2 (Light Manoeuvre) facilities deploying on operations will undertake pre-deployment validation training and audit. This is in line with best practice for Role 3 and Role 2 (Enhanced) Pre-Deployment Training.

5. A full review, by Defence Consultant Advisors, of all medical modules will be conducted in May 2007.

**First Responder Level**

6. In 2005 and 2006 several enhanced haemostatic products (designed to stop catastrophic blood loss) were successfully introduced in Operational Theatres. The urgent introduction of these products; HemCon®, QuikClot®, CAT® tourniquet and the new FFD, as well as the Team Medic capability, have already been attributed with saving over three lives by 2006. More recently the introduction of Intra-osseous Needles, Javid Vascular Shunts and Improved Pelvic Splintage are part of the continued rapid application of emerging capabilities into current operations.

**Additional Support**

7. DMS has led the UK in the introduction of telemedicine; in support of operations, land-based and maritime, and in support of our permanent deployments overseas. The DMS Telemedicine Unit has received national awards,

**Defence Medical Research and Training**

8. The RCDM Academic Division has expanded within the Birmingham Research Park to accommodate a new Defence Professor of Nursing and enlargement of the new Defence Professor of Surgery’s department.

9. Initial work on military trauma patients commenced in 2003 at Frimley Park. A trauma nurse coordinator and database were set up at RCDM in 2005, giving on- the-spot audit of trauma cases and looking at trends to inform best practice.

10. The RCDM Academic Department of Emergency Medicine was awarded the Hospital Doctor “Training Team of the Year Award” in 2006. The Team was led by Colonel Tim Hodgetts, “Individual Hospital Doctor of the Year”.

11. Sergeant Rachel McDonald, A Royal Air Force Paramedic has been awarded the “Paramedic of the Year Award 2007” by the Ambulance Services Institute.

12. Prof Keith Porter took up his Honorary Chair in Traumatology at the University of Birmingham (2006) and moved into the RCDM facilities at the Birmingham Research Park.

16 May 2007

<table>
<thead>
<tr>
<th>Harmony Targets</th>
<th>Separated Service</th>
<th>Tour Lengths</th>
<th>Tour Intervals</th>
<th>Maximum Separated Service Targets Calculated over a Period of 12 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Navy</td>
<td>In any 36 month period no one to exceed 660 days</td>
<td>Max 6 months</td>
<td>No more than 60% of time deployed in 3 years</td>
<td>220 days</td>
</tr>
<tr>
<td>Army</td>
<td>In any 30 month period no one to exceed 415 days</td>
<td>Max 6 months</td>
<td>24 months</td>
<td>166 days</td>
</tr>
<tr>
<td>RAF</td>
<td>In any 12 month period no more than 2.5% of personnel to exceed 140 days</td>
<td>Max 4 months</td>
<td>16 months</td>
<td>140 days</td>
</tr>
</tbody>
</table>
Memorandum from the British Medical Association

EXECUTIVE SUMMARY

— The Defence Medical Services (DMS) show a severe shortfall of 55%\(^{10}\) for trained Medical Officers.

— DMS doctors deliver high quality medical care to British military personnel working in challenging environments, yet they typically earn less than their NHS colleagues.

— The current constraints on the UK medical workforce are magnified for the DMS, given certain restrictions on recruitment within the wider workforce.

— There is a need to retain DMS Medical and Dental officers to support manning levels and operational capability.

— It is also important that pay levels between NHS and DMS doctors are comparable, to avoid an exodus of DMS doctors to the NHS.

ABOUT THE BMA AND THE ARMED FORCES COMMITTEE

1. The British Medical Association (BMA) is an independent trade union and voluntary professional association which represents doctors from all branches of medicine all over the UK. It has a total membership of over 138,000.

2. The Armed Forces Committee was established by the BMA “To consider matters relating to the medical branches of the armed forces and the medical branches of the reserve armed forces and so far as possible to ensure that medical officers serving in the medical branches of the armed forces are not disadvantaged in relation to their civilian counterparts.” The main focus of its work has traditionally been the production of evidence to the Armed Forces Pay Review Body. The committee also represents civilian doctors working for the defence medical services

MORALE

3. In its Supplement to the Thirty-Fifth Report 2006, the Armed Forces Pay Review Body acknowledged that continuing commitment to operational medical support, compounded by specialty shortages, resulted in a high rate of deployment would have a detrimental impact on retention.\(^{11}\) The DMS are currently involved in a greater degree of active service than many would have foreseen a few years ago and two in five respondents to the BMA Tripartite Cohort study of doctors\(^{12}\) reported that this had weakened their desire to serve in the Services.

MANNING LEVELS

4. Current DMS manning levels are significantly below requirements, with a severe shortfall of 55%\(^{13}\) against the total requirement (1080) for trained Medical Officers.\(^{14}\) It is acknowledged that shortages are most severe in specialty areas crucial to operational capability.

5. Table 1 indicates the manning levels in specialty areas as at April 2006 and shows that these deficits are greatest in anaesthetics, general medicine, surgery, pathology, A&E and psychiatry. The deficit of GMPs across the three Services is 34%\(^{15}\). These shortfalls must be seen in the context of continued shortages in NHS consultants and GMPs. Continued overstretch and increased operational tempo mean that DMS medical officers in specialties experiencing shortages will continue to face a high rate of deployment. This in turn will impact on the retention of medical officers in these specialties.

\(^{10}\) Thirty-sixth Supplement of the AFPRB Report 2007.
\(^{12}\) Health Policy and Economic Research Unit. BMA Tripartite Cohort study of doctors in the DMS, 2006, BMA: London.
\(^{13}\) Thirty-sixth Supplement of the AFPRB Report 2007.
\(^{14}\) Thirty-sixth Supplement of the AFPRB Report 2007.
\(^{15}\) Thirty-sixth Supplement of the AFPRB Report 2007.
Table 1

TRI-SERVICE REQUIRED MANPOWER AND DEPLOYABLE DMS DOCTORS ACCORDING TO SPECIALTY SHORTAGES, APRIL 2006

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Total Requirement</th>
<th>Trained strength*</th>
<th>Deployable trained strength**</th>
<th>Shortfall (%)***</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medical Practitioner</td>
<td>410</td>
<td>260</td>
<td>150</td>
<td>36</td>
</tr>
<tr>
<td>Dental Officer</td>
<td>290</td>
<td>260</td>
<td>150</td>
<td>10</td>
</tr>
<tr>
<td>Anaesthetists</td>
<td>90</td>
<td>48</td>
<td>42</td>
<td>47</td>
</tr>
<tr>
<td>General Surgeons</td>
<td>42</td>
<td>18</td>
<td>12</td>
<td>57</td>
</tr>
<tr>
<td>General Physicians</td>
<td>29</td>
<td>13</td>
<td>6</td>
<td>55</td>
</tr>
<tr>
<td>Accident &amp; Emergency</td>
<td>29</td>
<td>13</td>
<td>10</td>
<td>55</td>
</tr>
<tr>
<td>Psychiatrists</td>
<td>27</td>
<td>13</td>
<td>9</td>
<td>52</td>
</tr>
<tr>
<td>Orthopaedic Surgeons</td>
<td>28</td>
<td>19</td>
<td>16</td>
<td>32</td>
</tr>
<tr>
<td>Pathologists</td>
<td>13</td>
<td>4</td>
<td>3</td>
<td>69</td>
</tr>
<tr>
<td>Aviation Medicine</td>
<td>16</td>
<td>11</td>
<td>6</td>
<td>31</td>
</tr>
<tr>
<td>Rheumatology and Rehab</td>
<td>7</td>
<td>4</td>
<td>2</td>
<td>43</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>100</td>
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* The number of qualified officers in a particular specialty. Not all will be deployable in their specialty as they may be medically downgraded or working out of specialty.

** The number of officers who, as of 1 April 2006, were able to deploy in their specialty.

*** Measuring trained strength against requirement.

Retention

6. Retention of DMS doctors is critical and must be addressed as a priority. Evidence from the BMA Tripartite Cohort study of doctors17 highlights this issue, whereby only a quarter of respondents reported that they would continue on or transfer to a full career commission, whilst a further quarter reported that they intended to work in the NHS and/or private practice. Few reported extending their commission for three years or taking an intermediate service commission.

7. Morale and motivation is a key factor in the retention of doctors in the DMS. Separation from family and the impact of a career in the Services on family life were the main factors cited by respondents to the BMA Tripartite Cohort study as influencing their morale to the extent that they would or have considered leaving the Services. Results from the National Audit Office (NAO) study of recruitment and retention in the Armed Forces shows that the impact of Service life on family life and the ability to plan life outside of work are key drivers in the decision to leave the Services.

8. According to the NAO, whilst a degree of separation from home and family life is expected in the Services, substantial numbers of personnel have exceeded “harmony guidelines” within their respective Services on the maximum time personnel should spend away from home so as to achieve a sustainable balance between time away and time at home. Whilst this varies according to each Service, evidence shows that the extent to which personnel in Army pinch-point trades have breached individual harmony guidelines includes general surgeons (21%) and GMPs (6%).18

9. Results from the NAO study19 also show that the majority of serving personnel in pinch point trades felt that pressures on their time when not deployed had increased in the last few years and this may be indicative of a rising level of dissatisfaction with service life or the worsening of Service life conditions. This will impact on the longer term retention of DMS doctors.

Flexible Working

10. Increasingly women make up a greater component of the medical workforce, and improving opportunities for flexible working practices and balance between professional and family lives is required in response. Feminisation of the medical workforce will increasingly impact on the DMS as women now account for around a third of DMS medical and dental officers. We await the outcome of the MoD’s work in this area (Project 22).

16 Data supplied by the MoD—Manning figures as at 1 April 2006 from D Med Op Cap. The table shows total requirement for each specialty set against the number of officers who as of 1 April 2006 were able to deploy in specialty.


11. Changing aspirations of doctors, along with a greater acceptance that part-time working is a reasonable option for a whole variety of personal reasons, will mean greater numbers of part-time and flexible posts will be needed if doctors are to be retained in the DMS. A key factor in the morale and motivation of doctors is achieving an acceptable work-life balance and consequently more doctors are choosing career paths which allow greater flexibility and the ability to combine professional and domestic commitments. Increasingly, the desire for flexible working arrangements will impact on the morale and motivation of DMS doctors.

12. Retention of DMS doctors, particularly those with longer experience approaching mid career is of concern. An important reason for leaving the Services is reportedly the availability and increasing attractiveness of civilian employment in the NHS.

RESERVISTS

13. The DMS relies heavily on the contribution made by Reserves to our Armed Forces. Reservists serve alongside their Regular colleagues on operations, and they are vital to our ability to expand our forces in times of crisis. The continued increased operational tempo in the DMS and a smaller cohort of Regular DMS personnel who are deployable means a greater reliance upon Reserve Medical and Dental Officers in maximising operational capability. However, the Reserves also suffer manpower shortages, which will in turn contribute to overstretch. Retention and improving morale of Reserves is therefore crucial.

14. The main burden of support to the Regular forces has fallen on the Territorial Army (TA) and the ongoing mobilisation of volunteer reserves of all branches has resulted in a considerable net loss to the TA, which currently is at its lowest strength ever. Although this outflow has particularly affected non medical units, there is some evidence that medical units are increasingly facing retention problems.

15. The impact of active service upon the morale and retention of Reservists needs to be carefully evaluated if this strategy is to be sustained in the longer term. Recruitment may be adversely affected by not only the unwillingness of individuals to serve, but also the attitude of their employer. NHS employers are increasingly commercially oriented and target driven organisations, and are more likely, given the choice of two equal candidates for a consultant post, to appoint the candidate with no reserve liability.

16. Similar remarks can be made for NHS general practitioner appointments; unless existing partners are sympathetic to the concept of reserve liability, it will often be considered a handicap and a disincentive to recruit. NHS GP partnership agreements generally mention reserve liability and, for the practice, the need to cover the absence of deployed colleagues can represent a major financial commitment. These situations are driven again by the medical workforce shortage coupled with the severe lack of contingency capacity in most NHS organisations and general practices.

SATISFACTION

17. Satisfaction with overall career management is a further issue impacting on the morale and motivation of DMS doctors. Although half of respondents to the BMA Tripartite Cohort study were generally satisfied with working for the DMS, only two in five respondents were satisfied with their overall career management.

15 May 2007

Memorandum from the General Medical Council

INTRODUCTION

1. The General Medical Council (GMC) welcomes the opportunity to assist the Defence Select Committee in its inquiry into medical care for the armed forces.

2. All doctors working in the armed forces must be registered with the GMC to practise and we have taken the opportunity provided by this inquiry to clarify our role in this area and also where we have a role in the education and training of doctors. The GMC is not, however, responsible for the delivery of healthcare in the UK or healthcare provided overseas within the armed forces.

3. The purpose of the GMC is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine.

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4. The Medical Act 1983 gives us four main functions which are:
   — keeping up-to-date registers of qualified doctors;
   — promoting high standards of medical education;
   — fostering good medical practice; and
   — dealing firmly and fairly with doctors whose fitness to practise is in doubt.

5. Our governing body, the Council, has 35 members consisting of 19 doctors elected by the doctors on
   the register, 14 members of the public appointed by the NHS Appointments Commission and 2 doctors
   appointed by educational bodies—the universities and medical royal colleges.

SUMMARY

6. In accordance with the Medical Act 1983, doctors in the armed forces must be registered with the GMC
   if they wish to practise medicine.

7. All doctors are required to hold full registration with the GMC in order to be able to carry out
   unsupervised medical practice in the NHS or private practice in the UK. This requirement includes those
   doctors working within the armed forces. To obtain full registration, doctors must hold a medical
   qualification registrable with the GMC and have undertaken at least twelve months in a recognised training
   post. This training can be undertaken in the armed forces.

8. All registered doctors are required to practise in accordance with the principles set out in Good
   Medical Practice. These principles are the same for all doctors regardless of their place of work.

9. Doctors working in the armed forces are also subject to the same fitness to practise processes of the
   GMC as their colleagues working in the NHS.

REGISTRATION AND EDUCATION

10. The Medical Act 1983 requires doctors holding appointments in the naval, military or air service to
    be fully registered with the GMC.

11. A doctor whose undergraduate medical education takes place in the UK needs the experience
    described in the GMC’s recommendations on general clinical training, as set out in The New Doctor (2007).
    We also quality assure the delivery of undergraduate medical education.

12. On first graduating, new UK qualified doctors are eligible for provisional registration. They must
    complete 12 months provisional registration before becoming eligible for full registration.

13. Most doctors graduating in the UK undertake a two year Foundation Programme immediately after
    graduation. Doctors in the first year of this programme are often referred to as F1 (or FY1) trainees, doctors
    in the second year as F2 (or FY2) trainees. Doctors, including those serving in the armed forces, with
    provisional registration may be employed in F1 posts in hospitals or other institutions that have been
    approved by the universities, including the armed forces, for the purpose of Foundation Programme
    training.

14. The Defence Medical Services have a number of Foundation Training Programmes based in the
    Ministry of Defence Hospital Units (MDHU) within NHS Host Trust Hospitals (in Northallerton,
    Peterborough, Frimley Park, Portsmouth and Derriford). These posts are fully integrated into foundation
    training, carry full educational approval and deliver the required competencies of the Foundation Training
    Programme. Cadets selected for an MDHU placement undertake the full two year programme at the
    MDHU facility. These programmes would fall within the GMC’s quality assurance programme for F1
    medical training.

15. The GMC is aware that its quality assurance processes will include doctors who will work in military
    environments. Our quality assurance visitors include a medical officer now serving in the Royal Army
    Medical Corps who is currently engaged in the GMC’s process for quality assuring the foundation
    programme and has previously worked for one of the teams quality assuring medical schools.

STANDARDS AND FITNESS TO PRACTISE

16. The outcome of military tribunals and courts marshal, which suggest that a doctor’s fitness to practise
    maybe impaired, should be notified to the GMC.

REVALIDATION FOR ALL DOCTORS

17. Revalidation, which can be defined as the periodic evaluation of a medical practitioner’s fitness to
    practise, is a policy which has been advocated by the GMC and has been endorsed in the recent White Paper,
    Trust, Assurance and Safety—The Regulation of Health Professionals in the 21st Century. The White
    Paper, which was published on 21 February 2007, gave further details about what revalidation would
    include.
18. It is proposed that revalidation will have two core components of (relicensure the process of renewal of a licence to practise) and recertification (which is the process by which specialists will demonstrate that they continue to meet the particular standards that apply to their specialty).

19. Our approach to revalidation is likely to take account of the type of environments within which doctors are working. Where doctors are practising in environments which provide effective appraisal and governance systems, these systems should be capable of generating much of the evidence necessary for doctors to revalidate. We have enjoyed a positive working relationship with the armed forces as we consider in detail how this approach will work for this group of doctors.

_18 May 2007_

**Memorandum from University Hospital Birmingham NHS Foundation Trust**

Thank you for inviting University Hospital Birmingham NHS Foundation Trust (UHBFT) to submit evidence to your enquiry. I enclose a report and I am pleased that we will be able to discuss these issues with you more fully during your visit to Birmingham. If you would like any further information ahead of your visit, please do not hesitate to contact me. I would like here to provide a brief overview of the contract and recent events.

The contract to base the Centre for Defence Medicine in a major teaching hospital was entered into for the following reasons:

- The increasing specialisation of medicine means that only a major teaching hospital has the range of specialist services and staff to provide the education and experience for the military clinical staff.
- Much evidence exists to show that all patients do better in terms of survival and recovery if treated in a specialist centre by specialist staff.
- Major University Teaching hospitals have the expertise to support the research aspirations of the defence medical services.

The number of military patients meant that a stand alone military hospital of sufficient size could not be sustained by such a small population base. In addition, the small volume of patients was not sufficient to enable comprehensive education and training of the military clinical staff.

Since the agreement commenced in 2001, partnership working has grown and strengthened and is highly valued on both sides. Feedback has been received that the training given to military staff when deployed at UHBFT has enabled them to provide much better care to the injured when deployed to areas of conflict. The knowledge they have acquired whilst at UHB about treatment available at UHBFT has also allowed care on the frontline to preserve and maintain function prior to the patients being transported back.

Furthermore, the nature of injuries being seen now in the injured troops has not been seen in the UK for decades and the level of expertise in the UK in treating such injuries has declined with lack of exposure. However, at UHBFT, the civilian and military clinicians together have now developed a significant level of expertise in treating such injuries. They are now undertaking extremely sophisticated surgery and procedures to preserve and restore function in severely injured military casualties. It is doubtful that this level of expertise exists in many other institutions in the UK.

To achieve this level of specialised treatment requires that the injured military staff are treated in the appropriate clinical environment, eg, burns patients in the burns unit, neurosurgical injuries in the neurosurgical unit. Indeed the contract specifically asked for any military casualties to be treated in the appropriate area and not in one specific ward. Similarly, to ensure that the military clinical staff received the most appropriate experience, they were to be deployed within the hospital to different clinical areas and not be deployed on one ward.

Initially, there was a military managed ward to enable the military staff to gain and maintain experience in clinical management. This was a mixed sex general surgical ward (not trauma). This arrangement ceased on deployment of the majority of the ward staff with 24 hours notice at the start of the Afghanistan operation. Since that time the military had not managed a ward within UHBFT.

We have now been asked to have a military managed ward (ie senior nurse in charge is a military nurse) and the military preference is that this is the trauma ward where most of the injured soldiers are cared for. We have agreed to this and are working with the military to achieve this. The limiting factor is that the military did not have a nurse with the required skills and sufficient seniority to manage a ward. Over recent months we have been working with the military to train someone to assume this function. The military also did not have enough nurses to staff the ward and will not reach the required numbers to have a 70% staffing level (remaining 30% NHS staff) until July 2007.

Whilst there were inevitable teething problems and refinements to be made to the partnership, it has been extremely successful in delivering its objectives of education and training of the military clinical staff and providing specialist care for military personnel.
However, this was the contract to operate in peacetime not in times of conflict or war. For periods of conflict with increased numbers of injured casualties, a plan for the entire NHS to be involved in the treatment of the injured would come into play. This plan was initially called Joint Casualty Reporting and Reception Plan (JCRRP) and in 2002 was refined into Reception Arrangements of Military Personnel (RAMP). It was never envisaged that UHBFT would take all casualties from areas of conflict or war. RAMP has only been called into play once in 2003. With this one exception, UHBFT has taken all casualties sent back from both Afghanistan and Iraq.

This may be for a variety of reasons. There is a strong belief within the military that casualties should be sent to UHBFT. Aeromedical staff prefer to transfer to UHBFT where this is a regular occurrence and the staff are familiar with the process. Military doctors in Afghanistan and Iraq prefer the injured to return to clinical staff that they know and trust. The staff have also taken great pride in the care given to the military patients and have taken great efforts to create the capacity to ensure that the casualties can be admitted at UHBFT.

However, the partnership has been placed under tremendous strain by the recent negative press coverage and a lot of the goodwill that allowed UHBFT to continue to take all the casualties, has evaporated.

With hindsight, although there were excellent clinical reasons for the contract to be as it is, I believe that this was not communicated to senior non-clinical military officers and associated personnel, who expected to find all injured soldiers in one ward being cared for solely by military personnel. During several conversations with very senior military officers, they have admitted that this was the case, that they did not understand the nature of modern medicine and the increasing specialisation of medicine and the need for specialist care. I think that this is now understood.

I acknowledge that there are some things that could have been improved and where these have been brought to our attention, we have done so immediately. I certainly agree that the physical environment for all our patients is less than ideal as our current buildings are in excess of 70 and 100 years old. We are building a superb new hospital on track to open in 2010 and we are pleased that the RCDM is part of this development.

My concern is that these debates were played out in the press rather than by considered discussion between those concerned and senior hospital staff. This sustained negative press campaign has had a significant demoralising effect on clinical staff, NHS and military. I am sure it has affected the morale of deployed troops and their families and it has certainly affected our reputation with our own population and patients. In the report, there are details of the amount of press attention that we have had over this issue.

There are positive aspects to this however, in that I am now certain that senior military officers understand the nature of specialist healthcare and why military hospitals could not provide this. Furthermore, relationships between senior military officers and senior UHB personnel have now been established enabling speedy communication of concerns and resolution of issues.

18 May 2007

Memorandum from the Royal British Legion

Thank you very much for the invitation to take part in the Defence Committee’s inquiry into medical care for the Armed Forces.

We very much look forward to the results of the forum that you launched in April, and hope that the exercise will provide you with some valuable first-hand information. We would like to submit the following written evidence:

1. Transferring to the NHS—with regard personnel and families returning from overseas postings, and those being discharged from the military, more needs to be done to manage the transfer of medical care and the expectations of individuals. Many of the issues in this area seem to stem from the change from private/public or “medicare” health systems that operate overseas, and in-Service health care arrangements, to the NHS. There is little that the Ministry of Defence (MoD) can do to improve services in the NHS, or the administrative requirements to register with GPs. However, there is room for progress toward a seamless transfer of health care, particularly at medical discharge, and more that can be done to manage the expectations of individuals.

2. Healthcare for those on operations—the current survival rates for those who have injured in the course of active operations are very impressive. The evidence suggests that more people than ever before are surviving very serious and complex injuries on the battlefield. The efforts of field hospitals should be applauded.

3. Healthcare for those evacuated to the UK—the media criticism on this issue has been relentless. We believe that was cause for serious concern during the first few years of the conflicts in Afghanistan and Iraq. The main areas of concern related the lack of a military environment, security for patients and welfare support of both patients and their families at the Royal Centre of Defence Medicine (RCDM).
And, the Ministry of Defence (MoD) have responded to concerns raised by charities and the general public, including the newly introduced Military Managed Ward, improvements to security arrangements and additional welfare staff. These developments are welcomed.

Areas that we believe still need to be addressed include travel costs and further accommodation for families at both RCDM and Defence Medical Rehabilitation Centre (DMRC). We have been told that a charity supplied both furniture and leases for families’ accommodation at DMRC over the Christmas period—because funding could not be found within the MoD. We have also been informed that funding is not currently available for personal items (such as clothes, shoes and toiletries) for military patients at RCDM. These items are currently being supplied by a benevolent organisation.

The NHS Foundation Trust in Birmingham is currently taking forward plans to build new hospital facilities. We believe that the MoD should be planning for the best possible treatment solutions for military personnel. Priority should of course be given to clinical excellence, but the importance of a military environment should not be overlooked.

4. Mental Health services with the Armed Forces—we believe that there is a current shortage in number of psychiatric clinicians within the Armed Forces. Health surveillance being carried out by King’s College London has not yet shown an increase in mental health problems for Regular serving personnel. However, anecdotal evidence from the mental health charity Combat Stress suggests mental health problems, such as Post Traumatic Stress Disorder (PTSD), are often presented late. The number of vacant posts for psychiatric clinicians within the Armed Forces should be considered within the inquiry. The need for further efforts to reduce the stigma attached to mental health problems within the Services should be highlighted.

One issue that the health surveillance being carried out by King’s has brought to light, is the heavy drinking culture that exists within the Armed Forces; particularly among younger members. Alcohol is often used to cope with, and can mask, mental health issues. We do not believe that the MoD is currently doing enough to address this issue, or that they are giving due consideration to the effects on mental health problems.

The King’s study also recorded an increase in mental health problems among Reservists returning from conflicts. In a response to this issue, the MoD has introduced the Reservist Mental Health Programme (RMHP). However, while this programme is open to Reservist it is not open to veterans who have been recently discharged. This has created a two-tier treatment offer—as situation that needs to be addressed. The MoD are about to commission several mental health treatment pilots, in partnership with the Department of Health (DOH), that are aimed at veterans. However, results and roll-out will be several years coming. The RMHP could be considered as an interim solution.

5. Delivery of health services through NHS contracts—the figures being supplied by the MoD regarding NHS healthcare and rehabilitation contracts are encouraging. The figures indicate that all NHS contracts are delivering to the targets agreed by the MoD. The emphasis on providing care close to an individual’s place of residence is important, and contracting with the NHS does seem to be only cost effective way of achieving this. However, more than six contracts will be required if the MoD are to achieve this aim.

Additionally, while targets are being achieved we have yet to see any information regarding patient satisfaction. Information on the types of contracts, the NHS Trusts involved, the agreed targets and patient satisfaction rates all need to be made more transparent by the MoD.

14 May 2007

Memorandum from Ex-Services Mental Welfare Society (Combat Stress)

The media and Ministerial in trays testify to the widespread view that neither the MoD nor the NHS have anything to offer veterans with mental health problems; this view is supported to a great extent by the findings of a report entitled “Improving the Delivery of Cross Departmental Support and Services for Veterans” by Kings College London (Dandeker, Wessley, Iverson and Ross) published in March 2003. This study identified that the Health Service provided to veterans with mental ill health was in their view inadequate. A later report made by the Health and Social Care Advisory Service in 2005 makes similar findings (see below.) Since 2000 the Ex-Services Mental Welfare Society (also known as Combat Stress) (CS) had also been reporting that many of the veterans it was supporting were saying that the experience they had had with the Health Services was not a good one.

CS tempers its remarks by observing that this group of veterans, by the very nature of their disability and social circumstances, are often extremely difficult to deal with in an NHS setting, often quickly exhausting the patience of practitioners and the limited and frequently overstretched community mental health care resources available. This particularly applies to the much younger veterans which were starting to dominate in its treatment centres as early as 2000, a group with complex and chronic mental health and social problems whose needs were very much more difficult to meet than the more elderly WWII veterans the Society’s services were at that time best configured to cater for.
Like so many of the Services Charities which still exist to do their much needed work today, the Ex-Services Welfare Society was established in 1919 providing care in a residential setting to Great War veterans who were suffering from what was then commonly known as “shell-shock.” Much of this pioneering work was extremely innovative, in terms of the provision of occupational rehabilitation aimed at getting the disabled veteran back into work. The Society had both a factory (which manufactured heated flying clothing and electric blankets) and its own village in which veterans and their families lived, many for the whole of their lives.

Now known as the Ex-Services Mental Welfare Society, CS remains the sole specialist ex-charity in its field, looking after men and women who have served in the Royal Navy, British Army, Royal Air Force or the Merchant Navy suffering from mental ill-health. It provides a UK wide welfare service and has three treatment centres offering remedial treatment, respite and convalescence to veterans with a variety of mental health problems. In most of the veterans it helps, it sees disability related directly to in service experience and exposure to traumatic events is the main contributing cause of mental illness. However, combat experience, or a service related injury is not a pre-requisite for an admission any more than the need to be a qualifying War Pensioner to access the service.

Today, CS works in a spirit of cooperation and partnership with a whole range of interested organisations, the MoD, the Service Personnel and Veterans Agency, the War Pensions Welfare Service, the NHS, RBL, SSAFA Forces Help, the Service Benevolent Funds and many other service and civilian organisations in order to provide a whole range of capabilities to the benefit of its group of veterans. It helps other organisations to care for veterans with mental health problems within its capability to deal with, not least those dealing with homeless and rough-sleeping ex-service personnel.

Government funding for the so-called remedial treatment provided by CS was started in 1942. For about the last 50 years the War Pensions Scheme has funded War Disabled Pensioners with accepted service related mental ill health conditions to be provided with such treatment in a short stay residential setting at the Society’s homes. Currently, some 60% of the Society’s treatment is provided to veterans with a qualifying War Pension. The remaining 40% will be veterans who have a mental illness, usually attributable or aggravated by service, but for which they have either not applied for a War Pension or if injured post 6 April 2005 puts them under the Armed Forces Compensation Scheme (AFCS). The AFCS does not have in it any arrangement to fund treatment that might be provided by CS; it is the MoD’s view that this would be for the NHS to fund.

Back in 2000 admissions to the three CS homes were tailored almost exclusively to provide good, old-fashioned benevolent care to badly damaged WWII and Korean War veterans. These short stay residential admissions were mainly shaped to provide respite and convalescent admissions. For these old men the care provided by CS is extremely beneficial, not least because it is first class. These older veterans enjoy being taken out of social exclusion into a quasi-military setting where they feel safe and benefit from being in the unique therapeutic environment that is maintained in the homes. Indeed, this setting is an essential element for the veterans of all ages who use these treatment centres, and to which the old veterans contribute so much, particularly by helping to maintain the right level of good conduct expected by all residents regardless of age or degree of ill health, and to act as a moderator when the need arises.

In 2000, recognising that the needs of the younger and much more challenging group of veterans already referred to were not being properly addressed, the Society embarked on an ambitious programme of change, looking to improve its clinical capability through a Clinical Standards Uplift Programme to provide appropriate treatment programmes, and to modernise its UK wide Regional Welfare Service in order to achieve efficiencies and savings. It also set out to complete an expensive modernisation of its establishments to meet the new Care Standards Commission requirements (a programme which completes in October 2007 at an estimated cost of £4.5 million).

Despite its often severe and constraining financial position CS had made much positive progress by 2005. One of the issues which had been the subject of almost constant debate between CS and the MoD was the level of fees being set for the treatment of qualifying War Pensioners, one of the limiting factors in being able to put in place the extra clinical staff and additional skill mixes required to modernise its service. Discussions inevitably lead to the conclusion that it was time to review the Society’s services and its approach to the treatment to the veterans receiving MoD funding for remedial treatment, its approach to clinical government and so on.

The Health and Social Care Advisory Service (HASCAS) was then commissioned by the MoD with the Society’s full agreement to conduct a review of the Society’s programmes. The HASCAS team led by Professor John Hall completed its work and made its final report “Review of Combat Stress by HASCAS” in August 2005.

In its report HASCAS commented on the service provided by the NHS, observing that comments [by veterans] on the lack of help significantly outweighed positive comments. The report noted that Combat Stress was the only agency of any size in Britain dedicated to addressing the mental health needs of veterans and recognised the importance of the Society’s understanding of the experiences of veterans and their confidence in the Society; it also noted the significant changes over the previous five years in the nature of the services offered by the Society, designed to offer a wider range of interventions. It reported that
considerable work at all levels of the Society had resulted in significant improvements in its capability to provide the care needed and that the current staff compared well with the NHS in their level of skill and expertise, although the professional skill mix was relatively limited.

HASCAS made a series of detailed recommendations as to how CS services provided could be further improved, and CS has continued to refine and improve these services based on much of this advice. CS now has a service that focuses in on getting the veteran to engage in the first place, a very important component of its work. It is expert in the assessment of whole person needs (social as well as clinical) and in providing the safe therapeutic environment in which the most complex and enduring cases are often best dealt with. It continues to develop the necessary treatment options to be delivered by its staff and to continue the diversification of skill mix required to provide a holistic service capability. It has the capacity to deliver respite and convalescent care to the more elderly veteran, and values their presence in its treatment centres for the reasons already stated. Pilot schemes have successfully demonstrated that the needs of carers and adolescent child can be met through support programmes which have been successfully piloted and which it will start to roll out during the next year.

Returning to the work that followed the HASCAS Review, it was clear that any new model for the delivery of care to this needy group had to go beyond CS Services and to cover all veterans with mental health problems. The model and processes also had to have the NHS, and GP at the centre, reflecting current Health policy and practice.

CS collects statistics on veterans approaching the Society and confirms an increase year on year over the last several years (from 759 new referrals in 2005 to about 985 in 2007 last year—an increase of 30%). CS also has data that reflects the heterogeneity of diagnoses seen in clients and the wide variety of their different support needs. Beyond doubt, a very small number of those referred to CS do not actually have a mental health need. Some will be well able to be managed by GPs, others by more specialist community based services. A few will have complex severe enduring disorders that make them suitable to be dealt with CS. Future assessment programmes will need to address such criteria, as well as come to terms with the need to provide solutions to social as well as clinical needs where both are encountered (and they so frequently are.) There are also issues of accessibility and acceptability of treatment settings, all of which will need to be addressed.

However, on the basis of the HASCAS report, it was recognised that CS was needed as an integral component in any new arrangement being put in place to improve the delivery of cross Departmental support to veterans with mental ill-health. On this basis, an aim of any new model will be to integrate Combat Stress into NHS commissioning arrangements for the specialist service HASCAS suggests is appropriate.

22 May 2007

Memorandum from the Priory Group

1. From the inception of the tender the Priory Group has experienced the highest quality of relationship with the MoD.

2. The tender was fair and thorough and has been presented as a model to the NHS Confederation as a good example of contracting for mental health services.

3. Priory has delivered a high volume of work for the MoD, enabling care to be provided across our national network close to the home base of the service personnel.

4. Good clinical working relationships have developed between MoD staff in DCMHs and Priory Hospitals, which have enabled lengths of stay to be kept down and continuity of care to be high. We have agreed communication protocols at admission, 48 hours later, at 14 days if further inpatient stay is being requested and at discharge.

5. Contract monitoring is carried out in a professional manner and has resulted in real improvements in care and value for money over the life of the contract.

23 May 2007

Memorandum from the Plymouth Hospitals NHS Trust

I wish to contribute to this important debate from my experience gained over the last 20 years fulfilling a number of roles with Armed Forces Medical Services as: (i) Civilian Advisor in Cardiac Surgery to the Royal Navy since 1987; (ii) Medical Director of Plymouth Hospitals NHS Trust, one of the largest and most committed Ministry of Defence Hospital Units since 2000; and (iii) current NHS Medical Director to the Armed Services Consultant Advisory Board (ASCAB).

The issues that I would like to air are mainly, but not exclusively, concerned with relationships with the NHS. For brevity and clarity I will deal with them as bullet points.
To provide the critical mass to deliver high quality Medical and Surgical Specialties, all of which now interlink, and to train Military Clinical Staff of all types, Military Medicine needs an enhanced and rationalised relationship with the NHS and must at all costs resist the temptation to retrench into non viable “Forces Only” Units except where these could be of sufficient critical mass—for example, Rehabilitation and Mental Health.

The NHS is changing fundamentally and fast. Trusts must behave as businesses, cut out unnecessary capacity, and operate at a surplus in order to reinvest and develop. My own Trust is no exception. Waiting lists are becoming a thing of the past and target culture is moving on to an emphasis on quality in a competitive environment. The Military requires flexibility which can be at odds with the new world of the NHS. Trusts need to be incentivised to provide manpower flexibility by the commitment of clinical activity. With Tariff, this should not now be a financial risk. The temptation for Armed Forces Medical Services to increasingly rely on Reservists must be very carefully considered as Trusts are bound to become increasingly wary of appointing Reservists who they believe may be regularly deployed.

The NHS Hospital system is also changing. With the European Working Time Directive together with new training and Governance arrangements for Doctors; those Trusts providing the specialised services required by the Military, are getting larger. The model for the future is likely to be a small number of very large complex multi-specialty centres, a few of which will contain the appropriate specialties under one roof to qualify as Trauma One Units together with a network of District General Hospitals some of which will provide 24 hour General Surgery and Accident & Emergency, and some of which will not. The Consultant numbers at my Hospital have grown from 98 to 315 in roughly 8 years. In that time, Military Consultant numbers have remained about the same at 18. The Military is, therefore, becoming a smaller and smaller proportion of the Hospital which is good for neither party. To my mind, this means rationalisation of Military clinical activity to fewer, larger centres.

Specialisation is good for clinical standards, but the loss of generalists within large NHS Trusts and, therefore, the Military is good for neither. A new model for both General Medicine and General Surgery is necessary for both. We are developing such a model which will be a real collaborative opportunity for both NHS and Military Medicine.

As NHS Trusts are becoming more efficient they are taking out excess capacity. To make significant savings this means whole wards. One or two of these wards in the MDHU network could be converted to the requirements of the Military and mothballed until needed by any surge in clinical activity. This would cost only maintenance and capital charges and would provide inpatient intermediate medical facilities in an “all Military environment” following the usually specialist episode.

The quality of our Military Clinical Staff is very high. However, some are highly specialised in ways that must limit their clinical worth for the Forces and expose Trusts to added risk on deployment. This may have been necessary in times of difficult recruitment but leads to retention problems and is, in any case, not now necessary with domestic overproduction of Doctors possible. Also, successful Military Consultants are promoted to a rank which requires decreasing clinical involvement at an age when clinical experience is approaching its most useful. This is not good for Trusts or retention for Military Medicine. Losing the expertise of top class clinicians at or about 50 is not medically good nor to my mind necessary.

The provision of reliable, flexible, well trained Medical Services for the Military needs Armed Forces Medicine to work in close harmony with the NHS to the advantage of both. The three wings of the Armed Forces must integrate fully despite having different emphases. This needs careful consideration, taking into account the expectations of all involved—non-Medical Armed Forces, the NHS and the public—and must address immediate, intermediate and longer term care such as Rehabilitation, Mental Health and Counselling services.

I hope that the above points are helpful. Please let me know if the Committee requires any amplification or addition.

Terence Lewis, Medical Director

9 March 2007

Memorandum from Soldiers, Sailors, Airmen and Families Association (SSAFA)

1. In general SSAFA Forces Help believes that medical care for serving personnel of the Armed forces is very satisfactory, and in some cases outstanding as it relates to physical illness and injury.

2. Despite recent public and press interest in the treatment of wounded on repatriation from Iraq and Afghanistan, SSAFA has no evidence that the care provided by the Centre for defence Medicine (CDM) at Birmingham University NHS Trust, and other hospitals, is anything other than excellent in clinical terms. Rehabilitation services at the MoD facility at Headley Court are second to none in the UK.
Defence Committee: Evidence

3. SSAFA has less confidence in the far more complex, and less tangible arrangements in terms of support to service personnel once discharged from hospital, ie personal support welfare in the broadest sense, including psychological and mental health, including clinical aspects. This not just the immediate post operations support, but the ongoing care of service, and indeed ex-service personnel which may extend for very many years. To be fair, this is not a task which the MoD could, or indeed should be expected to do alone. This is not intended to be a criticism of MoD, which is just not equipped nor configured for such a highly complex task. We believe that personal support welfare and community mental health provision would be far more economically, and consistently performed by specialist civilian organisations, including charities such as SSAFA. This is a matter of practicality, expertise, concentration, continuity, and commitment.

4. It should be emphasised that mental health issues are not by any means restricted to those wounded or overtly exposed to trauma on active service. Life in the Armed Forces is in itself a high stress activity, and the effects are by no means restricted to the serving individual, but are invariably also suffered by families. The whole modus operandi of service life, even without active service operations, involves constant change, movement and uncertainty. Relationships and family health are often the casualties themselves.

5. The MoD only has responsibility for the healthcare of families who accompany the serving person on an overseas posting (eg Germany, Cyprus, Gibraltar). In general again this healthcare is generally very satisfactory) and indeed in most cases excellent, although it should be observed that the very substantial increase in funding enjoyed by the NHS in UK over the past 5 years has not been matched by the MoD in funding overseas health services for which it has responsibility, and these are steadily slipping behind in terms of parity with the NHS. In particular, the NHS budget as increased by some 5%/year since 2002. By comparison, spending on health by the MoD has risen in line with the RPI of some 2% in common with other Defence expenditure. Nonetheless, salaries of MoD medical staff and standards of care must be comparable with the NHS, albeit within tighter constraints.

6. The healthcare of service families (as opposed to the serving person) in the UK is not the responsibility of MoD. These families are dependent upon local NHS provision. The only difference with other civilian counterparts is however that service families move home often to “follow the flag”, and lack of continuity of residence can inhibit ability to access all parts of the NHS, particularly relating to prolonged or complex treatments. Of particular concern is the extreme difficulty in accessing NHS dental practice, which although is also common with civilian families, is much exacerbated for service families with young children.

7 June 2007

Memorandum from Lynne Jones MP, Richard Burden MP, Gisela Stuart MP and Steve McCabe MP

We are the local MPs concerned with University Hospital Birmingham (UHB). We have regular meetings with the directors of the Hospital Trust and have visited both Selly Oak and Queen Elizabeth Hospitals on several occasions. Many of the staff are constituents and the hospitals serve our constituents. Two of us (LJ and GS) have also visited the ward caring for most military personnel (recently 12 out of 20), which we shall refer to as the military managed ward, where we have spoken to military and non-military staff, as well as patients.

Prior to the establishment of the Royal Centre for Defence Medicine (RCDM) at UHB we discussed the implications with senior staff. We understood that the decision by the MoD to base hospital care of military staff in the NHS was taken primarily for clinical reasons. Health care has become more specialised and the range of specialities and depth of experience required to provide the full range of care (especially ensuring that seriously injured troops receive treatment at the cutting edge of what is available) can only be provided by a large acute teaching trust. We were also anxious that the location of RCDM should not be to the detriment of patient care for our own constituents. We were convinced that the proposal would be of benefit to both military and NHS patients.

Another benefit of this arrangement was that the training and education of the clinical military staff could be undertaken in an environment where the full range of injuries and illnesses are seen and treated. This is to better equip the military clinicians to deal with any eventuality when deployed at times of conflict.

It was explained to us that the achievement of both of these important functions (best possible care for injured military personnel and training of military clinicians) would require military clinicians to be deployed in whichever ward in the hospital would provide the relevant experience and training and that the injured and ill would be cared for in the specialist clinical environment appropriate to their medical condition. This would often mean a severely injured serviceperson being treated, over time, in more than one location in the hospital and this has proved the case. We have been pleased to meet with military staff in many different locations in the hospital eg physiotherapy and such meetings confirmed our belief that this has been to the mutual benefit of both the military clinicians and the NHS.
Unfortunately, over the past few months, there has been a vast amount of negative press coverage about RCDM, most of it, in our experience, inaccurate and ill-informed. One of us (LJ) recently met one of the injured men whose case has been given a high profile in the media. He was returning to the ward after a weekend away. We understand that, by his choice, he remains in the ward despite the hospital’s view that he is ready to be discharged to military-run rehabilitation.

As a result of this media coverage, which has resulted in concerns being raised in parliament, it seems that considerations other than clinical need are being brought into play to determine where injured military personnel are cared for and where military clinical staff are placed to gain experience. There is a danger that the views of those with the knowledge and skills to make those judgements, based on the clinical needs of the patients ie the doctors and nurses looking after the patients, will not be given due weight. As a consequence we fear that patient safety could be compromised, both for the armed forces’ patients in Selly Oak and Queen Elizabeth hospitals (run by UHB) and for those injured in the frontline before they are returned to the UK. We are therefore pleased that the Defence Select Committee is undertaking this inquiry.

Of course senior officers are going to be concerned for the security and well-being of members of their units who are injured but these concerns should not translate into interference with clinical care. Military welfare issues, whilst important, should be seen in the context of the overriding need for severely wounded personnel to receive the best possible treatment for their injuries.

We are concerned that efforts to make the military patients feel as though they are in a more military environment may be counterproductive. The two of us who have visited the “military managed” ward have been struck by how many staff, in particular military staff in uniform, were on the ward. We are told by the hospital staff that this is usually in double figures and on one recent occasion it was possible to count 19 non-clinical uniformed military staff on the ward.

There is no doubt that this ward is old and cramped, as is all the accommodation in UHB. However, the new build is scheduled to open in 2010 when all patients will have first class facilities. All the additional staff (referred to above) add to the feeling of the ward being cramped and busy. In contrast, other wards we have visited, run as “normal” NHS wards, with the same layout and design, appeared calm and ordered.

Arising from the publicity referred to above which, incidentally, has taken up a disproportionate amount of senior staff time that may well impinge on the wellbeing of our constituents, there have been calls for the reinstatement of military hospitals and military wards. Having discussed these issues with clinical staff, both NHS and military, we believe the model established to be the right one and it should be allowed to be run as was intended. It is vital for the wellbeing of our armed forces that we still achieve the two aims of the best care for injured servicemen and women and the training and education of clinical military personnel to the highest possible standards. We are dismayed that the views of military staff on the ground seem to be being overridden by non-clinical issues and that money is being wasted creating physical barriers between military and NHS personnel when the numbers of military patients and their location in the hospital can vary enormously.

14 June 2007

Memorandum from the Postgraduate Medical Education and Training Board (PMETB)

1. INTRODUCTION

PMETB welcomes the opportunity to provide evidence to the Defence Committee’s Inquiry.

1.1. Background to PMETB’s role

To set this in context PMETB:

— Took up its statutory responsibilities on 30 September 2005.
— Subsumed the functions of two Competent Authorities: The Specialist Training Authority of the medical Royal Colleges (STA) and the Joint Committee on Postgraduate Training for General Practice (JCPTGP).
— Has a remit which extends across all four nations of the UK.
— Has responsibility for postgraduate medical education and training. Undergraduate medical education is the responsibility of the GMC.

1.2. PMETB’s legal responsibilities

The principal functions of PMETB, as set out in the Statutory Instrument made on 8th May 2003—The General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003 are to:

— Establish standards of postgraduate medical education and training.
— Secure those standards and requirements.
— Develop and promote postgraduate medical education and training in the UK.
— Accredit training in hospital and general practice to meet PMETB standards.
— Issue (or refuse) Certificates of Completion of Training or eligibility for specialist registration.

1.3. **PMETB’s statutory objectives are to:**
— Safeguard service users.
— Ensure the needs of those undertaking training are met.
— Ensure the needs of employers are met.

1.4. **PMETB also has a statutory duty to cooperate with:**
— The General Medical Council.
— Any other body that appears to it to be representative of the medical Royal Colleges in the UK.
— Any other body that may be specified by the Secretary of State.

2. **Generic Standards covering all Postgraduate Medical Training**
2.1. In April 2006, PMETB published the *Generic Standards for Training*. The standards:
— Apply across the health sector in all places where postgraduate medical training is provided ie NHS, independent environments and military establishments.
— Cover all postgraduate training programmes after the end of the 2 year Foundation programme (which happens after undergraduate training) for all specialties, including general practice.
— Are relevant to all medical specialties and sub specialties.
— Are designed to run alongside PMETB’s Standards for Curricula and the Principles for an Assessment System for Postgraduate Medical Training.
— Form the basis of the quality assurance process with postgraduate deans.
2.2. The standards are built around eight domains:
— Patient safety.
— Equality, Diversity and Opportunity.
— Recruitment, selection and appointment.
— Delivery of curriculum including assessment.
— Support and development of trainees, trainers and local faculty.
— Management of Education and Training.
— Educational resources and capacity.

3. **Training in War Zones**

The legal framework governing postgraduate training and certification
3.1. Doctors who have undertaken and satisfactorily completed specialist or GP postgraduate training, in programmes approved by PMETB, may be awarded a Certificate of Completion of Specialist Training (CCT) by PMETB. Doctors who do not have a CCT may not legally work in general practice or take up consultant posts in any medical specialty in the NHS. Other doctors who have not completed UK training programmes but who demonstrate that their specialist training, qualifications and experience are equivalent to CCT standards may be approved for entry to the Specialist Register. CCT holders and those approved for specialist registration have equal status.

3.2. The legislation governing certification and postgraduate medical training—the General and Specialist Medical Practice (Education, Training and Qualifications) Order 2003—requires that all UK training undertaken for the award of a CCT is supervised and carried out in units and posts specifically approved and recognized for training purposes by PMETB. The legislation states that training may be interrupted in specific circumstances including military service. This, we understand, was primarily meant to cater for the one-year national service which is still compulsory in certain EU countries and often comes at the beginning of a doctor’s training. Inevitably, however, the continuity of planned CCT training for those in postgraduate training can be affected, particularly for reservists called up at short notice eg Afghanistan, Iraq. PMETB are clear that, as far as possible, individuals should not be unnecessarily disadvantaged as a result of their contribution to the military effort. Therefore, arrangements first
introduced by PMETB’s predecessor—the Specialist Training Authority—in liaison with the Defence Postgraduate Medical Dean, were adopted to ensure that as much relevant training time as possible, whilst on deployment, could be counted towards trainees’ CCT training programmes.

**So what steps were taken to safeguard UK postgraduate trainees deployed as a result of military action?**

3.3. It was agreed that those called up should have their overseas placements prospectively approved as a matter of course but that their actual time on deployment should be reviewed retrospectively, on the trainee’s return, so that any relevant training could be counted towards CCT requirements and any training gaps identified. In practical terms PMETB provides the following advice to trainees affected:

— individuals should maintain activity reports or College training logs whilst away;

— military consultant supervisors must assume the role of trainer and assist in the continuity of training;

— in-house training, lectures and other related activity should be available;

— military consultant supervisors must complete assessments at the end of the trainee’s deployment—preferably on College or Joint Committee forms—to cover the whole deployment period; and

— Postgraduate trainees must return to approved NHS training posts for a minimum of six months before the award of their CCT. This will enable an assessment of their progress, or otherwise, against CCT training programme standards to be made for the periods on deployment and the necessary sign-off processes completed.

3.4. Subject to the effective operation of these safeguards, trainees should be able to provide their next assessment panel with seamless evidence of their involvement in relevant training whilst deployed. On return to a training programme in the UK, following any periods of military deployment, trainees’ records would need to be reviewed on an individual basis and any gaps in the training identified and covered during the next training rotation or, if this is not possible, by extending the expected date for CCT certification.

How can others who have not completed a full UK training programme but have gained relevant experience as a result of military deployment, have that experience taken into account?

3.5. As mentioned earlier in this submission, doctors who have not undertaken or completed a programme of postgraduate training in the UK may be considered for specialist registration. Under the Certificate Confirming Eligibility for Specialist Registration, PMETB assesses applications for Specialist Registration from those doctors who have not followed a UK specialist training programme that leads to a CCT but who may have gained the same level of skills and knowledge as CCT holders. A similar route applies to those in general practice—the Certificate confirming Eligibility for GP Registration. These are sometimes referred to as the “equivalence routes”.

3.6. It is therefore open to a doctor, who wished to apply through one of these routes, to provide evidence to show that their specialist qualifications, specialist training and experience—which could include time spent on military deployment—were equivalent to a CCT.

15 June 2007

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**Memorandum from the British Armed Forces Federation (BAFF)**

**INTRODUCTION**

1. This Memorandum is submitted on behalf of the British Armed Forces Federation, an independent, representative staff association formed in December 2006 for serving members of the armed forces. Former members of the forces may also join. Members are drawn from all three services, including the reserves, with no restrictions as to rank.

2. BAFF’s membership includes serving and retired Defence Medical Services staff, and at least one member who has experienced the casualty evacuation chain from operations in Afghanistan.

3. Recent media stories about alleged deficiencies in forces medical care have been deplored as “bad for morale”. We agree, but real deficiencies could be worse. Confidence is not increased by denying deficiencies when they are first raised in the media, only for remedial action to be announced much later, rendering the original criticisms “out of date”. A case in point is that of helicopter availability for battlefield casualty evacuation in Afghanistan.

4. We therefore warmly welcome the opportunity afforded by the Defence Committee’s Inquiry to establish the facts in an impartial cross-party setting. We have played our part in helping to publicise the Inquiry and to encourage individuals to participate in the Committee’s online forum.
SUMMARY

5. BAFF seeks not to turn the clock back to the previous network of Military Hospitals, but argues that the present system requires more attention and investment before it fully comes up to the claims made for it. Anything less than world-class medical services for our country’s armed forces will damage recruitment, retention and operational efficiency. We welcome improvements which have been made. We also draw attention to a number of concerns relating to the after-care of discharged personnel, especially in the area of mental health.

HEALTHCARE FOR SERVICE PERSONNEL

6. It is, of course, the norm for advanced countries to maintain dedicated military hospitals for their armed forces. The former Naval Hospitals, British Military Hospitals, and RAF Hospitals had much to commend them, and criticisms of them by those seeking to justify the present arrangements have sometimes been exaggerated. An updated, streamlined system of military hospitals is theoretically feasible, although the investment required for a fresh start would be daunting.

7. Some military hospitals were able to treat non-military patients from service families or, in some places, from the local community. This widened the clinical experience of staff as well as, arguably, increasing value for money for the taxpayer. It has been suggested that a restored system of military hospitals could treat ex-service people (“veterans”) as well as serving members of the armed forces. We do not, however, consider that there is a realistic case for our UK veterans to be treated separately from other non-serving patients, with the exception of treatment for service-related psychiatric disorders, discussed further in this Memorandum.

8. We recognise the premise underlying the present arrangements that the more patients who are treated in any particular clinical specialisation, the better the average outcome is likely to be. In any type of hospital whether military, NHS or private there will always be some sub-optimal patient outcomes, for whatever reason. While we have no figures, we suggest that the standard of treatment provided to UK military patients is high, and that many of the reported problems relate to inadequate patient management rather than to clinical deficiencies. Nevertheless, poor management of a patient can have a very harmful effect on the psychological outcome of their physical injury.

9. The need for a strong military presence within, or dedicated to liaison with, the NHS is paramount. This is achieved at the MDHUs, and to an extent at RCDM, but is more difficult in non-MDHU NHS facilities.

10. The Military Administrative Officer (Civil Hospitals) [“MAO(CH)”] concept is good, but is severely under-resourced. These individuals have to track all Service personnel in NHS hospitals across the UK, and in addition need to engage with Primary Health Care trusts to track Service personnel under non-military GP care. Without a properly co-ordinated and mutually understood system in this area, any military input to (or even knowledge of) after-care is impossible. Again, the essential occupational aspect of the Service patient is missed, as civilian GPs (and indeed hospital practitioners) are unaware of the specific stresses placed on Service personnel.

11. The NHS is not an occupational service. It is not interested in getting people back to work, but in getting them out of hospital beds. For Service personnel this has a particular disadvantage. Civilian patients are discharged to the care of their NHS GP, and to their home environment. The Service patient may be a single individual living in barrack accommodation, and his “family” (including in some instances his Service GP) may be away on an operational tour—so there may be no real supervision of this individual.

12. Military medical records remain a problem area. Part of the problem relates to the need for records for Service personnel on posting to be transferred manually at present; speeding up the introduction of DMICP (Defence Medical Information Capability Programme) will undoubtedly assist in this. However, the complexities involved in this should suggest avoiding too rapid an approach, lest the technical necessities are overtaken by user unfamiliarity. Continuity of care may also be challenged by the frequent move of Service personnel, including, of course, the medical personnel who look after them, and the requirement for medical personnel to be removed from their “peacetime” locations for operational tours. Too great a reliance on civilian medical staff (either employed by the MoD or contracted to the NHS) removes the essential occupational medicine input to the military—an input which is needed to maintain their individual health and the operational effectiveness of the Defence Forces.

13. There must be no repetition of the widespread “disappearance” of inoculation dose records for personnel who served on Operation Granby (Gulf 1990–91), which remains a source of understandable concern to both serving and retired personnel.
MEDICAL SUPPORT FOR OPERATIONS

14. Albeit from a small sample, BAFF has received favourable reports of the standard of medical care provided in operational theatres. In-theatre and strategic casualty evacuation should be reviewed. Our comments here concentrate on the after-care of operational casualties.

15. In addition to the after-care of sick and injured who are returned from operations but are still members of the Forces, we also attach importance to the continuing after-care of those who have left the Service whether voluntarily, or otherwise.

16. In respect of physical injuries, the Defence interest in post-discharge after-care is transitional. For example, a patient who leaves the Service while on the waiting list for an operation, and returns to his or her home area, may well find themselves back at the bottom of the waiting list. There are also record-transfer issues.

17. From a purely medical perspective, the treatment and support of an amputee may be little different whether the injury occurred on the battlefield, or in a motorcycle accident. Service-related psychiatric disorders such as PTSD demand a more tailored approach, however.

DELIVERY OF HEALTH CARE FOR THE ARMED FORCES

18. The crucial point is the properly worked out, contractually agreed and mutually workable interface with the NHS. The limitations of the existing contractual arrangements (under the “Concordat”) need to be recognised, and managed for the future. The NHS may not be equipped to deal with specific problems of military service, such as PTSD.

19. The MAO(CH) system is not only under-resourced, it is single-service. The recent introduction of Sickness Absence Management has helped, but there remains a need for a tri-service system. In many cases lines of communication and protocols between hospitals and patients’ units are insufficiently defined, leading to duplication of effort. A combination of charities, senior officers’ wives and unit personnel may descend upon the patient and however welcome they may be, confusion can sometimes result.

MENTAL HEALTH ISSUES

20. Whilst we understand that PTSD may typically present within six months of the traumatic event, this may not be the case with service patients, for two reasons. Firstly, the military PTSD-sufferer may have experienced repeated events, having a cumulative effect which may not be apparent until some further event brings the problems to the surface much later. Secondly, serving members of the armed forces are supported by feelings of comradeship and esprit de corps, and may succeed in coping with their trauma while still in uniform; they may, indeed, successfully conceal their problems for a time for reasons of machismo and, even, the real fear of damaging or losing their career.

21. We welcomed the MoD announcement on 11 June, 2007 to extend the Medical Assessment Programme (MAP) to allow more former Service personnel to seek “professional advice” on mental illnesses which they feel are linked to their time in the Armed Forces. Apparently the “advice” will, however, only comprise screening. So as not to deter eligible individuals from seeking screening under the MAP, we would welcome an assurance that the results may not be used in relation to any pension or compensation issue without the consent of the patient.

22. We are also aware—as many NHS practitioners clearly are not—of the tri-Service Reserves Mental Health Programme (RHMP) established at Chilwell. This facility needs to be publicised much more effectively.

23. Eligibility under the RHMP is currently restricted to those reservists who have been demobilised from an operational theatre since January 2003. Eligibility under the MAP is restricted to those veterans who have served since 1982. Both of these date restrictions are arbitrary and unjustifiable, and we would urge the MoD to remove them.

24. Whilst ex-forces sufferers from mental health problems must not be directed away from the NHS if that is the treatment they prefer, NHS psychiatric services may not in some cases be the best source of treatment. Ex-forces PTSD sufferers have, on occasion, been asked not to continue NHS group therapy because their recounted experiences were upsetting the other patients.

25. Every veteran suffering from mental health issues linked to their past service should be eligible for whatever treatment they need either directly under Defence arrangements, or from Combat Stress (Ex-Services Mental Welfare Society) with adequate MoD funding.

26. We note the comprehensive arrangements in Canada for treatment of “Operational Stress Injury” both for serving personnel, and for veterans. British personnel and their families are given helpful information sheets on issues which might arise after an operational tour, but these sheets may be easily lost or discarded. In Canada, the information remains readily available to veterans and their families by various means, including the internet.
PRIORITY NHS TREATMENT FOR WAR PENSIONERS

27. War pensioners and equivalent are supposed to be entitled to “priority NHS treatment” for the condition for which their pension was awarded. There are two problems with this provision. Firstly, many NHS staff are unaware of it, and it seems likely that awareness will diminish as time goes on. Secondly, priority “is a matter for clinical judgement based on clinical need which means that the case with the greatest clinical need will receive precedence” (MoD 2007). Since the prime criterion is clinical need, and NHS staff are also required to apply numerous targets none of which include “care for veterans”, the priority entitlement appears in reality to be virtually meaningless.

18 June 2007

Memorandum from S W Rowley

Dear Mr Arbuthnot,

I was interested to read in the Summer edition of The Royal British Legion magazine that the Commons Defence Select Committee, of which you are Chair, is to launch an enquiry into the treatment of injured soldiers. It does not say so but I take it that the enquiry is into the treatment of soldiers, sailors and airmen of the current conflicts in Iraq and Afghanistan and will concentrate upon the here and now and it is right that you should.

That said I am iting to suggest to you that you could do worse than by opening up your enquiry to include comments from those World War 2 servicemen who were seriously wounded and are still alive. Hospital treatment is only part of the story and that can be bad enough but it is life after the Army where trouble really begins and they have a tale to tell, a unique story of coping with civilian life over the past 60 odd years, with the vagaries of the one time War Pensions Dept, the Veterans Agency, General Practitioners and the NIIS generally where the undertaking given by the government in 1948 to give priority treatment to those requiring medical attention for pensionable conditions is honoured more in the breach than in the observance. In my experience none of the connected agencies have gone out of their way to make life any easier and it is still necessary to fight for simple but vital things that should be on offer.

I hope the young men and women in your survey fare better in life after the Army than did their World War 2 counterparts but who will remember Iraq fifty years down the line other than those who fought there? More to the point will anyone care?

15 June 2007

Memorandum from Brigadier W E I Forsythe

I hope that this letter may be in time for your enquiry, which I only read about in the British Medical Journal the other day. It may also be that I am so long retired from the Army that my views are now of no value. However for what they are worth here they are.

MY BACKGROUND

I left the Army 17 years ago. My last appointment was as the Commanding Officer of the Queen Elizabeth Military Hospital in Woolwich, the largest military hospital in the Armed Forces. At different times before that I’d commanded the military hospitals of Dharan, in Nepal and the ones in Munster and in Rinteln in Germany. I was the most experienced hospital commander in the Armed Forces. When I left the Army Medical Services, I went into the NHS as a District Director of Public Health until the Health Authority was abolished 3 years later. Since then I have worked part time as a Medical Advisor to the DWP, and in the course of that often have to assess disability of ex service people for the Veterans Agency. I’ve stated all this for I feel each form of employment is relevant to my opinions.

THE ABOLITION OF MILITARY HOSPITALS

Happily for me this only happened after I’d left the Army. However it seemed to me to have been the result of the following factors:

1. The “Peace Dividend” expected as a result of the end of the Cold War.
2. The need to economise in spending an the Armed Forces.
3. The fact that the Gulf War forces had been over provided for with medical support, in that the casualties estimated by the war planners didn’t materialise.
4. I believe that the Surgeon General at the time was not able to present the case for retention of Military Hospitals adequately to the Adjutant General. The SG of the time had never commanded a military hospital, and so couldn’t know much about how they functioned. He had worked in one many years before, but that was in Hong Kong, which bore little relevance, to those in the UK which were always activity engaged in field training.

THE PRESENT MILITARY-MEDICAL HOSPITAL ARRANGEMENTS

I don’t wish to comment on these, for they have been set up since I left the Army and it is for serving officers to make the case for them to you.

THE BRITISH MILITARY HOSPITAL (BHM) AS AN ENTITY

The Military way of life is that of the “extended family”. The “Regimental Spirit” pervades everything, and a soldier who went to the Queen Elizabeth Military Hospital as a casualty or as a patient knew that he would be treated with the dignity he deserved by specialist of the very highest caliber. His unit would send a representative to see him and unit commanders would keep in personal contact with me to see how his soldier was getting on. We had a suite to accommodate visitors overnight or longer and welfare officers to look after them.

Our specialists were of the highest quality: Three of the consultants were CBE, and one OBE, (and he was concurrently the President of the Society of Rehabilitation). Several were Professors at the Royal Army Medical College at Millbank. All our support services were of excellent standard; I recall on one occasion a visit by the NHS to study our method of operating theatre useage, to find we achieved such a high throughput.

The specialists also had access through the Honorary Consultants to the Army (a most prestigious appointment for a doctor of merit) to the best advice and tertiary care from the teaching hospitals in London.

When a soldier was ready for discharge from hospital I would personally ensure that all the necessary return arrangements had been made

THE TYPE OF PATIENT AT THE QEMH

The facilities were there for soldiers, which were about 60% of the total. the rest were retired military people from all over the country referred by their GPs. This was an enormous benefit to veterans for they never needed to be felt “lost to the system”. I well remember Simon Weston who had been wounded in the Falklands coming for his Out Patients and others too.

I think this facility for veterans one of the most important things we did. I cannot imagine that the post Falklands War suicide rate that is so dreadful would have been the case if the QEMH would have still existed. The veterans I see in my present work hate being treated in civilian hospitals and all look back nostalgically to the good old days.

One of our particular facilities was being a Branch of the Far East Prisoners of War Association. FEPOWS came for their check ups and often for psychiatric help to a really welcoming environment.

A further fill up was with local NHS patients referred by local GPs. They liked the ambience: the daily visit by the Matron or a deputy, the daily visit by the duty chef, and the inspections by the head of cleaning service. They knew of the quality of the Consultants. They knew that I as the Commanding Officer did a weekly inspection of everything too!

THE ROLE OF MILITARY HOSPITALS

1. To provide medical care in the right environment for soldiers.

2. To provide medical, military and mobilization training for the staff.

How the army ever thought they could do without them baffles me! All of the other European Armies appear to find them necessary. Why are we different?

If you, Sir, can restore the proper medical support for soldiers you will get a very big cheer!

19 June 2007
Memorandum from Councillor Peter Langdon

PROPOSED RESOLUTION AT THE SOUTH EAST ENGLAND REGIONAL ASSEMBLY PLENARY MEETING, 15 NOVEMBER 2006

The Assembly calls for the Ministry of Defence and the South Central Strategic Health Authority to review the proposed closure of the Royal Hospital Haslar in Gosport.

BACKGROUND AND COMMENT

Present plans will see Royal Hospital Haslar lose its status as the last Military Hospital in the United Kingdom in 2007 and its complete closure in 2009. The loss of this hospital will create a severe healthcare deficit in the region, both for the Armed Forces and the residents of South Hampshire.

There is no good reason to establish the Headquarters of Defence Medical Services in Birmingham, this at very high cost, when Royal Hospital Haslar already exists, has been modernised and has all supporting staff and patient facilities needed.

Recent press and television reports have highlighted the public’s anger about the inadequate treatment of armed forces casualties returning from Iraq and Afghanistan, this situation arising from the decision to close the nation’s last military hospital, Royal Hospital Haslar, in Gosport, Hampshire. These notes give reasons why I believe it is essential for this decision to be reversed, for both the efficiency of our Armed Forces, NHS and the quality of medical care provided.

The present situation with the Royal Hospital Haslar is that the Ministry of Defence will withdraw funding for the hospital on 31 March 2007. The HPCT has negotiated for the use of certain facilities there until final closure planned for 2009. The HPCT is the commissioner of services and the PHT delivers those services at various hospital sites including the main Queen Alexandra Hospital in nearby Portsmouth. The closure of Royal Hospital Haslar, the last military hospital in the United Kingdom, was the decision of the Government in December 1998. There will be a small residual Ministry of Defence Hospital Unit based in the Portsmouth area for the foreseeable future and if Haslar continues under the control of the PHT some service medical personnel will be serving at Haslar under contract to the NHS until 2009.

Royal Hospital Haslar was originally a naval hospital that opened on 23 October 1753. Today, it is a superb, modernised hospital. Chosen by the Lawrence Committee in 1998 with the decision to combine service medical provision at a single location, Haslar was modernised at a cost of some £45 million to become the country’s 21st-service hospital during the early to mid-1990s. The hospital can hold up to 350 beds, has 10 new operating theatres, a state of the art scanner, new burns unit (never used), hypobaric chamber and much more. With high boundary walls and protected by MoD police, it is in all respects secure. Situated in Gosport in a perfect setting overlooking the Solent beside the entrance to Portsmouth Harbour and having every facility needed, it is an ideal place both for treatment and recuperation. MoD staff accommodation, recreational facilities (essential for fit and active servicemen) and service married quarters are available in the immediate vicinity—as is a field ambulance unit and the Institute of Naval Medicine.

For the purposes of morale, cohesion, military ethos, training and also very importantly, retention, the Defence Medical Services need a proper home—yet the chosen hospital, Selly Oak, an old, tired hospital in Birmingham situated in a highly developed urban area, cannot provide this. The plan to build a £200 million medical training centre and accommodation at Lichfield, 18 miles distant from Selly Oak Hospital has been cancelled for lack of funds. Forces medical staff at Selly Oak are living in an old YMCA building and lodgings. The hospital facilities are limited and there are practically no recreational facilities for staff. The move from Haslar to Birmingham has proved to be a disaster.

With no home to call their own and armed forces medical staff scattered amongst NHS hospitals throughout the country, morale has collapsed. The result has been resignations by the hundred. Today, there are huge staff shortages with the effect that large numbers of unwilling reservists have been called up for service in Afghanistan and Iraq. Press reports say Reserve doctors are earning up to £250,000 a year in compensation for loss in civilian earnings to make up the lack of service personnel.

At present Haslar is still under MoD management. It works closely with Queen Alexandra Hospital in Portsmouth and Southampton University Hospitals—taking many thousands of civilian patients annually for non-urgent surgery.

Queen Alexandra Hospital will have one less operating theatre and one less ward when its rebuild, currently in hand, is complete. With ambulances frequently queuing with sick patients waiting for access to A & E, it could not cope without Haslar.

80,000 and possibly 120,000 new homes are planned for South Hampshire in the next 20 years. That’s a population increase equivalent to double that of present day Portsmouth. No hospital provision has been made for this population growth.

One day the magnificent zymotic (isolation) hospital in Haslar’s gardens might be needed to cater for biological attack and the predicted flu pandemic. No other hospital has isolation facilities of anywhere near this capacity.
The threatened closure of St. Richard’s Hospital in West Sussex will, if this takes place, put further strain on Queen Alexandra Hospital. (Some 84,000 cases per year.)

The Haslar estate as a whole is a designated National Park and Garden. Many buildings are listed. The gardens are believed to contain at least 20,000 armed forces dead arising from the hospital’s 256 years of age. Not a good prospect for a future developer looking for profits. The buildings and their setting to the rear of the hospital are ideally suited for care of the elderly—where facilities in Hampshire as a whole are under severe strain.

To summarise the situation:

Defence Medical Services personnel need a proper home.

Our armed forces deserve a secure military hospital.

Our injured servicemen deserve proper medical care and facilities for recuperation in pleasant, familiar and safe surroundings.

Queen Alexandra Hospital in Portsmouth could not cope without the present support of Haslar and that’s before any of the new growth planned for the region takes place.

Southampton General Hospital, a teaching hospital, can provide the advanced training needed for more senior service medical staff.

Royal Hospital Haslar is in all respects ready to become the in-service military hospital and centre of medical excellence our servicemen deserve.

All married quarters, service accommodation, staff training and recreational facilities needed are available close by.

The £200 million that is to be wasted in Birmingham to duplicate facilities already present at Haslar can be saved.

Similarly, the NHS minor injuries unit can stay at its present location in Haslar Hospital, thereby saving many hundreds of thousands of pounds under the present plan to displace the doctors’ surgeries at the War Memorial Cottage Hospital in Gosport and rebuild a new minor injuries unit there.

Every civilised western nation has at least one military hospital. If Haslar is closed, the United Kingdom will become the exception.

A very high proportion of the nation’s armed forces and their families are based in the South East of England. They deserve our support. Health facilities are a vital infrastructure component and thus a proper matter for the Assembly to consider.

Save Haslar?—Yes! It’s simple common sense. How could anyone think otherwise?

There is still time for the HPCT, PHT, NHS, DMS, Health and MoD Ministers to get together to give the matter the attention it so clearly deserves. May I respectfully request that the members of SEERA give their full support to this resolution to signal their concern about the loss of Royal Hospital Haslar and the deficit in health provision this will cause both for the armed forces and South Hampshire’s residents.

22 June 2007

Memorandum from Robin Short, Martin Kinsella and David Walters

EXECUTIVE SUMMARY

1. The aim of this evidence is to provide the Defence Select Committee with an understanding of the effectiveness of mental health care provision for veterans, with particular emphasis on Post Traumatic Stress Disorder (PTSD). This evidence will also identify innovative solutions that match best practice in community mental health care for providing cost effective ways of addressing all aspects of PTSD.

2. The extent of the PTSD problem among serving personnel and veterans is considerable. Experience shows that the size of the problem is certain to increase in line with the high current tempo of operations. The result is already predictable in that limited existing resources, already over-stretched, will become completely overwhelmed. It is, therefore, essential that new approaches to dealing with PTSD should be developed as a matter of urgency, as it is clear that the current model does not provide damaged servicemen and women with the effective treatment they deserve.

3. The US military has made significant progress in de-stigmatising PTSD and now includes psychological maintenance as an integral part of post deployment activity. The lessons learned, and applied, by the US military should be carefully considered for inclusion within the British military’s medical armoury. Initiatives should be put in place to enable the British armed forces to develop a coherent, seamless transition for those who choose, or are obliged, to leave the service due to their PTSD injury.
4. Programmes for dealing with PTSD in veterans should be based around current best practice for community mental healthcare and should be willing to adopt new and innovative solutions and techniques. It is essential to break free from outdated thinking and ineffective programmes. Provision of adequate support in the community for casualties, carers and family members is an essential requirement of any programme. All programmes must be outcome focused with clear, measurable cost-effectiveness criteria built into them.

INTRODUCTION

Extent of PTSD

5. According to statistics from the National Centre for Post Traumatic Stress Disorder (NCPTSD), run by the United States Department of Veterans Affairs, 30.9% of male Vietnam veterans and 26.9% of female veterans developed PTSD. The prevalence of late onset PTSD is 15.2% in men and 8.1% in women. The UK does not have such a far reaching sample as this but generally accepted figures indicate the prevalence of late onset PTSD among UK veterans is 9% (source—Kings Centre for Military Health). Initial indications from Iraq suggested that 2% of regular soldiers and 4% of reservists developed PTSD. Subsequent review of the data increased these figures to 4% and 6% respectively. It now seems clear that more of our forces are likely to suffer psychological injury than physical injury as a result of combat.

6. Late onset PTSD typically manifests 12–15 years after the traumatic experience. This hits the most valuable cadre of our military personnel—combat experienced NCOs who provide the bulk of the operational corporate knowledge within the organisation. Many are lost to the service once the symptoms of the injury appear. During the period that it takes for the full blown symptoms to manifest, the performance of the soldier could be seriously degraded as they tend to operate in denial and adopt avoidance strategies, typically involving alcohol and drugs abuse.

7. We expect significant growth in the number of PTSD cases over the next 13 years. These are not short-term problems. PTSD is a lifetime injury. According to the 2004 NCPTSD report, 25,000 US veterans of World War Two were receiving disability benefits and 161,000 Vietnam veterans were receiving compensation for PTSD related symptoms.

Symptoms

8. The symptoms of PTSD include flashbacks, nightmares, emotional shutdown, hyper-arousal and avoidance. These frequently result in the casualty attempting to self medicate with alcohol or drugs. This reduces operational efficiency of the unit and often leads to discharge from the service for unsatisfactory performance. Self-harm, violent behaviour and suicide is common.

In Service PTSD

Failure of Policy

9. The MoD has still not published a coherent policy regarding the detection and treatment of PTSD in British service personnel. Despite convening a major conference to study the issue of PTSD as long ago as 2001, the MoD has failed to develop a policy in the interim period. Given that in four of the six intervening years our armed services have been involved in four major conflicts, the lack of a policy appears, at the very least, to represent a failure of planning. Part of the problem arises from a failure even to acknowledge the existence of PTSD. This seems odd when our major ally in all four conflicts, the USA, both acknowledges that PTSD exists, and has put plans in place to address its impact in existing and future conflicts. We believe that in its casual disregard for the mental health of our service men and women, the MoD’s failure to create a comprehensive policy to deal with the effects of PTSD is wholly unacceptable.

Increased Operational Tempo

10. The exact numbers of Falkland’s veterans with PTSD is unknown but it is an area of major concern for groups such as the Falklands Veterans Foundation and the South Atlantic Medal Association. If the 9% rate (see paragraph 5 above) is correct for this group, some 2,700 of the 30,000 who served in the campaign will have PTSD. 255 British service personnel were killed in combat. Since then over 1% (some 300, plus) of those who took part have committed suicide—ie more than died in the conflict itself. This baleful figure continues to increase and can be expected to rise further due to the current commemoration of the 25th anniversary of the Falklands conflict, triggering late onset PTSD in former combatants and aggravating the reaction in those already diagnosed. Experience shows that as more troops are rotated through Afghanistan and Iraq and the level of exposure to combat trauma increases, we will inevitably see more and more PTSD casualties. Marines and soldiers are 400% more likely to develop PTSD than sailors and airmen due to their repeated exposure to traumatic events.
11. In 1999 the journal of Consulting and Clinical Psychology reported that 3% of males and 8% of females in the Gulf War had PTSD on returning to the US. This doubled over the next 24 months. In 2003, the New England Journal of Medicine (NEJM) reported that 16% of those returning from Iraq had PTSD and the US Department of Defence (DoD) acknowledged that 16% had symptoms of severe depression and PTSD. The Pentagon mental health taskforce 2007 report states that the incidence of psychological trauma is rising with prolonged combat duty: 38% of regular soldiers, 31% of marines, 49% of National Guard and 43% of marine reservists had symptoms of post-traumatic stress, depression, anxiety, and other psychological problems within three months of returning from active duty.

12. The 2006 Annual Report from Combat Stress states, “With nearly 1,000 new cases referred, an increase of 25% on last year alone, the Society’s resources are stretched to the limit . . . since September the number of veterans referred to Combat Stress centres has almost doubled from 81 to 158 . . . The rate of admission from Iraq is much faster. The worry is that it is only the bow wave of what will be coming for many years.”

13. In line with the increased operational tempo of British armed forces, the level of PTSD casualties can be expected to increase significantly over the coming years; and if the US experience provides an accurate guide British PTSD casualties will number in the tens of thousands.

Impact on Morale and Retention

14. With over 100,000 soldiers having served in Afghanistan and Iraq to date, there is a risk that over 9,000 new cases of PTSD will develop among serving British troops. As things currently stand, this means that some 9,000 experienced combat soldiers will be lost to the army, which will further exacerbate the existing retention and recruiting problems. Experience suggests that many will seek early discharge to avoid the stigma of being exposed as a PTSD casualty. This leads to an unnecessary loss of “corporate” military experience, while those who remain are put under still greater pressure. Meanwhile, an increasing burden is placed upon the NHS and social care systems, both of which are ill equipped to handle PTSD in military veterans.

15. A further worrying factor to emerge from the US experience indicates that 8–10% of females deployed to Iraq went on to develop PTSD. It has become clear that the affects of PTSD are much more pronounced and debilitating in women. This will obviously act as a de-motivator for women seeking a career in the armed forces, which will adversely affect recruiting in the female population.

Stigma

16. US Department of Defense research indicates that 60% of PTSD casualties are unlikely to request help for fear of service repercussions. Similarly research published in the NEJM 2003 found that only 23–40% would seek help. There is still a reticence among regular forces troops to acknowledge that they may need psychological support. Those who have identified that they have a serious problem are reluctant to share this information with the chain of command; so they do not present themselves for help, rather relying on self-medication and voluntary discharge as a solution. Many are oblivious to their deteriorating condition, while those around them will often be in denial, unwilling to acknowledge the potential problems within their close knit community. This increases the operational risk to the casualty and those who may rely on him or her in combat.

PTSD Strategies in the US Army

17. One of the biggest issues in dealing with PTSD in combat soldiers is the ability to detect the problem in the first place. Many casualties do not realise that they have a problem. Those who do realise that all is not well often adopt a variety of coping strategies such as avoidance activities and self medicatin. This could go on for years adversely affecting the individual’s performance. Due to the machismo nature of the fighting soldier, and the prevalent misunderstanding that PTSD is a weakness or mental illness, few seek support or counselling.

18. The US Army has acknowledged the reality of PTSD as a combat related injury and they now build in attrition factors due to PTSD into their operational planning. Perhaps more importantly Lieutenant General Kiley (US Army Surgeon General) approved a proactive approach to de-stigmatising PTSD. This has been achieved by valuing the soldier as a fighting resource and like any tank, helicopter or aircraft this human resource needs careful maintenance after an operational patrol. The first element of the maintenance routine, referred to by the US military as a “reset” mission, is an all-encompassing medical assessment which includes psychological testing. Once the testing is complete the soldier is prescribed a comprehensive maintenance plan, including psychological counselling where necessary. This approach creates the understanding that PTSD is a combat injury. It also provides a regular opportunity to conduct a formal assessment of the mental health of the soldier; so early detection of PTSD, and effective intervention, is much more likely to take place. In our view a similar preventative strategy should be adopted for UK fighting forces.
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RESSETLEMENT

19. By definition, PTSD does not exist until 28 days after the traumatic incident. There is a risk of causing more problems by well meaning, but unnecessary intervention during this period. But, outside this window, the earlier PTSD is detected the easier it is to treat. If PTSD screening was provided better access to medical support on discharge. This would go some way to averting the view held by many veterans that they were dumped by the system. Meanwhile, it would enable delivery of a more coherent support system. Such screening would also offer an opportunity to reduce the number of experienced soldiers seeking early voluntary release as part of a strategy to avoid dealing with their PTSD symptoms.

20. PTSD resilience training could be offered as a pre-release training course to service personnel. This would have several benefits: it would show the MoD demonstrating a proper regard for the welfare of its fighting forces; it would also reduce the burden on the NHS and service charities because the PTSD problem would be addressed during its early stages before degenerating into complex PTSD. Moreover, this approach could actually reduce the number of experienced people leaving the armed forces, since following the successful completion of a PTSD resilience training course, they may feel able to continue in military service. These training courses would be designed to help protect existing servicemen and women, and veterans, from the effects of PTSD. We believe that these courses should be funded from Ministry of Defence resources and delivered by the MoD in partnership with voluntary sector and specialist providers.

SOCIETAL PROBLEMS

Prison

21. No precise figures exist on the numbers of ex-servicemen in UK prisons. According to the National Ex-Services Association as many as 7% of the total prison population in the UK is made up of veterans. Many of these prisoners are serving life sentences for murder, some committed while suffering from PTSD flashbacks. This is broadly consistent with US experience where 50% of Vietnam PTSD casualties have been arrested or jailed at least once. 34.2% more than once, while of those brought to trial, some 11.5% were convicted of the charges against them.

22. The UK prison population has just passed 80,000; so as many as 5,600 inmates could be veterans. If we take the conservative 9% figure for the rate of PTSD, then a minimum of 504 veterans are incarcerated as a result of their medical condition. A similarly conservative estimate for keeping someone in prison is £37,500 per annum. So we find that the taxpayer is spending almost £19 million every year to lock up British veterans simply because they cannot get effective diagnosis and treatment for their injury. If we assume that the average time in prison is 3 years, each incarcerated veteran costs the country £112,500. We firmly believe that this money could be better spent on funding a comprehensive programme of community support and training for PTSD casualties, which would reduce the strain on the prison system, the NHS, MoD and Treasury.

23. “Vets in Prison” conducted their own research among inmates at several prisons and found that the ex-services population was 9.8%. A former Captain in the British army surveyed the inmates in his prison and found that 10.85% of the population were ex-military. Of the 80 inmates on his particular wing, 12 were ex-soldiers, most serving life sentences. Of the 12 soldiers in this survey, 6 had attained the rank of sergeant or above. Many had been decorated for gallantry.

24. Even more telling is that when the “Vets in Prison” survey is analysed by service over 95% of the inmates were former army personnel, compared to just over 4% being former navy or air force. Yet only 55% of our total armed forces are army personnel. The army is experiencing a much higher level of active combat than the air force and navy, resulting in a greatly increased probability that soldiers will develop PTSD. Jimmy Johnson, founder of “Vets in Prison” conducted a poll of the inmates on his wing. Eleven of the 120 were ex-services, with ten of the eleven being ex-army. All of these veterans were serving life sentences for murder and none had been screened for PTSD before their trial. Without treatment for PTSD these inmates will be released untreated back into society, with the same problem that caused them to murder; or they will never be released because there is no acknowledged effective treatment that can be used to rehabilitate them. With no opportunity for rehabilitation, these men will be left to rot in jail for the rest of their lives. Can such an outcome be right for those who have risked their lives in the service of their country?

Family breakdown

24. The impact of PTSD goes far beyond the individual casualty. Due to the constant risk of violent outburst and substance abuse, family breakdown and divorce is common. A conservative estimate is that 10 people (parents, spouse, siblings, children, friends and co-workers) are directly impacted by every PTSD casualty. Citing Vietnam figures: 40% of veterans have been divorced at least once, with 10% experiencing two or more divorces; 14.1% had serious marital problems and 23.1% have high levels of parenting problems.
25. The US National Centre for Post Traumatic Stress Disorder estimates lifetime prevalence of alcohol abuse or dependence is 39.2%, and the estimate for current alcohol abuse or dependence is 11.2%. The estimated lifetime prevalence of drug abuse or dependence among male combat veterans is 5.7%, and the estimate for current drug abuse or dependence is 1.8%. As the veteran’s condition worsens they often find themselves unable to find or keep work, resulting in homelessness and criminality.

**Homelessness**

26. In the late 1990s a survey found that 25% of those sleeping rough in London were ex-services. More recently it was report that this figure had fallen to 6%. However, PoppyScotland, in conjunction with Veterans Scotland and the Glasgow Homeless Partnership, during October 2006 conducted a four-week survey of all the users of their hostels and day centres. This survey found that overall 12% of the homeless were ex-military. Of these, 69% had spent less than 5 years in the military, though 4% had over 22 years service. Of this homeless group 28% had approached service institutions for support, while 69% did not know what support was available to them. This leaves a large number of veterans with no effective support, and with an increasing sense of abandonment.

27. Research by the New Policy Institute and Crisis, the homelessness charity, has estimated that there are between 310,000 and 380,000 single homeless people in the UK at any one time. Taking a conservative estimate of the number of homeless as being 300,000 and the PoppyScotland figures as being representative of the national situation, this means on any given night more than 36,000 British veterans are homeless.

**Proposing Effective Responses**

**What Doesn’t Work?**

28. Currently serving, and former, military personnel are confronted by stigmatisation within the military, lack of identification on release, short term support by the MoD, difficulty in accessing social services and health support, unavailability of effective service by the NHS, long waiting lists and disjointed service provision by a variety of organisations. Frequently NHS therapists do not understand the experience and mind-set of a military veteran. Military PTSD casualties placed in NHS programmes typically do not do well because their experience is set at such a pitch that it re-traumatises the civilian casualties, with whom veterans are being treated, which has a disruptive impact on the therapeutic environment.

29. With the looming size of the problem over the next decade we can be sure that existing methodologies and resources, which are selective in whom they accept for treatment, will not meet the needs of this growing high-risk population. Paying almost £600 per day for personnel to stay at the Priory is a luxury veterans cannot afford. What is needed is a radical approach using latest best practice in mental health care and charitable outreach to present a coherent solution that starts in service and is provided to the soldier/veteran through the transition into civilian life.

**What Does Work?**

30. It has been widely acknowledged that the voluntary, or third, sector does better than government in certain areas, and that the charity sector has an important role to play as a service provider working in partnership with the MoD. It has also been acknowledged that military personnel and veterans should be treated in a way that respects their unique needs and experiences. P3 is a leading UK charity (UK Charity of the Year 2005 and 2007 Sunday Times No 1 in the Top 100 Best Companies list) specialising in client groups who find themselves socially excluded.

31. In a speech made in November 2006, Derek Twigg, the Minister for Veterans argued that community-based mental health services should provide the model for service personnel. Meanwhile, the British Medical Journal has reported that a patient-centred and flexible approach to mental health care is the most desirable route to recovery. A community initiative, the Doncaster programme, provided support workers from within the community to deliver local mental health support. Much of this treatment was delivered via the telephone. Clients reported that they greatly appreciated the low-intensity nature of case management assisted recovery and support workers were extremely popular. This programme was considered to be a clear public policy success. Similarly, the Expert Patients Programme is a lay-led self-management programme specifically developed for people living with long-term conditions. The aim of the programme is to support people to increase their confidence, improve their quality of life and better manage their condition. A stress management company, Help Me Overcome, has developed a new training programme for PTSD casualties teaching them how to self-manage their symptoms. The pilot programme achieved better than a 70% success rate for those who attended the training (ie being symptom free or able to self-manage any emergent issues). It is now being reviewed by various US veterans support groups and the Dutch veteran’s hospital.
Veterans

32. P3, in conjunction with Help Me Overcome, has created a comprehensive training programme, which will provide outreach and training services for veterans suffering from PTSD. The objective of the programme is to teach ex-military PTSD casualties how to manage their symptoms and be rehabilitated into society as effective members of the workforce. The training programme will be military focused with the trainers and field workers either being graduates of the programme, military veterans or experienced field workers who have developed expertise in working with an ex-military clientele.

33. This 28 day programme consists of a 3 day residential phase followed by 4 weeks of follow up coaching. After the initial programme has been completed the recovering PTSD casualty is then provided with ongoing support using P3’s existing infrastructure to rehabilitate and rejoin society as a productive individual. It is expected that rehabilitation would be achieved within one year. This provides the most cost effective initial intervention with the one year programme costing about half of the average cost of a typical stay at the Priory.

34. The aim of this programme would not be to duplicate existing service provision but rather to fill an unmet need. In particular, it will seek to provide effective treatment for those PTSD casualties who are currently abusing alcohol and drugs, a group other care providers in this sector tend to avoid. It will be provided nationally in partnership with associated providers.

Support groups

35. Evidence from the pilot programme and best practice in community mental healthcare indicate that the provision of an open, accessible and inclusive support network is essential for the long term effectiveness of the programme. Trainees can support each other, allowing them to gain a sense of self worth. Also carers, family members and children all need support, and possibly their own counselling, to help them overcome any emotional trauma caused by the PTSD casualty. The online support group provided for PTSD trainees is proving to be a very valuable resource to the graduates of the training, their carers and other PTSD casualties looking for answers. As the population of PTSD trainees grows, physical support groups will be established which will act as self-administered groups adhering to the “7 Commitments” (similar to the very effective Alcoholics Anonymous 12 step programme).

Complex Cases

36. There are many cases of complex PTSD in veterans where the co-morbidity of other issues makes it particularly difficult to treat them. Combat Stress, for example, is very selective in deciding which cases to accept because of quite reasonable concerns about potential disruption of its therapeutic environment. Consequently, Combat Stress only accepts 65% of referrals as clients, leaving a considerable number of veterans with no effective help in dealing with their symptoms. This means that there is now a major gap in tackling PTSD casualties, with a significant number of veterans falling through it.

37. In 1989, a residential home was established at Ty Gwyn, Llandudno, whose mission was to provide care for the more difficult complex PTSD casualties. It had become apparent that the respite care provided elsewhere had often proved inadequate. Indeed, at one point Ty Gwyn held a contract from Combat Stress to take the latter’s more demanding clients because the clinical care offered by Combat Stress was not designed to cope with more difficult cases of PTSD.

38. Ty Gwyn adopted the position that it would accept all ex-military PTSD casualties and provide full clinical care—where necessary to complete a thorough detoxification (for drugs or alcohol) before dealing with the PTSD symptoms. When this facility was forced to close due to lack of funding from the NHS over 1,500 veterans with complex PTSD were left without any effective support. Many of these had not been referred to Combat Stress, while others had found the level of respite care provided by Combat Stress ineffective for treating their condition. The majority of those who completed a recent PTSD resilience training course had been residents with Combat Stress, but were still experiencing full blown PTSD symptoms when they entered the programme.

39. The closure of Ty Gwyn provides the clearest possible example of the failure of policy with regard to moving the treatment of military personnel into the NHS and away from specialist military facilities. In the case of those with complex PTSD, whose psychiatrist had recommended that they should receive care at Ty Gwyn, all too often the casualty’s local PCT refused to sanction the necessary funding on the grounds that they were already paying for local psychiatric and psychology services. They saw no reason to provide the specialist intervention available to the very difficult cases accepted by Ty Gwyn and therefore blocked both referrals and funding. With Ty Gwyn’s closure those casualties rejected by Combat Stress were left to fend for themselves, since they had already been failed by the conventional psychiatric services.
Recommendations

40. A residential facility providing a more supportive environment for complex PTSD cases should be established and referrals to it encouraged. This would allow casualties to safely detoxify, which would provide the highest probability of success during the delivery of a comprehensive training programme designed to help complex PTSD casualties. This facility would provide short-term residential programmes, typically four weeks, for detoxification and PTSD resilience training.

41. As this model of service delivery becomes established it would also provide an opportunity to create specialist training expertise which would be made available to the MoD for inclusion as an in-service programme. This expertise could be deployed so as to offer protection against developing PTSD among serving personnel.

Conclusions

42. The extent of the problem of PTSD among serving personnel and veterans is already considerable and can be expected to continue to increase with the current tempo of operations. It is quite clear that the currently available approaches are inadequate for dealing with PTSD. It is also clear that existing treatment facilities, already overstretched, will be unable to cope with the increased demand for the services they provide. Accordingly, it is imperative that new models and innovative solutions are fully examined now for efficacy in dealing with the predicted demand.

43. The US military has made significant progress in destigmatising PTSD and already includes psychological maintenance as an integral part of post deployment activity. The lessons learned, and applied by the US military should be considered for inclusion within the British military approach to PTSD. Any such initiatives among British forces should be developed so as to provide a coherent, seamless transition for those who chose to leave the service due to their injury.

44. Programmes for dealing with PTSD in veterans should be based around current best practice for community mental healthcare and should demonstrate a willingness to adopt new and innovative solutions and techniques. It is essential that outdated thinking and ineffective programmes should be ditched in favour of those that can prove their effectiveness. All programmes must be outcome-focused with clear, measurable cost-effectiveness criteria designed into them.

45. Our armed forces and veterans deserve nothing less than proper care for injuries they have sustained while fighting for their country. Without a comprehensive policy designed to ensure the mental health of our armed forces, including programmes to deal with the more difficult PTSD cases, it is clear that our servicemen and women are being badly let down. As the number of casualties presenting with symptoms of PTSD increases with the raised tempo of operations, such a failure of policy can only be viewed as shameful.

28 June 2007

Memorandum from the British Red Cross

Summary

(i) The British Red Cross Society welcomes the opportunity to contribute to the above inquiry. We have a particular interest in one of the areas being addressed, namely:

“Medical support for operations, including the treatment of injured personnel—from immediate treatment in the theatre of operations to after-care in the UK—and the facilities provided for them.”

(ii) Our special interest stems from the legal and historical basis of our Society, as an officially recognised voluntary aid society, auxiliary to the Medical Services of the British Armed Forces.

(iii) British Defence Military Services (and its predecessors) have not required British Red Cross auxiliary personnel to serve with British Forces medical units overseas for perhaps half a century. However, the British Red Cross has always retained a role in plans for the reception of wounded and sick British Service personnel returning to the United Kingdom from the theatre of operations. Moreover, our legal commitment—as set out in our Royal Charter of Incorporation and in the 1949 Geneva Conventions for the Protection of War Victims, remains in force.

(iv) We note that circumstances for Defence Medical Services have changed in recent years, and that there may now be a need for increased auxiliary support, both within the UK and overseas. The British Red Cross, being mindful of its recognition as an auxiliary (in effect) to Defence Medical Services, and of related legal and statutory commitments, is willing to consider reinvigorating and developing its support role to Defence Medical Services, both within the UK and internationally.
BACKGROUND ON THE BRITISH RED CROSS

1. The British Red Cross helps people in crisis, whoever and wherever they are. We are part of a global network that responds to conflicts, natural disasters and individual emergencies. We enable vulnerable people in the UK and abroad to prepare for and withstand emergencies in their own communities, and when the crisis is over we help them to recover and move on with their lives.

2. The British Red Cross is part of the International Red Cross and Red Crescent Movement, which comprises:
   2.1. The International Committee of the Red Cross;
   2.2. The International Federation of Red Cross and Red Crescent Societies; and
   2.3. 186 National Red Cross and Red Crescent Societies world-wide.

3. As a member of the Red Cross and Red Crescent Movement, the British Red Cross is committed to, and bound by, its Fundamental Principles. These are: humanity, impartiality, neutrality, independence, voluntary service, unity and universality.

RESPONSE OF THE BRITISH RED CROSS TO THE INQUIRY

Long-standing auxiliary commitment to British armed forces’ medical services

4. The British Red Cross Society (BRCS) was founded in 1870. Its original role was as an auxiliary to the medical services of the British armed forces and this commitment has never ceased. The British Red Cross is one of the three officially recognised and authorised British Voluntary Aid Societies, as that term is understood under the 1949 Geneva Conventions for the Protection of War Victims. Unlike the other British Voluntary Aid Societies, the British Red Cross’ role as a humanitarian auxiliary applies in peacetime, as well as during armed conflict, and applies to the British public authorities in general ie not simply to British Defence Medical Services (DMS).

5. During the first some 80 years of its existence, the British Red Cross had an active role as an auxiliary to the medical services of the British armed forces. This gradually decreased following the Korean War in the early 1950s when there was less need for the British Red Cross’s direct support to UK military medical services. However, the British Red Cross has never lost its connection to the medical services of British Forces. Together with the other Voluntary Aid Societies, it had a role in civil defence plans during the Cold War. In addition, during the 1980s and the 1990s, the British Red Cross and the other Voluntary Aid Societies were part of plans to evacuate, and subsequently rehabilitate, casualties arising from a conflict in Northwest Europe to the UK and engaged in extensive joint planning and training to support that contribution. Although circumstances have changed in more recent years, the British Red Cross retains a role in reception arrangements for military casualties into the UK.

6. Following both World Wars, the British Red Cross provided financial and other support to ex-Service personnel disabled in those conflicts, largely through the Joint Committee of the Order of St. John and the British Red Cross Society (presently in the process of being dissolved). The Joint Committee had a Service Hospitals Welfare Department which stationed Welfare Officers at Service hospitals within the UK and overseas, and on deployment to mobilised field hospitals. This work is continued by the St. John and Red Cross Defence Medical Welfare Service, with which the British Red Cross continues to have a link.

Royal Charter of Incorporation

7. The BRCS’ Royal Charter of Incorporation sets out the government’s official recognition of the British Red Cross, both as a voluntary aid society, auxiliary to the public authorities, and as the only National Red Cross Society of the United Kingdom (this includes all territories under British jurisdiction overseas). The relevant provision makes express reference to the British Red Cross’s role in support of (in effect) DMS:

“The Society is recognised by Our Ministers as a voluntary aid society, auxiliary to the public authorities and particularly to the medical services of the armed forces in accordance with the Geneva Conventions for the Protection of War Victims of 12 August 1949 (as amended from time to time), . . . .”.

8. These two officially recognised roles—as an auxiliary, and as a National Society—imply certain obligations on the part of the BRCS. These obligations include the following:
   (a) to be prepared to carry out the special tasks of a voluntary aid society, auxiliary to the medical services of the United Kingdom’s armed forces;
   (b) to carry out the special tasks of a National Red Cross Society;
   (c) to co-operate with and support the public authorities as far as possible in the humanitarian field; and
   (d) to consider any reasonable request for assistance from the government, including the armed forces, and to respond as helpfully as possible.


Relationship between the British authorities and the British Red Cross

9. By virtue of such recognised roles, the UK government, and DMS, have the right to call upon the British Red Cross for assistance in the humanitarian field and to expect a positive response as possible. At the same time, under the Statutes of the International Red Cross and Red Crescent Movement (explained below), the UK is committed to co-operating with the British Red Cross as its National Society, and to supporting its work.

International responsibilities

10. The British Red Cross has legal or statutory obligations arising from international instruments, in addition to those resulting from its own Royal Charter and national law. These special sources of obligations include: the 1949 Geneva Conventions for the Protection of War Victims and their 1977 Additional Protocols; the 1986 Statutes of the Movement, and resolutions of International Conferences of the Red Cross and Red Crescent.

Tasks during armed conflict

11. The Geneva Conventions and their Additional Protocols give a National Society such as the British Red Cross, a number of humanitarian tasks related to armed conflicts. Those of direct relevance to the Inquiry include the following. The British Red Cross may act as an auxiliary to the medical services of its country’s armed forces on land (Geneva Convention I, Article 26) and at sea (Geneva Convention II, Article 24). British Red Cross personnel carrying out this role would be employed on the same duties as regular DMS personnel. This could include the search for, or the collection, transport or treatment of the wounded and sick of the armed forces, the prevention of disease in the forces, and the administration of Service medical units and establishments. The British Red Cross staff would enjoy the same protection as DMS personnel under the Geneva Conventions. They should be respected, cannot be attacked and have a special status should they be captured. They are, as a consequence, subject to military laws and regulations.

12. Although not directly relevant to the auxiliary role in support of DMS, it may be worth noting that the British Red Cross, as a National Society, may also provide relief to prisoners of war (Geneva Convention III, Article 125) and to civilian internees (Geneva Convention IV, Article 142). It has the right to assist civilians in its own country during armed conflict (Geneva Convention IV, Article 30). The British Red Cross also has a role in transmitting family messages and tracing missing persons, which continues in peacetime (Geneva Convention IV, Article 25, and 1977 Additional Protocol I to the 1949 Geneva Conventions, Article 33).

Requirement to be prepared to carry out these functions

13. Some of these treaty provisions are permissive in character ie the British Red Cross may or has the right to undertake a specified action. However, the Society would be failing to abide by the conditions for its recognition if it did not actively seek to be prepared to carry out these special tasks (eg Statutes of the Movement, Article 4(6)); it would be failing in its role as the only National Society of its country (ibid., Article 4(2)).

Training role in the Law of Armed Conflict

14. The British Red Cross also has a special role in disseminating knowledge of international humanitarian law (also called the Law of Armed Conflict), both on its own initiative and in co-operation with the government and armed forces (Statutes of the Movement, Article 3(2); Royal Charter, Articles 5.2 and 5.3). The BRCS is already starting to offer training on Joint Medical Officers Planning Courses, and we would be very interested to establish this on a regular basis. We would also be willing to explore the possibility of offering training—perhaps in conjunction with the International Committee of the Red Cross (ICRC)—to DMS in detainee/prisoner of war handling.

Challenges of capacity and perception

15. The British Red Cross would face certain challenges in reinvigorating its auxiliary role to DMS. It may need to recruit personnel specifically for that role, and individuals working for the NHS may have difficulty getting released for such service. We would need to develop joint training and planning with DMS; there would likely be a requirement to obtain equipment and uniforms. In addition to challenges of capacity, the Society may need to explain the neutrality of the medical function and of the auxiliary role. It is a basic

23 The last two named—the Statutes and International Conference resolutions, were adopted by representatives of all States party to the 1949 Geneva Conventions, including the UK, as well as by all Red Cross and Red Crescent organisations.
tenet of the Law of Armed Conflict, as established by the original Geneva Convention of 1864, that providing help to wounded combatants during an armed conflict is a neutral humanitarian act, regardless of whether it is carried out by the military medical services or by Red Cross workers.

Willingness to discuss a standing relationship with Defence Medical Services

16. Nevertheless, the British Red Cross in furtherance of its commitments and being aware of constraints on Defence Medical Services, is willing to consider developing its role as an auxiliary to DMS, both within the UK and overseas. The Surgeon General kindly approached us in February of this year to discuss the matter. We gave him an affirmative indication of our interest then, which we are happy to affirm in connection with the Defence Select Committee’s Inquiry.

25 June 2007

Memorandum from John Champion

I noticed the current work the Defence Committee is undertaking and wondered if an anecdote about a relative, one of your constituents, might strike a chord.

A tiny number of serving soldiers leave the Army to go to medical school as mature students. They are required to retire from the Army to do so, despite the seemingly perennial shortage of military doctors. Additionally, they receive no assistance from Defence Medical Services to gain a place at a medical school, which remains highly competitive, although MoD is a key stakeholder at Birmingham (which offers a 4 year course for mature applicants).

One assumes the underlying logic is financial, yet the cost of paying the small numbers involved as serving officers or soldiers would be minute in the larger picture. Policy implementation appears to be slavish. There is noting to prevent anyone applying for a bursary for the last 3 years of medical training or applying to rejoin the services after qualifying, but that is more haphazard than continuing engagement.

It seems strange that MoD does not make any effort to capture the continued service of a few doctors with full Sandhurst or non-commissioned training and previous military experience. I assume the policy is the same across the other Services.

23 June 2007

Further memorandum from the Ministry of Defence

Welfare Support for Service Personnel and their Families

Casualties’ Immediate Needs

1. Defence Medical Welfare Service (DMWS) staff supply casualties with “comfort kits” comprising toiletries, plus any clothing they require on arrival. Items such as rucksacks, TV cards, the loan of portable computers with Internet access, or TVs in their ward are also available on request.

2. The Defence Medical Welfare Service provides 24/7 on-call response to urgent needs.

3. The Ministry of Defence (MoD) has recently increased the allowances paid to all its hospital in-patients to assist with their short-term needs. Whilst hospitalised, all patients receive £5 per day for incidental expenses, without the need for receipts. If hospitalisation is overseas, Service patients receive £10 per day for incidental expenses. In addition, if a Service patient was in receipt of the Operational Allowance and/or Longer Separation Allowance at the time they were hospitalised, then these allowances would continue until they were discharged.

4. We are of course also grateful for the support that Service charities supply in meeting casualties’ needs whilst in hospital.

Travel/Subsistence Support for Families

5. The family of an injured Service person who has the required medical recommendations is entitled to travel, accommodation and subsistence at public expense.

6. The MoD covers the cost of travel, accommodation and subsistence for two close family members to be at the bedside of an injured Service person. This can be extended to allow other additional family members to travel to be at the bedside. This is done if it is deemed by the medical authority to be in the best interest of the patient’s recovery. Examples of exceptional circumstances include: split families; partners who are not next of kin and other close relatives such as siblings. Each circumstance is considered on a case by case basis.
7. Initially, these costs are covered for 7 days, but can be extended for as long as required, subject to medical advice. The regulations equally apply to the families of Foreign & Commonwealth Service personnel.

**Visiting Officers**

8. Families of an injured Service person are assigned a visiting officer whose main responsibility is to act as the link between them and the Service. The visiting officer is trained in this role and will be fully aware of the families’ entitlements. The visiting officer will advise families accordingly and will liaise with the appropriate authorities to make the necessary arrangements as required.

9. Welfare officers at Selly Oak also supply information to family members.

10. The appropriate publications, including JSP 751 (Casualty and Compassionate Policy Procedures) and JSP 752 (Tri-Service Regulations for Allowances), are widely available and clearly set out the entitlements for families.

**Accommodation**

11. The Royal Centre for Defence Medicine (RCDM), Birmingham, has allocated 5 rooms providing overnight accommodation, plus a “quiet room” in one wing of the hospital for use by relatives visiting Service personnel. These rooms are provided free and on a priority basis to the families of those most seriously injured.

12. Further accommodation is available on the Selly Oak site including flats which can be used as family rooms. Some of the flats have benefited from recent refurbishment funded by the Soldiers, Sailors, Airmen and Families Association (SSAFA), which is helping to provide a more suitable environment for the families of the patients concerned. RCDM can also provide a list of local B&B accommodation which has been inspected by Defence Medical Welfare Services (DMWS).

13. The MoD places enormous priority on the needs of its injured personnel and their families. To that end, procedures are under continual review to ensure that the best possible support is provided. In addition the MoD acknowledges the excellent support provided by charitable organisations in achieving this aim.

**Waiting Lists**

**NHS Treatment**

14. Serious injuries Service personnel sustaining serious injuries are treated immediately.

15. Elective hospital treatment Where military patients need elective hospital treatment, they are entitled to receive local NHS treatment in any District General Hospital, or they are referred to one of the NHS Trusts (referred to as host trusts) which host the five Ministry of Defence Hospital Units (MDHUs) or to University Hospitals of Birmingham Foundation Trust (UHBFT) where the Royal Centre for Defence Medicine is based.

16. In recent months, at any one moment in time, approximately 4,200 personnel across all three Services are in the process of being seen in the MDHUs or UHBFT. Many of these are being seen for relatively minor conditions (e.g., dermatitis or a vasectomy) that will not affect their deployability. The MoD has agreements with these Trusts to provide accelerated access for elective referrals of Service personnel to meet operational requirements. The MDHUs are situated in areas with dense military populations so the trusts are ideally located to provide the required accelerated access. The accelerated access at the MDHU Host Trusts currently provides for approximately 50% of cases being seen in 4 weeks to outpatient appointment, and 6 weeks to surgery, if this is clinically appropriate. We are working with the MDHU Host Trusts to deliver 100% within these targets by April 2009. These are much shorter timelines than current NHS targets, which are 13 weeks to outpatient appointment and 6 months to inpatient treatment. They will still be shorter than the future NHS target for the patient pathway from referral to treatment which must be within 18 weeks by the end of 2008.

17. We hold the following figures for purely elective referrals to MDHU Host Trusts for the year 06/07 (i.e., they do not include treatment of operational casualties; other emergencies that are treated on a clinical need basis; and the estimated 30–40% of elective referrals from single Service primary health care that are treated by local District General Hospitals that do not host MDHUs).

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24 Due to child protection policy at the University Hospital Birmingham Foundation Trust, children under 16 are not allowed to stay in the 5 RCDM rooms, since the accommodation contains communal facilities which are used by other adults staying in the accommodation.

25 i.e., they have been referred for an outpatient or inpatient appointment, or are already receiving a course of treatment.
18. The vast majority of these patients remain at work during the referral process.

19. Additionally, the MoD has developed a specific musculo-skeletal fast track programme to meet the relatively high incidence of these disorders within the military environment. Full details of this programme are provided within para 43 of the MoD’s Memorandum of Evidence.

_Treatment outside the NHS_

20. Many military patients receive treatment outside the NHS and do not, therefore, appear on NHS waiting lists. For patients requiring physical rehabilitation care, the Defence Medical Services (DMS) have their own facilities. We also have our own out-patient mental health facilities; inpatient mental health care is provided in psychiatric units belonging to the Priory Group of Hospitals. Last year’s figures for those treated and assessed in our Regional Rehabilitation Units (RRUs) and referred on for Fast Track treatment are set out within Annex C of the MoD’s original Memorandum of Evidence.

21. The latest available data for the year ending 31 March 2007 show that there are less than 800 Service personnel (around 0.5%) unfit to undertake any military duties.

22. Some 23,700 (13.7%) are not fully fit for unrestricted employment, but, for example, of around 16,000 in the Army in this category, some 11,000 are still “operationally deployable with medical limitations”. For example, an infantry soldier could still work in an operational HQ if he was unable to withstand high levels of physical activity. Similarly, many of those not fully fit for unrestricted employment in the Navy and Air Force are still able to play some part in maintaining operational capability (eg filling home base billets thereby releasing fully fit personnel for deployment.)

_Reception Arrangements for Military Patients (RAMP)_

23. Since April 2001, RCDM at Selly Oak has been the main centre for the return of UK Armed Forces casualties aeromedically evacuated from all over the world, including Iraq and Afghanistan. The NHS Hospitals in Birmingham have the capability to manage the full range of clinical needs that Service patients might present, and a significant proportion of these patients will be treated on trauma/orthopaedic wards, including the new Military Managed Ward.

24. UHBFT has the capacity to cope locally with the scale of surges seen to date in the number of military casualties.

25. In the event of a significant casualty surge, the MoD and UHBFT would jointly manage the receipt of casualties, and would be able to use the existing national Reception Arrangements for Military Patients (RAMP) plan. This plan is designed to handle increasing numbers of Armed Forces casualties returning to the UK from an overseas theatre of operations in time of conflict. Elements of RAMP have been invoked successfully in the past (eg in the early phase of OP TELIC) and we have established an effective partnership with the Department of Health (DH) at government level and locally between NHS Trusts and military units. Under RAMP, when casualties are aeromedically evacuated to the UK, the selection of the hospital to which they will be admitted is made in conjunction with the DH on the basis of clinical need and bed availability.

_Derek Twigg_

10 July 2007

26 Paras 22–4 MoD Memorandum of Evidence.
27 16,081 Army, 3171 Navy, 4450 RAF.
28 This covers those in medical categories P3 (fit for service including operations within specified individual limitations), P4 (pregnant) and P7R (temporarily unfit for full duties).
Further memorandum from the Ministry of Defence

**History**

1. RFA Argus was originally launched in 1981 as Contender Bezan; a combination freight, roll on and roll off ferry (RORO) and container ship. She was one of the ships taken up from trade by the MoD for use in the 1982 Falklands War.

2. Following purchase by the MoD in 1985, she was converted to an aviation training ship at the shipyard of Harland & Wolff, Belfast, with the addition of extended accommodation, a flight deck, aircraft lifts, naval radar and communication suites. Another role of RFA Argus has been that of RORO vehicle transport, with vehicles carried in the hangar and on the flight deck. She performed this role in support of United Nations operations in the former Yugoslavia.

3. A Primary Casualty Receiving Facility (PCRF) was added before Argus was sent to participate in the 1991 Gulf War.

**Primary Casualty Receiving Facility (PCRF)**

4. RFA Argus's primary role is now as a PCRF. PCRF is a purpose-built Role 3 medical treatment facility, which provides the Royal Navy with a floating hospital when needed.

5. The facility offers 100 patient beds; comprised of 10 Intensive Therapy beds, 20 High Dependency and 70 general beds. It also possesses a range of state of the art medical equipment and accommodates personnel with the relevant clinical expertise.

6. The PCRF can be manned to provide 3 levels of capability, involving the use of 25 beds, 50 beds and 100 beds. The mix of specialists that can be provided on board is tailored to the mission requirements but can include:
   - Oro Maxillo-facial
   - Ophthalmic
   - General Surgery
   - Orthopaedic Surgery
   - Ear, Nose & Throat
   - Neurosurgery
   - Burns & Plastics
   - Full laboratory capability
   - CT Scanner
   - Psychiatry
   - Medicine
   - Emergency Medicine
   - General Practice
   - Microbiology
   - Primary Dental Care
   - Anesthetics
   - Infection Control
   - Pharmacist
   - CSSD
   - Radiography

7. All medical specialties are supported by trained and experienced nursing and medical staff.

8. The hospital facility was initially fitted for the first Gulf conflict in 1991 as a portacabin structure. A major rebuild of the facility took place in 2001 which has resulted in the present permanent facility. RFA Argus deployed to the Iraq war in 2003 and regularly takes part in exercises in company with other vessels designed to test her PCRF capability.

9. Exercise Medical Endeavour will take place between 23 September and 6 October 2007. The exercise will dovetail with a 3 Cdo Bde exercise and will allow interplay between the Role 1 and 2 medical facilities on shore within 3 Cdo Bde and the Role 3 (hospital) facility on RFA Argus.
10. During operations and exercises, clinical staff drawn predominantly from the Ministry of Defence Hospital Units (MDHUs) in Portsmouth and Plymouth join the vessel to allow her to deliver the levels of medical expertise required.  

11. When the PCRF is not required for operations and exercises, RFA Argus still routinely operates as a Helicopter Platform Landing Training vessel. On these occasions, the PCRF is maintained by a small permanent cadre of 3 personnel. Additionally, a number of posts are pre-identified in Ministry of Defence Hospital Units (MDHUs) to provide Command and Control of the Facility. For example, Commanding Officer MDHU Derriford is also Commanding Officer PCRF.

11 July 2007

Memorandum from the Department of Health

1. The Department of Health is pleased to have this opportunity to provide a Memorandum to the Defence Select Committee and to reaffirm our commitment to ensuring that the Armed Forces, veterans, and their families have access to high quality health services.

2. For clarity, this Memorandum relates to the Department of Health and the NHS in England only. NHS services in Scotland, Wales and Northern Ireland are the responsibility of the Devolved Administrations.

3. This Memorandum covers:
   — NHS responsibilities for the Armed Forces, reservists, veterans and their families;
   — working together to provide modern and effective clinical support;
   — Department of Health/Ministry of Defence (MoD) working relationship; and
   — working together in practice.

NHS Responsibilities for the Armed Forces, Veterans and Their Families

4. The NHS provides a universal health service for all, based on clinical need, and centred on the needs of the patient. The NHS provides primary, secondary and tertiary services, through NHS Trusts, new NHS Foundation Trusts and other providers such as GPs and dentists. The NHS is responsible for healthcare for service families (although there are special additional arrangements for families abroad) and for veterans, and works in partnership with the Defence Medical Services (DMS) to provide health services for the armed forces.

5. Much healthcare for the Armed Forces, including primary healthcare and healthcare during operations, is provided through the DMS, as detailed by the Memorandum provided by the MoD. Upon mobilisation, reservists become the responsibility of the MoD and go through the same pathways as regular service personnel. When they are demobilised, they again become the responsibility of the NHS.

Healthcare for the armed forces

6. Health Service Guidance covers the treatment of service personnel in NHS hospitals and the continuing medical care of service personnel on retirement or discharge from the Armed Forces. The same Guidance also covers the use of DMS personnel in NHS Trusts.

7. The Guidance sets out a series of underpinning principles. These are that:
   — the treatment of service personnel should, as far as is appropriate, align with NHS arrangements for the treatment of civilian;
   — MoD is able to secure higher levels of access where required for operational reasons from any NHS Trust or other provider as appropriate, in return for enhanced payments;
   — NHS improved performance will also benefit healthcare for service personnel, and hence operational effectiveness;
   — DMS personnel working at Medical Defence Hospital Units (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.

8. Responsibilities are as follows. In primary care, members of the armed forces should be removed from GP practice lists when they enlist (as required by NHS Regulations), and should not be able to register whilst they are serving. During this time, the MoD is responsible for their primary medical services through the DMS. However, where a member of the armed forces does not have ready access to DMS (eg when on leave), they can join the list of a local GP practice as a temporary resident.

29 Staff are mainly Royal Navy personnel, although there are a small number of posts filled by the other Services.
9. In relation to secondary care, members of the armed forces based in the UK are entitled to the full use of NHS facilities on the same basis as civilians if appropriate military healthcare provision is not available. Equally, members of the armed forces serving overseas are also entitled to full use of NHS secondary care facilities without charge, should they return to England for their treatment. Primary Care Trusts (PCTs) are responsible for securing the provision of secondary care treatment for such personnel in the UK, ie they must make sure that services are available for them if they are not accessing military healthcare provision. The MoD is responsible for the provision and/or commissioning of healthcare to entitled personnel in the majority of places where service personnel are stationed abroad.

10. In addition to normal NHS responsibilities, the DMS contracts with the NHS to provide secondary care facilities for forces based in the UK. It has specific contracts with 6 NHS/NHS Foundation Trusts. MDHU has been established within the following:

- Plymouth Hospitals NHS Trust.
- Frimley Park Hospital NHS Foundation Trust.
- Peterborough and Stamford Hospitals NHS Foundation Trust.
- Portsmouth Hospitals NHS Trust.
- South Tees Hospitals NHS Trust.
- The Royal Centre for Defence Medicine at the University Hospital Birmingham NHS Foundation Trust—UHBFT. UHBFT is often referred to as Selly Oak Hospital. This is one of the hospitals in the UHBFT and the location of the main poly trauma ward where the majority of those service personnel medically evacuated back to the UK from Iraq and Afghanistan are located.

11. At the MDHUs, the MoD have agreements with the NHS Trusts to provide accelerated access for elective referrals of service personnel to meet operational requirements. There are also single contracts between the DMS and particular Trusts when needed. More details are given in the Memorandum provided by the MoD.

12. There were unfortunate media stories of alleged ill treatment received by military patients at Selly Oak Hospital, Birmingham earlier this year. As a high performing NHS Foundation Trust, UHBFT has publicly denied many of the allegations and has addressed these with the Committee in its written and oral evidence. The Department of Health shares the view of the Committee in recognising the important work that is done at Selly Oak. The Department is proud of the high quality of clinical care provided by the staff working at the hospital and wishes to extend its thanks to the clinical and management teams involved. The Department also recognises and endorses the move to establish a military-managed ward at Selly Oak, to provide an environment that is appropriate and welcomed by service personnel, with high quality clinical support on hand.

Continuing medical care of service personnel on retirement, demobilisation (in the case of reserves) or discharge from the Armed Forces

13. 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. The vast majority of personnel leave the Services fully fit or with minor ailments only. For the small number of service personnel who leave the forces with a serious illness, any outstanding or on-going care will usually have been arranged prior to discharge. For the small group of service personnel who have a significant and debilitating illness or condition at the time of military discharge, the aim is to reach agreement on future care pathways prior to the discharge from the armed services. This is enabled through early contact between the MoD and the PCT of future residence. We recognise that we need to keep working closely with the MoD to ensure that these “best practice” arrangements are operating well in practice.

14. Guidance also covers Priority Treatment for War Pensioners (HSG (97)31). These guidelines state that NHS hospitals should give priority to war pensioners, both as out-patients and in-patients, for examination or treatment which relates to the condition or conditions for which they receive a pension or received a gratuity (unless there is an emergency case or another case demands clinical priority). These priority treatment guidelines do not apply for unrelated conditions. The Department takes regular opportunities to bring these guidelines to the attention of the NHS. The Chief Medical Officer is planning to provide an update for GPs shortly.

15. War pensioners and veterans in receipt of armed forces compensation are also entitled to other benefits, if they are related to the relevant disability. These include free NHS prescriptions, NHS wigs and fabric supports at the point of treatment and the ability to claim money back for dental treatment, costs of travelling for clinical care, sight tests, glasses or contact lenses.

16. War pensioners can use the NHS complaints system to resolve any alleged breakdowns in the arrangements for priority treatment. This includes ultimately asking the Health Services Commissioner to investigate their case.
The families of service personnel

17. The families of UK armed forces members can—and would normally—remain registered with GP practices although they are able to access primary care from the DMS when overseas. They will access all NHS services on the same basis as any other UK citizen.

18. The particular pressures placed on families who may move around the UK on a more frequent basis than the general population are recognised. These should not, though, create any disadvantage in terms of access to NHS services. Usual arrangements are explained here. Again, this is an area where the Department of Health works closely with MoD to ensure that these arrangements work well in practice.

19. For primary care services, families access local services in the same way as anyone else and, in particular, register with local GPs.

20. Particular concern has been expressed about access to primary care dentistry by service families. Action is under way to improve access to dental services in England generally, following major reforms introduced from April 2006 and significant increases in investment in NHS dental services. Since 2003/04, the Government has increased annual investment by around £400 million (before taking into account annual pay increases). Overall expenditure in 2005/06 (including revenue from patient charges) was around £2.1 billion. At present, around 56% of the population of England receive NHS dental care at least once within a 24-month period—this compares with an historic peak of around 60% registration levels at a time when there were no significant reported problems of access to services.

21. New legislation (Primary Care Trust Dental Services Directions 2006) places a duty on PCTs for the first time to provide or commission primary care dental services to meet reasonable needs in their area. Most PCTs now have helplines to direct patients to practices with capacity to take on new NHS patients in their area. These helplines are well-placed to help service families to find NHS services in any particular area. It would also be possible for the MoD to make contact with the PCTs to discuss arrangements for providing dental and other care in preparation for service family moves.

22. There has also been some concern expressed about frequent moves making it more difficult to access secondary care services. Access to secondary care services has been improving for the whole population. Since 1997, the number of patients waiting more than 6 months for hospital treatment has fallen from over 283,000 to 312 at the end of June 2007. The number waiting over 3 months has fallen from over 570,000 to under 100,000. Waiting times have been reduced. Outpatient appointments—including those for fertility problems—are covered by NHS targets. The wait between a GP referral and the appointment should not exceed 13 weeks.

23. The Department of Health recognises that any NHS patient may have to move during courses of treatment. The Department recommends as good practice that when the original hospital sends patients to another hospital for treatment, both Trusts communicate with each other regarding the patient transfer. This enables the receiving hospital to take into account the length of time the patient had already waited at the original hospital. This would of course apply to service families.

24. This general approach would apply to fertility/IVF patients who move while they are on a waiting list or during treatment. Department of Health advice is that there should be discussion between clinicians and PCTs, so that an appropriate arrangement can be made for a patient who is moving. For service personnel or their family, the transfer should be agreed in advance between the two Trusts involved, the waiting time should not be reset and there should be no penalty.

NHS local funding and commissioning arrangements

25. Funding arrangements and guidance on commissioning services for local populations provide the framework for PCTs to meet the needs of service personnel and their families.

26. In England, PCTs are responsible for funding the healthcare provision of all patients registered with GPs in practices forming the PCT. PCTs are also responsible for residents within their geographical boundaries who are not registered with a GP.

27. The Department of Health provides funding to PCTs to meet these responsibilities. Revenue allocations are made to PCTs on the basis of the relative needs of their populations, to enable them to commission similar levels of health services for populations in similar need. A weighted capitation formula is used to determine each PCT’s target share of available resources. The components of this formula include the size of the population for which PCTs are responsible, their relative need (age and additional need) for healthcare, and unavoidable geographical differences in the cost of providing healthcare (known as the market forces factor).

28. With regard to the armed forces, service personnel are included in the secondary care elements and PCT revenue allocations, and excluded from the primary care elements, as these services are provided by the DMS. UK Armed Forces’ dependents and former service personnel are included in all elements of PCT revenue allocations, as of course the PCT is responsible for their healthcare.
29. From April 2008, it is expected that legislation and underpinning guidance will put in place strengthened mechanisms for the needs of service populations to be fully considered and taken into account in planning at local level. New legislation (the Local Government and Public Involvement in Health Bill 2007) clarifies the duty on NHS bodies, including NHS Trusts (including PCTs) and NHS Foundation Trusts, to involve and consult local populations on the planning of provision of services and the development and consideration of significant proposals for change. In areas with service populations, the Armed Forces community would be able to become involved in these consultation exercises to ensure that their concerns and needs were recognised. Further, a new duty is also placed on NHS Trusts and NHS Foundations Trusts to work with Local Authorities in determining local improvement priorities. These will be determined through Joint Strategic Needs Assessments. The needs of specific groups, such as service populations, which are relevant in particular local areas should be taken into account through this process. It is hoped that this Bill will receive Royal Assent in October 2007. We believe that this is important legislation which could be beneficial in providing new routes for the needs of the community to be recognised and addressed.

**Working Together to Provide Modern and Effective Clinical Support**

30. The NHS is fully committed to playing its part in supporting the UK’s Armed Forces by working in partnership to ensure that the Armed Forces has a well-trained and deployable operational healthcare capability.

31. The NHS does this through a number of means:

- putting in place arrangements within NHS organisations, both those which host MHDUs and others, to ensure that DMS personnel have access to training opportunities and to maintain and improve their clinical skills through working in NHS organisations, while being able to be released to support deployed operations and exercises when required;

- encouraging civilian healthcare personnel to join the Volunteer Reserve Force (VRF)—for example, East Midlands Strategic Health Authority (SHA) is encouraging their healthcare graduates to include the Armed Forces in their career options and is promoting this idea with the other SHAs—or to support defence medical requirements in other ways, providing important additional operational capability for the DMS; and

- loan and secondment arrangements to the DMS of NHS personnel to fill civilian medical management appointments in the DMS.

32. These are mutually beneficial arrangements. The NHS benefits from this through enriching professional and personal development opportunities for the NHS workforce; making good use of the skills of DMS clinicians to meet NHS requirements when not on deployed operations and exercises; and working closely with the DMS to share expertise in relevant clinical areas, for example trauma and rehabilitation. Experience in the VRF is seen as a good opportunity for professional development.

33. Department of Health officials are discussing with MoD ways in which NHS staff can be encouraged to join the VRF. These discussions will also include consideration of whether there is scope for cooperation over improving career options for healthcare graduates.

**Working Relationship between Department of Health/MoD**

*Department of Health and MoD Concordat*

34. A Concordat between the Department of Health and the MoD has been in place since 2002. This sets out how the DMS, the Department of Health and the NHS will work together to further their individual and mutual aims of delivering high quality healthcare to both the UK Armed Forces and NHS patients. The Concordat was extended in March 2005 to include the Health Departments of Scotland, Wales and Northern Ireland. The Concordat is an enabling document. It is designed to leave the detailed decisions about service delivery to be made locally by those who know and understand the delivery of local healthcare services, and those who understand the needs and best interests of the Armed Forces and their families. The Concordat sets out a partnership approach, which enables the DMS to work together with their colleagues in the Department of Health and the NHS in planning and organising the delivery of defence medical goals.

*Partnership Board*

35. The MoD/Department of Health Partnership Board meets three times a year to discuss at a strategic level areas of mutual interest and to identify areas for future co-operation. The Board is co-chaired by senior officials in Department of Health and MoD and its membership includes officials from the MoD, the Department of Health (including a Regional Director for Public Health), the Health Departments of Scotland, Wales and Northern Ireland, two NHS Foundation Trusts and a PCT. Its work is supported within the Department of Health and MoD at official level through an Executive Team that is charged with ensuring that operational and other issues are progressed as appropriate and to ensure the progress of Partnership board projects in between Partnership Board meetings.
36. Over the past year, the Board has discussed and agreed ways ahead on a number of key issues impacting on treatment of military personnel, their families and veterans, for example on full connectivity between the National Programme for Information Technology (NPfIT) and the DMS systems and on access to dental services for the dependants of armed forces personnel in the UK. It has also agreed a range of specific developments, for example, the introduction of shadowing between the DMS and Strategic Health Authorities and the NHS and the introduction of an awards scheme for those caring for armed forces personnel. The Board is in the process of developing a further joint strategy supported by a detailed work programme.

**WORKING TOGETHER IN PRACTICE**

37. The formal guidance issued and governance procedures operated by the Department of Health and the MoD ensure good joint working and the ability to tackle problems as they arise and to take forward work programmes on areas of joint concern. What matters though is what happens in practice and we wish to take this opportunity to highlight some areas where the Department of Health and MoD have worked together.

**Mental health programmes**

38. Mental health is an issue of concern for service personnel, veterans and reservists. The Department of Health and MoD are working together, and with Combat Stress, to ensure that good quality and appropriate services are available for those who need them. The aim is to bring Combat Stress services into alignment with current best practice and to achieve greater integration with the NHS services to allow appropriate and speedy referral for those who need it.

39. As part of this process, and linked to a wider project to improve NHS capacity to deal with significant levels of civilian trauma, we are jointly developing pilots based in NHS Trusts. These will provide an enhanced mental health service to veterans by providing dedicated staff time both to provide specialist assessment and intervention to individuals and advice and support to primary care practitioners. The MoD has provided some pump priming resource to move this forward and two pilots are almost ready to go live with another two being developed.

**Healthcare Commission**

40. The Healthcare Commission does not currently have a role in relation to the DMS. In order for the DMS to benefit from the type of assessments carried out by the Commission, the Department of Health, MoD and the Commission are currently considering the options for a one-off review of the DMS.

**Smoking cessation and legislation**

41. At policy level, joint working arrangements have resulted in programmes to reduce the effects of smoking in the armed forces. The Department of Health and MoD have worked closely over many years on ensuring smoking cessation programmes are provided to service personnel. The issue of second-hand smoke has also been taken seriously, and the MoD have comprehensive smoke-free policies in place that replicate the protection provided to the wider population through the smoke-free provisions in the Health Act 2006 (in England) and in smoke-free legislation that is in place in other parts of the United Kingdom.

**Sharing Expertise**

42. There is also significant sharing of expertise. For example, recently, the Associate Chief Medical Officer at the Department of Health accompanied the Surgeon General to Afghanistan to advise on the improvement of the Afghan Healthcare system.

**MOVING FORWARD**

43. The Department of Health is committed to building on the current good working relationship to continue to improve support to the Armed Forces, in terms of ensuring the availability of a well-trained clinical workforce and ensuring that service personnel, veterans and their families receive the services they need.

14 September 2007
Supplementary memorandum from the Ministry of Defence

Further to my letter to you of 10 July, I can now provide you with details of the formal complaints received concerning aspects of care of military patients at Birmingham hospitals.

As Julie Moore told you on 21 June at your hearing in Birmingham, seven military patients (two last year and five this) have complained formally to the University Hospitals of Birmingham Foundation Trust (UHBFT). All have been dealt with by the Trust, in consultation with the Royal Centre for Defence Medicine (RCDM) as appropriate. In each case a response was sent from the UHBFT Chief Executive to the complainant, addressing in detail every aspect of the complaint and offering to discuss the matter further if required.

The letters received relate to care received both last year and this. Two were from patients themselves, four were sent by the parents of a patient and one was sent by another NHS Trust on behalf of a patient. One complaint referred specifically to clinical issues surrounding the administration of a pain killer, and another to the inconvenience and distress caused by an operation being cancelled twice. In both cases a full apology was extended by clinical staff and the Chief Executive UHBFT. Other complaints primarily concerned nursing care and communications issues. The former category included complaints about delays in treatment and responses to requests for assistance, while the latter included concerns about inadequate communications either with the patient and their family or between medical staff involved in their care. Each incident detailed in the letters of complaint was looked into and addressed in detail in the response, with an explanation in each case and an apology for any errors or misunderstandings.

To put complaints in perspective, patient satisfaction surveys that were initiated last December show that the overwhelming majority of our in-patients rate the overall care they have received as good, very good or excellent.

Derek Twigg MP
26 September 2007

Memorandum from Mr K P Mizen

I write with respect to the major problem with Defence Medical services and the news that The House of Commons Select Committee on Defence now finally recognise this major problem and plan to carry out a review leading to a Select Committee Report.

I believe our MP for Gosport, Mr.Viggers has submitted a letter to you concerning this appalling state of affairs, and whilst I might not personally agree with all of his comments & actions, I feel he is 100% right with his comments that The Royal Hospital Haslar and the adjacent Fort Blockhouse must be retained and used and military medical care be based there.

It is common knowledge everywhere and especially here in Gosport, where we have had a large number of Military establishments for many years, that ALL service personnel wish to receive medical treatment in their own dedicated service hospital!!

This has been the case with Haslar for over 250 years as this has treated military personnel with excellent care and attention, both in secure and safe surroundings with state of the art equipment and dedicated, MRSA free wards.

The many, many well documented problems that occur at Selly Oak (injured troops picking up infections, receiving below standard care, facing racial tension and confrontation in the same hospital ) would just not happen at Haslar.

Haslar (located in Gosport on the South Coast) does not have any problems with racial tension, is based in a lovely part of the country with both ample accommodation nearby for service personnel and their families, plus the very secure grounds at Haslar offer an excellent setting for rest and recuperation.

You cannot escape the fact that many, many Service Medical staff are leaving the service and it is obvious that a large reason for this (I have spoken to many so I know this to be true) is that they (and their families) do not want to be located in Birmingham. They want to live and work safely in an area that their children can grow up safely in—we know that Birmingham can NEVER offer this !!!

The Birmingham experiment and trying to believe that racial problems do not exist has clearly failed and will never succeed and I implore you to please come and look at Haslar and what it has to offer both now and for the future and talk to the excellent Save Haslar Taskforce about this amazing hospital.

Surely you will be amazed that this current state of affairs has ever been allowed to happen, you have what all Service personnel want at Haslar NOW. How can some politician/s who have never served or received treatment in a NHS hospital be allowed to force such sub standard care on people who are fighting and dying for this country?
I implore you all, please, please come and look at what you already have at Haslar! It does not require huge investment and building programs and offers what people who fight and die for our country deserve, and should not have it’s future decided by some faceless MoD accountant and biased group of MP’s trying to appease their local constituents.

You have a chance to right a major wrong here as to carry on without using Haslar will not only ensure the exodus of Defence military staff, but will result in major problems and deaths in the future.

22 October 2007

Supplementary memorandum from Terence Lewis

I have submitted to this Committee on two occasions and in two different roles. The first was a written submission sent on 9 May 2007 in my role as Civilian Advisor in Cardiac Surgery, Medical Director of Plymouth Hospitals and current NHS Medical Director to ASCAB. That letter is in your possession and is self explanatory. More recently, on 21 June 2007, I attended the Council House in Birmingham and gave an oral submission on behalf of Plymouth Hospitals NHS Trust as one of the largest MDHUs in the United Kingdom.

Following that event, I would like to make some written comments on issues emerging from that meeting and, therefore, in my role as Medical Director of Plymouth Hospitals, taking into account the documentation made available at the time of the meeting from the existing clinical units.

It seemed to me that the submissions and the paperwork coming from the clinical units, including Birmingham, valued the link with the military but with reservations. The MDHUs raised concerns regarding the clinical exposure of military staff to patient case mix to allow the development and maintenance of the skills required on deployment to care for injured military patients. There were concerns regarding the appropriateness of the care for military patients in a holistic manner, close to their families and communities, with an aim to returning them to duty within an acceptable period of time, as well as concerns of the practicality of the delivery of the above within the host Trust’s clinical, financial and strategic envelope. The submission from Birmingham was surprisingly defensive, but I do understand that they have had a difficult and unjustified bad press. One or two of the MDHUs giving evidence were too small to provide the wide range of clinical expertise and specialties, which are necessary for the provision of a modern Trauma Centre, especially important where military trauma is involved. Peterborough commented on the difficult paradox of receiving military patients at the same time as losing military medical staff operationally.

The impression arising from the day was of an extremely Birmingham centred discussion. I can understand that the Select Committee would want to support Birmingham as strongly as they felt able, however, there does need to be some balance. The MDHUs were hardly mentioned in any of the available literature and the Briefing Paper was a remarkable document, entirely Birmingham focused without any understanding of the limitations of this form of provision or thought for strategic development. Indeed Plymouth, which was not even mentioned by name, is by far the largest, most comprehensive integrated tertiary service provider amongst the MDHUs with 1200 beds under one roof and virtually every tertiary service including Neurosurgery, Cardi thoracics, Pancreatic and Hepatic Medicine and Surgery, as well as being one of only two or three Trauma One Units in the UK according to the Templeton Criteria. There is already a military managed ward (Stonehouse Ward) and there is one of the largest collection of ITU/ Critical Care beds in Europe within the one building. There is a heli-pad within 50 yards of the resuscitation admission area and a fixed wing airport half a mile away with an international airport only 35 minutes away and a motorway into a hospital site which is never gridlocked. Sellyoak is a relatively small hospital, part of a much larger Trust, and their rationalisation by 2012 will give the same kind of configuration and centralised expertise as already exists in Plymouth.

Most importantly the demographics of the service personnel involved needs to be considered very seriously. It is inappropriate for complex and often protracted therapies to be undertaken far away from family, children, schools and community. Three Brigade Royal Marines, who have a high and early involvement in theatre of war, are centralised around the Plymouth area. There is a military ethos and tradition to the place and the community is tight-knit and self supporting, this includes medical services. It is entirely inappropriate that these patients are obliged to be cared for elsewhere when the capability manifestly exists within their own community. With the reorganisation of military centres, it would seem to me that the most appropriate UK distribution of battle casualties should reflect this, perhaps the James Cook in the North, Birmingham in the Midlands and Plymouth in the South. James Cook and Plymouth are fairly similar organisations with a comprehensive range of services. Birmingham will achieve that following rationalisation and rebuilding in the fullness of time. Plymouth already has a military medical headquarters facility on the Hospital campus, military medical management within the Hospital, and is close to extensive military infrastructure, including Mess facilities. We train and provide staff for RFA Argus which I did not raise at the meeting as I am not sure how appropriate it is to air Argus’ rather sensitive role in public. Be that as it may, we provide a highly comprehensive advanced battle receiving station in the absence of day to day management of repatriated battle trauma, which seems wholly inappropriate. With three centres, such as this, an integrated and networked approach to the treatment of repatriated battle casualties could be fostered with the flexibility that may be required with surges of activity when necessary.
One or two other separate points emerged during the day. The first is concerning outcomes. Modern medicine is driven by information. Quality is improved by clinical governance of which audit and an assessment of outcomes is vital. There appeared to be very little, if any, attention given to the discussion of outcomes and how they might be managed during that day. An advantage of a three centre provision for battle casualties would be the possibility of the development of an integrated outcome assessment for these complicated cases where final results may only be realised a considerable time down the line, often within the community.

Very little discussion was had concerning reservists which are a considerable challenge for employing Trusts and for the military as referred to in my written submission. The tendency for senior medical military personnel to be removed from the clinical environment at a time in their life when they are approaching their most experienced seems perverse and should be addressed.

There was mention made that military clinical deployments are as a ‘purple’, ie tri-services, organisation. My experience is that the tri-services element of military medicine does happen in the field with Naval and RAF personnel deployed to land operations. Integration elsewhere in my experience is extremely limited. It would seem to me that lip service is paid to the tri-services element of military medicine.

In summary, speaking with my Plymouth Hospitals strategic hat on, the case for Plymouth to be involved more comprehensively in the provision of military medicine, including being part of a network of three receiving centres for repatriated battle casualties, seems to be very strong. It is an established, single site, major trauma and teaching hospital with virtually the complete range of tertiary services, a medical school and a fast developing research record. There is already significant infrastructure that could be utilised for supporting functions, including accommodation and administration, with the cost savings that that brings with it. To involve Plymouth would avoid concentrating all the eggs in one relatively small basket in Birmingham. Rationalisation of military presence into three major trauma centres, one in the North, one in the Midlands and one in the South, would allow the development of proper networking and a comprehensive framework for the consideration of results and outcomes. Patients would be able to be repatriated to the centre nearest to their parent base unit to allow the unit to be able to continue contact and friends and family ease of access. All DMS staff would see the wounds of war in their Hospital and not just on operational deployments. The DoH is shortly to produce an assessment of civilian trauma services which will be very interesting and is likely to be critical of NHS existing provision. Plymouth is extremely well placed to become a major international contributor to the development of trauma services and I believe that the military should be a part of this. We would be anxious in Plymouth for reasons already explained to augment the presence of military medicine as, left the way that things are, it will become a smaller and smaller proportion of our overall activity. In order for such a development to make strategic sense for a rapidly developing Trust there needs to be the “carrot” of elective work as well as training. All aspects of this provision need to be considered in the round and relationships with the NHS will need to be a fundamental part of such consideration.

I hope that these points are helpful. I don’t believe that any of them, which arise from the meeting in Birmingham in June, fly in the face of my original written submission. I believe the two are complimentary. Please let me know if you require further amplification of any of the points made.

31 July 2007

Memorandum from the British Limbless Ex-Service Men’s Association (BLESMA)

The British Limbless Ex-Service Men’s Association (BLESMA) supports all serving and ex-service men and women who lose limbs or the use of limbs in service and those who lose an eye or the use of an eye. Amongst its objectives is the provision of a professional welfare service and it runs two care homes. For new amputees it provides a conciliatory service and a number of challenging and social rehabilitation events. By way of example in December 2006 we had new Members injured earlier in the year learning to ski in the Rocky Mountains. We are acknowledged experts on the old War Pension Scheme and very involved with high profile injury aspects of the new AFCS 05. BLESMA has 2,400 Members, over half of whom were injured in World War II. We also look after widows of members, which number 1,900.

The Association knows very well the BLESMA category casualty of recent conflicts including Afghanistan and Iraq. It knows all serving amputees—and keeps the MoD up to date in this respect. There are presently nearly approximately 60 serving BLESMA category personnel. There have been, we believe, 51 BLESMA category injuries in Afghanistan and Iraq—More than half of these in the last 16 months. Thus far comparatively few have left HM Forces. We support realistic retention and we hope that where eventual medical discharge is unavoidable that it does not take place until the soldier is as fit and ready for civilian life as possible.

BLESMA is very familiar with Selly Oak. Naturally we lament the closure of military hospitals but we do believe that to sustain high standards of technical medical care today would be unrealistic, and could dilute medical availability on the front line. We have watched the military presence evolve within Selly Oak and our new Members generally respond well to the nursing and welfare care they receive. We have seen distinct improvements in medical care coordination in the sense that the patient medical pathway though
Selly Oak, sick leave and rehabilitation at Headley Court is now much better. We believe there is some evidence of discontinuity in welfare care aspects and we have had to bring expertise and sometimes resources to bear—this is more to do with lack of experience rather than lack of resources. A typical example might be ensuring the parents’ home is actually suitable for a wheelchair—we can find the ramps, or knowing how to enlist the (statutory) assistance of local authorities in providing adequate social and nursing cover.

BLEMSA has developed a good relationship with military medical authorities and we are normally invited to meet new amputees shortly after their arrival at Selly Oak. An initial visit allows us to explain what BLSMA can do for those still serving and what advice we are able to give regarding pensions/AFCS and DWP allowances, which we have detailed knowledge and experience of. Shortly thereafter one of our experienced professional Welfare Officers (all former LE Officers) will visit with a BLESMA Member bearing a similar injury.

This normally has a major and positive impact and exposure to prosthetic application is usually a matter of intense interest. The overriding object of this early exposure is to map out the disabled life ahead optimistically but realistically. We work and liaise closely with service welfare organisations and they value our specialist knowledge and experience.

BLEMSA does not provide prosthetic equipment. We believe the state should always provide this and we do not believe serving personnel or veterans should have to resort to private providers. However prosthetic provision is vulnerable to the vagaries of the “postcode lottery”, an invidious situation for serving soldiers and veterans. Hitherto MoD medical authorities were not particularly aware of all the implications as soldiers moved and were posted to different parts of the country. We proposed to the MoD that a measure of centralised provision could be set up using DMRC Headley Court. Our hope was that Headley Court could become the centre of excellence for those newly injured and their “limb centre” whilst they remained in service—wherever they might be posted. For prosthetic users continuity is best served through the relationships established at a limb centre. We were more than pleased to hear that this service of care to in-service prosthetics was to be extended to all those already serving—if they so wished. We are pleased with the technical provision being offered and we doubt that “limb centres” around the country could afford some of the prescriptions on offer. Our concern for the future is that this will highlight poor provision due to under funding in a number of Trusts, when service men and women are discharged in the years ahead. It is generally received wisdom in the prosthetic industry, which provides services to the DoH, that provision of much that is provided at Headley Court would not be possible due to ever present financial constraints. It has long been a BLESMA contention that disabled veterans did not lose their limbs for a particular locality but for the whole country. We have alerted the MoD to this problem and we have been informed that structures and/or procedures are being explored to deal with this problem. This is becoming urgent as medical discharges are now beginning to take place for those who have been prescribed high tech and expensive prosthetic equipment whilst under MoD care.

BLEMSA has a long history of providing challenging rehabilitive training in a social environment. We believe this compliments the excellent physical rehabilitation casualties receive at Headley Court. We provide a special fellowship of shared experience that not only provides practical advice and support it also relieves the tensions and pressures that might otherwise lead to damaging psychological injury. By way of example we focus on developing amputee teamwork using offshore sailing and adventure training weeks in Scotland, which help individual confidence. In December we will be taking 15 Members to Colorado as guests of the US Wounded Warrior Project for adaptive ski training. 10 members of our group will still be serving. We believe such rehabilitation is an important part of the medical/healing process. Generally we try to do all our rehabilitation “in house”—on an amputee looking after amputee basis.

BLEMSA has a body that represents serving and ex service amputees individually and collectively. We will work with government where our aims and intentions converge but we campaign to right what we perceive to be wrong. In the field of medical care there is much convergence and improvements in prosthetic provision and rehabilitation are to be applauded. But—we are with our Members for life and we remain on watch.

23 November 2007

Further supplementary memorandum from the Ministry of Defence

In the course of the Committee’s visits last month to HQ 2 Med Bde at Strensall and Redford Barracks a number of issues were raised on which the Committee requested further clarification. These were:

— Information on the pilot scheme being undertaken by the Army looking at occupational health services for the TA;

— An explanation of how primary and secondary healthcare for the Armed Forces is funded (including the division of responsibility between MoD and NHS);

— An explanation of the provision of “accelerated access” to treatment from NHS trusts hosting Ministry of Defence Hospital Units (MDHUs), and the fast track programme to deal with musculo-skeletal injuries.
— An explanation, including anonymous case studies, on how medical discharges, both on physical and mental health grounds, are handled and how care is transferred from the Defence Medical Services (DMS) to NHS;

I also thought that you might find it useful to have a copy of the slides used during the oral briefing on in-Service mental healthcare that you received at Redford Barracks and some information on the processes for transferring medical records from DMS to NHS.

**Occupational Health Services Pilot Scheme for the Territorial Army**

Currently the provision of an Occupational Health support service to TA personnel has been delivered in an ad hoc fashion. This has been for a number of reasons: TA personnel have limited time; they are geographically widely dispersed; and there are often differences in Occupational Health requirements for civilian and military employment. It was agreed that a pilot scheme should be conducted in the Headquarters 2nd Division area (Scotland and the North of England) to allow an opportunity to demonstrate how the most important elements of an Occupational Health Service (OHS) could be delivered to the TA. The objectives of the scheme were to deliver OHS to the TA, maintain best clinical practice and deliver efficient management of the service. It is envisaged this would be provided by a commercial in-Service provider and would offer an opportunity to determine the projected overall costs of providing OHS to the TA.

The pilot scheme was initiated in July 2007 and was fully up and running by September. It will run until April 2008 when it will be evaluated by a panel including the Army Consultant Adviser in Occupational Medicine. It is too early at this stage to draw any conclusions.

**Funding of Primary and Secondary Healthcare for Service Personnel**

In the UK:

(a) **Primary Care**

1. Service Personnel: The MoD funds primary care for Service personnel. However, Service personnel are able to access NHS primary care on an emergency or immediate care basis. In addition, Service personnel can register as a temporary resident with a NHS GP for up to three months should the individual be unable to use a reasonably accessible military facility.

2. Dependents: In the UK, Service dependants are entitled to NHS provision of primary care and the majority are registered with NHS GPs. In a few locations, military GP practices in the UK register families so that the practice can meet the criteria required of a GP training practice (so that military GPs can attain the appropriate qualifications) or because the military practice has spare capacity. No funding flows from the local PCT to MoD in such cases.

(b) **Secondary Care and Community Services**

1. Service Personnel: All Service personnel are entitled to access NHS secondary care and community services. The allocation to PCTs is based on the National Census and the MoD informs the DH if there is likely to be a significant reduction (such as a base closure) or increase in the local Service population. The military population is included when the calculations take place for funding allocation from the Department of Health to PCTs. In addition, the MoD purchases accelerated access from certain NHS providers at additional cost in order to meet operational requirements. Secondary care is also purchased from the independent sector.

2. Dependents: All dependant secondary care and community services in the UK are obtained from the NHS. The MoD provides no funding for this care.

The funding arrangements at the MDHU and RCDM were determined when the initial units were established in the mid-1990s in parallel with the closure of Service hospitals. To avoid complex PES transfers, it was decided that the MoD would pay for all military patients treated at the MDHU Host Trusts. This includes both emergency and elective care, the latter being subject to additional premiums to obtain the accelerated access described above (and described in more detail below).
Overseas:

MoD is responsible for providing primary, secondary and community services to dependants and entitled civilians as well as Service personnel.

SECONDARY CARE “ACCELERATED ACCESS” AND “FAST TRACK PROGRAMME”

As a matter of definition, these two labels are attached to two separate schemes for serving personnel. In addition they should not be confused with the “priority treatment” to which veterans who are War Pensioners with qualifying conditions are entitled.

Fast Track Programme

The most common medical condition in military patients is a musculo-skeletal disorder. Since April 2004, for patients with these conditions, we have arranged rapid access to diagnosis and—for the minority who are then found to need it—surgery in NHS facilities. Typically we achieve a decision as to which path the patient will follow (either to surgery or physio/rehab) within 10-20 days of referral to a specialist multidisciplinary team (MIAC clinic).

Those needing only physiotherapy/rehabilitation treatment (the majority) are treated in MoD’s own Regional Rehabilitation Units (RRUs)—so no NHS waiting list issue arises. Typically, these patients will start physiotherapy within 4-6 weeks of the decision on their treatment path. If surgery is necessary (for the minority of cases) we can and do arrange fast access to surgery in the MDHU Host Trusts or other NHS Trusts (and in the past from the independent sector) within 6 weeks of the decision on their treatment path.

Accelerated Access

MoD pays the MDHU Host Trusts an additional premium to gain accelerated access for the assessment and treatment of Service personnel, with conditions other than musculo-skeletal conditions, in a faster timescale than NHS standard target times. MoD does this to meet operational requirements and maximise fitness for task when this is clinically deliverable. The MoD’s targets—aiming for full delivery of these targets by April 2009—are 100% to be seen as an outpatient within 4 weeks and with 100% receiving elective treatment within a further 6 weeks if that is clinically appropriate. Many of the MDHU Host Trusts are already delivering a good percentage of their activity in line with these targets as a result of our contract incentivisation programme. These targets compare very favourably with the current NHS targets of 13 weeks for outpatient assessment and 6 months for elective surgery, although these figures are constantly being updated as the NHS aims for an 18 week total package by December 2008.

How much does MoD pay for “fast-track” and accelerated access?

In financial year 2006-07 the Ministry of Defence paid just under £30 million for activity (outpatient and inpatient care) from the five NHS trusts hosting MDHUs and from University Hospital Birmingham NHS Foundation Trust (UHBFT) which hosts RCDDM. Approximately £6.5 million of this was for emergency care. This care by definition is delivered under NHS emergency access standards. The remainder (some £23.5 million) was used to commission care commencing sooner than current NHS waiting times. This includes both “fast track” treatment for those with musculo-skeletal conditions, and “accelerated access” for those with other conditions where this is deemed appropriate to meet the operational tempo and where it is clinically deliverable.

We also spend just over £1 million annually for other fast track access (for those with musculo-skeletal conditions) outside our MDHU Host Trusts. For example, this enables rapid access to MRI scans for the 13 Regional Rehabilitation Units (RRUs) in the UK to enable early diagnoses.

TRANSITIONAL ARRANGEMENT FOR SERIOUSLY ILL SERVICE PERSONNEL MEDICALLY DISCHARGED FROM THE ARMED FORCES

The key to successful transition of the small group of complex patients who are medically discharged from the Armed Forces with significant illness is an individually tailored care plan that integrates both the ongoing clinical and welfare needs of the patient. Early engagement with the relevant civilian services is essential.

Physically Injured

There is a social work department at DMRC Headley Court for those that are medically discharged from DMRC. They work closely with the single Service welfare services and the appropriate ex-Service charities to help to ensure a seamless transition to civilian life. We have placed a contract with the Brain Injury Rehabilitation Trust (BIRT) which has improved the transition for those with acquired brain injury as they
provide regional centres around the UK to continue neuro-rehabilitation and importantly are always seeking to maximise the eventual independence of the patient. For those that are not capable of being managed at DMRC, the DMRC consultants have the responsibility to assess each patient and determine the most clinically appropriate facility for the continuation of care. The Healthcare Directorate then attempts to place individuals in facilities as close to their homes as possible. In all cases discussions are commenced with the local PCT and Social Services so that they are aware of the needs of the patient and their responsibilities once the individual is medically discharged from the Armed Forces. Joint planning is crucial and every attempt is made to facilitate this.

**Mentally Ill**

The Mental Health Social Workers (MHSWs) play a key role in ensuring a smooth transfer of the patient from the Armed Forces to civilian life. Once it appears likely that an individual will require medical discharge for mental health reasons, one of the MHSWs will be assigned to the case and work with the patient. The MHSWs are community-based in the military Departments of Community Mental Health.

The MHSWs provide an all-encompassing service for vulnerable patients in their transition to civilian life. Their responsibilities include:

- One to one support to patients in preparation for and understanding of Medical Boards.
- Support and advocacy regarding local authority/private accommodation, post service.
- Information, advocacy and support regarding the resettlement process.
- Advice and advocacy regarding Pensions and Veterans Agency processes and decisions.
- Support and explanation to dependants of patients regarding mental health issues.
- Visiting and social work support to mental health in-patient, at NHS and independent service provider locations.
- Written legal reports and liaison for Mental Health Review Tribunals (MHT’s), for detained military patients under the Mental Health Act.
- Briefing and advocacy for patients needing State Benefits, such as Incapacity Benefit and Disability Living Allowance.
- Ensuring GP and NHS support is available ongoing after the patients’ discharge.

They work with the DMS consultant psychiatrists and mental health nurses to achieve this transition.

**PROVISION OF DEFENCE MENTAL HEALTH SERVICES IN UK**

A copy of the slides used during the presentation the Committee received on mental health services are attached.

**TRANSFER OF MEDICAL RECORDS FROM DMS TO NHS**

*Following routine discharge*

When a member of the Armed Forces is discharged from the Services a summary of the individual’s medical record is sent to the relevant Service manning agency. The individual is provided with the address of the agency which they should then give to their new civilian GP when they register for the first time. The GP may then write to the Service manning agency, either directly or through NHS Central Register (NHSCR), to request a copy of the individual’s medical summary. A copy of the entire Service medical record may be obtained on application supported by the patient’s written consent.

*Following medical discharge*

The same procedure applies as that following routine discharge. In addition however, the specific DMS health team who have been caring for the individual to be medically discharged will liaise with appropriate civilian healthcare providers (eg General Practitioner/PCT/civil mental health team/NHS Trust) to ensure that the transfer of care and patient history takes place. Additionally we have specialist health social workers who manage the individual’s wider resettlement issues, liaising with relevant civil agencies such as local housing authorities, financial authorities, service welfare and charitable organisations; again to endeavour that the individual’s transfer into the civilian environment is as smooth and as seamless as possible.

22 November 2007
Memorandum from the Haslar Task Force

I write on behalf of the Haslar Task Force to make representations in relation to Defence Medical Services. The Haslar Task Force comprises representatives of each of the three political Parties and includes medical and other professionals. It is supported by Gosport Borough Council and Fareham Borough Council.

The Government announced in December 1998 that the Ministry of Defence would withdraw support from the Royal Hospital Haslar which was then the only remaining military hospital in the United Kingdom. This decision was based on the recommendation of the Lawrence Committee which recommended that the Ministry of Defence should not be in the business of hospital management. Effectively, the umbilical link between Defence medical practitioners and Service patients was broken with the intention that Defence medical staff would train within the National Health Service and Service personnel would similarly be treated by the National Health Service. After consideration of various other sites it was eventually announced that there would be a centre for Defence medical excellence at Selly Oak Hospital in Birmingham where £200m. was to be spent to build a new Centre for Defence Medicine which would operate in conjunction with the University of Birmingham Hospital Trust. Subsequently, the £200m. development was abandoned for lack of funds. The original plan to have a centre of administration and of accommodation which would provide the focus of the esprit de corps of Defence Medical Services has therefore not materialised. The plan to improve retention of staff, and particularly doctors, has therefore failed.

Various plans have been considered to rectify the situation and the latest plan involves the conversion of Royal Air Force Lichfield to take over the role of administration and training. Whilst Lichfield is in the Greater Birmingham area, it is not close to Selly Oak and there will be no meaningful synergy between the two sites. The question which now arises is how to rectify the position and create a Defence medical environment which will improve retention of trained staff. There is the further point that Service personnel prefer, if possible, to be treated in a Service environment. It is also well established that Service personnel recover more quickly when treated together in a service environment. Government has recognised this, to some extent, by creating a Service Ward at Selly Oak but there is an unmet need for Service hospital accommodation for Service personnel who are recuperating or in need of less acute treatment.

Selly Oak appears to be succeeding in providing acute treatment to Service personnel who are brought out of Iraq, Afghanistan and elsewhere by air through Brize Norton or Birmingham airport. What Birmingham cannot do is provide the needed Centre for Defence Medical Services with adjacent accommodation, training, sports and messing facilities. Birmingham is not a popular location for Service personnel and their accommodation in particular is widespread and unsatisfactory. There is scope and need for facilities to be provided elsewhere and the best solution would be in South Hampshire where there is the largest concentration of Service personnel. The Royal Hospital Haslar has exceptionally good facilities. It is currently operated by Portsmouth Hospitals Trust and this arrangement will continue until 2009 when a PEI rebuild will be completed at Queen Alexandra Hospital in Cosham, Portsmouth. Until the Ministry of Defence withdrawal on 31 March 2007, Haslar provided messing and other facilities for Defence medical staff. Medical training takes place at Fort Blockhouse adjacent to Haslar. These arrangements are secure and satisfactory and there is no need for them to change. We therefore propose that the Ministry of Defence should study a South Hampshire solution to the problems of Defence Medical Services. Acute medical care can continue to be provided through Selly Oak and the University of Birmingham Hospitals Trust. Rather than the development of RAF Lichfield (where a PFI project is already seriously over budget without having yet reached Main Gate), the Ministry of Defence should study a project of developing the required resources at Haslar/Blockhouse, Queen Alexandra Hospital, Portsmouth (where there is already a Ministry of Defence hospital unit) and the University of Southampton Hospital. Such links would provide the requisite medical experience to Defence medical staff and would also provide the facilities which currently cannot easily be provided in the Birmingham area.

The Ministry of Defence must recognise that the strategy of moving all Defence Medical Services to the Birmingham area has failed. Recruitment of doctors and other medical staff has remained satisfactory which is not surprising because the Armed Forces provide a subsidised and attractive entry to the medical profession. Retention, however, has not only failed to improve but is deteriorating. Doctors, and in particular the key specialities of orthopaedic surgery, general surgery, general medicine and anaesthetics, find the career choices of being located in Birmingham (most likely) or an MDHU (less likely) together with repeated attachments in Iraq and Afghanistan to be unattractive.

We trust that your Committee will visit Haslar and Fort Blockhouse as part of its studies. Indeed, we regard such a visit as essential if you are to have a satisfactory appreciation of defence medical training and practice.

The Ministry of Defence has been stubborn in its determination to focus Defence medicine on Birmingham. The strategy has not succeeded and cannot succeed. The South Hampshire way ahead would provide a solution and the Ministry of Defence should implement a study of this alternative.

Peter Viggers MP
Haslar Task Force
15 August 2007
Further supplementary memorandum from the Ministry of Defence

SURVIVAL OF TRAUMA CASES ON OPERATIONS

Following our oral evidence session this morning, I thought the Committee might appreciate sight of some numbers that demonstrate that the survival of operational casualties is the best ever achieved by the UK.

The Defence Medical Services monitor the survival of trauma cases on operations. The available “Killed in Action” data demonstrate survival rates similar to those now experienced by US forces. Our separate detailed medical audit of each serious casualty shows our overall approach to treating operational casualties is resulting in “unexpected survivors”.

TRADITIONAL MEASUREMENTS

Traditionally, medical “success” on operations has been measured by a number of indicators, including the percentage rate of those “Killed in Action” (KIA). This illustrates the proportion of those who die before reaching medical care, compared with the total of operational casualties who die or are significantly wounded. Historically, KIA rates have remained fairly constant at between 23–27%, with only rare US and Israeli instances in the last 40 years of campaigns with KIA rates below 20%. KIA is a measure of a combination of factors—the lethality of the weapons used by opposing forces versus the combination of personal protection, the effectiveness of battlefield medical care at the point of wounding and the availability of evacuation from the tactical setting.

We have calculated current UK rates^{30} (%KIA) for Iraq as 13.7% and for Afghanistan as 15.1%. These are broadly similar to results claimed by the US in the current conflicts, noting that a complication arises over US and UK definitions over the total of personnel wounded, since the KIA value is sensitive to the definition of overall injured, which forms the denominator for calculating the rates. This makes precise direct comparisons between UK and US rates unwise, and we wish to do further work to confirm the data.

However, notwithstanding these provisos, we believe:

(a) the calculated values are the best ever achieved by the UK; and
(b) the calculated values are of the same order as the US.

INJURY SCORING

Another measure of medical success is “injury scoring”. This looks at seriously injured survivors to ascertain whether their survival was unexpected, given the wounds they received (“unexpected survivors”). A number of internationally accepted methods exist to predict survival following injury and allow comparison of performance with civilian institutions and other military trauma systems. They include the Injury Severity Score (ISS), which is a score based on the anatomical injuries and the Revised Trauma Score (RTS) a score based on physiological changes. RTS and ISS are combined in a complex mathematical formula to give TRISS, or the “%Probability of Survival”. As each method carries its own limitations, DMS uses the full range of these and other analytical tools.

ISS has a maximum score of 75. An ISS greater than 16 is the accepted definition of “major trauma” and relates to a predicted death of 10%. Those with a score of 60 or over are not expected to survive and thus any survivor with a score over 60 is classified as an “unexpected survivor”.

ISS methodology identified that for HERRICK 4-6 [April 2006 to September 2007] there were 18 unexpected survivors and for TELIC 8-10 [June 2006 to date] there were four unexpected survivors, taking all the casualties we treated into consideration (who were a mixture of UK military, coalition military and local civilian). The UK military subset was six unexpected survivors for HERRICK and three for TELIC.

TRISS methodology, when applied to UK Service casualties (hostile and non-hostile action) identified seven unexpected survivors for HERRICK 4-6 and 1 for TELIC 8-10.

COMMENTARY ON IMPROVED SURVIVAL

The improvement in KIA is almost certainly a result of a combination of improved body armour and the enhancements to the immediate battlefield medical first aid equipment issued to all our troops and their medics, and available at or close to the point of wounding, appropriate training in the use of these improved items and the speed of evacuation to medical facilities. The “unexpected survivors” are also a testimony to the skill of our medical teams in field hospitals, and the life-saving equipment and techniques they use to save lives that would be lost in almost any other scenario.

SUMMARY

Our processes show that the DMS has continued to improve its performance on deployed operations. We continue to undertake medical audits on all our serious casualties in order to provide assurance on our quality of care. We also continue to liaise with the US, both in order to seek to improve our ability to benchmark our outcomes against theirs, and to ensure that any new developments that either of us identifies are available to both nations, to coalition partners, and to our other patients in theatre.

Derek Twigg MP
27 November 2007

Memorandum from Martin Deahl

I am a fellow of the Royal College of Psychiatrists and for 25 years a Colonel in the Territorial Army. I have served on many operations and Commanded the UK Medical Group in Iraq. I would be most grateful if you could bring the following to the committee’s attention as you feel appropriate.

My colleagues and I have been making efforts to improve access to mental health services and quality of care for ex-servicemen and women and I would very much welcome the Committee’s support and lend its weight to this initiative which is tackling a largely hidden but significant problem that is only going to get worse over the coming years.

More than 100,000 servicemen (and women) have served in Iraq and Afghanistan since 2003 and we are likely to continue (at least in Afghanistan) for a generation. As a result more veterans are presenting to NHS Mental Health (MH) services that are arguably ill-equipped to deal with their needs. Their veteran status and its potential relationship to MH problems is frequently overlooked, and when it is acknowledged the problem is often mis-diagnosed as PTSD. In the Voluntary Sector, Combat Stress provides care, however it is not “joined up” with statutory services, has a lack of professional clinical input, and has limited ability to offer evidence-based treatments to its service-users. The average time to presentation from leaving the service to presenting to Combat Stress is currently 13 years!

My Trust (South Staffordshire and Shropshire Mental Health Foundation NHS Trust) has become a Pilot site (funded by the Veterans Agency) to tackle this: we have appointed the UK’s first Community Veterans Mental Health Therapist (CVMHT) and we are establishing academic and clinical networks between Combat Stress, defence medicine and ourselves. This project will be independently evaluated by the Health and Social Care Advisory Service (HASCAS) after 2 years and (assuming there is the political will) rolled out across the UK if health outcomes are demonstrably improved.

My aim is to provide a system of seamless integrated care to servicemen and women from in-service to veteran status. There is a potential gain to other service users as expertise and experience gained will improve the management of adjustment and other “neurotic” disorders. Finally, I hope the service will become a model for joint working with the voluntary sector and Government interdepartmental working. Louis Appelby the Mental Health “Tsar” and the DoH are aware of developments and we have their blessing.

The pilot is making good progress and I do believe the Committee should at least be aware of our initiative.

21 November 2007

Memorandum from Caroline Richards

Whilst ISAF was deployed in Afghanistan last year there were several cases of Whooping cough. One officer who came back for R&R with the “Kabul cough”, which was in fact whooping cough, gave it to his newborn baby, who nearly died. When the baby was discharged from hospital, it stopped breathing at home a week later and had to be resuscitated by its mother and readmitted. There were several other cases known to me personally. These included my husband, COMARRC, who was airlifted to the French field hospital in Kabul, on a drip & oxygen, and then was flown back to Germany by US forces to recuperate. Another senior officer in the ISAF HQ was also very ill with whooping cough.

I am informed that the pertussis immunisation was implicated in Gulf war syndrome, and that is the reason that our troops are not being vaccinated. However, I am also told that other armies do vaccinate against whooping cough and I would like to feel that this has been properly researched with regards to our own troops. It is a condition that is hard to diagnose but can be very debilitating. And I would hate another family to go through the anxiety and distress that the family above had to endure.

14 November 2007
Memorandum from the Scottish Executive

Following my officials’ appearance before the Defence Committee on 11 October, I wish to reinforce the importance the Scottish Government attaches to the provision of quality healthcare services for serving armed forces personnel, their families and for veterans.

You will wish to know that at a meeting of NHS Board Chairs on 5 November, I reminded all Chairs of the high expectations that the Scottish Government (and, I am sure, the Committee) have of the role and performance of NHS Scotland in relation to Service personnel. I asked that they look closely at what their Boards are doing in this area, and to assure themselves that there are robust arrangements in place both in relation to any treatment required by serving personnel and their families, and meeting the needs of veterans. I also reminded them of the relevant guidance and asked that they assured themselves that their Boards are meeting fully the terms of that guidance. A copy of the guidance is at Annex A.  

As my officials made you aware last month, army medical staff have developed close ties with NHS Lothian and Edinburgh Royal Infirmary. However, clearly there are particular concentrations of service personnel in other parts of Scotland and Defence Medical Services (DMS) have confirmed that their Service medical personnel have also developed good working relationships with local NHS Scotland facilities. Navy medical staff have developed close ties with the Gartnaval Hospital in Glasgow and the Royal Alexandra in Paisley, reflecting the fact that the main naval presence in Scotland is at Faslane. RAF medical staff have developed close ties with Ninewells Hospital in Dundee for the personnel based at RAF Leuchars in Fife. Those based on the Moray Firth (RAF Lossiemouth and RAF Kinloss) are treated both at Dr Gray’s Hospital in Elgin and Raigmore Hospital in Inverness. Those stationed at Fort George in Inverness will also be treated at Raigmore. Some patients requiring specialist treatment are sent to the Aberdeen Royal Infirmary.

It is also worth noting that DMS have indicated that because of our relatively short waiting times, Service personnel based in Scotland, in the main, have little need to travel to England for treatment, although I appreciate that there will be occasions when, due to particular medical conditions, this will be necessary.

The Committee may wish to note that the MoD and Scottish Government are currently considering piloting in Scotland a new community-based model for addressing the particular mental health needs of veterans. This is part of a wider initiative with health authorities across the UK. It is designed to meet the needs of health professionals who are seeking expert advice and help with the assessment and treatment of such veterans and to address the concerns of some veterans that the military background to their mental problems may not have been understood within the NHS. The pilot model would establish networks of a wide range of NHS clinical staff and academics and, where appropriate, would also capitalise on the experience of specialists from the Defence Medical Services community mental health teams. These projects would be NHS led, and reflect evidence-based NHS best practice, with access through a wide range of “gateways” and increasing input matching increasing case complexity.

On 11 October, the Committee asked specifically about access to mental health services for veterans. As my officials explained, the Scottish Government is currently in discussion with the MoD and Combat Stress to identify service improvements that can be made to make services more accessible and more appropriate to the needs of veterans, building on the work that has already been taken forward by the Rivers Centre in Edinburgh. This is in addition to the significant additional investment that has been made in the services provided by Combat Stress in 2007/08.

I should like to take this opportunity to re-emphasise that we have not had any indication of specific problems from NHS Scotland or DMS. However, from the transcript of the session on 11 October I note that the Committee had significant concerns about whether enough was done to meet the special needs of service families, who will also be more mobile than the general population; whether the transition from the services to the NHS post-discharge was well handled—for example, whether medical records are transferred effectively; and whether the health needs of veterans are properly recognised. Further information on these issues are set out in a Supplementary Memorandum at Annex B. That memorandum also contains the very detailed information that the Committee requested from my officials:

— the number of people in prison with a history of being in the armed forces;
— the number of reservists working in the NHS in Scotland;
— the number of consultants and other clinicians in hospitals in Scotland whose salary is paid by the MoD; and
— GP/Primary Care Dental Services.

I have also appended, at Annex C, a summary of the contact that the Scottish Government has had, and continues to have, with the MoD.

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31 Not printed.
There is of course a long-standing arrangement to provide priority treatment for war pensioners for the condition, or conditions, which gives rise to their war pension or gratuity. I have decided to extend the priority treatment scheme to include those who have served in the armed forces and have a Service related medical condition, but are not currently in receipt of such payments.

It is right that all veterans who have health problems as a result of service to their country in the armed forces should get priority access to treatment. We will, however, consult on the proposals before providing guidance to NHS Scotland and to veterans’ organisations in Scotland at the beginning of 2008. We wish to implement the extension to priority treatment in a measured way that ensures that the benefits are fully realised for veterans, without compromising the work of NHS Scotland.

I have also asked NHS Board Chairs to take steps to ensure that their staff are aware of the guidance in this area and that it is being fully met, and to review if there are other steps or measures the NHS should be taking to ensure that we, as a community, meet Scotland’s obligations to veterans. I believe there is a serious interest from the MoD in working together with the devolved administrations and the NHS to address these issues, and that the continuing work and recommendations of the Defence Select Committee will continue to highlight this area.

I hope this letter reassures you and members of the Defence Committee that the Scottish Government and NHS Scotland takes its responsibility for the health of armed forces personnel, their families and veterans, most seriously.

I have copied this letter to Christine Grahame MSP, Convener of the Scottish Parliament Health & Sport Committee.

Nicola Sturgeon MSP
Deputy First Minister and Cabinet Secretary for Health and Wellbeing
21 November 2007

Annex B

THE NUMBER OF PEOPLE IN PRISON IN SCOTLAND WITH A HISTORY OF BEING IN THE ARMED FORCES

1. The following table illustrates those prisoners in Scottish institutions who have reported as having been a member of any of the armed forces:

<table>
<thead>
<tr>
<th>Service</th>
<th>Count</th>
<th>% of population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Navy</td>
<td>9</td>
<td>0.12</td>
</tr>
<tr>
<td>RAF</td>
<td>3</td>
<td>0.04</td>
</tr>
<tr>
<td>Army</td>
<td>94</td>
<td>1.26</td>
</tr>
</tbody>
</table>

2. The percentage is calculated based on the total Scottish Prison Service population of 7,466 as of July 2007. This includes those released under the Home Detention Curfew scheme.

THE NUMBER OF RESERVISTS WORKING IN THE NHS IN SCOTLAND

3. The most up to date information that is available is that 285 staff employed in NHS Scotland have confirmed that they are retained/reserve services members.
   — This information was obtained from a self-reporting staff questionnaire in 2005.
   — Completion of the questionnaire was optional.
   — Staff had the option to leave the relevant section blank.
   — The response rate across Scotland was around 30%.
   
   NB The figures are provisional and for “management information” only. They should not be placed in the public domain.

THE NUMBER OF CONSULTANTS AND OTHER CLINICIANS IN HOSPITALS IN SCOTLAND WHOSE SALARY IS PAID BY THE MoD

4. NHS Education Scotland has confirmed that there are five MoD funded trainee doctors working in NHS Scotland, who will go on to work for DMS once qualified.
5. NHS Lothian has confirmed that there is a DMS consultant (anaesthetics) working at the Royal Edinburgh Infirmary.

GP/PRIMARY CARE SERVICES AND THE TRANSFER OF RECORDS FROM THE MoD TO THE NHS IN SCOTLAND

Service Personnel Posted in UK

1. Service personnel are not eligible to register with a NHS GP practice, but rather are registered with MoD medical services. The NHS records of a serving member of the armed forces are removed from their registered GP practice and are stored centrally by NHS Services Scotland (or equivalent if previously registered in another part of the UK) until return to civilian status. The MoD have their own record system. See section 10 below for information about transfer of clinical information on discharge from the services.

2. In some postings, where the nearest MoD primary care services are too far away and there are too few Service personnel for an MoD healthcare facility to be set up, Service men and women use a local NHS practice through an arrangement with the local NHS Board. They can also choose to travel to the nearest MoD medical service rather than use the local NHS arrangement if they prefer and, even if they are attending a local GP practice, will be able to use other MoD services such as physiotherapy if needed. The MoD will provide transport to these services.

Service Families

3. Accompanying families of Service personnel register with local NHS primary care services. If the posting means a move to a new area, they will need to register with a new GP practice. Information on local practices and how to register is available through the local Health Board and a variety of sources including NHS 24, Health Board web site, libraries, CAB, pharmacies. On registration, the previous NHS GP records will be traced and transferred to the new GP practice.

Dental Care

4. Dental treatment for Service personnel is provided by the MoD.

5. For families of service personnel, dental services are provided by the NHS or private dental services locally. Those wishing to register with a dentist under NHS arrangements can obtain a list of all dentists in the area who provide NHS dental treatment from the local NHS Board. NHS 24 also provides this information by telephone or through its web site. It is, however, up to the patient to find a dentist willing to provide them with NHS treatment, as is the case with the general population.

6. Dental records belong to the individual dentists and do not transfer with a patient when the patient moves. A patient can request a care and treatment summary, which will provide information on the patient’s dental health and/or treatment, but for which they will be charged for unless they are entitled to free treatment.

NB NHS Boards have an obligation to provide an NHS GP for every (non-Service) person living in their area, but this does not apply to NHS dentists in Scotland.

Service Personnel Posted Abroad

7. The MoD provide primary care medical services to both Service personnel and their families on postings abroad. Family members who accompany Service personnel who are posted abroad leave the list of their NHS GP practice if they leave the UK for three months or more. Their GP records are transferred to the central store pending future registration with a UK GP. On return to the UK, the MoD will again provide medical services for their personnel and the families become eligible to join a practice where they are then living.

Discharge from the Service

8. Discharge from a UK posting—Ex-Service personnel are no longer eligible for the MoD primary care services. Their families will have been under a local NHS GP practice all along. If they move to a different area, the Service person will need to register with a local GP practice and the family will need to transfer their registration. See section 3 above.

9. Discharge from a posting abroad—The arrangements will be similar to section 8 above, but in this case, the family will also have been under the MoD’s care. On registration with a UK GP practice, the previous NHS GP records will be transferred from the central store to that GP practice.
Records and information transfer: medical and non-medical discharges

10. **Across the UK, records transfer between NHS GPs is set out at sections 3 and 7 above.**

11. For MoD personnel, form FMed4, containing all the Service GP records plus hospital letters etc., is archived by the Navy, Army and RAF. All departing Service personnel have a discharge medical and an opportunity to document any harm that has occurred that could be attributable to service (e.g., high-tone hearing loss in gunners), to ensure there are no loose ends and to prepare a summary for the civilian GP with whom the patient registers. This summary is two sides of A4 and, as well as significant events, it includes vaccinations etc.

12. When the ex-Service person registers with a civilian GP practice, that practice can apply to the Central Registry at Smedley Hydro, Southport, to obtain a copy of the medical summary. The GP of the ex-Service person (with his/her written consent) can also apply to the Service authorities, through Smedley Hydro, for a copy of the complete record. This is the case whether or not the person was medically discharged.

13. However, in addition to the above, if there is relevant clinical information which the new NHS GP or specialist needs to know urgently, the MoD clinical staff would ensure that the patient has this and, if there is need for ongoing care, that a direct contact is made to ensure this is arranged.

14. The degree of severity of the condition needing ongoing care will affect how this is done. For example, the discharge from rehabilitation hospital after major injury will be much more direct than ongoing treatment for minor illness. This means for medical discharges from the services, a more direct communication between MoD and NHS services would occur with appropriate handover of clinical information and responsibility.

Annex C

**Contact between the MoD and the Scottish Government**

*General—between August 2004 and October 2007*

— Contacts on specific pieces of work, which included the smoking ban and the mental health of veterans.
— Meetings between the Director General Army Medical Services (DGAMS) and some of his staff and senior figures in the SG Health and NHS Scotland.
— Meetings between the Director Army Nursing and CNO (Scotland) and between CMO (Scotland) and DGAMS.
— Surgeon General met with CMO whilst he was DGAMS. He also attended a meeting of the UK CMOs which happened to be in Edinburgh, although was not formal interface as such.
— Scottish CMO and CNO visited 205 Fd Hosp (V) (the Scottish Field Hosp) in Strensall, near York, as they trained to deploy to Iraq in Spring 2005.
— CNO visited Iraq as part of an employer liaison visit.
— There was also a large meeting in Summer 2006 where DGSAMS played host to various NHS Scotland senior management and the CNO to consider remote and rural interface issues between the military and Scotland, in an attempt to set up formal links between NHS Education for Scotland and other Scottish organisations and the military.
— Meetings with the Army Medical Directorate periodically to discuss relevant issues.
— Attendance at MoD/UK Departments of Health Partnership in Excellence Awards Meeting.
— Professor Peter Donnelly, as Scottish DCMO, visited the Hedley Court Rehabilitation Centre and reported on that visit to the Partnership Board.
— Officials in Patient Quality & Safety Division are in regular contact with their counterparts in England with regard to the Priority Treatment for Veterans Scheme.

*Mental Health*

— The Mental Health Division within the Directorate of Healthcare Policy and Strategy has been in regular contact with the MoD in respect of funding arrangements for Combat Stress and the development of pilots for community mental health services for veterans. The most recent face to face meeting was on 8 October and there have been telephone conversations since then.
Veterans

— Since October last year officials in Social Inclusion Division have had the following contact with MoD at which medical care (more so for veterans rather than serving personnel) is likely to have been discussed:

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
</tr>
</thead>
<tbody>
<tr>
<td>5/12/06</td>
<td>Veterans’ Forum meeting</td>
</tr>
<tr>
<td>19/2/07</td>
<td>Veterans’ Programme Scotland Steering Group</td>
</tr>
<tr>
<td>28/3/07</td>
<td>Veterans’ Plenary meeting</td>
</tr>
<tr>
<td>15/6/07</td>
<td>Veterans’ Forum meeting</td>
</tr>
<tr>
<td>31/8/07</td>
<td>Meeting with MoD Officials</td>
</tr>
<tr>
<td>23/10/07</td>
<td>Veteran Programme Scotland Steering Group</td>
</tr>
<tr>
<td>24/10/07</td>
<td>Meeting with MoD Officials</td>
</tr>
</tbody>
</table>

— The First Minister has met with Des Browne MP, in his capacity as Secretary of State for Scotland, when we understand there has been some discussion about veterans’ issues.

— Officials will attend a further Veterans’ Forum meeting on 4 December.

— Stewart Maxwell, MSP, Minister for Communities and Sport will meet with Derek Twigg, Under Secretary of State for Defence and Minister for Veterans on 11 December.

e-Health

— Four times a year we encounter Defence Medical Services within the context of the UK e-Health Forum.

Housing

— In January/February 2007, SG officials were in regular contact with the MoD’s property agency Defence Estates (Andrew Blessing) in relation to some Parliamentary Questions asking whether MoD housing in Scotland was required to meet the Scottish Housing Quality Standard (SHQS). Not medical care as such but relates to the wider welfare of MoD staff. As the question(s) also concerned the Tolerable Standard, officials in Housing Markets Division, were also in touch with MoD officials in London (Marie Neenan).

— Officials in the Homelessness Team had some contact with MoD officials this summer on the subject of allocation of houses to ex-service personnel and the issue of local connection. Discussions are ongoing.

— Officials from the Homelessness Division sit on the Veterans Programme (Scotland) Steering Group which brings together MoD, the Scottish Government and the services benevolent organisations to discuss issues relevant to veterans in Scotland.

Education

— There is contact with Royal Army Nursing Corps re potential joint educational initiatives.

21 November 2007

Further supplementary memorandum from the Ministry of Defence

During the evidence session on 27 November the Committee asked my Department to provide information on the throughput of cases of Service personnel being treated at the Priory, and how many were subsequently discharged from the Services.

In July 2006 the MoD carried out a one-off snapshot on the long-term outcomes of Service patients admitted to the Priory hospitals between 1 April 2004 and 31 March 2005. This exercise looked at the cases of some 260 Service patients who were admitted as in-patients under our contract with the Priory Group in that year. Of these, around 65% returned to work and 35% had been discharged by July 2006. Of those discharged, slightly more than half were medically discharged. The rest were discharged either as temperamentally unsuitable, by premature voluntary release or by other means, for example, at the end of engagement.

The MoD is currently developing systems that will enable us to have much better visibility of clinical outcomes as a matter of routine in the future. In January 2007 the Defence Analytical Services Agency (DASA) began collecting information on patients who had attended a Department of Community Mental Health facility (DCMH) and patients admitted to the Priory as in-patients. The data so far collected is too recent to allow us to draw meaningful conclusions as to clinical outcomes and relationship to discharge data.
I would also like to take this opportunity to clarify how we provide mental health services to our serving personnel and to rectify any potential confusion about the provision of mental health care in the community. The MoD’s own mental health services are configured to provide community-based mental health care in line with national best practice. We do this by providing outpatient assessment and treatment at our military regional Departments of Community Mental Health (DCMH) centres sited in military bases with care provided by either military mental health care professionals or civilians employed by the MoD. This means that serving personnel usually remain with their units and receive outpatient care in a military environment. This means that serving personnel have no need to, and do not, receive outpatient care via the NHS in a civilian community environment.

In-patient care, when necessary for acute serving personnel cases, is provided through our contract with the Priory Group in dedicated regional psychiatric units. Close liaison is maintained between local DCMHs and the Priory units to ensure that all Service elements relating to an in-patient care and management are addressed. The arrangements with the Priory Group mean that the majority of our patients can be treated much closer to their parent units than was the case when we maintained the last of our own psychiatric hospitals.

Derek Twigg MP

15 December 2007