HOUSE OF COMMONS

Select Committee on the Armed Forces Bill

Oral evidence: Armed Forces Bill, Session 6, HC 1281

Wednesday 24 March 2021

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Watch the meeting

Members present: James Sunderland (Chair); Stuart Anderson; Tonia Antoniazzi; Miss Sarah Dines; Leo Docherty; Martin Docherty-Hughes; Darren Henry; Mrs Sharon Hodgson; Mr Richard Holden; Mr Kevan Jones; Jack Lopresti; Stephen Morgan; Mrs Heather Wheeler.

Questions 289-379

Witnesses

I: Nadine Dorries MP, Minister for Patient Safety, Suicide Prevention and Mental Health, Department of Health and Social Care, Kate Davies CBE, Director of Health and Justice, Armed forces and Sexual Assault Referral Centres at NHS England, Dr Fiona Jenkins MBE, Veterans lead and Executive Director for Therapies and Health Science at Cardiff and Vale University Health Board, and Interim Executive Director for Therapies and Health Science, Cwm Taf Morgannwg Health Board, William Vineall, Director and Chair of the Armed Forces Partnership Board, Department of Health and Social Care, Professor Jason Leitch, National Clinical Director, Scottish Government, and Dr Jonathan Leach, Armed Forces Clinical Lead, NHS England.

II: Lieutenant General James Swift, Chief of Defence People, Ministry of Defence, Caron Tassel, Head People Secretariat, Ministry of Defence, Ben Bridge, Deputy Director, Command, Discipline and Constitutional Law team, Ministry of Defence Legal Advisers, Helen Helliwell, Director of Armed Forces People Policy, Ministry of Defence, and David Howarth, Head Service Complaints and Justice Transformation, Ministry of Defence.

III: Johnny Mercer MP, Minister for Defence People and Veterans, Ministry of Defence, and Minister for Veterans' Affairs, Cabinet Office, and Damian Paterson, Deputy Director, Office for Veterans' Affairs.

Examination of witnesses

Witnesses: Nadine Dorries MP, Kate Davies CBE, Dr Fiona Jenkins, William Vineall, Professor Jason Leitch and Dr Jonathan Leach.

Chair: Good morning. My name is James Sunderland, and it is a great pleasure to welcome all of you to this sixth and final day of evidence gathering in support of the Armed Forces Bill Select Committee. This morning we have a panel of eminent witnesses and a number of MPs who will ask them questions. Let me introduce a number of guests.

First, we have: Nadine Dorries MP, Minister for Patient Safety, Suicide Prevention and Mental Health; William Vineall, director and chair of the Armed Forces Partnership Board; Kate Davies CBE, director of health and justice, armed forces and sexual assault referral centres for NHS England; Dr Jonathan Leach, the armed forces clinical lead for NHS England; Professor Jason Leitch, the national clinical director for the Scottish Government; and Dr Fiona Jenkins MBE, the veterans lead and executive director for therapies and health science for Cardiff and Vale University Health Board, and interim executive director for therapies and health science for Cwm Taf Morgannwg Health Board. Thank you so much for joining us.

We have a list of prescribed questions, but because we have so many witnesses and lots of questions to ask, please can I urge all to keep questions and answers succinct and to the point? I also urge Members to steer a question to the person or persons best qualified to answer. Thank you.

Q289 **Mr Jones:** Can I first ask what priority treatment for veterans means in practice and whether the need to have "due regard" under the Bill will make a practical difference to the way veterans and their families access services? Can Nadine answer first, and then perhaps we can go to Fiona for a Welsh perspective and then Jason for the Scottish angle?

Ms Dorries: Unfortunately, I did not hear the first half of the question—I do not know if anyone else did—

Mr Jones: Shall I repeat it?

Ms Dorries: As the Chair said, we need to be succinct. I think it was in regard to what impact "due regard" will have on veterans' treatment. Am I correct?

Mr Jones: It was, but also what in practice priority treatment means at the moment.

Ms Dorries: Okay. Well, I will hand over to William Vineall on this. I am not sure whether William is on the line yet.

William Vineall: Yes, I am here, and I heard the question. Shall I fire away?

Mr Jones: No, I would like the Minister to answer the question, not the

civil servant.

Ms Dorries: Okay. First of all, I will start by saying good morning, everyone, and thank you for inviting me here this morning. Mr Mercer, as the Minister for Defence People and Veterans, has led on mental health and campaigned on mental health throughout his time as Minister. He has very much led on this particular specialised area, and quite rightly so, because it has been a main focus of the Office for Veterans' Affairs. As a former serving officer himself, he has been very passionate about this, including mental health provision, suicide prevention and many other areas.

The term "priority treatment" as it stands today forms part of the current Armed Forces Covenant, which as you know was published in 2011 to combine with the Armed Forces Act. Veterans receive their healthcare from the NHS and should receive priority treatment where it relates to a condition that results from their time in the armed forces, subject to clinical need.

To be clear, the proposed legislation will not include priority treatment. The legislation will introduce a new duty on health, education and housing public bodies, when exercising certain aspects of their public functions, to have due regard to the three principles of the Armed Forces Covenant. Those principles are: recognising the unique obligations of the armed forces; removing disadvantages arising from time in service; and the fact that special provision for service people may be justified by the effect of their time in service. Priority treatment in terms of the Covenant relates to health only. Priority treatment means, in practical terms, that when a veteran presents, for example with a hip injury, it is down to the clinician to assess, first, whether that hip injury can be attributed to the veteran's time in service and, secondly, where that veteran should sit on the waiting list, according to the clinical needs of all other patients with similar injuries.

The term was introduced when the country was in a very different place. I have to say, and I hope members of the Committee—Chair, I think you said that this is your sixth day of evidence—will understand that, in terms of mental health provision for veterans, the place we are in today is very different from where we were two years ago. In fact, it is very different from where we were even 20 months ago, when I took up my post.

We do have to be careful with the term "priority treatment", because it is open to misinterpretation and misunderstanding. It does not mean that a veteran can jump to the front of a queue. Better identification of veterans through the healthcare system means not only that veterans have access to the most appropriate service; it can also help veterans to receive priority when applicable.

In terms of "due regard" and embedding this understanding in the public sector, decision making via a new statutory duty to have due regard to the principles of the Covenant and the legislation is expected to help to

improve overall delivery of public services for the armed forces community.

Chair, I fear that I may have spoken longer than you would like me to, so I will stop here. I will just say that William Vineall, although Mr Jones referred to him as a civil servant, is actually a very senior civil servant who has worked for many years on the Armed Forces Covenant and mental health services for veterans and is an expert on the subject, so I think we would miss a great deal by not having his input.

Q290 **Mr Jones:** We may well do, but you are the Minister responsible for this. Your statement was well read, but I think we will move on to Fiona Jenkins.

Dr Jenkins: Thank you very much for inviting me. I work in the NHS in Wales. I am an executive director within the Cardiff and Vale University Health Board, and I am also the executive lead for the armed forces and veterans there, so I guess I am at the end of delivering, practically, what priority status means. We do this equitably across all the health boards in Wales.

With regard to priority status, there is not much difference, actually, between England and Wales in the way we would deal with this. The legislation we have is very similar, and the way we implement it is similar. As has just been stated, it doesn't necessarily mean that veterans jump to the front of a waiting list, but they do go to the front of the waiting list for people with similar clinical priority needs. This is managed through our health board booking systems. I guess the difference between England and Wales is that Wales is a health system: primary and secondary care is one system, so that we can more easily manage referrals across, rather than just having hospital-based systems, where perhaps in England they don't know the primary care end quite so well.

So priority treatment is something that we have in place and we have good processes for managing it. Obviously, coding for veterans from primary care, from the GP practices, to alert hospital services that the patient is a veteran is really important when we are looking at priority status, because we can't give priority if we don't know that the individual is a veteran. I think that's one of the key things that it is important that we work on.

With regard to the Covenant and how it is deployed in Wales, we already have a Welsh Health Circular on the Covenant, which was published in 2008—I think it is the Welsh Health Circular on Priority Treatment (2008) 051. There was an update on that in September 2017 to give more clarity around the Covenant and what priority status means within that, too. Sometimes veterans think that they can just go to the front of any waiting list, and it is really related to an injury at the time that they served. Priority status can be looked at by medical staff, allied health professions and others within in it. We have done some work in Wales to try and give some clarity around what priority status means and what the Covenant

means. I don't think I can add much more on the Covenant element. That was covered adequately in the answer before.

Q291 **Mr Jones:** What difference do you think this Bill will make in terms of the duty to have due regard? You have already described the delivery, Fiona.

Dr Jenkins: On due regard, we understand the need to consciously consider the Covenant principles, and we absolutely do that. It has some similarities with other "due regard" measures, such as the public sector equality duty. When we look at the difference for the devolved Government in Wales, we need to think about how we would implement this, and would welcome some consultation with partners in Wales around the implementation of due regard with our local government colleagues, the NHS and other stakeholders to ensure that the relevance as much as possible is implemented in our devolved context. So we would absolutely welcome engagement with stakeholders to draw out any lessons that can be learnt for other similar "due regard" measures. It is looking at it in the context of the devolved Government, which I suggest would be similar for other devolved countries, too.

Q292 **Mr Jones:** Thank you very much. Jason?

Professor Leitch: Thank you, Chair, for having me today, and thank you, Mr Jones. I am the National Clinical Director of Scotland and also the Chair of our Armed Forces and Veterans Health Joint Group, which holds me to the fire around priority treatment inside the National Health Service. We have Armed Forces Champions in each of our 14 delivery systems. They are the conduit if there are any challenges with that priority treatment that you have just had described. It works relatively well, in the main. In Scotland it is not about queue jumping; it is about appropriate and person-centred care for each of those individuals when they present, and whatever they present with—whether mental health challenges or hip challenges.

I don't think due regard will have a huge influence in Scotland. We have not seen the guidance. We don't know what it will require yet. We look forward to seeing it. We already have an Scottish Veterans Commissioner who holds me to account and holds our health boards to account for that due regard. If this adds a layer of reporting and data to that, we will be very comfortable following it.

Mr Jones: Thank you.

Chair: Thank you. We are going to take this session to 10.20 am, so that we have another five minutes if we need it, which I think we probably will. I ask Stuart Anderson to come in next.

Q293 **Stuart Anderson:** My first question is to the Minister. Yesterday, the all-party parliamentary group on the Armed Forces Covenant heard compelling evidence from witnesses about veterans' particular needs. Do you believe the NHS understands veterans' particular needs?

Ms Dorries: I suppose I would like to start by saying that approximately 95% of veterans go on to lead happy and productive civilian lives. The

Department does not want to contribute to the perception that all veterans are damaged by their service, because that is incorrect and 95% are not. We have Dr Jonathan Leach on the line who spent 25 years in the forces himself. He is a GP and is part of the team that develops our services for veterans. With your permission, Chair, I would like to keep my answer short and hand over to Dr Leach. All of NHS England's commissioned services for the veterans are evidence based and they have been developed and delivered from intensive engagement with experts—members of the armed forces community and service charities—and have been informed by people such as Dr Leach and Kate Davies, who leads the development of our clinical service with the NHS for veterans.

The NHS England and NHS Improvement armed forces patient and public voice group escalates issues and helps to identify unmet needs. We work with many charities and organisations that help in the development of services. This work has been incredibly productive and has enabled us to get to the point where we are now. I am very proud of the services that we have now, and I am proud of the work that has been done by my colleague, Minister Mercer.

These services can be accessed quickly and easily. The point we are at in delivering services for veterans now, compared to where we were two very short years ago, is testament to the work that has gone into the development and the engagement with experts, charities, and veterans themselves. With permission, I will hand over to Dr Leach, who has come here as a witness this morning, and who I think may have a few comments on this.

Q294 **Stuart Anderson:** Yes, I would like to hear from Dr Jonathan Leach, and then I will come back to you with another question, Minister.

Dr Leach: Good morning. As the Minister said, I am Jonathan Leach, and I am a general practitioner here in Worcestershire. I am the associate medical director of NHS England for military and veteran health. The question, I think, was about what knowledge and understanding the NHS has of military and veteran issues—

Stuart Anderson: Dr Leach, my question is slightly different. Do they understand veterans' particular needs? I am not asking about knowledge.

Dr Leach: In fact, the answer would be the same. In many cases, yes. We have done a huge amount of work. For example, we were the first to get military veterans into the curriculum for all GPs—and this is across the UK, not specifically England. My daughter is a trainee GP and as she qualifies, like all GPs, she will need to understand, and will potentially be asked in the exit exam, about military and veteran health issues. We have done a huge amount of work.

Within England we have done a lot of work and the feedback is really positive. The most recent data shows that we have set up a network of 877 GP surgeries. If I use my surgery as an example, because we are that veteran practice, we have got veterans coming to us. I am the lead, but

my colleagues have actually developed much more experience and knowledge around military and veteran issues.

I would say that we have done a lot, but I would also be the first to say that we have a long way to go. We have been working with our nursing colleagues, with our general psychiatry colleagues and with emergency medicine. Particularly, we have been working with the GP accreditation and veterans' covenant healthcare alliance. Those would be the mechanisms we would look at to improve the knowledge, understanding and general service to veterans. I will stop there for the purpose of time.

Q295 **Stuart Anderson:** Thank you, Dr Leach. To summarise, you have come a long way but there is still a lot to be done. Minister, could you outline what steps you have taken to improve the level of service to veterans so far?

Ms Dorries: The framework for all services for veterans, and for everyone in relation to mental health services, is the long-term plan, which we commit £2.3 billion to a year to support those with mental health issues.

Chair: Minister, your broadband is dropping in and out. It may be better if you turn your camera off and just go on to audio.

Ms Dorries: Apologies; I did not realise. *[Inaudible.]*—for all mental health services, with a £2.3 billion investment, more than has ever been invested in any mental health services in the UK. Within those services, veterans' services are developed. We are at a point where we are almost able to bring parity of esteem between mental and physical health.

As part of that long-term plan, we have developed TILS—the transition, intervention and liaison mental health service for veterans—leading on to crisis services for those who have PTSD or who need crisis intervention. So there is a whole three-step package for veterans: TILS, CTS and crisis services. Those services are constantly being reviewed and developed. I think we are at the point now where £16.5 million a year is dedicated to those services, in addition to the finances that have been allocated during the long-term plan.

Kate Davies, who leads on this, works constantly on development and the design of services to meet the needs of veterans as they change. If you wish, you could bring in Kate, who could answer that question even further as that is her role.

To be clear, we did not have the long-term plan, the £2.3 billion or any veteran-specific mental health services. We have all those things now, which is why I am very proud of where we are in treating veterans against where we were when I first took up my post as a Minister nearly 20 months ago. We are in a very different place. It is a good place, but we are constantly working on how we refine and develop those services to meet the needs of veterans in the future.

Stuart Anderson: Thank you, Minister. I will hand back to the Chair now. I know we would love to bring other colleagues in, but time is not on our

side.

Chair: I want to bring in Sharon Hodgson for a supplementary question. I urge Members to seek responses from the witnesses who have not already spoken.

Q296 **Mrs Hodgson:** Thank you, Chair. I have a quick supplementary question for Minister Dorries. It relates to certain personnel and veterans who may be symptomatic with breast cancer. From the research I have looked at, it looks like the two-week time limit target for armed forces personnel who are symptomatic has not been met for the last three years. I know this is similar in the wider community, but what plans are in place to address this? Could this Bill be an opportunity to address that?

Ms Dorries: I was not aware of that, but I will take that away as a matter of priority and feed back to you with an answer promptly. I was not aware about the two-week wait. Anyone who is suffering from breast cancer symptoms should be seen within that time frame, whether they are serving in the forces or not. We will find more information on that and get back to you.

Q297 **Mrs Hodgson:** Excellent. I can share with you where I got that information. My office will do that today. Thanks, Minister.

Ms Dorries: We will make contact with them. Thank you.

Chair: Thank you, Sharon. Please could I bring in Heather Wheeler?

Q298 **Mrs Wheeler:** Thank you, Chair. I am interested in how things have improved in the NHS and this alphabet of acronyms that we have with us today, particularly on the waiting lists. I don't mind who takes the question first—Fiona, perhaps? How are the waiting lists for veterans in your patch?

Dr Jenkins: It depends on what service you are talking about. In Wales, the major service that we have for veterans is our Veterans NHS Wales service, which is our mental health service and has been in place for 11 years.

It is an evidence-based service that takes referrals from veterans themselves, from third sector sectors and from GPs, so there is a wide access into the service. It is available across all of Wales and is co-ordinated from Cardiff and Vale University Health Board. There are veterans' therapists in all the health boards. We talk about waiting times at the moment, but it has been a bit of an abnormal year, in that veterans themselves have not really presented as much for treatment as they would have done the year before. Things have improved, and referrals are getting back in line with where they were a year or so ago; the stats at the moment are a bit abnormal but are getting back towards normality.

Mrs Wheeler: That is really good. Thank you so much. That was actually superb. Perhaps you could give us an idea of another veteran-specific scheme that you run.

Dr Jenkins: We have a few veteran-specific schemes. We have an artificial limb and appliance service that we provide for veterans in Wales. Waiting times for that are small, and the veterans actually get really good, bespoke limbs. We have invested in giving high-spec limbs to veterans. There are very minimal waiting times for those services.

Last year, we set up a veterans trauma network, linked with the rest of the UK's major trauma networks. We recognise that we were establishing a veterans service for south Wales. Again, waiting times for that service are minimal; there is quite quick access into those services.

Mrs Wheeler: Thank you very much for those answers.

Chair: Thank you. I will bring in Stephen Morgan.

Q299 **Stephen Morgan:** I have a question for the Minister. For the past two years, waiting times for face-to-face appointments offered to veterans through the TILS have been way off target. What are the Government therefore doing to address this, and how will this Bill help?

Ms Dorries: The NHS continues to work hard to deliver the maximum amount of activity, utilising the full use of available capacity both in the NHS and in contracted independent hospitals. Particularly throughout the pandemic, we have continued to deliver the most urgent treatments, such as emergency and all care for veterans, and both mental health and urgent cancer care, and we have brought down average waiting times by 40% compared with July 2020.

We have a very pragmatic approach to this, and we are prepared to continue this approach in 2021 to support the response to what has happened as a result of covid-19, and also in the longer term, as we come out of the pandemic, towards waiting times and to veterans.

We have a system now with GPs and referral. Op Courage can be contacted very rapidly and quickly by veterans and service personnel directly—they can self-refer—or they can go to their GP. That helps to keep waiting times to a minimum. Although we realise there is disparity across the four nations, it would be wrong to have a UK-wide approach in terms of waiting times. Perhaps Kate could come in on that, because she will have more specific data on waiting times for particular areas, in terms of veterans' health, particularly veterans' mental health.

We are in what I believe is a successful and improving position at the moment, and we constantly try to continually improve that, to see people quicker and faster and to deliver services such as IAPTs—improving access to psychological therapies—which we know have a huge chance of success, faster to veterans. Kate, did you want to come in on that?

Q300 **Stephen Morgan:** Minister, I am conscious of time, so I am keen to ask the second part of the question. How do you think the Bill will help to reduce waiting times for veterans?

Ms Dorries: I think it is important to say again, in the context of mental health, which is my portfolio, that 95% of veterans do very well. It is important to always keep stating that, because I know that some veterans

are unhappy with the perception that they are victims or that they automatically suffer with issues because they have served in the armed forces. We are talking about the 5% who need continuing help.

I think our services have got to such a position—I don't want to sound overconfident, but Kate, her team and Jonathan have done great work on designing services such as TILs, CITS and other services, which are very specific and bespoke to the needs of veterans and can deal with veterans' problems incredibly quickly.

Accessing treatment quickly, and having the appropriate treatment delivered, really contributes to people's recovery times and their lack of dependency on services moving forward. I think we are in a really good place to have minimum waiting times moving forward, because we have bespoke services that accurately meet the needs that veterans are presenting with.

If I was sat here in front of you two years ago, I would be giving you a very different answer to that question; it would be a very different picture. But having bespoke services, which meet the particular needs that veterans present with, will go a huge way to ensuring that people have less need for access to services than they did before. Those who present with problems can be tackled early and effectively, which in itself will cut down waiting times.

Stephen Morgan: Minister, thank you. I will hand back to the Chair, because I know lots of other people want to ask questions.

Chair: Can I bring in Jack Lopresti, please?

Q301 **Jack Lopresti:** My question is for Nadine and William Vineall. There are two bits of it, but I will put them together, because I know we are stuck for time. Are there significant variations across the UK in the level of treatment for veterans—for example, with waiting times? I know we have touched on that. More essentially, how co-ordinated are NHS England, Scotland and Wales when providing services to veterans?

William Vineall: Shall I start with an answer to that?

Jack Lopresti: The Minister is still on mute.

Ms Dorries: Sorry. Let William take over, and I will come in at the end.

William Vineall: The major part of our co-ordination is through the UK Armed Forces Partnership Board, which meets three times a year. We have an exchange of information, and we look at how we can learn from one another to improve services.

Clearly, there are differences of approach in different parts of the country, but the purpose of the Covenant has been to try to give a consistency of approach for all those veterans who present to services. That is not universally achieved, but we are extremely supportive of the due regard principles in this Bill, because, in a sense, that will build on the principles

of the Covenant and ought to address some of those areas if people are not getting decent access to services, which they should be, from the specific bespoke services that have been introduced in the last couple of years.

Q302 **Jack Lopresti:** Nadine, do you want to start again?

Ms Dorries: I completely reinforce what William has said. We recognise that variation exists, because health is devolved. Therefore, in all areas of health, whether it is veterans' health or anybody's health, the provision varies between the nations and localities. It varies particularly for all mental health services, not just those that are specifically aimed at veterans.

Variations are also as much a part of the difference in the veteran population as they are in service provision. However, although these variations exist, they should never be a disadvantage to a veteran, who should always expect quality of care irrespective of their location.

As I said in my previous answer, as health is devolved, it would be inappropriate to discuss services that are offered in our home nations. However, we just want to emphasise the work that we are doing to ensure that key messages and best practice are shared across the whole UK. As William said, we work very closely with our devolved nations in terms of joint development of services. I am sure the Committee is aware of the work of the MoD and the UK Department of Health partnership board, which William sits on. This has continued to meet during the pandemic.

Q303 **Jack Lopresti:** Can I just ask a brief supplementary question about England? How much liaison input is there from the local authority armed forces champions, as far as you aware? What do they add, as far as highlighting and signposting veterans and linking in with NHS providers and councillors?

Ms Dorries: They feed into the clinical forum and the board chaired by Dominic Alderton. We work with almost all organisations and charities across the UK, in terms of outreach and developing the service for veterans, because the services are bespoke. We need the expert input of those who experience mental health issues, those who suffer from mental health issues, and those who have been in the forces and are aware of the issues.

Because it is such a bespoke need, we outreach to anyone who is out there who works in this area or has experience. That is Kate Davies's role in NHS England. Her job is to work with all of these organisations—and it is the board's role—to gather the information and data and develop services, which we now have, which are bespoke and meet the needs of veterans. We have got to that point because of the outreach work and working with different organisations across the sector.

Jack Lopresti: Thank you very much.

Q304 **Chair:** Just before I bring in Tonia Antoniazzi, I will ask Professor Leitch

and Dr Jenkins whether they have anything to add from the devolved Administrations' perspective.

Professor Leitch: I think it is an important question. I agree with William that at a senior level those relationships are good, intact and shared across the nations. Just before the pandemic, we hosted the MoD and the UK Department of Health Partnership Board in Edinburgh and we were able to share best practice.

There is also very good sharing at an operational level. If a veteran, for instance, is in Portsmouth and then leaves and comes to live in Fife, those operational level conversations are excellent between GPs and hospitals, passing on very practical things such as medical records, drugs lists and so on.

Some people do fall through that net. William and I and others—Jonathan—are constantly aware of trying to link the four UK systems together, particularly as we move a bit more electronically. We need to ensure that those records are passed. It could be as simple as a pregnant veteran moving to a different country from somewhere where they have been looked after. Those generally work well but we need to be vigilant for them to continue to work.

Dr Jenkins: Shall I just add where we are in Wales? A lot of the third sector services are UK services, so there is some quite good synergy across the four different countries. As we speak, there is a meeting held in Wales by the Deputy Minister, which is our armed forces expert group. I am normally the NHS representative on that group. We will have the tri-services there and the third sector services, which are often from their UK bases there.

We try to learn from other devolved countries and share practice ourselves. I mentioned the veterans trauma network. We had really good conversations with the English services that were already up and running, and had great support in developing those.

What do we do with our local authorities? In Wales, as part of the health boards requirement, we have a non-executive veterans champion. We also host an armed forces forum, where we bring together our local services and some of the national ones, such as the Royal British Legion. It is a UK force and we learn and share across the piece. I sense that there is a lot of synergy between us. There is more synergy than there is difference, but there is unique difference, too. I think we manage this quite well.

Chair: Thank you. I will now bring in Tonia Antoniazzi for a supplementary.

Q305 **Tonia Antoniazzi:** Fiona, on that last point about the veterans trauma network, which you have spoken highly about. Could the Bill be used to support further its objectives?

Dr Jenkins: Yes. The veterans trauma network was established for the veterans who have the most significant health needs. Prior to having that,

we recognised that veterans weren't perhaps having the services wrapped around them, and they were having to visit various different elements. Yes, I think it would be great to have the veterans trauma network wrapped within this. We are in our first year of delivering this in Wales, so we are still learning—as I said, it has been an abnormal year—but it is great that the veterans can have more services locally. I think that is really important.

Q306 **Tonia Antoniazzi:** Thank you very much, Fiona. I have a question for the Minister. According to the tri-service families continuous attitude survey, the proportion of families able to continue GP treatment without difficulty following a move has decreased from 72% in 2015 to 62% in 2020. What has caused that drop, Minister, and what plans are in place to address it?

Ms Dorries: I am sorry, but I do not have that here. If you could give us more information about where you got that data from, we will get a note on that to the Committee. I am not aware of the report you are talking about.

Tonia Antoniazzi: Would you be able to answer that, William?

William Vineall: I cannot answer the question in detail, but the general answer would be that the upshot of the efforts to improve services to veterans means that there is some more satisfaction than there was five or six years ago. We can get you a detailed explanation based on that evidence.

Tonia Antoniazzi: Thank you very much.

Chair: We have about 10 minutes left and two prescribed questions to follow. I call Martin Docherty-Hughes.

Q307 **Martin Docherty-Hughes:** My first question is to the Minister. What specific support does the NHS in England offer to veterans' families, and if the rumours of a 40% cut to the veterans office are true, would that have a detrimental effect on NHS England's offer to veterans' families?

Ms Dorries: Well, service and ex-service families experience a very unique set of challenges. Although families have access to NHS care, there are no dedicated services to support their health and wellbeing specifically, so they are treated like anyone else accessing NHS services.

As we recognise the impact on service families, we are working hard to ensure that families' needs are catered for. In the NHS long-term plan, we set out nine priorities for the coming year. Three of those nine priorities focus on families: working in partnership to commission safe, high-quality care for serving personnel and their families; supporting families, carers, children and young people in the armed forces community; and improving veterans', and their families', mental health.

I do not want to go into a long answer on this, but we now have a family federation representative sitting on the partnership board; we also have the UK-wide service families working group, with representation from all

the nations, the MoD and the Families Federation, to address long-term policy issues. The answer is that we are looking into the service. It is committed to in the long-term plan: three of the nine provisions are dedicated to families. We are looking into developing services to provide better provision to service families, particularly in terms of mental health.

The group that is working on this has been a great success. It offers a place to deal with the issues that families raise, and it deals with those issues quickly and effectively. There are members who have agreed to lead on and take forward implementations of the health and wellbeing recommendations that the MoD commissioned in the "Living in our shoes" report, understanding the needs of the armed forces family. That was a piece of work, as I am sure you are aware, by Andrew Selous. That will be pivotal in the implementation of the refreshed MoD family strategy. We are really aware of the issue that you have raised. Andrew Selous has done a great piece of work with his report, which we are taking very seriously, and we will move forward with that.

Q308 **Martin Docherty-Hughes:** Briefly, Minister, before I move on to my two other questions, would a 40% cut to the veterans office have a detrimental effect on your ability to deliver on those services?

Ms Dorries: I am not aware of the 40% cut. The funding for the services does not come out of the veterans office; it comes from the long-term plan and it counts as—

Q309 **Martin Docherty-Hughes:** But if the veterans office, which was set up with a Minister, were not funded properly and there were a reduction in investment, that would be detrimental to its co-ordinating and working with your Department and others.

Ms Dorries: I do not believe so, because the funding comes from DHSC and it goes to the NHS. We work with the Office for Veterans' Affairs to develop strategy—

Martin Docherty-Hughes: I think we have lost the Minister.

Ms Dorries: —so I don't think it will have an impact.

Q310 **Martin Docherty-Hughes:** I will move on to Dr Jenkins briefly. What specific support does the NHS in Wales offer to NHS veterans' families?

Dr Jenkins: As part of the Covenant, veterans' families will get access to priority services. If a family is on a waiting list in England and they transition to Wales, we would honour their wait. They don't have to join the start of an NHS queue again. It is important we give priority status to their families.

For children, we have an additional learning needs Act in Wales, so if any veterans' families have children that require our support, they would be wrapped up with support from our services in that regard.

We also have armed forces liaison officers linked to our local authorities. They would have local contact with veterans' families and access to health

services. As part of our local armed forces groups, the armed forces liaison officers would be there as a voice of the families of veterans. Likewise, we have representatives from the Families Federation on our local groups. I know very recently one of our GPs was keen to follow up with the armed forces family representative to make sure that the information was circulated around primary care colleagues. I guess my short answer to this is we would listen and act as we can.

Q311 **Martin Docherty-Hughes:** Thank you. I come to Professor Leitch. First, on behalf of my constituents may I thank you for your work during the national lockdowns? It is very strange to see you in these circumstances, rather than talking to us daily on the television.

Can I ask about the specific support NHS in Scotland offers to veterans' families? More importantly, do you think that the announcement by the Veterans Minister in Scotland yesterday of an additional £1 million in support for veterans' charities, which includes support for their families, will be of benefit to the NHS offer across Scotland?

Professor Leitch: Thank you, Mr Docherty-Hughes. This does feel like my proper job, rather than the job I have been doing for the last 14 months. I think a number of us here today feel exactly the same, including Jonathan.

I will answer your question in two parts. The first is that the National Health Service is the National Health Service, in Scotland - t provides mental health services to anybody who requires them. The obvious next question is what do we offer additionally for veterans' families and veterans and armed forces personnel. That is done through funding principally of third sector organisations, often in partnership with the National Health Service, the best example of which is Veterans First Point, a globally leading organisation—I don't use those words lightly—for peer support mental support for armed forces personnel and veterans, a model that has been copied in other parts of the world.

Veterans First Point is not universal in Scotland and I would like it to be. It requires further roll-outs. One of the things the recent funds from the Scottish Government may do, is help those third sector organisations. The other one, UK-wide, is Combat Stress, which will see you pretty much within a week of your referral. I think the last time I looked, even during covid, it was nine days from your assessment to being treated within that system.

Those are the additional layers we have in place on top of conventional National Health Service provision for Armed Forces and veterans. It could of course be better, but the Scottish Veterans Commissioner, who writes an annual report on health and other things and talks to me regularly, is of the view that we have made terrific progress in the last few years and, of course, we want to continue to improve.

Martin Docherty-Hughes: Thank you.

Chair: Thank you. I regret that we are now out of time for panel 1 and we need to move on to the next panel, because witnesses are waiting. I thank

Nadine Dorries, William Vineall, Kate Davies, Dr Jonathan Leach, Professor Jason Leitch and Dr Fiona Jenkins for your time this morning. It was a fascinating and very informative session. We will break for 30 seconds before moving on to panel 2.