



Defence Committee

Oral evidence: The Armed Forces Covenant in Action? Part 5: Military Casualties, HC 940 Tuesday 1 April 2014

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Written evidence from witnesses:

- Sue Freeth, Director of Operations, [Royal British Legion](#), Air Vice-Marshal David Murray, Chief Executive Officer, [SSAFA](#), Bryn Parry, Co-founder and Chief Executive, [Help for Heroes](#), Peter Poole, Director of Strategic Planning and Partnerships, [Combat Stress](#).
- Air Marshal Paul Evans, Surgeon General, [MOD](#), Rear Admiral Simon Williams, Assistant Chief of Defence Staff (Personnel and Training), MOD, Caroline Pusey, Head of Service and Veterans' Welfare, MOD, Surgeon Captain John Sharpley (RN), Defence Consultant Adviser in Psychiatry, MOD, Jon Rouse, Director General, Social Care, Local Government and Care Partnerships, Department of Health, and Kate Davies, Head of Public Health, Armed Forces and their Families and Health and Justice, [NHS England](#)

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Members present: Mr James Arbuthnot (Chair), Mr Julian Brazier, Mr James Gray, Mr Dai Havard, Mrs Madeleine Moon, Derek Twigg and John Woodcock

Questions 90-198

Witnesses: **Sue Freeth**, Director of Operations, Royal British Legion, **Air Vice-Marshal David Murray**, Chief Executive Officer, SSAFA, **Bryn Parry**, Co-founder and Chief Executive, Help for Heroes, **Peter Poole**, Director of Strategic Planning and Partnerships, Combat Stress, gave evidence.

Q90 Chair: Welcome to this meeting on military casualties. Thank you for coming, Air Vice-Marshal Murray. You gave evidence to us before—as did you, Mr Parry—but welcome to all of you. The first half of this session will be about military casualties. Please briefly introduce yourselves.

Bryn Parry: Bryn Parry, chief executive of Help for Heroes.

Peter Poole: Peter Poole, deputy chief executive of Combat Stress.

Sue Freeth: Sue Freeth, director of operations, Royal British Legion.

Air Vice-Marshal Murray: David Murray, chief executive of SSAFA.

Q91 Chair: Thank you. Air Vice-Marshal Murray, you have to go by 4. I hope we will finish at 3.30 so that we can move on to our next panel, and I hope that members of the Committee will ask brief and snappy questions and that we can get brief and snappy answers from our panel. You do not have to answer everything, if you feel that the issues you would have covered have already been covered by something else that has been said.

Let us start by asking about mental health problems. Has the support for personnel with mental health problems over the last, say, five years improved or not?

Peter Poole: I think it certainly has improved. I have been with Combat Stress for 12 years, and the society has been dealing with people for 95 years. Over the last seven years we have seen a much improved service for people. We, of course, can only talk about veterans, but we are seeing them come forward much quicker, and we think that is perhaps because of the work that the MOD has done to remove or at least diminish the stigma that veterans previously felt, and that servicemen feel about mental health injuries.

Q92 Chair: That is good. Mr Parry?

Bryn Parry: From our perspective, we work with Combat Stress, but we are seeing well-being issues in addition to mental health, the difference being that one is treatable. People tend to talk about PTSD and treatable mental health conditions. There is level 3 and level 4, and we are seeing a lower area. Of the people who have had their lives affected

by injury, almost 100% of them—and their families—have got mental well-being issues that need addressing, and they can lead to other conditions if they are not addressed.

Q93 Chair: But is that a change?

Bryn Parry: No, I think that is because it has not been a diagnosable condition, it probably has not been as recognised as perhaps it is now.

Sue Freeth: In relation to the changes that have gone through the new structure of the NHS, the role of GPs is going to be particularly important to support serving personnel, but particularly their families. There is still some work to do to educate and train GPs, but there is some really good practice. The covenant has really motivated some areas of the country. I think we have highlighted those in guidance that has been produced around the covenant, but I think there is a lot more work to do in terms of encouraging people to come forward. Family members themselves need support, but they are also a good route into individuals taking up support, particularly in mental health.

Chair: I hope that we will cover some of those issues over the next hour.

Air Vice-Marshal Murray: I think it has become rather a larger issue, because people have been willing to come forward—it is on the table and now accepted that it is an illness that is part of life and part of service. Those who have been in service more recently are willing to come forward and present. There are still some issues around the cohort of older people who are not willing to come forward, but in general, because it is on the table and now acceptable, it is getting better.

Q94 Chair: Have you been answering on the basis of serving personnel or formerly serving personnel?

Sue Freeth: Serving personnel.

Q95 Chair: Okay, thank you. Would you say that the defence community mental health teams were adequately resourced? Are they doing a good job?

Air Vice-Marshal Murray: You can never get enough.

Peter Poole: Yes, they are doing a good job, but of course there are few of them and there is a lot of travel involved in getting to one—I am answering now from a veteran’s perspective, because they do in some cases look after veterans and those who are wounded, injured and sick.

Sue Freeth: Stigma, I think, is still a very significant issue with this community, both while they are serving and later on. It is not a very actively help-seeking community—that is an element of its training—so you have to work extra hard, particularly in mental health, to encourage people to take up services and to take them up early.

Q96 Chair: What about alcohol misuse? How much attention has been given in recent years to that?

Peter Poole: We were fortunate—this is veterans, not serving personnel—to receive LIBOR money to set up an alcohol pathway: a management scheme where we can help veterans who are suffering with alcohol problems through the services which are provided by the National Health Service. According to the figures that we have collected, some 60% of veterans do have an alcohol problem. Many of them are binge drinkers who can actually disguise the effects of their drinking, but now, with our longer courses, they actually do have to have gone through some sort of detox programme.

Q97 Chair: Just for the moment, let’s restrict this question to serving personnel. Is there anything about alcohol misuse that you think the MOD is getting right or wrong?

Sue Freeth: I believe that there is a piece of research work, which we are all looking forward to seeing being published very shortly—I do not know what stage it is at, but I am sure that colleagues in the Ministry of Defence can refer to that. I gather that that will have some really good information, precisely about where some of the pressure points are.

Some of the reliance on alcohol starts while you are serving. Access and opportunity is greater, or is certainly learnt at an early age. Certainly, those of us working with the veteran community think that this habit or dependency does not start when they leave; it is something that has been cultivated earlier. I recognise that socialising is a very important part of service life, but it is something that we have found difficult to get agreed approaches on so far.

Air Vice-Marshal Murray: There is a piece of context out there about the broader society and the young people outside the services and the way they behave with alcohol. Whatever we talk about in terms of young servicemen and young servicewomen in particular, there is a context of what is going on in the broader world. The MOD are working very hard to try to reduce that. It is a bizarre environment, particularly for young men and women who go away for six months and do not drink at all and then come back and perhaps binge.

We are seeing some significant issues in terms of domestic violence relating to alcohol. A number of the wives, in particular, then end up being referred to us at support and there is always alcohol behind that. If I think back 30 years, the context and the culture have changed. There is a lot more drinking going on outside overtly with younger people than perhaps there used to be. The MOD is trying very hard, I think, to reduce what is going on inside the services, but there is always, again, more to be done. It is a contextual issue.

Chair: Do either of you want to say anything about domestic violence or veterans? Mr Parry? No? Okay.

Q98 Mrs Moon: Part of the community is often mixed. Are you noticing any particular outcomes in relation either to alcohol or mental health among those who join at a very young age, at 16? Do they stand out as indicating any particular problem?

Air Vice-Marshal Murray: We have a lot of experience on camps. We have social workers on many camps and we also run, in conjunction with the WRVS, as was, a number of facilities where the youngsters in particular are targeted to ensure that they are kept away from alcohol and those sort of influences. Again, there is a very clear programme inside MOD to support those individuals. I cannot talk about mental health, but I can certainly talk about the “stopping them getting alcohol” bit within the confines of the armed forces. What happens outside the gate might be another issue.

Sue Freeth: I think that in the research that is about to be published, it will be very interesting to see whether the younger age group actually features in any way. Perhaps we do not make enough of the public health opportunities inside the serving community to promote health and well-being a little more, which would be much more accessible and perhaps much more acceptable.

Q99 Chair: In the past when we have talked about mental health issues, we have always talked about PTSD. We have learnt, I think, not to do that quite so much, but is there a big issue on PTSD, Mr Poole?

Peter Poole: Are we talking about veterans or serving?

Chair: You may choose.

Peter Poole: I think you were given evidence by Professor Sir Simon Wessely, who is one of our trustees. His figures for the population as a whole are probably right. From our perspective, our population is seeking help and so the numbers diagnosed with PTSD by our psychiatrists are much higher. I think that common mental health injuries take up the largest space and those do not necessarily mean PTSD.

Q100 Chair: Are you talking about mental health injuries or brain injuries or traumatic brain injuries?

Peter Poole: I am talking about mental health injuries.

Q101 Chair: And is there a problem of traumatic brain injuries being confused with mental health issues?

Peter Poole: Of course. This is not my area of expertise, but I did discuss this with Dr Busuttil. It is something which he is keeping an eye on. Our figures are around 9%, whereas in America they are somewhere in the region of 25%.

Q102 Mr Brazier: Sorry, 25% of what?

Peter Poole: Of veterans from the infantry.

Q103 Mr Brazier: You still haven't said what you are talking about. Twenty-five per cent of veterans have what?

Peter Poole: Mild traumatic brain injury.

Q104 Mr Brazier: Sorry, 25% of all veterans or 25% of those diagnosed with mental health problems?

Peter Poole: The figures we have are for the infantry in general.

Q105 Mr Brazier: Twenty-five per cent have brain injury?

Peter Poole: Have mild traumatic brain injury. If I may just refer to my notes, I want to be clear on this as well. They are of combat soldiers returning from Afghanistan and Iraq. That was a single British study conducted some time ago, which said it was 9.5% of combat soldiers returning from Afghanistan and Iraq. That figure is low in comparison with the United States, where a much higher incidence—of between 15% and 23% for all US combat soldiers in the infantry—is evident.

Sue Freeth: This is the King's study.

Q106 Chair: When we were in the United States, we went to Walter Reed hospital and also to an offshoot of it which deals with and has pinpointed this issue of mild traumatic brain injuries. Those studies have not been replicated in the UK, as I understand it. Is that right?

Peter Poole: I similarly understand that that is the case.

Q107 Mrs Moon: On post-traumatic stress disorder, are you able to deconstruct the figures as to what the trauma has been that people have suffered? Again, in the US, they were picking up a lot of people with PTSD who had worked in the medical corps, rather than as a result of front-line experience. It was the trauma of constantly dealing with severe injuries that had caused the trauma. With other people, the trauma was caused by things that had happened to them during their service, but again not in theatre—it was not combat-based trauma. Are you able to do that with the figures that we are seeing? Has anyone done that work?

Peter Poole: I don't believe that anyone has and it probably is an area for research. I was a welfare officer for some time with Combat Stress and I saw a number of people who had been in the medical services who were suffering from that, but we do not at the moment count those numbers and it is perhaps an area where there is a call for more research.

Sue Freeth: There is a research unit in Oxford—the Scars of War Foundation—which has been trying to promote an equivalent MTBI study

in this country. The charities were invited to consider whether they felt this was something that they would be willing to support. We came to the conclusion that it was so late in the campaign that it would be difficult to find a big enough study to get anything of real consequence from with immediate effect. This is a longitudinal study proposal, and I believe the Department of Health and the Ministry of Defence have been consulted, so they may refer to it, but I do not think we felt that this was something that we, as charities, ought to be initiating. If it was needed, the Ministry of Defence, particularly, and perhaps the Department of Health, ought to be investing in this.

Q108 John Woodcock: Peter Poole and Sue Freeth, specifically on veterans, how do you think the increased level of services for those with mental health problems are working?

Sue Freeth: I think we have seen some improvements. We referred earlier to where we have been able to encourage GPs to become more aware and to encourage people to identify themselves once they become veterans. There are some really good pockets of the country that are doing that, but it is still very patchy.

Q109 John Woodcock: That is the second time you have mentioned GPs. It is interesting. You seem to be putting quite a glass half full perspective on this. When you say pockets, is it still a minority of GPs who are doing the right thing?

Sue Freeth: I don't think it would be unreasonable to say that it is a minority. The GP community is very large. It is the gateway into primary health and it is very important that GPs help us to identify individuals, particularly veterans and family members of veterans, so that we are able to encourage them to take up help earlier. The King's research suggests that people are often not looking for help early enough. Interventions and treatments are available. We see GPs as being absolutely key.

I have just joined the Armed Forces Clinical Reference Group. One of the conversations that we have started is about the conflict in the NHS: it is trying to come to terms with identifying an occupational group as a priority, and it is trying to deliver its constitutional objectives, which are almost counter to that. Persuading GPs that veterans who have been injured, or veterans who have just left the forces and are in a transition

period, may need encouragement to come forward for assistance is something we have to keep chipping away at.

Peter Poole: The Murrison report, “Fighting Fit”, was a very good start. Issues around devolution make matters a little bit more difficult. The veterans fought for the UK forces, but if they are in Scotland and in England, they may get more than those who are in Northern Ireland and Wales. There is an issue regarding standardisation of what is available to veterans with mental health problems—provision is clearly not standardised at the moment.

Q110 John Woodcock: There is clearly a disparity between nations within the UK, but would you say that there is a postcode lottery within those nations as well?

Peter Poole: I would have to agree with Sue that there are areas of extraordinarily good practice, and there are areas where that has not been the case. I think that perhaps we should be careful to ensure that any further money that goes into this actually hits those areas, or spreads good practice across those areas where practice is not so good.

Q111 Mr Havard: You mentioned Wales. I am Welsh. Why are we getting less? That is the question. Or, rather, are we getting less? Could you deconstruct that for a minute? We will have evidence at a later date from Ministers, but Health Ministers tend to have “for England” in brackets after their title. The question of devolution and consistency of approach across the UK is really important. Could you say a little bit more about why you think it is worse in some areas than in others?

Peter Poole: I will start with the service that has been commissioned from us by NHS England, which actually provides for English veterans. The Scots have also put in some money for the intensive six-week programme we have had commissioned, but that is not the case with Wales or Northern Ireland. We help those veterans, but we help them from charitable funding rather than from any statutory funding, because they are not included in that particular contract with us. That is one area. From our perspective, we provide the same across the board. We operate in all parts of the United Kingdom, and we actually provide the same across the board. You have your own service in Wales which provides a lot, but it doesn’t provide any in-patient treatment, which is provided elsewhere.

Q112 John Woodcock: You say that only a minority of GPs are currently switched on to best practice. GPs are now responsible for commissioning, including mental health services. Presumably that must be a real concern for you.

Peter Poole: I think it is, because there are a lot of CCGs out there. I would suggest that, in many of those areas, there will not be a critical mass of veterans. There is a need to look at this. The area networks might well help, but none the less, there is a declining number of both ex-serving people and veterans from longer ago. That critical mass will be quite important.

Q113 John Woodcock: Can I ask how much sooner veterans are presenting for help than in the past? Can you measure that?

Peter Poole: From our perspective, the figure of 13 years, which I think was mentioned earlier, is about right across the board. However, we notice that the veterans from Afghanistan and Iraq are coming forward much more quickly. From Afghanistan, it can be within two or three years, but overall for that particular cohort it is about six or seven years, which is a huge improvement. Of course, the quicker we can get them, the more we can do for them.

Q114 John Woodcock: Can you say how many veterans from Iraq and Afghanistan you expect to present?

Peter Poole: Fourteen hundred and ninety have presented as of a week ago.

Q115 John Woodcock: Do you have a projection for the future based on what has happened so far?

Peter Poole: No, but we expect the figure to increase. We have seen the numbers of people referring to us increase by 10% year on year and we expect that to increase, probably to 12% or 15% in the near future. Our difficulty is that the focus may well have left veterans issues before many of our people actually present for treatment.

Sue Freeth: The governing structures in the NHS—the new commissioning structures—are very important. Picking up the best

practice that some parts of the country are developing and spreading it across all commissioning groups is the only way to make it stick.

Bryn Parry: Although it is not my area of expertise, we understand that there have been 1,105 claims awarded in the past five years for mental health conditions. Of those people who have been to Iraq and Afghanistan, 4% have possible PTSD, 19% or 20% have common mental disorders and 13 reported alcohol abuse. We do not know what is coming in along the tracks, as it were. We had nearly 1,500 veterans presenting with evidence of combat stress. What we are seeing is that all those who have had some life-changing injuries, so that they can no longer do the job that they wanted to do, are presenting with some mental condition. They have concerns. They are not sleeping, they have anxieties or depression, and they are turning to alcohol and so on.

There is an increasing number of people who are isolated, particularly those who have left, because they are no longer with their unit or with their friends. The question that I fear I am bouncing back is that we do not know how many people are sitting at home with a problem who are not going to see their GP, because they don't know that they have a problem. In some cases, they could be relatively well served if they could present themselves, but they don't know. They are hidden numbers we can only guess at, but there are quite a lot of them. Certainly, 100% of the wounded, injured and sick who come to recovery centres—all of them—wish to have some counselling.

Chair: That may be a by-product of this inquiry. Let us hope that it is.

Q116 Mr Gray: May I ask you all a general question first? It is an obvious presumption that there will be a higher percentage of people suffering mental health problems or alcohol or drug dependency—and people often say, anecdotally, homelessness and imprisonment—among veterans than there would be in the general population. How much greater do you think it is?

Sue Freeth: I shall pick up the prison area. The reliable data that has been published does not suggest, as far as I understand, that there is a large community. It is difficult not to be led by some of the media stories.

Mr Gray: What about mental health, alcoholism and drugs?

Chair: Before you go on to those, I think Hugh Milroy of Veterans Aid would say the same about homelessness.

Q117 Mr Gray: Yes. So let us leave prisoners and homelessness to one side as probably being statistically incorrect. What about mental health problems and drug and alcohol dependency?

Sue Freeth: Simon Wessely's data suggests that it isn't necessarily any higher—pretty much a slice of the community. What the Legion and parties we work with experience is the impact on the veteran, which we see as being a significant disabling and limiting effect. As charities and organisations preoccupied with their support, it is not an effect that we think should be ignored, because it has an impact not only on the individual's ability to continue to live independently, but on the lives of many other people who live with them, many of whom are young. The current legacy cohort consists of young people, whom everybody wants to be living full and independent lives.

Q118 Mr Gray: Sure. I am not suggesting for a second that we should ignore it. I simply wanted to get the facts right. What we are saying broadly, therefore, is that a similar percentage of veterans suffer mental health problems or alcohol or drug dependency as those in their cohort in society in general. Assuming that that is the case, to what degree do you think that those mental health, drug or alcohol problems are directly associated with, or the result of, their military service? Is it not merely because they come from a particular group of young people who suffer from those things?

Air Vice-Marshal Murray: I think it is worth making the point that if they come from a group of people who have suffered from those sorts of issues, once they are in the services, the vast majority change. The vast majority become disciplined, grow up and become good members of society. Those who then suffer from mental health issues, alcohol abuse and so on have slipped back further than some of the people around them, if that makes sense.

Q119 Mr Gray: Yes, that is an interesting qualitative point. It is worse for them than it would be had they simply remained.

Air Vice-Marshal Murray: Absolutely.

Q120 Mr Gray: That is an important point. Sorry, Mr Chairman, I have deviated from my task. Forgive me. Perhaps that conversation will be useful background. I wouldn't mind focusing on the particular problems faced by Reserve veterans. First, are the health and mental health problems greater or worse? Secondly, do Reserves particularly—as opposed to regulars and Reserves—suffer any problems pre-deployment, on deployment or post-deployment?

Air Vice-Marshal Murray: We do a lot of work with the Reserves. To put it in context, we have 92 branches, so we are seeing people all around the country. That is where the Reserves are—they are not generally around the garrison towns and so on. That means that they have a particular issue. If bad things have happened to a platoon of riflemen regulars, they can deal with them when they come back in a particular way inside the garrison with the support of the MOD, the regiment and so on. Those in the Reserves have a very different perspective. They are on their own. They might come from Bridgend. They might be a local bus driver there. They will come back and the other bus drivers will have no idea what has happened to them, where they have been, what they have seen or the experiences they have had. Nor would their wives, loved ones or partners have any idea. If they are inside the wire—if they are part of the regiment and the battalion—the other wives and so on will understand. So the support mechanisms that you get with the Regulars are not necessarily there for the Reserves—there is a particular issue around the Reserve cohort. I don't think anybody understands the different welfare issues that they and their families have. We are looking to work with others, hopefully with a lead from the MOD, on understanding the particular needs of the Reserve cohort, who are largely on their own when they come back. The welfare network that might be there for the regiments, squadrons, the ships and so on is just not there.

Q121 Mr Gray: Understanding that problem is one thing—it is not that difficult to do but, as you say, they are spread out around the country—but more difficult is deciding what on earth we do about it.

Sue Freeth: A number of us have hit on Reservists as being an area where more work is needed. The first point, as David has said, is to understand where those communities and those individuals are, so that we can put more effort into areas where there are a larger number of them. In terms of how we adapt what we already do, we just have to work harder and smarter at connecting the services of the Ministry of

Defence, the Department of Health, the military charities and others, and really watch out.

Q122 Mr Gray: Does the MOD maintain a database of Reserve veterans after they have left? Is there a central body of information about who these people are?

Peter Poole: No, not as far as I know. From our perspective and that of the Reservists who are veterans whom we see—and some who are not veterans—there is an issue of clarity. We are crying out for clarity about who is responsible and when. That is not just from us; it is also from the veterans. We don't treat serving personnel, but we do treat veterans. When is a Reservist one and when is he another? How are the medical notes going to be passed? What is the transition between the two? For me, those are the fundamental issues.

Q123 Mr Gray: So there is infrastructure work that needs to be done with regard to Reservists that does not need to be done with regard to the regiments?

Peter Poole: We do know that Reservists are slightly more likely to have mental health problems.

Sue Freeth: Post-operations.

Q124 Mr Gray: Is that right? Why would that be?

Peter Poole: To go back to David's point, it is this business of being isolated on return. They don't really have the support mechanisms that might be there for someone who is living alongside the person they were serving with in Afghanistan or on operations with.

Air Vice-Marshal Murray: Young soldiers understand where to get help from; Reservists—this goes back to the isolation point—don't really understand, and nor do their families. They don't really know how to hook into and how to get support from the Army, the Air Force and the Navy, which is there if they need it, but it is about getting into it. They are also pretty independent people running pretty independent lives, which is a strength. But when things go wrong, they can go horribly wrong and they are on their own.

Q125 Mr Gray: One final question about Reservists: when there is a fatality among the Reservists, is the support that is provided to the families equivalent to that provided to bereaved families of Regular soldiers? Is there equally a gap there with regard to Reserve families who are bereaved?

Air Vice-Marshal Murray: There are two parts to that. I am answering because we run bereaved family support groups for the MOD. Back in 2008, it asked my charity to do that, because MOD cannot do it and nor should it do it—it is a charitable activity. So we look after about 300 bereaved families at the moment. When the Reservists know about us, we can support them, but again it is a question of knowing about them. When they are bereaved, people will gather around very quickly and the regiment will gather round very quickly, but some of them are not really a full member of the regimental family, so they can be forgotten about a bit. Some regiments are better than others. I am not saying that it is a two-tier process. There is not a deliberate two-tier process but, again, the people are in the community. They do not hook naturally into the military and their surviving families do not naturally hook into it. They don't know where to go to get that support, so we are working very hard to get that information out.

Chair: The panel that is following you—many of them are from the Ministry of Defence—will have been listening to the points you have made about Reservists not being fully aware of where to go. During the course of their evidence, I hope that they will be able to answer some of those points because they are most important.

Q126 Mrs Moon: Do families get sufficient support when they are bereaved and is there a difference depending on which service they served in?

Air Vice-Marshal Murray: As it happens, we are just doing a piece of work on that. We have been commissioned by the MOD to do an independent piece of work, talking to the families we look after to get their views about the experiences they have had—good, bad and indifferent. We are not judgmental. It is a very candid report, and we will give it back to the MOD and it can do what it wants with it. As a general point, the support that the families get now compared with perhaps 10 years ago is much, much better.

There are still issues. There are still some problems, some of which can be resolved, but some which just cannot be resolved because of the

bereaved individual and they are very specific to particular families. The support they get, particularly in the immediate aftermath of death—both combat deaths and non-combat deaths—is getting better. It can always be improved—of course it can—but the charitable sector is working with the MOD and particular regiments and units to make it right. It is a very personal thing. A lot of resource is put into it, which is as it should be.

Long term, we don't know how good it is going to be and, particularly with the demise of combat operations, whether it will be so—"sexy" is an awful word—interesting to the greater public, we don't know. But, at the moment, it is pretty good. It can always be improved and there is more to be done, but it is a partnership between the armed forces—not necessarily the MOD—particular regiments and the charities.

Q127 Mrs Moon: Who does the support go to? Does it go just to the identified next of kin? What about the wider family such as parents and siblings?

Air Vice-Marshal Murray: We provide support, bizarrely enough, to everybody but the wife. We work closely with them, but the wife is looked after by separate charities—Army, Air Force and Navy widows' groups. As for the rest of the family—the broader family—do you know what? We don't really look too closely as to what "the family" really means. We look after people who need help. It might be partners or girlfriends. I was up in Glasgow recently with 250 families and there were some quite diverse families. One doesn't ask too much. If they are in pain and they need support, they get it.

Q128 Mrs Moon: Is it up to the families to come to you for support, or do you go to the families? How do you know who needs the support?

Air Vice-Marshal Murray: It is a bit of both. We work closely with the armed forces and their welfare teams, and they are offered our support. We have only been going since 2008—that particular part of the charity—and the vast majority of those who were told about us would come along. That may be for one or two meetings or it might be for much longer. We now have people from the Falklands who come along looking for support. A father from the Falklands came along recently. We are working very hard to ensure that people know about us. We don't want to be in their face, but we certainly want to be as supportive as possible. We are not going to ring them up, but we will work through the visiting officer

and the supporting teams to ensure that they know we are there for them when they want us.

Q129 Chair: Bryn Parry, did you want to come in on that?

Bryn Parry: Just to make the point that it is not only the bereaved families who need help. We have more than 1,500 loved ones who belong to our support group for people who are in relationships with the wounded, injured or sick. We are here to talk about the wounded, injured or sick. We have talked a lot about mental health and bereavement, but there are a lot of issues to do with these people—again, to do with the point about Reservists—who are finding it very hard to live with their loved one who has now changed and is experiencing all sorts of mental conditions and issues, and needs to be part of a fellowship, particularly when they are Reserves or anybody recovering at home in isolation. That is an issue we are concerned about.

Mrs Moon: You pinched my next question, Mr Parry.

Bryn Parry: I do apologise.

Q130 Mrs Moon: That is exactly where I was going to go, because in a sense there is a longer-term engagement with someone who has had a life-changing injury. It is not going to be—

Bryn Parry: It is not finite.

Mrs Moon: It means a longer engagement. Do we have the capacity to maintain the level of support and recognition for that wider family?

Bryn Parry: Hitherto there wasn't any recognition. Our particular group is growing at about 50 a month. It is on a trajectory that is completely silly. Clearly, as people hear about the support—it is central support and also mutual support—there is a need and this needs to be co-ordinated.

Sue Freeth: The service charities have been working with a number of communities. The Afghanistan community is obviously new and bringing new challenges, some of which are similar to those of previous decades. In terms of whether there is enough resource, if the organisations in this space work together, we can make a lot more of what we already have. I certainly think that the service charities are

doing that better than they have done before, but there is still a way to go. I think that, working with the Ministry of Defence and also parts of Government, there is a way to go. We have worked and are working closely together, but we have to, because the resources are to support individuals who are often increasingly isolated and not willing or able to know where to find help, and they are going to be more and more difficult to find as they become more dispersed and resources are less available.

Peter Poole: I think the trick here is working together. If we do not work together, we will duplicate and therefore waste money. The resources are going to be much more difficult to come across, I believe, so partnership working, which we all do, is absolutely vital.

Sue Freeth: I have drawn the attention of the Committee secretary to a piece of research that has been published this week in the United States, which actually looks at the needs of what they call the care-giving community to the military injured. I think there are some very interesting things in that. We do not have that kind of data available to us at the moment. We have the data and the experience from those of us involved in individual cases. I think there are some interesting features in there and I would be very surprised if they were not similar here. A much younger age group of people are affected. Their partners are often parents; they are at work, and in their 20s and 30s, not their 40s and 50s. There are some specific issues about this legacy group. We need to work hard to make sure that they know they can come forward for support and that they get the kind of support they are looking for.

Q131 Mrs Moon: We have talked about veterans and Reservists. What about those who are still serving? I appreciate that this group might be harder for you to reach, but what if you are serving alongside somebody who is killed or receives a traumatic injury? We know that treatment is available. Are you seeing people coming to you particularly for emotional and mental health support who, while serving, were alongside someone such as a friend who was either killed or traumatically injured, and who felt they did not get the support they needed while still serving? Are they coming to you once they leave?

Sue Freeth: We are certainly increasingly seeing people coming to us for support who have difficulties, especially financial difficulties. Those may be related to either an injury or a bereavement, but we encourage them to realise they can come forward for support, particularly to the charities. I think that many people serving still do not realise that the

British Legion is a place where they can get support. Whether we can get that message over better is something that I think we should work at.

Q132 Derek Twigg: In terms of the Army recovery capability, does it have sufficient capacity to deal with the numbers of wounded, injured and sick soldiers? I think that Bryn and Sue are probably the best people to answer that. What is your latest position and what do you think?

Bryn Parry: On the Army recovery capability, obviously that is for the serving. At the moment, there is a two-tier system, as Lord Ashcroft brought out in his transition review. The figures at the end of October last year were 1,700 wounded, injured and sick in the Army, of whom about 800 were in the Army recovery capability—the rest were not. Again, I suggest that the people within the Army recovery capability are getting very good support. They have a personnel recovery officer and they are part of a personnel recovery unit. Then they, in turn, come through recovery centres. The recovery centres that we run are open to both serving and veterans. We would like to see a wider capacity so that everybody who is wounded, injured or sick is linked to a recovery centre and able to take that through transition and into civilian life.

Q133 Derek Twigg: Is that throughout the recovery pathway?

Bryn Parry: Yes.

Q134 Derek Twigg: Which is not happening now.

Bryn Parry: No. At the moment, the defence recovery capability is limited by the number of personnel recovery officers. As you are aware, what they have gone for is a brigade-based solution. Each brigade has a personnel recovery unit. Within the unit are a number of officers who can look after their wounded, injured and sick, which is limited to about 12 to 15. The reality is that the personnel recovery officer therefore travels to see the soldier, who is normally at home, so a lot of their time is spent on the road. If we could better resource or better utilise and centralise our resources, the expertise could be centralised and the resident or the candidate could be brought to the expertise. At the moment, we are asking for a review, and one is in process. When you have a personnel recovery officer, on the whole it works very well, but there are a lot of people without one.

Q135 Derek Twigg: Do you have any idea what the cost of going down that road would be for the MOD?

Bryn Parry: The whole period is provided for free. At the moment, we have four recovery centres, but—

Q136 Derek Twigg: But it is free in the sense that you are using your funds to provide it.

Bryn Parry: In one of my centres, for example, I have 43 members of Help for Heroes staff and there are five members of the military, of whom one is not there at the moment because there is no one to fill the job. Yet there are about 134 recovery officers out there in the brigaded areas visiting people, so I do not think it is the best use of resource. I would advocate a more centralised solution.

Sue Freeth: I would agree that a lot of effort has gone into trying to maximise and optimise capability, especially capability in the recovery centres. There is still a way to go, and I am sure that colleagues will speak about that. A lot of effort is going into it. I think there are some resource constraints, perhaps, as Bryn was saying.

Q137 Derek Twigg: Have you got a handle on what they are in terms of actual numbers? What amount of money or resource will you need?

Sue Freeth: Support Command has just taken over responsibility for delivering and using this capability. A lot of analysis is going on to look at exactly how many people are in the system at any one time, and to look at how well that matches the capability that Bryn is referring to. Certainly, as charity partners, we are very keen to see the recovery centres optimised. There are always going to be people who would prefer to recover at home and to dip in and out of the recovery centres. They will not necessarily always want to stay away from home, particularly if they spend long postings away from home. In fact, their recovery is probably better supported by enabling them to stay as close as possible to the community where they are going to be residing and living as they spend more time away from the armed forces and start to move away.

I think we need—we have been pressing for this for some time— independent evaluation of the recovery pathway so that we can answer

the question that you are posing. We know that colleagues are now taking that on. I believe that Ofsted has been brought into the picture to put together an assurance framework so that we can all be assured that the capability is being fully optimised.

Chair: Can I bring in Julian Brazier?

Q138 Mr Brazier: Sorry, Derek; I am rushing off to another defence engagement shortly.

Just one quick question, mostly aimed at Bryn Parry. The brigade recovery centres, as you say, are very well resourced and have a very good reputation. I have heard allegations from one or two people that Reservists do not get equal access to them. Do you have a view on that? Have you heard anything anecdotally? I will not be here to put the same question to the MOD.

Bryn Parry: Certainly anecdotally, yes. In every organisation, there will be very good people and people who are less good. It is a very mandraucic solution at the moment, because it is limited by the number of people whom a personnel recovery officer can look after, and there are stages of recovery. As Sue said, there is a time when it is best to be at home and reintegrating into your life and moving on. But, certainly in the early parts of recovery, there is pretty good evidence—that we have, anyway—that people are better together, rather than sitting on the sofa.

Q139 Mr Brazier: Sorry, that was not my question. My question was: do you think that in terms of getting into the brigade recovery network—the recovery centre—the Reserves get an equal opportunity?

Bryn Parry: I believe they do; I know they do. There is equally the problem of disenfranchisement. You feel more lonely—the point we made earlier about being a Reservist—and they are happier when they are still effectively in uniform. That is better.

Chair: I will just record that Sue Freeth was nodding.

Q140 Mr Gray: Is there a map somewhere? Has anyone produced a map of the people who are in need of your collective services and where the four recovery centres are? Do the two match, or are they entirely different?

Sue Freeth: I believe that that analysis work is part of the review that Bryn has been talking about.

Air Vice-Marshal Murray: But it is important to note that where those people are when they are serving is not where they will be when they leave.

Q141 Mr Gray: No, but a map would show us, because if they were all clustered around Aldershot and Tidworth, it would be clear.

Bryn Parry: To be clear, the recovery centres are based on garrisons. The Army ones are in Catterick, Colchester and Tidworth, and the naval service one is in Plymouth. Especially in the case of Plymouth, a lot of people then retire to or live in that part of the world. The Catterick one serves the Newcastle area. About 46% of our armed forces are recruited in the north-east. We have one in Scotland; there is probably more need for something in Scotland.

Sue Freeth: No, the one in Scotland is well used—

Bryn Parry: No, I am saying that there is a need for more in Scotland.

Mr Gray: A map would be nice and easy for simple people like me to understand.

Chair: We visited those in our last inquiry. Sorry to hurry this along, but we have a lot to get through.

Q142 Derek Twigg: Going back to the point about the evaluation of the recovery pathway, given when we set it up, why are we evaluating it only now?

Sue Freeth: It has a number of different disjointed elements to it.

Q143 Derek Twigg: Could you explain?

Sue Freeth: The recovery centres are offering a number of core courses and also providing support for people who have nowhere to go, so the periods there can be much longer than others. The units are

providing different interventions. It is not a smooth pathway; it is a completely new capability, and I think there is a great deal of good going on within it. What we do not know is whether it is happening at the right time for every individual.

For some time we have been suggesting and strongly encouraging that because such a significant amount of resource from the Ministry of Defence's side and the charities' side—probably the biggest chunk of charitable funding—is going into capability for people who are still serving, we need to learn the lessons from that so that the 10-year commitment that the Legion and others have made is really well spent in the right places. We will not know unless we do proper independent evaluation.

Bryn Parry: I agree with Sue. The thing is we started from somewhere and got the places built. They have been at full operating capacity for less than a year and, as we are running them, we are learning the right lessons. So there is need for constant review and constant improvement.

Q144 Derek Twigg: I would accept that that is great, but what I am trying to suggest is that perhaps the pathway should have been set out in the first place and then built around that. Then, of course, you can evaluate how that is progressing. I am just concerned—

Air Vice-Marshal Murray: I think it is worth making that point that Mr Twigg, in a previous life, was involved in this right from day one. There was a present and clear need for things to be done in a hurry to help people who had a problem—

Derek Twigg: Unfortunately, I left before—

Air Vice-Marshal Murray: You moved on. But things needed to be done in a hurry. An awful lot of things were going on that were pulled together—I would not say haphazardly, but at the best way at the time. We now need to stop, see how we are getting on and improve it, but it was done in a rush.

Q145 Derek Twigg: That was more than six years ago, but I take your point.

Are you satisfied that the return to the civilian population for the service personnel who have been injured or wounded is smooth enough

now? Are they being referred to the right places for voluntary sector help? This has been an ongoing issue.

Bryn Parry: This is work in progress. With every day that goes by, things are getting better, because this is new business. As David said, there was no third phase of recovery: there was hospital and medical rehab, but no recovery or reintegration transition phase at all. That has now been created, so we are learning huge lessons. What we have to ensure now is that, from the learnings that we are making, we create a structure that is in place for decades to come.

What we do not want to see is that just at the end of this particular conflict, it is all pulled apart and we then have to rebuild in years to come. The people who have been wounded today will take years to recover and reintegrate, so let's not pull the system apart after that; let's get it in place for the day-to-day wear and tear on the wounded, injured and sick in the British armed forces—we damage people just in normal training—so there is a structure in place so that when we have our next conflict, which, frankly, is inevitable, we are ready to deal with this and do not have to rebuild it.

Q146 Chair: I am going to have to break in here. Because these questions are extremely important and interesting, we could go on with them for a long time, but we must be very concise now, please, if you do not mind.

Peter Poole: Could I just add that I think that whenever people leave the service, there is sometimes a cliff edge when there should be a slope. On the transmission to the third sector, especially for us from Defence Medical Services and so on, it would be easier to work with the records of the people identified as leaving and that we were involved as they left, rather than having this cut-off point.

Chair: That is an important point, and I think that you have just taken away Derek Twigg's next question.

Derek Twigg: I have finished, Chair.

Q147 Mrs Moon: Could you say something about the long-term sustainability of services to personnel and veterans, given public generosity fatigue? In the long term, is the Ministry of Defence going to have to go back to picking up some of the responsibilities that are currently with the charities?

Peter Poole: Quite a lot of us here have been here for quite a long time. SSAFA has been here the longest, we are probably second and the Legion third—they are the new boys. So I think there is sustainability, but we have to be careful about not wasting money, as I said before, with duplication and doing things that are not required.

Sue Freeth: I think the concern is actually the opposite. Charities are concerned that their role will have to increase to meet the expectations of this community. That is one of the reasons why the Legion and the rest of the community believe in doing studies and evaluation work. It is only by gathering real evidence rather than anecdote that we will really be able to present, plan and sustain the services that everybody believes should be there for this community. I believe that the Surgeon General is conducting a study, which we hope we can encourage him to implement quickly, which will follow the injured group as they go into civilian life. We need to be able to understand the ongoing health and social needs of that group, for prosthetics and mental health services, so that commissioners can plan for it and resource it.

Q148 Mrs Moon: Have we got too many charities and should there almost be a register of charities? It is very easy for people to come into the field of mental health and think that they can offer a new solution, whereas what we need is to consolidate what we have. Could you comment on that?

Air Vice-Marshal Murray: The four charities here are four of the five largest charities in the military sector.

Chair: That is why you are here.

Air Vice-Marshal Murray: Indeed. The point is that a number of the smaller ones will disappear; they are not sustainable. As the world goes on and they cannot attract any funding, they will disappear. All of us, I think I am right in saying, will work only with particular charities. While there is no “register” per se, if they are not NICE accredited, for example, we will not work with them. If they are not a member of Cobseo we will not work with them. That is almost self-regulating. So to answer your question briefly, there is no register, but there is an informal register, because we are only going to work with people who know what they are doing.

Q149 Mrs Moon: How are we going to make sure that the public know who is going to use their money effectively? In terms of long-term sustainability needs, how are we going to help the public understand which charities they should be supporting?

Bryn Parry: Judge us by what we deliver.

Sue Freeth: And by encouraging and supporting us to work together. Sometimes Government are overly concerned about making sure that they are even-handed. Sometimes, one has to encourage collaboration. We certainly need to continue to put that pressure on people. The Charity Commission will tell you, however, that the military charity sector is not growing, but is actually shrinking; it is just not perceived to be shrinking.

Bryn Parry: The big issue is co-ordination. We all work very closely together, but co-ordination is now the key, because we have to recognise that post world wars—we are now into expeditionary wars—the charities and corporate sector have a role to play in this partnership. Hitherto, the MOD has tended to look after everything itself, certainly for the serving. Now, with the game change, we have charities like the Royal British Legion, Help for Heroes and others working with the serving and veterans. So the world has changed. Now, that needs to be co-ordinated and a structure put in place for the long term.

Peter Poole: And I think it is not just the MOD, it is the NHS as well, because the people who they work with will become known for doing work in that particular area. So I think there is a case there for widening this, not just with the MOD but also with the National Health Service.

Chair: Help for Heroes, Combat Stress, Royal British Legion and SSAFA, thank you very much indeed, it was most valuable evidence.

Examination of Witnesses

Witnesses: **Air Marshal Paul Evans**, Surgeon General, MOD, **Rear Admiral Simon Williams**, Assistant Chief of Defence Staff (Personnel and Training), MOD, **Caroline Pusey**, Head of Service and Veterans' Welfare, MOD, **Surgeon Captain John Sharpley (RN)**, Defence Consultant Adviser in Psychiatry, MOD, **Jon Rouse**, Director General, Social Care, Local Government and Care Partnerships, Department of Health, and **Kate Davies**, Head of Public Health, Armed Forces and their Families and Health and Justice, NHS England, gave evidence.

Oral evidence: The Armed Forces Covenant in Action? Part 5: Military Casualties, HC

Chair: Okay, you've heard all the questions, what are the answers? Could I ask you please to introduce yourselves? Surgeon General, would you like to begin?

Air Marshal Evans: I am Paul Evans, the Surgeon General.

Rear Admiral Williams: Simon Williams, the Assistant Chief of Defence Staff for personnel and training.

Caroline Pusey: Caroline Pusey, Head of Service and Veterans' Welfare.

Surgeon Captain Sharpley: John Sharpley. I am the Surgeon General's Adviser on psychiatry and mental health care.

Jon Rouse: I am Jon Rouse. I am Director General for Social Care and have responsibility for Armed Forces' health at the Department of Health.

Kate Davies: Good afternoon, I am Kate Davies and a Director in NHS England. I am the Head of Armed Forces, Health and Justice and Public Health.

Q150 Chair: Thank you very much. I was only partially joking when I said: "You've heard all the questions, what are the answers?" Let us begin with: how do you think the support for serving personnel with mental health problems has improved over the last five years? Who would like to begin?

Air Marshal Evans: I will start by saying—as I think was said earlier on—that by and large the care offered has considerably improved right from the battlefield, as it were, through to return home, looking at vulnerable groups, the seriously injured, and the people who work in the medical services. Before I hand over to John, I would say that generally it has improved considerably and our efforts in that area are very much concentrated. The Department of Health has worked very closely with us and Jon Rouse, who with me co-chairs the MOD/DH Partnership Board. Again the ongoing work into transition has improved considerably. I will hand over to John Sharpley first for the in-service side.

Surgeon Captain Sharpley: Five years is not quite the period that I would like to talk about. I would like to talk about 10 years ago, because

that is when we probably started to improve our mental health care in terms of resources and people available to provide the care. In the last five years we have been working hard to improve things, for example, by improving the transition for veterans through implementation of the Murrison recommendations, and improving operational care to the physically injured. Perhaps here I could mention Role 4 and the Birmingham and Headley Court provisions. We have more people doing the business, as it were, and we are also probably doing more business. We are seeing more people come through the door because our commanders are now better educated about stigma, and because we have Trauma Risk Management—TRiM—which signposts people to mental health care. We are educating our primary care colleagues. So we have been doing an awful lot to improve things. The job is not done, of course. There is more to do, but I think that we have done a lot in the last five years.

Jon Rouse: Perhaps I could take that into the veteran sphere. There are two elements to this, both of which tell a story of improved services. First, there are the specialist services for the veterans themselves, including the 10 veteran mental health centres, the development of Big White Wall as an online provision, the 24-hour helpline, and the mental health network for veterans. These bring together good practice between the different mental health teams and providers. That is obviously a very important landscape.

The second element is the improvement in community services. The big shift has been the development of the Improving Access to Psychological Therapies (IAPT) programme. Over the last five years it has grown from nothing to providing for over 600,000 people per year, which includes veterans and indeed the families of veterans and of serving soldiers, all of whom can access those services.

Kate Davies: The important thing for NHS England within the new commissioning landscape is not only the proactive work and what that means in terms of pathways, particularly for serving personnel and their families, but the work we are doing across CCGs, local authorities and public health to support parity of esteem of mental health services within the community.

I can obviously only speak from within NHS England directly for the last year, but one thing that we have certainly done and is work on closing the gap for mental health. This is highlighted by particular pieces of work. The case studies include the circumstances of serving personnel and their families, particularly veterans and reservists. We have been

very overt in ensuring that, through our commissioning networks, we highlight what those pathways mean for veterans and reservists. I am not sure that that has necessarily been done on a national basis in the way that we have been pushing it, particularly in the last year and the last six months, with the mental health concordat and parity of esteem.

Q151 Chair: When you say that you are not sure that it is being done on a national basis, does that really mean that you are pretty sure that it is not being done?

Kate Davies: Sorry, Chair. I am not sure how we could have evidenced that that was done consistently on a national basis before the commissioning network that we have now was created. For NHS England, the whole purpose of direct commissioning responsibility for armed forces and their families is to ensure that we provide services across the country and that we do not get a postcode lottery. This applies to England; obviously, I can't talk for the devolved Administrations.

Q152 Mrs Moon: Who can talk for the devolved Administrations?

Air Marshal Evans: Jon and I co-chair the MOD/UK Department of Health Partnership Board, on which the devolved Administrations are represented at the strategic level. Clearly, we could say that by and large Scotland, Wales and Northern Ireland are very conscious of the need to look after their veteran communities. Each of those countries has a considerable number of veterans settling there. With NHS England now having been set up for a year, one of the things that we agreed at the last partnership board meeting was to set up a sub-group to look specifically across the devolved Administrations and the regions of NHS England to make certain that we have the evidence and the confidence that care is consistent across the country. That is just the sort of question that you are asking me, and that is what we intend to do in the next few months.

Q153 Mr Havard: The covenant is about what the MOD and therefore the Government are promising. How do you get a consistent application of what you are supposed to be applying? That is where I start from and what you are speaking to at the moment. I still have a few reservations about the fact that we are not terribly clear about what we are trying to apply, but we will come back to that.

What interests me is that people, of course, are complicated. I'll speak from the experience of my own community in Wales. People are boomerangs. Half of them are serving in Germany. They are not actually in England, but they will come to England and then they will come to Wales. They will be veterans and they will go from place to place. That will be equally true of the Scots, the Irish and everyone else. It is a United Kingdom issue in that sense, so what is going to happen with the cross-border stuff? We have some sort of unity in England and we have some sort of consistency in Wales—maybe—so what happens to the cross-border stuff?

Jon Rouse: First, it is based on really good relationships with the devolved Administrations. The principle, of course, is that the money follows the individual; that is the way we work the system, but, as I think the Surgeon General said, we have now been operating for a year under the current NHS England system of national, directly commissioned provision in England, and we can see that there are certain cross-border flows; we hear certain anecdotal evidence. I think it is the right time to take stock, compare the standards and approaches in each of the countries and ensure that standards are consistent. It's a case of recognising that, within different commissioning systems there may be different emphases, priorities and approaches, but there is consistency.

Q154 Mrs Moon: The money follows the individual. How? Does the individual have a pot of money that someone dips into in the MOD, or is an unhypothecated sum of money sent to the devolved Administration? How does the money follow the individual and how do you ensure that that money is spent on the individual and not just dissipated?

Jon Rouse: First, it is based on, in effect, a tariff system, so a particular episode of care will cost a certain amount of money and then we reconcile, so it does not impact the individual directly at all. It is about knowing what care has been provided in which institutions.

Q155 Chair: How does the money follow the individual if there is no database of veterans?

Kate Davies: One of the things to emphasise is that as part of the new NHS framework, we now have NHS coding for all armed forces personnel and their families, so there is an appropriate resource supporting that patient care and pathway. That is particularly important for secondary care. What it means for CCGs, in terms of the money

following the patients and the work that we do collectively with the MOD, particularly if there is rebasing or if men and women and their families return to a community and a GP practice in a CCG, is that resource also goes to that CCG and that GP practice as part of the individual's care and support.

I completely understand and agree that men and women and families cross borders all the time. That's life—I'm a Davies. Part of that is about ensuring—we have done this on a number of occasions, collectively, I have to say—that we do work, with the Welsh Assembly and with Scotland, to check out some of the points, as Jon was saying, where that crosses over. That said, it absolutely is important, and I think that is why the partnership board has agreed, that we should take stock of that now and improve it as part of those pathways. That is also really important because there are 211 CCGs. We may know the position in, for example, Bristol or the north-west, but we don't necessarily know that there is a consistent pattern, and we need to do so, as part of the patient NHS coding, regardless of where the push points are.

Q156 Chair: Can I just get this clear? There is NHS coding, which presumably amounts to a database of veterans. Is that right?

Kate Davies: What we are actually doing at the moment is ensuring that when a veteran is flagged up with a GP that that is part of the development of the mental health network and the work that we are doing in the very first year on this new development of prioritising the pathways of veterans and Reservists.

Q157 Chair: What do you say about that? Would you say that there is a database of veterans?

Air Marshal Evans: I would not say that there is a database that is catching 100% of veterans. I think that this is work in progress. We are identifying, as Kate said—within the serving community to start with—that, as part of commissioning practice for the future, everybody will have a NHS number. Our practices will be coded and we can follow a patient through the care pathway, whether they go to hospital X or hospital Y. That is an amazing improvement from where we have been in the past. That is the first position.

If we then look at people becoming veterans, the vast majority of people—certainly those who have been in service for some time—will

know the civilian GP that they are going to move to and the transfer of records and information is relatively straightforward. The difficulty we have is that when people leave the service relatively young, they may go and work abroad for the next five to 10 years. We lose track of them and don't know where they have gone. Then they come back into England, Wales, Scotland or Northern Ireland and then register. I was at a meeting with senior GP colleagues from the NHS last week, and one of the things we are working on is how can we make certain that we link those people to the process as soon as they come back and register. One of the ideas is a drop-down menu that will ask, when someone registers with a GP in the future, "Have you been a veteran?" That sounds very straightforward, but that is a way that we will start to capture the totality of the numbers that we are talking about. To answer your question, I think to retrospectively capture all veterans—we are talking about four point something million in this country—is not going to be easy from that starting point, but I think we will get a transitional process that will improve that situation.

Chair: But luckily we have you working on that. We will come back to this later.

Q158 Mr Havard: This coding—is it an England number or a UK number? You just illustrated the point that I was making about the boomerang.

Air Marshal Evans: Exactly.

Q159 Mr Havard: That's the problem. We recommended you did something like this years ago. I would chip them so that you can read them when they come through the door—make it easy for the GPs, because they are not that bright at asking the questions, but they are not going to ask the questions if they don't know to ask the question. Your point about informing the GPs, which was made earlier, has been absolutely crucial in all of this. Is that going to be a UK system? Computerising records and all that goes wrong consistently.

Kate Davies: I can speak only for NHS England, as far as what I know and what I am commissioning and responsible for. This is very much about a NHS number. We are ensuring that we are doing that joint work across Wales and Scotland. So for example, we know for Scotland that if someone gets treatment in England, the payment will follow through the Scottish system. What is really important is to take a look

back within the first year of NHS England to get a really robust way of looking at the trends and the data, so we can do some more work with GPs.

We now have an agreement to do training with the Royal College of General Practitioners, particularly around Armed Forces and pathways, patterns of care and systems. We will do that as part of the partnership governance group and in the partnership with the devolved Administration—that would be the lessons learned. We are doing exactly the same for Scotland at the moment, with lessons learned on areas of work that they have been doing, particularly around public health and improving screening and immunisation. I think that is important to note.

Chair: We are getting way off the point here. Bear in mind that we will come back to this when we have Anna Soubry in front of us on 29 April. I should think that would be the right time.

Mr Havard: They will have a number when they are born, a number when you give it to them and another number if they are Reservists, presumably. We will have questions about that, so can you just have a think about that?

Chair: Anyway, we will come back to that in due course. I won't ask about alcohol misuse, post-traumatic stress disorder and domestic violence, but we will write to you about that to ask how the incidence of those things has changed over recent years and what you are doing about it.

Q160 John Woodcock: I want to ask you the questions that I asked the previous panel—the charities—on the health problems of veterans. First, do you recognise the pretty difficult picture that was painted of the problems of the CCGs coming in and their lack of expertise with mental health?

Jon Rouse: I did not entirely recognise it, because the CCGs came from the PCTs that were before them, who were also commissioning mental health services, so there is a significant amount of knowledge in CCGs about mental health commissioning.

Q161 John Woodcock: Forgive me, but the point is that it is a significantly different system of procuring services. That is why we have been through all this change and why we now have GPs in the driving seat for it. It is either true or not that only a minority of GPs are switched

on to the mental health needs of veterans, and if it is true, surely you recognise that as a problem.

Jon Rouse: I think it is an issue we have to address, and the way we are addressing that is that we have mandated Health Education England to prioritise training for general practitioners in terms of veteran and reservist mental health. We have asked them to appoint very quickly a specialist clinician in this area to lead the work, and we have given them an aim that by June 2015, every CCG in the country should have at least one GP who is specifically trained in recognising the needs of veterans and reservists.

Q162 John Woodcock: And that will be a recommendation?

Jon Rouse: It is a mandate. We are asking them to do it through the mandate from ourselves to Health Education England, so it is our expectation that they will put those things in place. They will be held to account for doing so.

Q163 John Woodcock: Do you recognise the issue of a lack of critical mass across any CCG area? Is that an issue? How do you tackle that?

Jon Rouse: I think it is an issue. This is very difficult, because there were previously 150-odd PCTs—there are 211 CCGs—so this has genuinely always been an issue to a certain extent. We have one big advantage now, which Kate alluded to earlier, which is that NHS England has certain direct commissioning responsibilities, as well as oversight of the CCGs. It can develop a single set of commissioning standards and roll them out through the infrastructure. This is difficult, because people talk about a postcode lottery, but one person's postcode lottery is another person's localism, and actually there is some really interesting and bespoke provision that is being developed in localities that you would not get if you had just a single national blueprint that was rolled down from on high. So there is a balancing act. We do need to ensure that there is consistency of standards, but by the same token we need to ensure that localities, linked to their community covenants, are able to develop localised responses as well.

Q164 John Woodcock: Briefly, you heard the evidence presented by the charities on veterans presenting particular issues sooner with Iraq

and Afghanistan. Is there anything you would like to add to what you heard, or anything that you would offer a different perspective on?

Surgeon Captain Sharpley: The earlier presenting—we do not really know why that might be. I surmise that that is a success of the stigma reduction and the health promotion we have been doing, but I cannot prove that to you. So it will continue.

Chair: Apparently to good effect.

Surgeon Captain Sharpley: To good effect; it makes people present, but it means, of course, that we are going to see a steady rise in the number of people knocking on the door for mental health care.

Q165 John Woodcock: Kate, do you want to comment?

Kate Davies: I particularly want to comment on both, because I think it is also the development of the armed forces networks. We have a number of armed forces networks now that are particularly there to support the pathways and the transitions for the individual, and they are also there to work with CCGs around the consistency of their understanding of individuals' needs, but also any specialisms that may arise.

Going back to your original question around the CCGs, there is the autonomy around localism. Obviously, I sit here as a commissioner for NHS England centrally, but what is really important is that in those armed forces networks, particularly where there is good practice, we make quite sure that that is seen very quickly and that lessons are learned and duplicated. Also, where there are individual stories, what we have now is quite a strong network of putting together that passage of care around that individual. Those networks have also been very important to seeing that quicker response, as and when needed, for families as part of that overview.

Q166 John Woodcock: Finally, do you recognise that there is a problem with those who have traumatic brain injury being incorrectly diagnosed with mental health conditions? Do you have a sense of how significant a problem that is?

Surgeon Captain Sharpley: I don't, actually. The two are different. They can co-occur.

John Woodcock: I can attest to that.

Surgeon Captain Sharpley: Right. That is why they can seem to occur together, and it is why we have in the MOD a centre of MTBI excellence, a project that is very near—

Chair: MTBI being mild traumatic brain injury?

Surgeon Captain Sharpley: Sorry, yes, MTBI being mild traumatic brain injury, also known as concussion. As far as I am concerned, the two are the same thing. In Headley Court we have a mental health team who see people with post-traumatic stress disorder and the usual mental health conditions. That is very close to the MTBI project, which sees serving personnel as well. The experience of the MTBI—as in mild traumatic brain injury—team, is that mental health conditions are not at a much higher rate than in the rest of the general population, which is unusual. The Americans have a different experience of that, but then the Americans have a different experience of a lot of things, which I am sure we do not have time to go into now.

Q167 Mr Gray: May I ask you to focus, as we did a moment ago, on the Reservists? It seems to me that there are two or three questions that need answering. First, SSAFA tells us that the incidence of mental health problems among the Reservists was higher than among the Regulars, which is interesting, but may or may not be related. The second question is: what are we going to do about the fact that they are geographically more spread than the Regulars and—I am asking it this way for the sake of speed, Mr Chairman—both those two things being related to the question of information that we can get about where veterans are, both Regulars and Reservists, and isn't there a better way of handling it? Sorry, that was a rather long, jumbled question, but on Reservists—

Surgeon Captain Sharpley: May I take the first question, about the different rates of mental health problems? It is true that Reservists have a higher risk of post-traumatic stress disorder, but they also have a lower risk of alcohol misuse. If you consider the totality of mental health problems in Reservists compared with Regulars, you will find that it is relatively equivalent. When you convert the rates of illness to questions like, "How many psychiatrists or mental health nurses do you need to treat this group?" the differences are not so important.

Air Marshal Evans: Simon, would you like to come in on the chain of command position with Reservists, and I will come back on the other point?

Rear Admiral Williams: I think I would. Having heard from the expert clinicians of the armed services, I would just pick up on one point that they have all made: to be better and more effective at dealing with mental health problems, one has to change the culture of people like me in the command chain who have the responsibility to look after individuals within that chain. We have to understand a little more about mental health problems, be alert to mental health problems and encourage an environment in which those problems are easy to raise, and in fact we encourage people to raise them. That de-stigmatisation of this issue has been the single most important thing. That extends to the Reserve, because everybody that deploys now on operations—everybody, that is, in the Regular armed forces and the Reserve—has that de-stigmatisation message marbled throughout our command chain. Therefore those who go out into the Reserve, at the very least, are alert and aware that these problems may occur.

Q168 Mr Gray: Because we are not just talking about people being deployed; we are talking about all servicemen. They might be suffering from mental health difficulties, even though they have not been deployed. Is that not the case?

Rear Admiral Williams: That is absolutely correct. The characteristics I have just described are throughout the armed forces.

Q169 Mr Gray: The change of attitude that you described with regard to senior officers in the MOD, who tend to be Regulars, is common to all of the changes that are coming about because of Army 2020, but what can we do to change the approach of the Reservists? They don't seem to know what is available to them or how to access it. How can we change the culture within the Reserve forces to make accessibility of the resources easier or clearer?

Rear Admiral Williams: I think that the approach to how we deal with the Reserve forces has been to bring them closer to the regular chain of command, to mirror, certainly in the blue services—

Q170 Mr Gray: That wasn't what I meant. At the moment they don't seem to know about it. What can we do to improve their awareness of what is available to them? For example, why don't we have a database of all Reservists? Why is it not possible to maintain a database of Reservists, both those serving at the moment and veterans?

Rear Admiral Williams: We do know where all these Reservists are.

Q171 Mr Gray: How long back?

Rear Admiral Williams: Current Reservists.

Q172 Mr Gray: We know where current Reservists are, but I am talking about veterans.

Rear Admiral Williams: Veterans are a different issue entirely.

Q173 Mr Gray: That is what we are talking about. Sorry, I beg your pardon; it is veterans we are talking about. When you are a Reservist, you have been deployed, you come back and you leave. How do you keep track of those people who have left? We are talking about veterans, not those who are serving. Why is it not possible to maintain a database of Reservists who are veterans?

Rear Admiral Williams: I am not sure that anything is impossible in this area, but there are certain issues that we have seen in the way that armed forces personnel like to conduct themselves. Very many of them would tell you that they do not want to be tracked as a veteran. They wish to transition from the armed forces as an individual and they see no reason why they should be tracked, tagged, given any kind of number, stamped, when they move on to a career—

Q174 Mr Gray: I am not saying it should be compulsory, but surely it could be helpful to them. At the moment, they could not do so even if they wished to do so. No one is suggesting they should be tagged. That, of course, would not be right. My question to you was this: is there not some way in which the MOD could keep better track of our Reservists when they leave the service, particularly with regard to mental health care problems?

Air Marshal Evans: There are a number of areas that your question covers. Under the White Paper, there is going to be a greater involvement of the defence medical services in the provision of occupational health support to Reservists. Those who are mobilised are treated as Regulars, as you will know. Those who are not mobilised will have greater access than they had in the past. That will apply to occupational health—so, advice. That is a potential sign post. Admittedly, there will be all the problems of stigma and people coming forward, but those who come forward could be given the advice that is necessary.

The second thing is that there will be greater support for rehabilitation for those who get injured during training, and mental health services will also be more available to Reservists in future. This links very closely with the work that we talked about with veterans and the developments within the NHS. Ultimately, for these patients when they are not mobilised, their GP is still an NHS GP. So the greater education we give the GP community in the NHS about veterans and Reservists, the more likely we are to capture the needs of those Reservists. As I say, there are processes as part of the new reserve forces White Paper that will help that in the future.

Rear Admiral Williams: Mr Gray, to come back and answer your question directly, that is the absolute essence of it. It is a positive handover from being a serviceman to being a veteran and a veteran as part of society. We have a pretty good National Health Service and provision in this country. Therefore what I am after is an adequate transition from the military to being looked after in a civilian sense. As for the practical ability to maintain tabs, addresses or whatever—I am not sure how much detail on veterans you would want to track—that would be a task of enormous complexity. We have certain areas of database—for example, we certainly know who we pay pensions to—and even for those people, in whose interest it is to get money—

Q175 Mr Gray: Hang on. Let me just suggest to you the reason for my question. It is said, and I think it is absolutely correct, that because Reservists do not have the regimental family and do not come from a particular base—they are spread around—they have greater difficulties than Regulars do. It is said, and I think it is almost certainly correct, that part of the greater problems they have with mental health, for example, is because they do not have the support of the regimental family. That is why SSAFA have identified that they have greater needs. It therefore seemed to me logical that the military would seek to keep better track of

Reservists after they leave than Regulars. You seem to be telling me that that is too complicated. Is that correct?

Rear Admiral Williams: I think that would be a fundamental change in the MOD's responsibilities—

Mr Gray: Yes, that's right. We like those sorts of things—that is the purpose of a Select Committee.

Rear Admiral Williams: —and there would be a significant increase in the resource required to track all those people.

Q176 Mr Gray: Right, so you are saying that it cannot be done now. We might conclude in our report that it would be a good thing to do—we might not—and there would of course be resource implications in doing that. But the question to you was not about whether you can afford to do it, it was: would it not be helpful to Reserves' mental care if better track was kept of them after they left the service? That is the question, to which, presumably, there is a very simple answer. You are quite right in saying that that may well have resource implications for the Ministry of Defence, but we are not tasked with looking into that here. We are tasked with looking into how we can improve the mental health care provided to—in this case—our Reserve veterans.

Rear Admiral Williams: Mr Gray, that is enormously helpful contextual guidance. If we are talking about a point that suggests that—

Q177 Mr Gray: It wasn't guidance, it was a question.

Rear Admiral Williams: Well, you have helped me in understanding where you were coming from, for which I am grateful. The issue of whether the Reserves are so much worse off and the postulation that they have no regimental structure to be part of, I think I would take issue with. I think they do have a very strong—

Q178 Mr Gray: You are not here to take issue. You are here to answer questions, not take issue with those who are asking them, but please go on.

Rear Admiral Williams: Sir, I am absolutely not taking an issue with it, but you said "It has been said" that people who are in the Reserve are looked after very much less by their regimental organisations. I

simply say that I know that that would certainly be the case for some, but not all. Very many Reserve regiments look after their own very well—indeed, both the serving and the retired are part of various associations and get that link that one would be after. That was all I was trying to say.

Q179 Chair: Admiral Williams, you heard the charities suggesting before that some of the Reservists appear not to know where to go for information. How can the MOD address that directly? I will then ask Caroline to come in.

Rear Admiral Williams: She is itching to come in.

The issue to which you refer, Chair, was one of education. We have very many bits of service provision—we have the Veterans Welfare Service and the Service Personnel and Veterans Agency, as you know, which pertains to veterans' support—that are there to provide appropriate support. We think we have a very positive success in selling that within the Regular and the Reserve, but it seems that we will never catch everybody. We must keep our focus on doing better in information and in ensuring that the Department and the armed services do every little bit they possibly can while people are in service—telling people what is available—and most particularly when they—

Q180 Chair: It sounds as though you may have a bit of work to do.

Rear Admiral Williams: Well, I would firmly accept that.

Caroline Pusey: I have a couple of points ranging over the issues that have been raised. First, we are in the process of commissioning two pieces of research that will give us some answers to some of these questions. One will look at the different mental health needs of Reservists and what we can do about those—that might begin to address Mr Gray's question about whether a database would help, if we could do it. The other is looking at the efficacy of the current Reservist post-operational stress management systems. That will give us some evidence around some of this stuff.

On communications, we think that we have made some progress in terms of communicating with serving Reservists, rather than those that are no longer Reservists, through the unit and use of new media, which makes it much easier to communicate to dispersed people in that way. And, as part of FR20, we have funded an additional communications post in main building to look at communicating with Reservists.

A final point, just on the database. My understanding is that it is something that we have tried to keep in terms of Regulars and not particularly Reservists. It relies on them, as the Admiral said, to keep us informed of changes of address, but a lot of them do not want to. That makes it very hard and that would be equally true—I surmise potentially more so—for Reservists, who have got their own life and day job anyway, so would perhaps be less inclined.

Mr Gray: It would be interesting to see the outcome of the research. I simply comment in passing that Her Majesty's Government keeps a detailed record of every cow, every sheep and every horse in Great Britain today; it is disappointing that we cannot keep track of every single Reservist, but there we are.

Chair: I don't think we want their ears clipped.

Q181 Mrs Moon: May I also suggest that perhaps some of the work that you need to do is with MPs? Just tell us what is available, because they often come through our doors. When anyone comes through our door looking for help, the two questions my caseworkers ask are: "Were you in the Armed Forces? Or a member of a trade union? Because, if you were, we can sort it out." Anything else gets more complicated.

May I ask you about the defence recovery capability? How well is it working? Will it be large enough to deal with the problems that are coming its way?

Rear Admiral Williams: How well is it working? To take that point first, I think that it is improving rapidly. My predecessor, David Murray, was here in his charitable hat and, having taken over from him and moved the recovery capability on, it has shown very significant improvement. The provision is, I think, unique in an international sense in that the MOD is working with charitable partners to deliver a facility for serving personnel.

It has certain characteristics, which were developed by the charities: in terms of the control of those in the defence recovery capability, how well we do in ensuring that each and every one of them gets the right kind of support during their individual recovery pathway. There are a couple of options open in terms of how you structure that. The way that we have gone at the moment, as Bryn Parry said, was for a distributed system. We have done that very much eyes open and we believe that to be the best way to deal with people who are in a recovery cycle; some of whom will be leaving the service.

We believe that if you force them all into a centre, then it may not be the optimal thing for them, because you take them away from, perhaps, family and friends and other support. Most particularly, you may take them away from the very place that they are going to conduct their recovery transition from the service to the outside. So we support a distributed system, using our personnel recovery centres in an optimal sense, so flowing an individual from being looked after in his community by his regiment in his area through to the recovery centre at the appropriate time to get the intervention that that centre can provide, and then going back into that community to carry on and then coming back to use the recovery centres all the time as catalysts. That, I think, works pretty well.

In terms of the enduring capability of the system, it is certainly sufficient for capacity. The charities, when they looked at the original figures that we planned for, put a little extra into the system, so I think that our current capacity requirements are something in the region of 170 beds and I think that that is exceeded by the current defence recovery capability, so the capacity is there.

I do think that we need to walk forward with our charitable partners. We have talked a little about the year in since we declared full operational capability in the system. I wanted to get everybody together a year in to have a very open forum and to listen to the charities themselves as to what they thought was the best way ahead, to allow the Ministry of Defence to put its position for why it wanted what it wanted and to develop a number of those things and perhaps see whether there are areas, a year in, that we could do differently. That is planned and it will be led by me and my team, and it is absolutely designed to be open and inclusive and to listen to the people who are actually delivering the interventions.

Q182 Chair: When is that going to happen?

Rear Admiral Williams: That is planned for May, so it is about a year on from the full operational capability.

Q183 Mrs Moon: We are running out of time and I want to ask about the transitional protocol. Can I ask you for a paper telling us how the transitional protocol is working to ensure that MOD patient records are going into the NHS system? In particular, could you tell us the pros and cons within the devolved Administrations? We have had a lot of

presentations on what is happening in England, but we would like to know that people have access to at least a minimum level of service wherever they are in the UK. Could you just give us that?

Chair: Or would you like to answer now? We are not quite running out of time, but if you are able to answer, answer quickly.

Air Marshal Evans: Of course we will produce a paper, but to reassure you, I think the work across England and the devolved Administrations is equally linked to ultimately getting the patient record transferred directly electronically. One of the problems is that not every NHS practice is fully electronic, and therefore just pressing a button when somebody leaves the service is still not possible for everyone. Also, we still have the bit in the middle where people disappear out of the country for two or three years to work abroad. Notwithstanding that difficulty, wherever you are in England, Wales, Scotland or Northern Ireland there is work ultimately to create an electronic record that is a single link that links everything together. We have made major strides on that.

We tend to quote England because it has the biggest part of the population, but major strides have been made in the last 12 to 18 months on commissioning, patient choice and other things that are now part of everyday practice for serving personnel. The advantages of that moving forward, therefore, are very good and promising.

I would like us to reach the stage at which there is one record for life. People will start off in the NHS, and we will have their record to look at in the recruiting office when they join the military—we will not literally have the record in the recruiting office, but the medical people will be able to see it during their assessment. The record will remain with us during service before ending up back in the NHS, so it is a complete through-life process. Five or 10 years ago we were not getting anywhere close to that. We had old Lloyd George records popping up at Smedley Hydro near Blackpool, but now I think we are a lot closer. I would not want you to think that we will be there within a very short space of time, because it is very dependent on the capability of information systems across the NHS GP network.

Jon Rouse: I think we are making really good progress. One of the good pieces of news is that, because NHS England commissions primary care, it can be quite demanding about IT systems—only four or five key systems tend to be used by primary care in England—so we can ensure that there is an ability to transfer data securely down what we call the NHS spine, the N3 network. When a GP registers the veteran, it should immediately come up that that individual has veteran status and a

summary record will be transferred direct to the general practitioner from the Defence Medical Services.

Q184 Mrs Moon: Again, Mr Rouse, you refer to England.

Jon Rouse: Yes, I did.

Q185 Mrs Moon: I asked for the devolved Administrations.

Jon Rouse: We will do a note.

Q186 Chair: SSAFA suggests that the families of defence personnel who have been either killed or injured are not getting enough help, or at least that not enough progress has been made. What would you say?

Rear Admiral Williams: I think we have looked very hard, and we are continuing to review the support we provide post-bereavement. We have conducted improvements in visiting officer training, and we have looked at all the aspects, including listening to the charities and others that have a lot of experience of dealing with families during bereavement, and we are desperately trying to get the system right. It seems to me—certainly this is the feedback I have—that the system is improving. Disappointingly, we have had a lot of practice at it. But I think that we can always work harder to support families and bring them into the regimental and other support systems that we have, via the very large network of associations and other areas where the families can belong.

We are using things such as the internet much more than ever we had, to allow families to connect to each other. For example, they are able to go on to certain forums that they can only get to if they have signed in; you have to pass a number of hurdles to get in. Certainly for deployed brigades, we find that to be very helpful for the families to talk to each other via the internet when an individual has been killed or seriously injured.

In terms of facilitating and trying to work better at providing the broadest support we can, I think significant progress has been made. However, I am certainly not sitting here today saying that we have got it all sorted, because I am sure that is not the case.

Caroline Pusey: I think we have made significant progress in the past couple of years, but we are not complacent in this area at all, so we

are consistently talking to SSAFA particularly, but we also engage with something called the bereaved families support group. We are consistently trying to hear back from people who have experienced this. As David Murray said, they are just completing a study, talking to recently bereaved families, so that we can make sure we are taking notice of their most recent experience. We are not complacent at all in this area.

I guess that the only other point we would make is that clearly bereavement, by its nature, is a very challenging and personal issue, and the people who are providing the support are individuals as well. So, we can do as much as we possibly can to put the policies and the training in place, but the experiences that individuals will experience will be as a result of those individual judgments made on the ground. They are almost always made for the best reasons, but we could not sit here today and say that that would always give the right outcome.

Q187 Chair: You referred to a study. Was that study the result of the recommendation we made that you should carry out a review? If so, does it have any findings attached to it, and what are they?

Caroline Pusey: They haven't reported to us yet. We understand that they have almost finished, and so we hope they will be coming to us very soon.

Q188 Chair: But you haven't seen anything from that study?

Caroline Pusey: Not yet, but it will be very soon.

Chair: Okay. Moving on then—Madeleine Moon.

Q189 Mrs Moon: What about the long-term sustainability of the support being given to serving personnel? Are we going to be able to sustain it, especially to the seriously injured? Is that something that you think we are ready for? Are we planning that far ahead?

Air Marshal Evans: Yes, we are. In terms of the work that we have just commenced, by setting up a cohort study for the injured, there will be about 600 in that study, set up from Headley Court. It is quite important that we do that relatively soon, because we want to capture in the study as many of those severely injured people as we can. With the likelihood that more people will start to leave the service in the next 12 to

18 months as they finish their courses of treatment, it is really important that we start that work. We are now literally in the process of putting that study together. That will mean that we then have a cohort with a control group set aside that we can follow through for the next 50 years, if we want to, in terms of the effect of amputation—clearly we would not look at all amputees—on things such as the cardiovascular system, social well-being and the psychological effect. We will follow those people through and see what will be required, or not required, in the future.

Your question was clearly related to sustainability of support. Without that evidence, we will not know, but I think that study will provide the evidence that will dictate to us where we look to seek improvements in the future. That is exactly what we did in changing people from the original C-Leg—microprocessor leg—to the next phase, which is the genium. That change has been based on evidence and clinical need. As a doctor, I would say that is really the way that we should be working the process through in the future.

It is difficult to answer your question, but we are looking to keep ahead of the game in terms of our requirements: looking at research, doing the research and then delivering the appropriate care that our people need. That will be so important, not just in the next two or three years, but for what they may need in five, 10, 15 or 20 years' time.

Q190 Mrs Moon: How you manage disability when you are a young person changes very much with the ageing process. The issue is making sure that that care is going to be able to keep up.

Air Marshal Evans: Absolutely right. We do not know; we could find that several of the people—50%—are in wheelchairs within 10 years of leaving the service. That is the sort of information we need to know. One hopes that, by giving them independence and the ability to function and get employment—maybe not in the military—that is the best we can do to get them to a point to deliver something useful for their lives ahead. That is obviously really important.

Q191 Mrs Moon: I cannot even begin to tell you how difficult wheelchair services are.

Jon Rouse: I just want to add that we have an opportunity to improve our aggregated information about veterans' health needs by making better use of the national health survey. That would enable us to

plan ahead better by comparing a different piece of data within that data set against the fact that that individual is a veteran. That is something that I do not think we have done very well previously.

Kate Davies: On sustainability, I think it is really important to recognise that there are some very important Department of Health programme moneys that are now with NHS England to commission particularly improvement in mental health and prosthetic services. That also links into wheelchairs and the LIBOR funding. An important part of sustainability is that we look at what it tells us about what we need to commission and how we need to commission it.

Alongside that, in the first year we have agreed centrally to do some research on long-term living with disabilities and the impact of that, particularly for men and women. That is also about the long-term impact and how disability works with independent living. That research will have an advantage for the civilian population. That research was led by the sustainability element that we need to be aware of as part of commissioning and supporting that work that we are doing together.

Q192 Mrs Moon: What about long-term funding through the charity sector? Do you think that the money will continue to come in or is the cost ultimately going to revert back to the MOD?

Air Marshal Evans: I think there is a balance to be had, as the people from the charities suggested. To me, there is a very clear requirement in-service for the MOD to look to support our people wherever possible. I think that the charitable sector has a lot to offer in terms of research. There is no difference in medical research outwith the military where research is often helped and supported by charities, as is already happening. Sue from the British Legion was clearly saying that their work supporting the blast centre at Imperial College is making a big difference to us in medical research and in looking into areas of improvement, whether in terms of self-protection or the effects of blast injury. These are the sorts of areas where I would see, as a clinical person, real help from the charities in the future. But inevitably, as we go on, the MOD should be looking for support. This should be a collaboration where we are looking to work together as best we can. There is an obligation, clearly, on the MOD while people are on the service line.

Q193 Mrs Moon: May I say in conclusion that this Committee is a very mixed bag? We have two Welsh MPs and a Northern Irish MP, so we

like to know what the devolved Administrations are doing. Every time you say NHS England, you scratch an itch. You do not have the figures for the devolved Administrations.

Air Marshal Evans: I apologise. I think we do have a knowledge of them. It is the way that we tend to answer things easily, rather than the mouthful of saying, NHS England and the devolved Administrations for Wales, Scotland and Northern Ireland, but they are very much involved in the partnership board. I am Welsh, so I can say that too—that is a difficulty that we have. But I do really mean that they are involved in that process.

Q194 Mr Havard: The Chairman is related to the King of Scotland, as was.

Q195 Chair: He, unfortunately, is dead. Can I draw attention to something you have just said? You were referring, in answer to Madeleine Moon, to the cost in future years possibly falling back on the MOD. You were talking about those still in service, were you not?

Air Marshal Evans: Absolutely, yes.

Q196 Chair: So for those who are no longer in service, if charitable donations reduce because Afghanistan is not in the public eye, the cost will presumably fall back on the NHS, will it not?

Kate Davies: Yes, Chair.

Q197 Chair: And that is something for which I hope the NHS is well-prepared now?

Kate Davies: I think that one of the things that is really important about being prepared is the Government structure that we have put in place to review and ensure that. That absolutely is crucial. So one of the things that is key is that the partnership board and now the joint commissioning group—which does look across borders, but actually that obviously is the joint commissioning group that I chair in partnership with Defence Medical Services—are planning to see what is up river as well as what is in front of us now.

So whether we are talking about rebasing, about conflict or what that means for the information and evidence that we need to have about mental health, I have to sit here and say that one of the things that is absolutely crucial is that, as part of the armed forces covenant, there is no disadvantage. For NHS England and for other NHS commissioning bodies it is about quality for all. Actually, what we have got to ensure is that quality element is understood for all families, whether they are ex-mobilised Reservists, veterans or whether they are current. That is certainly part of the governance structure and is the biggest question that we are asking as we start this process.

Q198 Mr Havard: I assume you have the change of balance between the Reserves and Regulars very much in mind in all that work you are doing?

Kate Davies: Absolutely. It is our mantra. It is absolutely part of what we are doing. What is really important in the new commissioning structures within the NHS reforms is to be very clear to people about who commissions what and who pays for what. Very clearly, what we have had to do is not say: "Because I am Kate Davies, head of armed forces, then that means that that commission is for A, B, C and D". If it is very clearly a CCG, local authority or a Defence Medical Services responsibility, we act constantly to ensure that we get that very clearly understood as part of that new structure.

Chair: Thank you very much indeed to all of you. All six of you managed to give us really useful evidence, so we are grateful to you for your restraint and your contribution as well. I am going to draw this evidence session to a close.