

Defence Committee

Oral evidence: Armed forces and veterans mental health, HC 813

Tuesday 26 June 2018

Ordered by the House of Commons to be published on 26 June 2018.

[Watch the meeting](#)

Members present: Dr Julian Lewis (Chair); Leo Docherty; Mr Mark Francois; Graham P. Jones; Johnny Mercer; Mrs Madeleine Moon; Gavin Robinson; Ruth Smeeth; John Spellar.

Questions 147 - 249

Witnesses

I: Rt Hon. Tobias Ellwood MP, Parliamentary Under-Secretary of State and Minister for Defence People and Veterans, Ministry of Defence; Lieutenant-General Martin Bricknell, Surgeon General, Ministry of Defence; Jackie Doyle-Price MP, Parliamentary Under-Secretary of State for Mental Health and Inequalities, Department of Health and Social Care; and Kate Davies, OBE, Director of Health and Justice, Armed Forces and Sexual Assault Services Commissioning, NHS England.

Written evidence from witnesses:

[NHS England](#)

Examination of witnesses

Witnesses: Rt Hon. Tobias Ellwood MP, Lieutenant-General Martin Bricknell, Jackie Doyle-Price MP, Kate Davies OBE.

Q147 **Chair:** Good morning and welcome to this final public session on our inquiry into the armed forces and veterans' mental health. It is a pleasure to welcome our panel, consisting of two Ministers and two other highly qualified individuals, whom I will invite to say a word or two of introduction about themselves. When everyone has done that, I believe, Minister, you will kindly make a few opening remarks, but we will come back to that in a moment.

Kate Davies: Good morning and thank you very much for today's Committee. I am Kate Davies. I am a national director in NHS England with responsibility for armed forces commissioning as well as health and justice and sexual assault. I am very pleased to be here today. NHS England had a model of commissioning armed forces commissioning after the Health and Social Care Act in 2013 and we have been doing that in partnership with the MOD ever since.

Jackie Doyle-Price: I am the Minister for Mental Health and Inequalities, and veterans' health generally falls in my portfolio, too.

Mr Ellwood: I am the Minister for Defence People and Veterans at the Ministry of Defence.

Lieutenant-General Bricknell: I am Lieutenant-General Martin Bricknell. I am the Surgeon General. I am responsible for the provision of healthcare to armed forces personnel across all three services.

Chair: Thank you. Tobias, you have kindly indicated that you will make a few opening remarks on the subject of the inquiry. I am going to take a slight liberty and suggest that, as our own report on NATO, defence expenditure and the US connection was published today and there is an upcoming summit, you would be more than welcome to work a few remarks on that into your opening comments, but please do not feel obliged to do so.

Mr Ellwood: Let me treat the two separately, because I think the opening remarks on mental health need to be set alone. Thank you for the report; it is helpful to the debate. Clearly, there has been a rising public profile of defence spend, and that is good. If we are honest and fair, it has got a little undignified, and we must move to making a more reasoned, convincing and cost-effective argument that unites rather than divides opinion.

I am minded to reflect on the first line of the SDSR 2015, which says, "Our national security depends on our economic security, and vice versa." There are four stakeholders that all of us who are minded to look at defence spending need to convince. First, we need to persuade all MPs—not just



HOUSE OF COMMONS

20—that a failure to invest would lead to a demise in our capabilities at the very time when the world is getting more dangerous. We need to persuade the Treasury that the world is getting more dangerous. With a post-Brexit economy ever more reliant on security and access to international markets, without that access there is no prosperity, and if there is no prosperity there is no money going into the Treasury's coffers and no money for any Departments.

We must also underline to No. 10 that defence posture does matter. It is part of our national identity—that allows us to sit with authority at the international top table and helps us shape global events. The last stakeholder to persuade is the nation, which expects us to step forward as a global influencer but possibly takes the security that we have, and have enjoyed, for granted and is perhaps worryingly naive about the need to invest in our armed forces. It is not an issue on the doorstep, as we know, in every general election.

I simply pose the question, which nations are willing to step forward? We are approaching an inflection point, where we have to decide who we are—what our role is in a very changing and dangerous world. We need to make sure that we are a force for good as global rules are, indeed, challenged. I do believe that we can only achieve this if we see an increase in defence spending of at least 2.5%. The world is changing fast and I don't want us to be left behind.

Q148 Chair: Thank you very much for that. Before we move to the ostensible business for today, can I just check one point with you, Minister? You will have seen our report “Indispensable allies” today and the annex to it, which calculates that a 0.5% increase in GDP allocated to defence would amount, under any projection of the growth of GDP, to an additional £10 billion a year, of which £8 billion would probably come to the MOD. Do you agree that that would be more than enough to fill the black hole, which is at least £2 billion at the moment and that we have to find if we are not going to make further cuts, so that 2.5% of GDP on defence would enable us both to fill the black hole and gain some additional capability, even if we have to wait a bit longer for the 3% that should be our ultimate goal?

Mr Ellwood: I agree with the premise of what you said and what is in the report, but I make it very clear: the first thing the Secretary of State did was to confirm that we are going to have a defence modernisation programme. This is the very vehicle that allows us to make a persuasive case as to what that increase should actually be. Yes, there are challenges to do with the in-year defence budget, and over the next 10 years as well, which has been spelled out, but, as I say, the four stakeholders that we need to convince need to understand that. We cannot rush ahead and claim, “This is what we need.” We need to win the arguments, and that is the purpose of presenting this paper, which will lead up to the NATO summit—an excellent opportunity to confirm to our allies that we want to remain a tier 1 nation.

Q149 Chair: And do we know when the paper on the modernising defence



HOUSE OF COMMONS

programme will be published and presented?

Mr Ellwood: It has always been an intention that there will be a paper put forward for the NATO summit. The details of the actual spend will come out in the autumn statement.

Q150 **Chair:** Thank you. Would you like to say anything now on the subject of our inquiry, to which we will devote the rest of this session?

Mr Ellwood: Chair, could I thank the Committee for calling this inquiry into armed forces and veterans mental health. I want to start by emphasising up front that life in the armed forces is a rich and rewarding experience and the vast majority of personnel serve well, transition well and leave well. They have benefited from their time in uniform, and the nation has benefited. The nation continues to benefit, given the arguably unique combination of transferable skills that they have. The absolute majority of personnel reintegrate back into civilian life, with around 90% transitioning into civilian work or, indeed, education within six months of leaving.

I strongly hope that the Defence Committee inquiry will rightly highlight how we can improve our mental health support package, but also that it can help debunk the myth, often portrayed in the media, that veterans are mad, bad and sad. They are not. They make a vital contribution to our society, and, as Lord Ashcroft's report on perceptions of the armed forces highlights, if we do not keep the issue of mental health in context, we do a disservice to those in the armed forces as a whole—inadvertently underlining false perceptions. That, of course, is not good for the fair and hard-earned reputation of the armed forces. It does little to help with recruitment, and can lead to employers having a skewed view of what to expect if they employ a former member of the armed forces.

However, I make it absolutely clear that we are not complacent. We recognise that those who experience mental health issues deserve the very best care and attention. Indeed, we have a moral obligation and duty of care to service personnel and their families, as enshrined in the armed forces covenant. However, it is also important to place this overview of mental health in context. It has long been misunderstood, left in the shadows, considered an unacceptable stigma and seen as secondary to physical health. Indeed, one third of us are likely to experience some form of mental health issue during our own lifetime. Today, we know that if there is early intervention on mental health issues, we can help, but if they are left unaddressed they can incubate. They can effect a downward spiral that reduces confidence, impacts on employment, destroys relationships, feeds loneliness and, in extreme cases, leads to homelessness and, indeed, suicide. So we have undertaken a comprehensive overhaul of how we approach mental health in the armed forces. Last year, we launched our mental health and wellbeing strategy, promoting positive mental health and wellbeing, with mental fitness being on a par with physical fitness. We must help to prevent and detect the onset of mental illness as the earliest priority and treat such illness when it is diagnosed. We are now incorporating mental health screening and



HOUSE OF COMMONS

resilience training to cope with the rigours of combat environments and those handling operational stress. We have improved detection, plus early treatment, which is already helping personnel with recovery and to swiftly return to their duties.

But we also have to look at those who have left the armed forces. We have introduced a wave of new initiatives, offering increased support and provoking cultural change. We have the veterans' gateway, which the Committee will be familiar with, which provides simple, online access to a multitude of recognised veterans' charities. The veterans' board itself commands key Departments: Health, Education, Work and Pensions, devolved Administrations, Local Government and so on, to meet their covenant responsibilities. We will soon have a veterans' champion in every single local authority to make sure that anybody who served is not disadvantaged locally, and we have had the roll-out of veterans' ID cards, which will allow swifter recognition of those who have served.

However, let me be the first to recognise the significant work now required to realise the frontline benefits of those initiatives and to sharpen the practical impact of the covenant. There is much work to be done. This cannot be done alone; that is why I am pleased that Jackie Doyle-Price is here and we are able to work together. I think we can be extremely proud of our armed forces, given what they do for the nation, but our commitment must go beyond equipping them and training them well when they serve. We must make sure that we support them after they have left.

Chair: Thank you very much.

Jackie Doyle-Price: Obviously, the NHS is there to serve everybody at the point of need, but within that we recognise that we owe particular responsibility to our veterans under the military covenant. We need to make a real effort to make sure that veterans are not disadvantaged in accessing services. With that in mind, we have put more transitional services in place to make sure that we are able to support veterans as they navigate going into civvy street and accessing all kinds of health treatment.

Specifically on mental health, to endorse what Tobias has said, we see a prevalence similar to that in the rest of society. We need to reject the idea that all our veterans are suffering from mental ill health, because it does not help them get work, which is their best way to get good mental health. That said, there are higher rates of PTSD, which is entirely understandable, given the service that some of them have undertaken. It is also not significantly higher, which is a testament to the resilience of our military personnel. With that in mind, we have put real effort into making sure that we are able to support veterans to access the right services when they are going through particular trauma. As the discussion develops, Kate will be able to say a bit more about that.

Chair: John Spellar will start off the questioning. You will find that certain questions are directed to certain members of the panel, so do not feel that everyone is obliged to answer every question.



HOUSE OF COMMONS

Q151 John Spellar: We are certainly pleased to hear from the Minister's opening statement that the MOD acknowledges the link between national prosperity and the money available for defence spending. We certainly hope that that is reflected in its purchasing decisions, prioritising buying British and employing British workers paying British taxes. We look forward to seeing that working through in the Department's programme.

This is primarily a question to the MOD. What do you think are the main reasons for the reported rise in mental health disorders in serving personnel over the last decade?

Mr Ellwood: We have some experts here as you say, and I will turn to General Martin in a second. As I highlighted, there has been a stigma in the armed forces, and people do not talk about it. I have said this before in Chamber debates, and those who have served will be aware that physical injuries take precedence over mental injuries. We are now getting to a place where the stigma is being challenged, and a cultural change is taking place. People are recognising that their career prospects will not be affected if they put their hand up and say, "I've got something wrong with my mind." This is cultural. This is the whole of Britain. This is not just the armed forces. The fact that we are now making ground here and changing the attitude means that more people are coming forward, and that will be reflected in the statistics that you have seen.

Lieutenant-General Bricknell: The Committee will be aware that we published the armed forces mental health summary last week. At figure 1, we have the percentage of armed forces personnel who have a diagnosed mental health condition from our community health services. The graph shows a plateau over the last few years since 2013 at around 3%. I would agree that the graph did show an increase during the 2010 to 2013 period, but now the evidence is that it has plateaued.

Q152 John Spellar: Thank you. Is this recording self-reporting? Given that it is still evolving, to what extent does the welcome change described by the Minister actually mean that more people are seeking help? Is any of the movement down to that, rather than being down to an increase in or maintenance of the number of people with those actual disorders? Did you manage to disaggregate that?

Lieutenant-General Bricknell: It is quite difficult to determine those who do not seek help. We do that through some of the epidemiological studies commissioned by us through King's College in a way that is neutral to the MOD's seeking that information, which might be perceived as invasive. We have to look at the evidence from two perspectives: one is service utilisation, for which we have good data, and the other is based on the prevalence studies suggesting that there might be barriers to seeking help. We then ensured that we put in place campaigns to encourage those in need of help to come forward. During Mental Health Awareness Week, campaigns were run inside military communication systems to raise awareness and encourage people to seek help. The newly introduced helpline is yet another method through which people can seek help without having to declare to the executive that they are doing so.

John Spellar: Minister, you wanted to come back on that.

Mr Ellwood: Briefly, you touched on the situation of an individual who is stepping forward. It could be an individual, or their buddy, or their platoon commander, or the captain of a ship. The idea is that the armed forces community is allowing and encouraging this to happen. Self-referral: absolutely. It is simply because there is more of an attitude of, "Do you need help, do you need a hand?" and that is a cultural change that we have had to introduce.

Q153 **Chair:** I have a few more follow-up questions of a fairly technical nature, mainly to Lieutenant-General Bricknell. The first is, why are charities and academic studies reporting much higher rates of mental health disorder, especially PTSD, in both serving personnel and veterans than you do?

Lieutenant-General Bricknell: Again, it comes back to this definition and the design of the study. We can only report those who have sought help.

Q154 **Chair:** So are more people going to these charities and seeking help than are willing to come to their authorities?

Lieutenant-General Bricknell: In terms of people seeking help as a veteran, which is primarily the complementary service between NHS provisioned or commissioned services and charities, it is better for our NHS colleagues to report on that. In terms of our armed forces personnel, we have access to services for those who need it, particularly for PTSD, but again from the data we have, I would emphasise that PTSD as a specific diagnosis accounts for only 6% of those seeking help from our mental health services. It is much more important to focus on the wider common mental health conditions, which have a much greater prevalence, and making sure that we have services for them too.

Q155 **Chair:** Would you like to come in at this point, Kate? Could you throw some light on the fact that we often hear now that anybody who has been through stress or trauma or been upset, whether in civilian or military life, is suffering from PTSD? Could you make some comments on the precision with which it is diagnosed?

Kate Davies: Following on from my colleagues and the question, there are 2 million veterans in England and 2.6 million in the UK. The evidence shows us that our ex-serving personnel have about the same level of mental health need as the general population. That is higher than the percentage that has been alluded to up to now. The recent Mind work, done in conjunction with NHS England, shows about one person in six, back to one in three of us—different elements will have some need of mental health, and that is the same for our veterans population.

I will support the Surgeon General's overview. A lot of people are coming forward to our services now—mainstream NHS services and GPs, and also specialist services for veterans—who think they have PTSD. They often come forward saying, "I think I've got PTSD," but looking at the individual assessment it is often around anxiety, depression and alcohol, and maybe



HOUSE OF COMMONS

a mixture of issues that also includes their life circumstances. Certainly the Committee cannot ignore the correlation and need around housing, employment and social care. That is exacerbated if people are in a downward spiral of their own coping mechanisms, and their family coping with them coping, as well as issues in employment, housing and relationships.

We estimate that—these are our statistics at the moment—6% of veterans have PTSD. It is about 4.2% to 4.4% for the general population, so that is slightly higher. We are keen that this is work in progress, and certainly with the new services focusing on the assessment in transition—earlier intervention with our men and women leaving, either on medical discharge or for other reasons—we want to continue to produce the evidence to see whether that 6% is the right level or whether we are looking at higher levels.

To follow on from my Minister in the Department of Health and Social Care, in a year—it has been going for only a year—the new transition, intervention and liaison service has seen over 2,800 people, and of that number certainly 70% are assessed as needing and are receiving some support and intervention. That now includes more complex pathways of treatment and care.

So, back to your last point, Chair: we certainly think that some of the estimates on self-reporting of PTSD are higher and may be misunderstood in some cases, but certainly when we have people who are, to put it bluntly, very poorly with some of their needs from serving and with coping, the levels of PTSD are generally slightly higher than for the general population.

Q156 Chair: You are satisfied that there are objective criteria by which one can decide whether someone is suffering from PTSD.

Kate Davies: I am satisfied, but I certainly think that with the work we are doing, particularly with the review of the NICE guidelines at the moment around trauma—Dr Leach, the chair of the armed forces clinical reference group, has been part of that work with a number of other clinicians, specialists, partners and stakeholders—it is really important to look at the criteria and the consultation phase of the NICE guidelines, which is around trauma at the moment, to review that and support those findings around the criteria as we go forward with the assessment.

Q157 Chair: General, are you satisfied that you are using criteria for assessing and reporting PTSD that are consistent with the UK's civilian healthcare and with the academic studies? We want to be sure that people are not using these terms in an unscientific and unspecific way.

Lieutenant-General Bricknell: Absolutely. The term "PTSD" can only be diagnosed by a mental health professional using the criteria in the appropriate diagnostic standards, and we follow the same clinical processes as set out in the NICE guidelines. Indeed, this year we are refreshing our system for delivery of mental health to ensure a common standard for the provision of mental health services to serving personnel

that links very much to the standards applied in civilian practice for veterans.

Q158 **Chair:** So you do follow the NICE guidelines on mental health care. Do you feel that the NICE guidelines are sufficiently relevant to the experiences of serving personnel?

Lieutenant-General Bricknell: In terms of making a diagnostic criteria, absolutely. The NICE guidelines are the best available national evidence, which is the purpose of NICE guidelines.

Q159 **Chair:** Can serving personnel self-refer directly to DCMHs without going through their unit?

Lieutenant-General Bricknell: They have access to health care, without having to go through the executive, if you see what I mean.

Q160 **Chair:** Obviously, we are thinking in terms of whether people are reluctant to come forward for fear for their careers. Is there general agreement that people are less reluctant than in the past to report that they have got a problem?

Lieutenant-General Bricknell: That is very difficult to measure. What I would hope that we have described to you is how the executive is absolutely committed to reducing barriers to access to care. Indeed, the most recent edition of *Soldier Magazine* included an article about mental health not being about being softer and encouraging people to come forward and the Commander Field Army personally emphasising the importance of people seeking help should they think they need it.

Q161 **Mrs Moon:** Minister, I want to bring you in here because of the concerns that we felt at the variation between the devolved Administrations about access to services. Are you aware of the variations? Are you monitoring this? What will the Ministry of Defence do, for example, with a constituent of mine, where there is no in-service mental health support provision, because the Welsh Assembly Government do not purchase from Combat Stress and they rely on Combat Stress having a little spare cash available at some point and offering a place for free? How are we making sure that, because someone lives in a devolved Administration, they are getting the same services, and how are you monitoring that?

Mr Ellwood: You raise such an important issue, which is why the veterans' board was created. I am the Veterans Minister, and there is an immediate assumption that somehow I have a magic wand and can provide answers to this, whereas this audience will know exactly where the remit of the MOD begins and ends.

Where we are trying to leverage greater clout is through the responsibility to raise the profile, understanding and recognition of what other departments should do, including the devolved Ministries. The veterans' board has only just been established to underline—to confirm—that, whether in Scotland, Wales or Northern Ireland, or indeed whether it is Work and Pensions or Health, each Department is meeting its



HOUSE OF COMMONS

responsibilities to armed forces personnel that are serving and the veterans community as well.

I am very happy to look at the individual situation to deal with your constituent. I do not know if anybody wants to talk about the relationship specifically to do with Wales.

Lieutenant-General Bricknell: In terms of the armed forces, I co-chair, with a senior director from the Department of Health, the MOD and the Department of Health's partnership board. All four devolved Administrations are represented at that board, and our job is to make sure that access for serving personnel is equitable across the four nations.

In terms of what the MOD commissions, we commission access to in-patient care, independent of location. For armed forces personnel, I am confident that there is no geographical inequality, depending on the nation in which they are serving, or if there is, there is a mechanism whereby that is brought to senior attention and we resolve the issue.

Q162 **Mrs Moon:** But that is not in place for veterans. Are you saying that that is only for serving personnel?

Lieutenant-General Bricknell: That's for serving personnel only.

Q163 **Mrs Moon:** So, for serving personnel only. Minister, I wrote to you last year about this gentleman. He is still waiting, a year on, and he is still unable to get the support that he needs. His situation is fairly critical.

Mr Ellwood: You underline why it is important that we emphasise and can raise this very issue. We are happy to raise this case at the next veterans' board meeting. This is exactly the purpose of the veterans' board: to underline these issues. In fairness, the NHS has long understood its relationship, requirements and responsibilities but, without doing a disservice and being disingenuous, I think there are some Departments that are unaware what their duties are to ensure that no serving personnel or veteran is disadvantaged because of their service.

We are advancing; we are getting better. There is the veterans' board and sub-committees that meet under that—the Surgeon General just mentioned one. We are very happy to take it this away; we have got to get it right.

Q164 **Mrs Moon:** Thank you. I would be grateful if you could monitor what is happening across the Administrations.

Mr Ellwood: Very happy to.

Q165 **John Spellar:** But Minister, do you have to wait for a veterans' board? You know your ministerial colleagues and your private office know their opposite numbers. When they get these problems, why don't they just ring them up or email them and say, "This is a problem. Let's move it on"? We don't need to put that through the formal structure. The formal structure can deal with the overall policy, but you need to be pressing these issues, don't you?



HOUSE OF COMMONS

Mr Ellwood: This is the Welsh Assembly we are having to work through, which you might have strong contacts with yourself, bearing in mind the colour of who is in charge there. They now attend this and they are being held to account. They attended the last meeting.

On a blank sheet of paper, would we end up with this structure, bearing in mind devolved responsibilities? It is what it is. We have to make it work and ensure that the devolved Administrations, through the nuances of how they do things differently, ensure that the standards that we provide are the same, regardless of where in the country the veteran is.

Q166 **John Spellar:** I agree with that, but shouldn't you establish a contact and a relationship with your opposite number down there and actually just pick up the phone, or get your office to talk directly to their office?

Mr Ellwood: Yes, it is. That is exactly what happens. All I am saying is that, if it doesn't happen, there are challenges in place, which is why we have created this veterans' board—to ensure that it can be highlighted. We embarrassed the Department in saying, "If you have not met your obligations, then you absolutely need to."

Jackie Doyle-Price: It is worth saying that there is dialogue across the nations on these issues. Setting big policy questions aside, I am regularly in contact with the Ministers in Wales and Scotland. Kate, you have a regular forum, as well, don't you?

Kate Davies: Yes. The armed forces partnership board has been going for four years, co-chaired by the Department of Health and Social Care and the Ministry of Defence. It has been invaluable in ensuring that devolved Administrations work together, and that includes my partners in Scotland, Northern Ireland and Wales. We have seen changes in all areas. I am meeting my Scottish counterpart later this week and we are in Wales in two weeks' time.

One of the major pieces of work that has been important around veterans' mental health, across the devolved Administrations, was that NHS England, in partnership with Forces in Mind, commissioned a report, "Call to Mind", in 2015. All devolved Administrations then chose to do their own needs assessment around mental health veterans and pathways of care, because you are quite right that there are different systems in different areas of the country.

It was really important then to do an analysis of how that was working, where the challenges were, where the strengths were, particularly for families, in different parts of the UK. Only at the end of last year, we came together as a UK-wide collection to look at what our commonalities and priorities are. My colleagues and I were assessing that yesterday. We very rarely get individual cases where there are issues in transition across from one devolved Administration to the other.

We do pick up the phone and we do meet each other. In NHS England, I certainly get patients and families who are unhappy and concerned, and



HOUSE OF COMMONS

that is exactly the approach. I know that my Welsh counterparts are certainly doing the same.

Q167 Ruth Smeeth: Apologies; I have got a constituency crisis, which is why I have been in and out. Can I move on to serving personnel within the MOD? Have we got enough qualified clinicians to diagnose mental health disorders in serving personnel?

Lieutenant-General Bricknell: At the moment, we are not fully manned for our mental health workforce, both on the regular component and the civilian component. That does reflect the challenge in achieving full manning across the whole of the mental health workforce. What we are doing about it is looking at adjusting our offer for civilians. Indeed, we have shown an increase in the number of civilian mental health nurses who are working for us. We are working with the individual services to look at how they are going to improve their recruiting and retention for uniformed personnel working inside mental health. We also have money for locum cover and other methods of providing the necessary workforce, so that in the immediate short term, manpower is not the primary constraint to delivering services.

Q168 Ruth Smeeth: Does that answer mean that those people you may consider to have PTSD are not seeing a consultant psychiatrist?

Lieutenant-General Bricknell: Absolutely not.

Q169 Ruth Smeeth: So everyone is?

Lieutenant-General Bricknell: Anybody who has a major diagnosed health condition will be seen by the appropriate mental health professional.

Q170 Ruth Smeeth: As they are being diagnosed?

Lieutenant-General Bricknell: As they are being diagnosed. One of the things we have been looking at is the care pathway, including getting early assessment built into our care pathways from a multidisciplinary team, and then aligning the patient's needs to the most suitable healthcare practitioner. It is very important to regard mental health services provision as a multidisciplinary action, with a multidisciplinary team, utilising the skills of the whole team, not just psychiatrists or psychologists.

Q171 Ruth Smeeth: Thank you, General. How many legal cases have been brought against the MOD for misdiagnosis of mental health disorders over the last five years?

Lieutenant-General Bricknell: None.

Ruth Smeeth: None?

Lieutenant-General Bricknell: At the moment, we do not have any evidence of any complaints or legal cases with regard to misdiagnosis attributable to the wrong diagnosis for a mental health condition.ⁱ

Ruth Smeeth: That's a very confident statement.



HOUSE OF COMMONS

Mr Ellwood: Can I just add that I am concerned about the manning issue—the number of personnel that we have in diagnosis. You are right to ask the question to make sure that we are providing value and are able to do the necessary assessments. Again, it goes into the pay review of what we need to do to attract people into these particular posts. We are looking at what civilian recruitment we need to do to make sure these posts are filled, so I am pleased you raised it.

Q172 **Ruth Smeeth:** How many vacancies do you think you have currently?

Lieutenant-General Bricknell: If you just excuse me, I'll get the figures.

Mr Ellwood: We are at 79%.

Lieutenant-General Bricknell: Yes, 79% with permanent manning. We do not count the temporary manning to meet that gap.

Q173 **Ruth Smeeth:** So you have locums that are meeting that gap?

Lieutenant-General Bricknell: Yes.

Q174 **Leo Docherty:** Can I ask you, Surgeon General, whether there are specific monitoring and support arrangements in place for those groups of service personnel at higher risk of developing mental health disorders?

Lieutenant-General Bricknell: Both the evidence that you have been presented by various expert witnesses, and indeed the MOD's own data, identify groups that are more vulnerable than the average. The recently published data has produced a demographic profile. Certainly, women are likely to come forward for mental health support more often than men. Personnel aged between 20 and 44 are more likely to come forward for help than other age groups, and other ranks are more likely to come forward for help than officers.

Q175 **Leo Docherty:** Do you consider those under the age of 18 at higher risk, or not?

Mr Ellwood: Under, did you say?

Leo Docherty: Yes.

Lieutenant-General Bricknell: In terms of those who seek help, the group that are under 20 actually seek less help than the group aged 20 to 44 from our service utilisation statistics. I recognise that there is other data, which is more prevalence data relating to reported ill health rather than service utilisation, that has been quoted by other experts to say that younger people are more vulnerable.

Q176 **Leo Docherty:** It does not mean that they are not at high risk just because they are not seeking help.

Lieutenant-General Bricknell: Absolutely. It is that balance between service utilisation data and prevalence data from other studies. What is important is that that group in particular is the group that is going through training. There are well established regimes for welfare and mental health



HOUSE OF COMMONS

support for younger people when they are going through training. That is that link between welfare alongside clinical treatment services.

Of course, training is supposed to be challenging and stressful because we want to make sure that people are trained for service in the armed forces. It is that balance between testing physical robustness and mental robustness in training, and making sure that those people who perhaps are not suited to military life are correctly selected.

Q177 **Leo Docherty:** Absolutely. Do you monitor those who have been physically injured?

Lieutenant-General Bricknell: Yes, we have data on physical injury as well as mental health conditions. I'm afraid I do not have the detailed data around physical injury with me today.

Q178 **Leo Docherty:** But do you specifically monitor them subsequent to an injury for any mental health risk?

Lieutenant-General Bricknell: If I can follow your question, for those who are very seriously injured and sick, we deliver a complete package of care around our rehabilitation and recovery services. That is very much looking at holistic care. For those with greatest need, we put in the most effort in terms of support during transition. Does that make sense?

Leo Docherty: Absolutely. Thank you.

Mr Ellwood: Chair, can I just qualify something? An important question was asked about under-18s. I want to make it clear that no under-18 will face any hostilities. They do not go into operations.

Leo Docherty: They are not operational.

Mr Ellwood: They are not operational. They can join the armed forces at 16, but they will not be deployed overseas.

Q179 **Gavin Robinson:** Why is there such a lack of comprehensive data on veterans' mental health across the United Kingdom? Perhaps we can hear from the Ministers for the MOD first.

Mr Ellwood: It is an important question that we do need to address. First, how many veterans are there in the UK? At the MOD, we started to keep proper records only in 1975. So, apologies, I am not to blame for going back in the past. It is worth pointing out that the veterans' profile will change over the next 10 years. We have about 2.5 million and that is going to drop to about 1.5 million, because many of the veterans who served in the second world war will no longer be with us.

We are improving our ability to track who is where and what they are doing, but there are historical reasons why the data is not as accurate as it could be. Many people—90% of the people—leave well, depart well, and are in a job within six months. Many of them actually live their lives and have no requirement or need to touch base with the armed forces in any way, from an expectation perspective. If they do anything, it is simply

reunions and so forth. But this is something we need to get better at and, thanks to technology, we are able to do so.

Jackie Doyle-Price: I think collecting data is always challenging for the NHS, but this is a particular challenge, not least because veterans do not always want to identify as such. We are now in an atmosphere where we are showing pride and respect for our armed forces and veterans but that has not always been the case, so there would be no reason to identify.

Certainly, if you look at the data that GPs collect, quite often the box about veteran or otherwise was left empty, because the question was never asked. That is history. We are now where we are. The data we are now beginning to collect will build a much better picture of where we are. We are seeing a sort of spike in people presenting and declaring themselves as veterans, which is skewing the data a bit, but over time we will have a much better picture.

Mr Ellwood: Can I add that the national census is coming out in 2020? We have secured a question on there to ask if you are a veteran. There is a big debate about that; that is helpful. We have armed forces-friendly doctors. Stickers are being put up in surgeries to encourage them, because people don't necessarily come up with that. That is helpful.

Then there is the ID card, which is the entire practical recognition of having served. So it would be on your driving licence or keeping your MOD 90. We should be less reserved about saying that we served in the armed forces. That is slowly changing.

Q180 **Gavin Robinson:** May I say this, Minister? I know you accept the point that Northern Ireland veterans live in what was their theatre. Therefore, there are issues with self-identifying, whether it is on a driving licence with their address and so on. I know you accept that point.

Mr Ellwood: I just want to make the point that I was in Coleraine for Armed Forces Day on Saturday. For anybody who served in Northern Ireland, I could not over-estimate the wonderful change in Coleraine to see the armed forces parade down the high street. It was a spectacle I never thought, nor anybody who served there, would ever see. There is a bond between society, reservists and those who served. It was absolutely fantastic to see. People were proud of the fact that they wore the uniform and could display that in public. Absolutely fantastic. Thank you to the people of Coleraine.

Q181 **Gavin Robinson:** It is very welcome for you to say that. My colleague, Gregory Campbell, was very pleased that you were in attendance.

Do you draw on other Departments and their datasets? Do you talk to the Ministry of Justice, for example, to see how many people come into contact with the justice system who may identify as veterans? Are you able to draw on those datasets and incorporate them into the information that you have on veterans?

Jackie Doyle-Price: As Tobias said earlier, it is really important that all Departments understand where the requirement and the need sit to look



HOUSE OF COMMONS

at the needs of veterans, not just for mental health, but to do with adjusting to civilian life. Many of the men and women that we speak to are saying that they spend a long or short time in the military and that the adjustment element of coming back to living as a civilian is absolutely key. Across all Departments, it is not just when you hit crisis or health issues, and we want to avoid that.

To go back to your question on the Ministry of Justice, the Stephen Phillips report did some work looking at the number of men and women who are in the criminal justice system at the moment. It gave a figure of around 7% of serving prisoners at that time, who may be self-reporting as identifying as ex-serving. That percentage has gone down slightly, but on the whole it is holding.

When men and women are in contact with the criminal justice system, they are more likely, if they are ex-serving, to have violent offences or sex offences. However, the numbers are relatively small and the numbers in relation to the general population are smaller in the armed forces community than in the general population, but their need is probably more acute. By the time somebody who is ex-serving is in contact with the criminal justice system, it may be because of their behaviour and their offence, but it may be because of their mental health as well.

There is absolutely a piece of work that we are now doing to invest in and commission in how we work with our colleagues in the MOJ, the Prison Service, the courts and police custody at identifying those men and women earlier. We have just invested an additional £500,000 in pathway services in the criminal justice system for veterans.

Q182 Gavin Robinson: Can I ask specifically whether you track suicide rates among veterans?

Jackie Doyle-Price: That is a really important question and one that I think we can do better on. At the moment, certainly from the work that the Department has done around the policy on zero tolerance of suicide, we feel that again it is about the same as the general population, so a 10% figure that we want to achieve in the reduction of suicide, but the correlation of men as between a certain age group, who unfortunately and very sadly are prevalent to suicide as part of mortality suicides, is about the equivalent for ex-serving.

My colleagues in the MOD were also really keen to look at the correlation with early leavers and how we can pick up and support early leavers, as part of the numbers that are also about self-harm and suicide. As well as never events, it is nearly events.

Q183 Gavin Robinson: So is a dataset emerging there?

Jackie Doyle-Price: That is certainly something that we are working on with the Royal College of GPs and the work that we are doing around earlier identification.

Q184 Gavin Robinson: I ask that question because while you may be right in



HOUSE OF COMMONS

saying there is comparability with societal rates, you will remember the damaging headlines around more people having taken their life following combat than having served or suffered during combat and the damaging impact that has for the Ministry of Defence. Can I ask you about the representative board of health officials that you referred to, which you have with the devolved regions?

Jackie Doyle-Price: The armed forces partnership board?

Q185 **Gavin Robinson:** How is Northern Ireland represented on that board?

Jackie Doyle-Price: There have been changes, but it is not for me; it is for a Department of Health and an MOD board to comment on the way that people are represented or chosen. In health terms, because it is a health board, it is about asking the devolved Administrations. For England, it is about NHS England's responsibility. Simon Stevens is the chief exec of NHS England, then we would nominate the most senior person—in that case, it is me—and also the most senior clinician, which is also important. I believe that is a similar model that has been requested across the devolved Administrations.

Q186 **Gavin Robinson:** Forgive me, I assume you attend this board?

Kate Davies: I do.

Q187 **Gavin Robinson:** And so you are there, you see that there are representatives from other devolved regions?

Kate Davies: Yes.

Q188 **Gavin Robinson:** So who represents Northern Ireland?

Kate Davies: There has been a change recently, so I am afraid—

Q189 **Gavin Robinson:** Is it a departmental official from the Department of Health?

Kate Davies: It is an official.

Q190 **Gavin Robinson:** From the Department of Health—

Kate Davies: I believe so.

Q191 **Gavin Robinson:** In Northern Ireland, or a commission from the Health and Social Care Board?

Kate Davies: Because of the current situation around the Government and devolved government in Northern Ireland, there have been some considerations on the membership.

Q192 **Gavin Robinson:** Forgive me, but that is why I am asking you a question particularly around health. It's irrelevant what is happening in the regional Government. Is there a departmental official?

Kate Davies: There is.

Q193 **Gavin Robinson:** And has there been for the last number of years?



HOUSE OF COMMONS

Kate Davies: There has.

Q194 **Gavin Robinson:** There has. Was there in 2016 a Department of Health official for Northern Ireland at a time when the departmental Minister was saying the Army covenant does not apply to Northern Ireland?

Kate Davies: I will defer to the Surgeon General, but I do not think, in all the time the armed forces partnership board has been going, that there has been a gap in any of the devolved Administrations attending from a Health Department perspective.

Lieutenant-General Bricknell: I'll confirm that. There has not been a formalised gap for any Department refusing to be present and there has always been a representative from each of the Departments.

Q195 **Gavin Robinson:** Have any of those representatives been curtailed in the information they can give through the ministerial clearance they are given for the information they can provide?

Lieutenant-General Bricknell: Not that it has been declared to the board.

Q196 **Gavin Robinson:** Thank you. Mr Ellwood, I just wanted to touch on the veterans' board itself. Have we got a workaround on the Northern Ireland issue or is the NIO still representing Northern Ireland on this board?

Mr Ellwood: First, the Secretary of State represents as well, but yes, there are some local difficulties you will be aware of that we have to work through. When I was there, there were, I think, the 11 districts—

Q197 **Gavin Robinson:** You are right; there are local champions in the local councils in Northern Ireland. Our local councils have no involvement in health, no involvement in education and no involvement in housing, so they do not operate in the departmental sphere where you imagine the military covenant might operate. Given that the NIO does not have any competence in any of these areas either, is there a way in which we can involve, whether departmentally or through the head of the civil service for Northern Ireland, so that those who are actually operating and responsible for our health service, our housing and our education are represented at the veterans' board?

Mr Ellwood: We do need to look more cognitively at this. Coleraine was a great example whereby it had just merged into a larger authority, but it has not received more powers from the centre. The appetite seems to be that, as time goes on, more powers would be devolved down to the new districts. With that, I hope, will come responsibility for veterans. You are right to say that, at the moment, it continues to be centralised, and because of the political situation it is stagnating and we do not want that to happen.

Q198 **Gavin Robinson:** I am sorry, Chair, for flogging this, but the reason it is important is because we are considering regional variations in the service that we give. It is okay talking boards and these forums where we bring people together in the hope that it will work, but where there is no



HOUSE OF COMMONS

involvement in the key aspects of service delivery, there is no benefit for our veterans, be it in Northern Ireland, Scotland or Wales.

Mr Ellwood: We all appreciate that in Northern Ireland there is a unique set of circumstances that we have to recognise. As I suggested, there is an avenue we can pursue, but I hope to go back again soon to work this through. We need a two-track approach: first, if the devolved Administration does not receive its power, and, secondly, if things do advance and more powers get down to the districts.

If I could just touch further on the veterans' board itself, one of the things we are trying to encourage is for people not just to do their baseline work, but to see what more can be done to support veterans. One of the initiatives I am looking at is in the Prison Service. We have small cohorts of veterans who are in prison. Would they fare better if all veterans who were under a two-year prison sentence were in the same locality? I pose that as a question. It is something that I would like to look at as a pilot scheme and I am pleased that Minister Rory Stewart is happy to engage with us to see whether that is something we can do. Anything we can do to stop the reoffending, which is around 45% to 50%, must be a good thing. If they are familiar with the armed forces environment, if we can go back and engender that a bit, working with charities, perhaps that is something that could be successful.

Q199 **Gavin Robinson:** Finally, as part of the commissioning, whenever we are commissioning work from the NHS or commissioning work from charities themselves, can we ask for a collection of regional data—where people are coming from? We know in Northern Ireland. We don't know how many people served during Operation Banner, we don't know how many veterans live in Northern Ireland and if they require in-patient care, they can't have it in Northern Ireland; they have to go to Scotland. Is it okay that you can start asking questions and collecting data to say, "If you are in Scotland, if you've combat stress, they will retain information as to where you live and where you served," and share that?

Kate Davies: I certainly cannot answer on behalf of my devolved Administration leads, but certainly the whole culture of the work that we are doing across the UK is to be more detailed about the needs of local variation, as well as breaking that data down.

Q200 **Gavin Robinson:** But from a commissioning perspective, it is okay, if you are paying for the service, to ask for the added collection?

Kate Davies: We can certainly now. There was a question that I didn't answer, because it was not channelled to me, about how we get data better. This is also generally about mental health data, not just about the mental health data of armed forces or veterans. Across England, I am proud that NHS England has been, after decades of not looking at this in this way, looking at the details and needs—by service, by commissioner and by service user—of mental health data. Some of the partnership work is also about looking at different patient groups. One of those patient groups, particularly for NHS England, also includes families, veterans, those serving and reservists as well.

Gavin Robinson: Thank you very much.

Q201 **Chair:** Can I just check with the Surgeon General? We have heard about the NHS giving their data on a regional basis. I gather that the MOD does not break down its mental health data by region. Is that right? If so, why could it not do so?

Lieutenant-General Bricknell: We can break down our mental health data by the location of the community mental health clinic that provides care for that patient, but we have quite a large number of them. We use that information for internal monitoring of performance, but we do not routinely publish it as part of the annual statistics, because we produce the aggregated data.

Q202 **Chair:** Right, okay. If that data were to be considered useful, could it be made available?

Lieutenant-General Bricknell: We can look to make it available to you, but it would be less useful because of the mobility of service personnel. The regional variation is more to do with their physical employment for work as opposed to any other factors.

Q203 **Chair:** Just another loose end: we referred a few moments ago to the monitoring of the level of veteran suicides. Kate, back in 2010, Dr Murrison recommended that individuals ought to be followed up a year after discharge. Do you know if that has been implemented?

Kate Davies: Certainly: not only a year after discharge, but also six months after discharge. We have had positive feedback on following some of those Murrison recommendations. What is important is the transition element is not waiting for follow-up; it is actually identifying people before they leave, and also as part of a more proactive self-referral position. From our local feedback and a major engagement piece of work we did where there were barriers to access, in particular for people with most acute need, they were saying that they felt self-referral was confusing or not available. It is important as part of risk to look at suicide, self-harm and breakdown of relationships, marriage and employment.

Chair: Thank you. Tobias, you wanted to come in?

Mr Ellwood: I just wanted to underline and support your call for clarity in statistics. The Forces in Mind Trust is doing a lot of work to ensure that we have a realistic playing field, as a yardstick to understand what is happening and see whether things are improving and where we should focus our attention. I hosted a ministerial NATO veterans conference recently and we discussed this, talking about comparing data or looking to see whether we should have NATO standards on this, taking something from the NATO Parliamentary Assembly—some members are here—to consider as well. When we are looking at yardsticks, the immediate response is to compare them with the general population, but how do suicides compare with Canada or the United States? In both cases there were eight per 100,000. In the United States it is 20 per 100,000, in Canada it is 24 per 100,000. Every suicide is a tragedy and we must do all



HOUSE OF COMMONS

that we can to prevent that. The general population in the UK is 18 per 100,000, so it places the challenge we have into context.

Chair: Thank you for that. Johnny has to leave us in a few minutes, so I am going to bring him forward to ask a couple of questions that will be slightly out of the normal batting order.

Q204 **Johnny Mercer:** Surgeon General, you have talked about how difficult it is to gather this data. Certainly within the military, you get what is presented to you, and some people go to charities and elsewhere. Looking at that in the round, what do you think is the true rate of mental health disorders in service personnel and veterans?

Lieutenant-General Bricknell: Here lies the question of what we mean by “true”. One of the things that I would strongly support is the fact that we have information from a wide variety of different sources that allows us to understand the prevalence of people who might seek help. I have explained the source that we use, from service utilisation. As the amount of information becomes larger and larger, we need to look at how we integrate that information. I would like to highlight that at the end of the Defence People mental health and wellbeing strategy, we put together an annex that we believed to be a summary of the state of knowledge around mental health in armed forces personnel and veterans. I commissioned a routine report from the King’s College team to produce that aggregation of information for policy makers around all these different sources of data. In many ways there is no right answer, just as we can never know the precise figure. What we have got is some indication of overall percentages. The primary highlight is that the rate of mental ill health in our forces personnel is not substantially different from matched populations and those groups who we know would be more vulnerable—we have mentioned potentially the under-18s, but in fact that does not seem to be the case now—and women, and so on. We have the evidence to identify those people who would be regarded as more vulnerable. I am not going to give you a per cent, because my answer is less valid than the expert answers—for example, this Committee has already heard from Professor Wessely and Professor Fear.

Q205 **Johnny Mercer:** But you would support their general assertion that mental health presentations of mental health problems is slightly less, on the whole, than the civilian cohort equivalent at the moment?

Lieutenant-General Bricknell: Because of the nature of the people we recruit and, indeed, because of our selection and training process and what we try to do to support their resilience, I would expect our prevalence of mental health conditions to be less than the general population.

Q206 **Johnny Mercer:** Okay. Can I ask you, Minister, why you think there is the perception that you spoke about earlier—that there is a huge presentation of veterans with mental health conditions who generally are not fit to re-integrate into society? How have we become so far removed from the reality that, to be fair, was the same reality three, four or five



HOUSE OF COMMONS

years ago, when King's College first put out the report that those who were serving had a chance of suffering mental ill health that was one percentage point less? How has that situation arisen and what are we going to do to combat it?

Mr Ellwood: That is a really good question; I know that it is something you have touched on in the past. As I alluded to earlier, it is unfair to those in the armed forces, the majority of whom are very capable as they serve and then go on to lead absolutely normal and thriving lives—although that is not to diminish our responsibility to help those who require help. I look at Lord Ashcroft's report, which was very helpful in this area. That is something you may want to write to him about, if you wish to learn more. He did a comprehensive study. I have a copy here and it has a chapter on why he believes that is the case. It is to do with the movies that we watch, the loss of direct communication between those who serve—the pool of people who actually have genuine combat experience, and the general population, which of course has gone down since the second world war. It is also because we are not doing enough to challenge it. We are not doing enough to promote and celebrate a career in the armed forces as something absolutely positive. You then have the charities that, by virtue of needing to raise money, have to underline some of the challenges that individuals face, and that can give a perception too. We all need to work hard on this because it is having a detrimental impact on the hard-earned reputation of the armed forces. That is not to take away from our obligation and the work to help those who genuinely need it.

Q207 **Johnny Mercer:** Thank you. Surgeon General, do you think that you can adequately identify the potential mental health effects from neurotoxicity within the services? I refer to the idea that things like Lariam and so forth will have had a profound effect on some—very few—individuals. Are you comfortable that you are in a position to assess that? Is it something that you believe is a factor?

Lieutenant-General Bricknell: This is deep science, for which you need to do the appropriate studies. That is not something that the MOD has the capacity to do, so we rely on expert advice from other sources. Obviously, the Committee will be very familiar with the issue, with its investigation into the use of Mefloquine, as you mentioned. We rely on the advice from the advisory committee on malarial prevention. We rely on the advice from other experts in the scientific literature to determine risk and balance.

In his evidence to you, Professor Wessely highlighted the real challenge in mental health between understanding association and causation, which is probably much more difficult than with other physical health conditions. It is therefore very difficult to prove anything more than a statistical association in a level of causation. I am not going to give a public statement on that question, because I don't know the answer. That is part of the reason why people are doing research—to answer that question.

Q208 **Johnny Mercer:** If you look at the studies that are going on in Australia and Canada, would it be a fair assessment to say that we are beginning



HOUSE OF COMMONS

to finally grapple with the issue of neurotoxicity, or do you think there is more we could do in this country to support that?

Lieutenant-General Bricknell: You will be aware of our policies and how they have been adjusted to make sure that we have the risk balance right, particularly for the selection of anti-malarials. Indeed, the rate of prescription for Mefloquine has gone down since the time that you conducted your inquiry. We use our electronic health record to make sure that every single person who has been prescribed any anti-malarial complies with the template—we can do that because we have this integrated electronic healthcare record—and we can follow up every case for which there doesn't seem to be a complete record of compliance with policy. In terms of what you asked us to do, and of providing you with the evidence that we have done what we have said we would do, I believe that we have met what you asked us.

Q209 **Johnny Mercer:** Excellent. Finally, are you comfortable that, down to unit MO level, people are content with the whole issue around mild traumatic brain injury and whether that has had an effect on individuals and whether it can be easily identified? Or is it a little bit too difficult to identify the effect that that has had?

Lieutenant-General Bricknell: One of the challenges even with the term “mild traumatic brain injury” is the diagnostic criteria around which you would then attribute the label, or not. What is clear is that the rates of positive diagnosis of it in the UK are substantially less than the US. To a certain extent, you could argue that there is a social and environmental context associated with having that label, which would vary between nations anyway. Mild traumatic brain injury and its association with mental health is an area that is being researched, and we will clearly respond to any new evidence that comes out of the research evidence.

Johnny Mercer: That is very helpful. If you are happy, Chairman, I think we have answered question 11 on data.

Q210 **Chair:** Is there anything that you haven't mentioned already about what you are doing to improve the coverage and quality of the data that you provide?

Lieutenant-General Bricknell: In terms of accuracy and precision for our mental health service utilisation data, we continue to look at that. Because we have got this integrated electronic health record and defence statistics that can look at it as a complete service, we absolutely have got all of that under close monitoring.

Johnny Mercer: Brilliant. Thank you very much.

Q211 **Mr Francois:** Ms Doyle-Price and Kate, do NHS medical practitioners properly understand the medical health of the sort that is affecting veterans?

Jackie Doyle-Price: Yes and no. It is improving. One thing we have done as part of the increased investment in transition services has been about making GPs understand that they own the care of their patients. In the



HOUSE OF COMMONS

case of veterans, they will have to go to more effort to establish any need, not just for them but for their families. There is quite a lot of work going on in this space. Do you want to say more about that, Kate?

Kate Davies: NHS clinicians and professionals work with patients all the time and give the best possible care they can. Jackie is right that we want to improve the knowledge and the expertise. Some of the services we are commissioning, as well as mainstream services, are about getting a mixture of both mental health and specialist care, alongside the knowledge of military, serving and combat mental health.

As part of that, we are working with the RCGP on a GP accreditation programme. We have just run the first pathfinder for that in the West Midlands, where more than 90 GP practices have now very willingly been participating with the criteria to look at their competence in working and assessing the needs of veterans on a daily basis, and their families at all levels.

We are rolling that out now, as part of a national piece of work. That is not a small piece of work to do. We have many thousands of practices and 55,000 professionals. That is a challenge we are going to take, and we have the full support of the RCGP on that.

We are working closely with the Royal College of Psychiatrists as well, in looking at the criteria of support, assessment and clinical awareness. Most recently—in fact, only in the last week—we have had conversations with the Royal College of Nursing. When you have a patient group with a specialist need, the most important thing is to work with the mainstream services to address the knowledge base and the training. We have done that in partnership with the HEE as well.

So the Minister is absolutely right. We are a lot better than we have been. We are commissioning, developing and nurturing specialist services. It is a workforce and market issue that you can't have those specialist individuals and that knowledge if you do not also commission and support and train that need and requirement as a baseline. Those are the two angles to address that.

The other thing to say is something I was talking to the Surgeon General about. We are also exchanging quite a lot of our professionals across both Defence Medical Services and also the NHS. "Step into Health", which we are rolling out within NHS England, and the reservists policy mean that a lot of clinicians and specialists are also working across both the NHS and Defence Medical Services.

Q212 **Mr Francois:** On the RCGP, I think you have now included some questions about veterans' mental health as part of their exam service.

Kate Davies: We have, absolutely, and the criteria. Dr Leach, who is in the room today, has been very much the architect of a lot of that work. We are highly delighted with the amount of interest and the number of GPs. It is not just in areas that we would expect such as Catterick or



HOUSE OF COMMONS

Winchester. This is across the board, and there is a real acceptance, for families as well, that that is really important.

Q213 Mr Francois: Is there any chance that you are going to extend that questioning into the Royal College of Psychiatrists' exams as well?

Kate Davies: Yes, certainly. That is the work that we have already started.

Q214 Mr Francois: Can I ask you a more general question? We have anecdotal evidence. To take a classic example, we have a serviceman who completes service, has the exit medical and leaves in good order. Maybe they served in a combat zone. A few years after leaving, they suffer some kind of traumatic shock. Let's say, their father is diagnosed with terminal cancer at short notice. Suddenly, their dad dies and it all comes out very quickly. They start shouting at their wife and at their kids, they are aggressive at work, they are generally very angry with people. They lose their job, they start drinking heavily. Their marriage breaks down because, eventually, she can't stand it and takes the kids out of that environment. That could all happen extremely quickly, unfortunately. One of the things we have come across is that that person may get diagnosed, but there is still quite a long time before they get into active treatment, sometimes because the pressure on the local mental health trust is such that they get the diagnosis but are still a long way back in the queue.

Earlier you mentioned the importance of early intervention. In that scenario that I have given you, what more can we do to get to that person far more quickly and prevent that deterioration before their family breaks up and their life goes into a downward spiral? How can we get to the problem quicker than we are doing?

Kate Davies: In the last year, because of having really strong communication and the media campaign, and working with our health professionals—media is probably the wrong word; it was more to do with a campaign to do with our health professionals—we have already seen that that barrier to access that our consultation came back with time and time again is beginning to break down and improve. I think you are right: there is lots of evidence to say that it is years after someone leaves and is ex-serving that those issues come up.

We know that, at the moment, the average assessment within our new transition, intervention and liaison service is 23 days. Actually, the target is 14 days. We are here to say we are not quite meeting that at the moment. That is also to do with—people are coming forward and it is about demand. Around intensive clinical intervention support, at the moment that is on average 46 days, but I know, with my visits to a service in Hull recently and in Manchester two weeks ago, that when people are very poorly they are getting much quicker to where they need to go to have assessment. The issue with how you can help is capacity. What we absolutely want to do is get those services as local as possible and integrate them with our mainstream services. Out of the 900,000 people that are accessing IAPT services in any one year, 24,000 last year



HOUSE OF COMMONS

were veterans. We now know that because of the data and the coding, but that is also largely reliant on self-reporting. People are still slightly nervous to come forward when they hit that crisis spot. I think your diagnosis is absolutely correct.

Q215 Mr Francois: While they are still in the service, while Tobias and the Surgeon General have got them, our understanding is that the provision of mental health services, by and large, is pretty good. When they leave and become a veteran, it is over to Ms Doyle-Price and yourselves in a sense. You said you are getting people assessed sometimes in 14 to 23 days. Okay, they are getting a reasonably quick assessment. You then said that sometimes it is taking an average of 46 days to get them into treatment. That is too long. Also, you well know that sometimes these people are reluctant to accept help and it is their friends or their families that are coming forward and saying "Look, something's happened to Bill here. You've got to help him. I can't cope with this." One and a half to two months from these people starting to go downhill to getting them into treatment—unfortunately, we are losing far too many people along the way. That is why I make no apology for pressing you on this. What can you do to speed that up?

Kate Davies: I would come back with the answer, to you quite rightly pressing me, that it is also about capacity and about increasing that specialist care, but alongside mainstream support and the mainstream training of services and professionals. I want to emphasise that all patients are assessed on their level of risk and their level of need. I would hope, as part of that assessment—alongside our GPs, our mental health and our secondary care services—that patients with high levels of need and risk are being seen immediately, within days. We know that. We also know that, certainly for some of our patients coming forward through the TIL service who have been offered packages of pathways of care and support, they have declined those and then have come back. What is really important is that we have a service that completely and utterly has an open door policy, so that people can come, sometimes back days, weeks or months later. That seems to be one of the barriers.

The other barrier is when people have complex cases to do with alcohol. We have talked about mild traumatic brain injury and other issues. I think those are the other elements that we have to get better at—working across a number of dual assessment needs and co-morbidity needs. Commissioning those services with a complex treatment service that we are rolling out at the moment is absolutely essential.

Jackie Doyle-Price: If I can add to that, if we view this as part of the broader Government ambition to improve the performance of mental health services, we are investing in more personnel—they are coming down the track—and we have big ambitions to improve treatment in this area. That cannot be done overnight, sadly. We often talk about money, but often workforce is as much the problem in enabling us to deliver these services. In that sense, given that most veterans will be accessing services in the same way as anyone else, they will get a material improvement as part of the broader ambition.



HOUSE OF COMMONS

You made an important point about the role of families and whether there are sufficient support services for them. They are the gateway to making sure that we give the right support. I come back to this cultural difference that we need to be much more sensitive to. That is why we are giving GPs very strong messages that they need to look at the holistic needs of patients.

I also wish to point to the fact that we are working on the new plan for the NHS. I am very open to receiving representations from this Committee about your expectations. That can be part of the conversation.

Q216 Mr Francois: I will have one more go at it and then I will stop hammering the nail, but I think it is important to us. According to the covenant, the principles of which are enshrined in law in the 2011 Act, some priority is meant to be given to veterans. That often becomes a bit of a postcode lottery, depending on which mental health trust they get referred on to. Again, anecdotal evidence is that some mental health trusts—partly depending on who is on their board and whether they have a senior consultant who may have served in the forces—do give some priority in treatment to veterans. Others just say, “Sorry, we don’t really recognise that. We will do it purely on the basis of clinical need.”

Jackie Doyle-Price: Under NHS legislation it has to be on the basis of clinical need. We are enhancing our offer to veterans by taking positive steps to make sure that they are not disadvantaged. Priority treatment does not sit comfortably with an NHS whose call is to treat everyone without fear or favour on the basis of clinical need.

Q217 Mr Francois: Haven’t we got a conflict here between two different pieces of legislation? We have an Act of Parliament saying that we should prioritise veterans and you are now telling me that the NHS view is done purely on clinical need.

Jackie Doyle-Price: Absolutely. Our offer to veterans is to make sure that they are not disadvantaged in accessing that care. But it is very clear that the NHS serves everyone on the basis of clinical need equally.

Kate Davies: For us to meet the obligations around the armed forces covenant, but also the practical engagement with stakeholders, armed forces charities, service users and families and veterans, there were three key areas that people said we should focus on, if we wanted to address prioritisation and no disadvantage. Services are commissioned alongside mainstream services to support transition and care co-ordination, and that is what we are doing and what we would like to increase and continue to increase, as well as training and support, to focus on some of the complex issues that may be are not always presented and understood in mainstream services—including alcohol and drugs, but also traumatic brain injury, and we have talked about PTSD already—and, lastly but not least, what that means in crisis, when somebody presents in crisis, because it may well have all come tumbling down as you quite rightly said, whether in an A&E department, at a GP’s or in a mental health service, so that there is a much broader understanding of what those complexities and



HOUSE OF COMMONS

needs are around veterans and their families, as well as other specialist needs and conditions.

Q218 **Mr Francois:** Rather than do it to death here, could you provide us with a note about what you are trying to do to get that 46-day average down?

Kate Davies: I would very happily follow that through.

Chair: Mark, I know you will be coming in on data sharing in a moment. I want to bring Ruth in first.

Q219 **Ruth Smeeth:** I just seek clarification. I have had correspondence about a constituent's case with both Ministers. I have not checked with my constituent whether I can name them, so I won't raise the detail of their case, but one of the issues is continuity of care. These are veterans away from the military environment.

I understand that the focus of the NHS is on delivering care, based on need, for everybody, but there is a responsibility under the covenant. My constituent has very specific requirements and he has trust in the clinicians who look after him now, but it has taken years to get him to that point. He is out of the military environment, but all his illnesses relate to his service. We have been trying to get to a point where he can get additional support in the transition as his clinicians retire. He needs that specifically because of the illness that relates to his service, yet he cannot access it, because under the protocols of the NHS he will just be given appropriate treatment going forward. So there is a conflict between what we expect under the armed forces covenant and what the NHS is delivering. It isn't working yet, or at least in specific cases I don't think it is transitioning yet, because of the requirements of veterans when they are outside the service environment.

Jackie Doyle-Price: That is exactly that kind of case that we are trying to tackle by improving the transition services so that we have an ongoing relationship—so that, where someone has complex needs as a result of their service, we have a system in place to enable that to be monitored. These services were brought in only last year, but I am happy to look again at your case.

Kate Davies: On that particular case and other cases like it, I think one of the things that is really important is the partnership work we have been doing with the MOD around personalised care packages and personalised care budgets. I agree that it is not appropriate to go into an individual patient's case, but an example—there are a few that we have been working with across the country—is working very closely with the local commissioners of that healthcare transition, that continuity of care, and also the existing assessment of trust and need, so that we can hand that over, and also through an individual payment package. That is something that we are doing in policy terms as well as practical terms—just to give you that confidence at the moment.

Q220 **Ruth Smeeth:** You know that this is something that I have raised previously, and I should have declared that I am chair of the APPG on the



HOUSE OF COMMONS

armed forces covenant, but one of my concerns is this. Let's say you are a veteran, you now live in an area where there are very few other veterans, you are accessing healthcare in the way you are entitled to under these processes, you finally get the package right—as a veteran, you have found the one person who can help you—and then suddenly, when that all changes, we're not transitioning, because there are not very many other veterans for healthcare professionals to look after in that area, to engage. I appreciate you are trying to deal with that in terms of the ambassadors, but even so, there is still a specific clinical need for people to understand how to deal with veterans specifically, because it is very different. PTSD and the potential for them to have a "break" is a very different issue from what someone normally experiences.

Mr Francois: Our argument is this. We are saying that if these people have been mentally wounded by fighting for their country—because of what happened to them in a combat zone some years ago—the country has a debt of honour. These people have fought for us and therefore, when they become ill, there should be some recognition of that in the system and some priority given to them, bearing in mind how that injury, as it were, was received.

Kate Davies: NHS England is really clear—I say this as a director for armed forces—and it is also within our NHS constitution that the armed forces covenant is absolutely appropriate and clear. The work that we are doing around GP accreditation, rolling out mental health services and our care co-ordinating is also to bring people with us to understand what that means in armed forces covenant terms.

It is worth remembering the important point that 90% of veterans get, and are very happy receiving, their care through the general NHS, across devolved Administrations.

Q221 **Ruth Smeeth:** They don't want to be treated as special; most of them genuinely don't.

Kate Davies: Absolutely. The reason NHS England, and I can only speak for England, continues to have a direct commissioning function for armed forces—serving personnel, families, reservists—and mental health is that there is a legal requirement to continually improve and also understand how we can support those packages of care and continuity, and that's exactly the challenge that we need to continue.

Q222 **Ruth Smeeth:** I have this argument with veterans, because they do not want to be treated any differently. They do not want to be treated over a rape victim, for example, for mental health provision. They are brave people and they do not want to think that they are being put above other survivors of other illnesses. We want better for them than they want for themselves, but typically there are some cases that are so specific to their service that that has to be recognised.

Kate Davies: I agree, and I think the bit that is key is also about funding, because it is about continuity and trust, but it is also about some very complex patients. There are some questions that need to be supported



HOUSE OF COMMONS

and explained to pick up what that means in commissioning terms. We understand that, and that means quite a lot of intense work. That is intense work that the national team and the local commissioning teams are doing on a daily basis, and we are putting in a proposal to increase that in the future.

Mr Ellwood: You are speaking about quite a specific challenge, and we are happy to look at that. If it is continuity of support by individuals, then absolutely we need to get that right. The reason we had to create the veterans' board in the first place is that this is not as good as we want it to be, and that is why there needs to be an umbrella body that is able to recognise where the fault lines and gaps are, and to improve it.

Q223 **Mr Francois:** Will the new IT systems you have got under Project Cortisone resolve the issues around data sharing between the MOD and NHS bodies, and when will the system be ready? We would find it difficult to believe that any IT system provided to the MOD could possibly be late.

Lieutenant-General Bracknell: And in healthcare, there is also the challenge of delivering the promises of IT systems, so you can claim a double whammy.

The reality for us is that we do have a good, comprehensive, integrated electronic healthcare record, and we want to make that more easily accessible to the NHS with our existing healthcare record. We are going to look at a mechanism whereby we might create a virtual practice to place our records in, which can then transfer across to the NHS. I am really keen to utilise our existing systems to improve the connection to the NHS as soon as we can practically achieve it.

The programme Cortisone is our aspiration for a much better family of health information applications within a better data architecture. It is a big vision, and clearly—with big visions—it will take longer than a couple of years to realise the entire benefit. What is critical for us is to make sure that we keep up to date with the pace of health information technology that is going on inside the NHS, and we work very closely with NHS Digital to understand that, and to understand how we can appropriately invest into the technologies as they come together.

Our biggest challenge with working with the NHS is the fact that it is still local, where we are a national, and indeed global, system. So we have to transfer information in an information architecture that we do not immediately nest into. We understand the challenges and we understand what is best for our patients, which is the seamless transfer of as much information from the record that we hold in the MOD to the NHS, and we will do our best to make that as comprehensive as we can.

Q224 **Mr Francois:** For the record, when is the projected IOC for Cortisone?

Lieutenant-General Bracknell: We are still in the phase of going through investment appraisal approvals, so I cannot put that date on the public record yet, because I need to get confirmation that the money will flow against what we need to buy.



HOUSE OF COMMONS

Q225 Ruth Smeeth: Given what I was just saying, this is going to sound contrary, but can we talk about the definition of early leavers and their qualification as veterans? If they have had only one day's service and they have left during training—if they were hurt during training—they still qualify as a veteran under the veterans' gateway. If they have mental health challenges, they will still be included in your statistics, so should we be considering a slightly more nuanced and sophisticated definition of "veteran"?

Mr Ellwood: What would you recommend?

Ruth Smeeth: I'm asking you!

Mr Ellwood: I throw that back at you because it is a big question; it is not something for which there is a NATO standard. This came out in the NATO ministerial conference that we had with Denmark, Holland, France, Germany and Italy. Last year, we had a Five Eyes veterans conference with Canada, Australia, New Zealand and the United States, and again there was no parity of recognition. For some, it is a number of days; for others you have to have been in combat and in harm's way to gain the accolade of "veteran". We seem to have lost all the veterans who serve on the Committee; I was going to pose the question back—

Gavin Robinson: They're early leavers.

Mr Ellwood: The question is whether the term "veteran" even applies to those who served in Iraq and Afghanistan, who often consider themselves as ex-forces rather than veterans. The term has symbolism—a label attached to it.

From a legal perspective, if something happens on day one, we have a responsibility to look after them. In fact, I have met a couple of people who were not able to pursue an armed forces career because they damaged their backs getting off the bus on day one, which is so unfortunate. Because they had signed up on their first day, we are obliged to look after them until they are fit again.

The question is philosophical, but as far as legal responsibility is concerned, our duties to look after them start on day one.

Q226 Ruth Smeeth: Obviously, you will be aware—for some veterans, anyway—how many were early leavers versus others. How many people are we talking about? Is this skewing the data or not?

Mr Ellwood: What is your definition of "early leavers"? Someone not finishing basic training?

Q227 Ruth Smeeth: Someone with less than a year's service.

Lieutenant-General Bricknell: I mentioned the age breakdown of people who use our services: those under 20 are proportionately less represented than those over 20.



HOUSE OF COMMONS

I would also like to emphasise the issue of early service leavers. There is an association between people with limited time in service and leaving, but what we do not know is causation: did they come in with a condition or vulnerability that made military service unsuitable for them, or was their very short time in military service *de novo* the cause of the problem?

One of the values of at least knowing that there is a question to answer is that we can begin to look at how we might answer it. I know that Dr Bergman appeared before the Committee; in the Scottish veterans mental health study that she is doing in Glasgow, she is particularly looking at this subject.

On what causes people to leave, musculo-skeletal injury is a greater cause than mental health issues.

Q228 Ruth Smeeth: I would argue that if they got damaged at basic training or in their first 12 months, they might well end up—regardless of age—getting some form of depression, which is a much higher mental illness than PTSD for veterans anyway. It would be causal: because of the fact that they had got hurt, they could not do their dream job and therefore they left. There would be a medical consequence.

Lieutenant-General Bricknell: There is this question of causal versus association. One of the challenges for us, of course, is trying to predict vulnerability during the entry process, to make sure that those who are most vulnerable do not come in, but equally to make sure that our aperture is sufficiently large so that people who can benefit from armed forces service in spite of some childhood vulnerabilities can actually have that benefit. We have to be really careful to make sure that what we have found so far is an association. The evidence of causation of limited exposure to the military is not yet proven.

Q229 Ruth Smeeth: There is almost an understandable logic behind why someone might end up needing additional support if they have left with less than a year's service. That transition process is very different from that for someone who has left after fulfilling a 15 or 20-year career. Are we looking at specific support for those people who are leaving early in their transition? Is there a targeted package for early leavers compared with late leavers?

Mr Ellwood: For mental, or for physical support? There is a transition process, which is a wide package of support, and that actually increases the longer the service you have.

Q230 Ruth Smeeth: Yes, but there might be very specific support that someone needs—say a young man or woman in their early 20s, who is leaving because they are not happy. In my head, I have a new intake person who has not got through basic training for whatever reason. That is going to have consequences on them. It is a different type of support.

Mr Ellwood: I don't think it is targeted that way. It is on the requirement of need. If somebody steps forward and they require support, there is support that can be provided. For example, SSAFA does some specific



HOUSE OF COMMONS

work on looking to support those who have left early and to provide that support as well.

Q231 **Ruth Smeeth:** So we are putting in support for those who are transitioning early?

Mr Ellwood: As a charity, they specifically focus on this, but as I say, it is done the other way round. It is, "Where is their need?" and, "Let's provide that need," rather than saying, "There is a cohort and are we meeting the targets from there?"

Q232 **Ruth Smeeth:** So we are dependent on SSAFA to find them?

Mr Ellwood: I hope you are not being dismissive in the way that you phrase that.

Q233 **Ruth Smeeth:** Not at all. It's about the duty of care. I think they do incredible work, but the duty of care is yours, not theirs.

Mr Ellwood: I have here a little diagram that I can share with you, but it shows you the huge variety of support that comes from our charitable sector.

Q234 **Ruth Smeeth:** But Minister, my point is that the duty of care to these individuals comes from you, not the charities. They are the provider.

Mr Ellwood: Again, there is a misnomer in the idea that all charities do is stand on street corners shaking tins. You know as well as I do, but I would underline the point, that we are reliant on the expertise and the knowledge and depth of experience that these charities provide. That is a model that we have in this country, which has developed over hundreds of years. We have, for example, Blesma, Combat Stress and the Royal British Legion. Some charities have existed for more than 100 years, doing an absolutely incredible job, which we rely on. We provide funds and commissions and so forth to support the service that we need to give.

Lieutenant-General Bricknell: I have just been given a note that the career transition partnership, which is the body that facilitates transition for all members of the armed forces, has a particular support package for early service leavers as part of its suite of support.

Ruth Smeeth: Thank you very much, and thank you to the official who delivered it.

Chair: Thank you. The finishing tape is in sight. We have one more substantive question from Graham, and I think Ruth might want to come in on that as well, then there are a couple of loose ends from Gavin and myself, and then we are done. Graham, would you like to go ahead?

Q235 **Graham P. Jones:** To turn to armed forces families, what is the impact of military service on armed forces families? I know that seems a broad question, but I would be interested to know where the starting point is.

Mr Ellwood: Whenever I speak of the armed forces, I always talk of the armed forces community, because it isn't just the individual who is in



HOUSE OF COMMONS

uniform. It is all those in the immediate surroundings. It is the children who need to be going to school. It is the spouse or partner, the husband or wife, who is also supportive. In fact, the biggest cause for departing the armed forces is the pressures on a family. Often, people join when they are young, single and have few responsibilities, but as time goes on, they grow. It is critical that we take into consideration the needs of that wider aspect. We work closely with the armed forces families' federations to give us feedback on some of the challenges that we face, whether that be accommodation or welfare, to make sure that we can provide the necessary support. It is important that we do not just consider the individual, but the wider environment that that individual works and lives in.

Q236 Graham P. Jones: And the mental health and wellbeing of armed forces families?

Mr Ellwood: It is all included. It is part of the community. You wouldn't isolate one from the other, because of the pressures on an individual at home. We need to make sure that the services are provided right across the board for everybody involved—for everybody who is part of the family of any individual.

Jackie Doyle-Price: That is very much part of the GP accreditation scheme—to look at what support needs to be going to families too. As I say, we are at a very early stage in that, but we are very much factoring it into our plans.

Kate Davies: One of the important things is that from the partnership agreement that we have formally with the MOD, which we haven't mentioned, one of those elements is for the families of serving personnel. Quite often, they are part of a package of care with a family care service and their GP on a local basis. What is really important is to look at the different needs of those families. That is a really important question, so certainly rebasing and movement of families are quite important—what that means for children, particularly with growing up with the needs, the stresses and the strains, when they are rebased.

We certainly are doing a lot of work at the moment in consultation with families for our public and patient involvement group, where there is improvement particularly around medicine management if families change areas or when they may well change GP or change practices. Where there are long-term conditions within families, both mental health and physical health, it is really important for both children and adults, in safeguarding terms, that we get that right as well. I am really pleased that you have asked that question, because it is paramount as part of the mental health and welfare of the serving person, as well as the ex-serving person. It is something that needs to be given due regard and consideration. My colleague asked me a question earlier around what we can do. That is around capacity, but also understanding.

Q237 Graham P. Jones: Beyond GPs, what assessment is made of families of serving armed forces personnel? I would widen that: beyond GPs, what



HOUSE OF COMMONS

assessment is made of veterans' families and perhaps the mental health challenges they have, or issues or problems that they develop? What assessment is made beyond GPs? What monitoring and evaluation is there? How do you go about caring for these families?

Kate Davies: Beyond that work is the absolutely essential part of primary care, because that—for all the population, for all our families, for my family—is mainly the first port of call for someone's health needs or someone's concerns. We are also developing armed forces networks and commissioning health networks across local communities. We find that families and carers are very active participants in those armed forces networks, and it is absolutely essential and fundamental that it is done in partnership with our armed forces charities, as our Minister has said, but also with local authorities and with local partners, where families are obviously part of that community.

There is a great example that we are working together on at the moment in Catterick, where the local authority, the local commissioning from the CCGs and the garrison itself are all coming together to co-commission and to look at the model of a community facility and a community health facility for families and serving and non-serving, as well as people who have never served and are never going to serve.

Certainly, that is a great example of how a community basis can be really important. The women, I have to say, have driven that largely in that community—not exclusively—but there is a really good piece of work that is being done through community engagement.

Mr Ellwood: General Bricknell wanted to come in here.

Lieutenant-General Bricknell: I particularly want to highlight the good work that King's College has been doing to undertake research on the mental health of families. That information definitely informs us in policy terms as well.

Q238 Graham P. Jones: How many people—family members, carers of serving personnel and veterans—do you think are suffering some form of mental ill health and are falling through the safety net that you have just described? Do you think that there are a lot of people who are suffering or a few people? How do you ensure that all those who are suffering but who might not have seen a GP are provided with some form of treatment or provision and that they do not fall through the net?

Mr Ellwood: Can I add that the families' federations have an opportunity through the armed forces covenant annual report to submit a section that is unedited, so they get to comment on this themselves? It might be worth you appraising yourself of that, because it is quite helpful.

You touch on a very important question, because many people do not want help—they shun help. They do not want any form of organisation to affect their lives, and therefore they are falling through the cracks by virtue of not wanting anyone telling them what to do. Thankfully, that is a small proportion. We can perhaps write to you with more details.



HOUSE OF COMMONS

It is important to recognise the wealth of support that actually does exist. I mentioned the charities and the work that we do, the NHS and so on. The critical thing is making sure that when somebody is in a very dark place—in a dark chapter—they know where to turn. That is the important piece. It is all very well us putting out 24/7 telephone numbers and so forth, or even promoting charities, but people do not necessarily listen to that when all is fine and well. When somebody is experiencing hardship, it is about either those around them or close to them being aware that there is help and support out there and marrying the two up. The veterans' gateway is a single portal that does an awful lot to help with that.

Q239 Graham P. Jones: I want to turn to one particular group of people: family members who have suffered bereavement in the armed forces. What do you do for those individuals? I have gone such constituent, Mandy Rawstron, who lost a son in Afghanistan. What ongoing provision is there from you for people like Mandy to deal with the tragic and difficult set of circumstances she faces and the challenge in overcoming that loss?

Mr Ellwood: Sadly we have experience of this and have had to put together a structure to be able to ensure that individuals' families are looked after. There is a process we follow that involves a number of stakeholders and organisations. I do not know whether Kate or the Surgeon General would like to comment on that.

Lieutenant-General Bricknell: The key to this is using the networks, particularly built around the Families Federation, to support mutual support. Indeed, there is a bereaved families working group that looks at how we can nurture those supporting relationships without necessarily directly providing services ourselves.

Mr Ellwood: First, there is the process of the initial informing of the family that something has happened. It is carefully conducted. It may involve a padre and other support as well. Then a programme is followed. A liaison officer is allocated to help with the initial challenges. This is something that sadly I was affected by when I lost my brother—we had to go through the same process. It can involve civilian authorities as well.

We do try to get it right. Every so often, I am afraid—perhaps because an individual has divorced parents in different locations—we have not been as good as we should be in making this very difficult period in learning about a bereavement as smooth as possible. We have to ensure that we get it right.

Q240 Graham P. Jones: So it is fair to say that these individuals who have suffered a bereavement in the family get ongoing one-to-one support until the time comes when they do not want that support, but even then it is still available.

Mr Ellwood: Absolutely, it needs to be offered to make sure. Not everyone does want it—some people choose to do it in different ways. They need to know that help is there and is available.



HOUSE OF COMMONS

Q241 **Graham P. Jones:** And you as a Minister and the Government and the MOD are mindful to the circumstances that these families and individuals find themselves in, and you are proactive in responding. Would that be a fair statement?

Mr Ellwood: We are. It is fair to say that whenever we feel that a family has had concerns or has ongoing concerns about a situation, perhaps to do with the coroner's report or a repatriation, I step forward as a Minister to invite them into the MOD in order to speak to them on a one-to-one basis, because that is the level at which I feel it should be dealt with.

Q242 **Graham P. Jones:** You are doing everything you possibly can to improve your understanding of the issues faced by all families with service personnel or veterans, or even those who are bereaved. You are trying to understand their circumstances and provide them with the support that suits them.

Mr Ellwood: We are. The biggest challenge is social media: being able to ensure that we control the messaging and so forth without a wider message going out and them hearing from another source that something has happened or a situation has changed. That is always a difficulty that we have in this day and age.

Q243 **Gavin Robinson:** Just to pick up on your discussion with Mr Francois about the midlands pathfinder pilot, you mentioned that it was going to be rolled out nationally. When you say nationally, do you mean across the United Kingdom or across England?

Kate Davies: I apologise; I mean England, because that is my jurisdiction. We have been talking to our colleagues in the devolved Administrations about our piece of work, and I will give you the undertaking, along with my clinical lead colleague in the room, that we will certainly pursue it with the devolved Administrations.

Q244 **Gavin Robinson:** That would be really useful, because the Royal College of General Practitioners and the Royal College of Psychiatrists are obviously national organisations and—

Kate Davies: Absolutely, and that is why we are delighted that the RCGP are leading this work. From my perspective, in front of you today—I am giving that undertaking for England—the work that we are doing is about the body of need around serving personnel in the UK. I hope that helps to clarify.

Q245 **Chair:** In my last point, I want to take a step back, because we have the unique opportunity of two Ministers being here together. There was a slight contradiction in that, from the MOD covenant side, we are talking about prioritisation for veterans, and understandably, equally, from the NHS side, there is a different terminology that says that veterans should not be disadvantaged but will be judged on a level playing field with others, depending on how ill they are.

I think the idea of prioritisation for veterans is that they get some extra-special consideration because of the dangers that they have put



HOUSE OF COMMONS

themselves through that have resulted in them suffering mental injury, but can you both see that there is a bit of a contradiction there? If we cannot resolve that contradiction, it will be very difficult for GPs, who are faced with pressure on their lists, to decide who gets priority or who does not get disadvantaged. In a final presentation, as it were, can the two of you say how that apparent paradox is meant to be dealt with?

Jackie Doyle-Price: I will start, if I may. You are right: there is a tension there, because the military covenant clearly says that we should prioritise delivering services for veterans, which is absolutely true—

Q246 **Chair:** Forgive me for coming in, but that would seem to suggest that if you have two people with the same level of need, the military veteran ought to get the first tranche of help.

Jackie Doyle-Price: But it is also a fundamental principle of the NHS that no one is given favour over anyone else. We have chosen to deal with our obligation to veterans through specialist commissioning, so we are giving access to bespoke services for veterans. That is the basis on which they will not be disadvantaged, because it recognises that they will have a different journey to accessing health services. We are tackling it through that commissioning, rather than by effectively giving a points system for people on the NHS.

Q247 **Chair:** So they are getting a special unit of treatment that is not available to non-veterans. Is that the argument?

Jackie Doyle-Price: It is about arranging services that are specifically designed for veterans.

Q248 **Chair:** The word I was looking for was “pathway”. They are getting a pathway—

Jackie Doyle-Price: It is bespoke, I suppose. Yes.

Chair: And that is available to them, but not to others, and you would argue that that fulfils the argument for priority.

Jackie Doyle-Price: That is the way we have chosen to do it, in line with our legislative constraints and our ambition to do the right thing.

Q249 **Chair:** Okay, that seems to make sense. Tobias, would you like the very last word?

Mr Ellwood: Yes. You are right to highlight this. Again, this advances the package of support measures for veterans. We are embarking on a veterans strategy that will be released in the autumn, which will focus on, first, promoting the recognition and celebration of what veterans have done for our country, something which from a British perspective we are a little more reserved about than we should be; secondly, improving co-ordination between the services that are provided and improving communication to ensure that no one is left behind; thirdly, challenging the cultural shift in the image and the stigma that are linked to veterans; and finally, linked to this, looking at key areas where we need to advance improvement and upgrade our support, such as mental health and its co-



HOUSE OF COMMONS

ordination, homelessness and suicides. That is the veterans strategy that will come out in September. The veterans' board will ensure that we advance and take that forward.

Chair: Thank you very much. By my calculation, we have just reached exactly the two-hour point. We have discussed the distribution of data in some detail in those two hours and you have certainly distributed a great deal of data to us. The Committee specialist has been writing away with great rapidity. I am sure that we will benefit greatly when it comes to producing our report as a result of this session. Thank you all very much.

ⁱ Since giving this answer, some evidence has emerged of legal cases brought against MOD for misdiagnosis; however, this information is not definitive and further work is required to validate it against official records held.