HOUSE OF COMMONS

Defence Committee

Oral evidence: Mental Health and the Armed Forces, Part Two: The Provision of Care, HC 1481

Tuesday 18 December 2018

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Watch the meeting

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

Questions 335-448

Witnesses

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

II: Johnny Mercer MP.

Written evidence from witnesses:

Ministry of Defence

Kate Davies

Examination of witnesses

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

Q335 **Chair:** Good afternoon and welcome to our final hearing in our inquiry, "Mental Health and the Armed Forces: The Provision of Care". It is a great pleasure to have a particularly distinguished panel that includes two Ministers. We will start with a couple of opening statements from the two Ministers. Before we then come to the main subject area of mental health, and given that there has just been a statement about the Modernising Defence Programme, we will have a few questions on that after Tobias has made his short opening statement and then a few questions on one or two other topical defence issues before we then hone in on the main substance for the rest of the session. Can I ask Kate and Richard to introduce themselves formally for the record?

Kate Davies: Good afternoon. I am Kate Davies, the director for NHS England for the Armed Forces, but also for health and justice and sexual assault services commissioning.

Lieutenant General Nugee: I am Lieutenant General Richard Nugee, the Chief of Defence People from the Ministry of Defence.

Jackie Doyle-Price: Thank you, Chair. It is a pleasure to be here engaging with the Defence Committee again on these issues. One of the things we discussed when I last appeared before you about six months ago was the tension between the NHS being a universal provider and at the same time having responsibilities under the Military Covenant. As I explained at the time, we discharge that tension by commissioning veteran and armed services-specific services. Where we have got to with mental health is that we are massively advanced since then.

In April 2017, we launched our Transition, Intervention and Liaison Service for veterans to do some in-reach in respect of mental health and to ensure that we have got sufficient care and provision for those leaving the service, particularly where there are serious mental health issues. We are now 18 months down that track. We have got a much better evidence base about what works, and we want to build on that. On that basis, as part of the 10-year forward plan, we are extending our investment in those services, and obviously have announced further funding just this weekend.

We are very ambitious to make sure that we deliver good mental health care for all those who need it, and deserve it under the Military Covenant.

Q336 **Chair:** Thank you very much. We look forward to coming back to that in a little while. Tobias, would you like to open with a short statement about the latest developments and about the area of mental health?

Mr Ellwood: "Latest" refers to the statement this morning?

Chair: Yes.

Mr Ellwood: I am grateful to be back in front of the Committee with my colleague Jackie to talk about these important issues.

Regarding the MDP, I am very pleased that the Defence Secretary had an opportunity to share his and the MoD's ambition to step forward to provide the necessary changes to ensure that we remain a tier 1 armed force, with the reach, lethality and indeed the mass to be able to make our mark across the world. The MDP underlines the pace of change that we are experiencing around the world, unseen outside a world war.

I hope that the MDP will act as a warning order. If we are to stay relevant and effective, and indeed to prevent the instability that we are experiencing becoming the norm, it is up to countries like us to step forward. I also hope that it will trigger a conversation with the British public about the Armed Forces, explaining where we are today and where we need to go.

I don't think that there has ever been a period of greater popularity for the Armed Forces, but that does not necessarily translate into more spending, if required. We must be honest with society about what we are up against, why we need to be stronger, and the consequences if we stay where we are. Last week, the Chief of the Defence Staff said in his speech at RUSI that Russia and China know more about our strengths and weaknesses than the public do.

Russia and China are certainly exploiting our weaknesses across a series of domains. We have seen what has happened at the Kerch bridge, where fighting has moved from land to sea. China's navy is increasing its size by the size of our Royal Navy every single year. We know what they are doing in the South China sea, and the Chinese are now setting up ports and interests in East and West Africa, in countries with which we would assume we had a relationship through the Commonwealth. Their dominance of 5G and AI is well recognised, but with an impact on data—ownership of data has almost overtaken terrain as the prize—that we need to recognise.

We always point to the fifth-generation kit that we are bringing in. We can be very proud of the professionalism of our Armed Forces and their kit—carrier strike, for example—but we have tanks and APCs that are a couple of decades old. They need updating, and that is now being addressed.

France is about to overtake us—next year—as the lead nation in Europe on military spending. That might have consequences for our relationship with the United States but, most worryingly, the tried and tested diplomatic conventions that we use to retain the peace and the rules-based order, are being eroded, as we know. They are no longer fit for purpose.

Which country can step forward, and has that credibility, gravitas and soft power to change and challenge what is happening around us? I certainly believe that that is the role that we should aspire to play. The danger is, without investment in our hard power, we will be unable to respond to this fast-changing world even if we want to. We remove ourselves from influencing, and indeed leading—a role that we have prided ourselves on over the years—and it is not just about money for defence. I hope this is something that I do not need to convince this Committee about, but by investing in our defence, we invest in our prosperity, because we guarantee the security of our access to the markets that we choose to engage with.

I simply make the point that to date, we have enjoyed an enviable reputation around the world as a pragmatic, engaged nation, but we must be honest with ourselves: that soft power will diminish if we do not invest in our hard power. In summary, this MDP spells out a strong and convincing case for why we need to modernise and the threats that we face, but it is not possible to do that on the current budget, and we need to take the argument to the nation. I hope that that is what this MDP will achieve.

Q337 **Chair:** You were present in the Chamber when I put the point to the Secretary of State that, in the context of the sorts of threats we are facing today, we really ought to be looking to a figure such as 3% of GDP. That is not the level of investment that we made in the Cold War, which was regularly between 4.5% and 5%, but it was the figure that we invested as late as the mid-1990s. As the Defence team, you have had a tremendous battle to get this extra £1 billion out of the Treasury, which is presumably on a one-off basis. Are you as a team going to continue to make the case that if the threats have gone back, if not entirely to Cold War levels, to a level that is seriously en route in that direction, we must begin to boost defence spending significantly to the sort of priority status that it had in the 1990s, if not in the 1980s?

Mr Ellwood: I fully agree with you. We need to take the argument to the people. We need to make it clear that if we end up where you are suggesting, at 2.5% or 3%, that is a consequence of "this is the defence posture that we need to create. This is what we need to do in order to protect the five domains that the Defence Secretary spoke about." It is crude to talk about an arbitrary GDP figure, as you know. The purpose of this modernisation programme is to spell out the threats that are there and the role that Britain aspires to make, and I stress the fact that if we do not make it, look around us: which nations want to remain engaged in the world around us, aspire to help shape it, and have the necessary hard power at this moment to influence it? We remain one of the players, but unless we invest, we remove ourselves from that equation.

Q338 **Chair:** I would just observe that the point about arbitrary figures and so on is true, but it does give us an understandable point of comparison when we look at the percentage spend on defence, as compared with health, education, welfare benefits and so forth. Whichever way you cut it, defence has massively fallen back since those days when we faced threats similar to the present day, has it not?

Mr Ellwood: It has indeed, and the most powerful argument we can make is that if you want increasing budgets in other departments, then the only way we can make sure prosperity continues is by defending access to the very markets across the world that we wish to engage with, particularly the new markets. We are seeing the movement of China, Russia and other state actors around the world, pressing on traditional accesses and so forth, which will limit our ability to have access to those markets and therefore affect our own economy.

Q339 **Chair:** Before I bring in my colleagues, I just have one more question, which is about process. We have not yet had a chance to read the document that has been published today. I do not get the impression, from what I am told and from a very cursory look at it, that it is a particularly specific document. Am I right in thinking that there are further stages in this process to go?

In particular, I recently had a written question answered. The question was to ask when the MoD plans to publish the maximising competition in defence procurement strategy, for example—I know that is not your part of the bailiwick—and the reply was, "The Ministry of Defence plans to publish the strategy for maximising competition in defence procurement in 2019, on completion of the acquisition review elements of the modernising defence programme." That suggests that there is more to come in this MDP, so is what we are seeing today the final document, or are there more pieces yet to be revealed?

Mr Ellwood: You raised that question in the actual statement, in Question Time itself. I am sorry that the document wasn't there for you to look at. What you did get in assurances was that when this is produced, there will be a subsequent debate on this matter. I think it is probably best to raise this particular question then.

Chair: Okay. I won't push you further on that.

Q340 **Mrs Moon:** I will start with a compliment, Tobias. That was a much punchier summary of the MDP than we got in the Chamber. I have to commend you, because it really was much more forward-leaning. Thank you. There are two things here. You talked about soft power. People think of soft power as something soft and fluffy—like broadcasting or overseas development—but we need to be alerting the public to the "grey zone," real and oppressive threats. So how do we start getting the public aware of the really strange threats that they are facing that they may not actually see: the misinformation, the deliberate use of social media to sell them false impressions of their Government, their country and the world that they live in? How are we going to do that? How are we going to get the levels of analysis and understanding across Government, so that they

too can engage in some of the defence roles that they have, which we seem to be missing out on their engagement in?

Mr Ellwood: You touch on something that goes to the heart of what is being launched today: to gain a greater understanding of the very fast-changing world around us. We are moving away from the standard, traditional types of threats, often to do with terrain, to non-lethal, sub-Article 5 threats, where there are not any rules that have been written. These are countries where, when you try to hold them to account at the United Nations, it is not possible to do so because they hold a veto. What you are seeing is an encroachment. You are seeing countries where power has grown actually challenging our way of life, but we are unable to step forward.

We have been distracted for other reasons, as has the United States. It is important: unless we do step forward, the change, which we realise is happening now, will be permanent and we will have lost that opportunity. It is in the five domains particularly, but we are seeing particularly the information warfare as being hugely vulnerable in that space—of us having elections interfered with and our actual viewpoints distorted, because of interference from the outside. The more we discuss these things, the more we can actually ensure that we have the Defence budget to change it. We can then also work out what the new rules are. What is the new norm? How do we hold these countries and non-state actors to account?

Q341 **Leo Docherty:** Very briefly, Tobias, the language and intent in this document is excellent, but without more money, it will be meaningless. Is there the active expectation in the Department that more money will be forthcoming at the comprehensive spending review?

Mr Ellwood: We have set out our stall. We have made it very clear. This is the starting point. This is why I am saying that this is almost a journey. We have a nation, as I mentioned before, very proud of our Armed Forces, but I think somewhat naive about the threats we are facing, just as the question from Madeleine Moon suggested. Our world will change fundamentally. If we think the last 10 years has been bumpy, wait for the next 10, when we see an encroachment on the introduction of 5G, owned, potentially, by China. This will have machines talking to machines, the infrastructures and so on, and the internet of things. If we don't own that, if we don't stand up to it, we will have no ability to control it. It will be omnipresent. The way that these countries that own these things will affect our economy is by affecting our machines and the way we do business to their benefit. It is so important that we wake up to this and step forward.

Other nations actually expect us to do that. We have a history and reputation of recognising the threats that are coming forward, and producing answers and solutions. Other nations will then follow. We need to get back to that. We have become too risk-averse, in my view.

Q342 **Mr Francois:** Tobias, does this document have the status of a White Paper?

Mr Ellwood: Yes, I think it would.

Q343 **Mr Francois:** You have had about a year to work on it. In the Chamber, Nia Griffith said the statement was 26 pages, of which 10 were photographs. I have had a look and it is actually 25 pages, of which 10 are photographs. I have only had a chance to look at it, but, to be honest with you, for a year's work it looks very thin.

Mr Ellwood: Do you want me to answer that?

Mr Francois: That's why I asked the question.

Mr Ellwood: If you look at the details of what the actual intention is, where we need to go and what needs to happen in the five domains of our commitment to actually stepping forward, that is the intent that you get. You get a strategy document. If you want the detailed plan, that is another matter, but that is where the difference is between what happens at front of house and what is happening now behind the scenes. We take this document and the further detail that sits behind it. We go to the Treasury and to No. 10 and we make the case to say that this is what should happen, and that is where we are. So you have got the intent and the direction of travel. I hope you will agree on the detail of Britain stepping forward, recognising that our baseline of where we are now is not substantial if we wish to participate on the global stage. The direction of where we want to go is very clear from this document, even if it does have a lot of pictures.

Q344 **Mr Francois:** For an SDSR, you normally get something nearly twice the size of this. You might say it's all very punchy and summarised, but it doesn't look like a deep piece of work.

Mr Ellwood: It is not an SDSR. The SDSR was provided in 2015. What this recognises—I said it in my opening piece—is that the profound change we are now experiencing required an additional study to recognise the threats. It requires us to take stock of where we are and what we need to do to change and mitigate those threats if we want to remain a major player on the top table and actually protect our way of life.

Q345 **Mr Francois:** The NAO produced an excoriating report on the Capita contract last week. It showed that every year since they have had the contract they have failed. They have been nearly 3,000 recruits short. It's a disaster. It's something this Committee has long been critical of. Now that the NAO has crawled over it and said it is not fit for purpose, when will you sack them?

Mr Ellwood: I am going to let Lieutenant General Nugee touch on the details because he has been very close to this, but let us put our hands up and say that recruitment has been tough. You have looked closely at this. You have been following this as well. We are haemorrhaging a couple of thousand people every single year. We need to recognise that. It has an impact on having the necessary engineers to put out on the ships and so forth, and it will come close to affecting operational capability. We are addressing this in a number of ways, which the General will touch on.

You also have to recognise the difficulty in recruiting in the modern-day context, but it comes back to the point that ultimately you need the Defence budget to make sure that we provide attractive policies, the necessary infrastructure, including accommodation, and the necessary kit, so that people will step forward and say, "I don't want that civilian job; I want to join the Army, Air Force or Navy." That is where we need to be, which is why a more honest conversation with the public about the state of national affairs when it comes to defence is most urgent.

Q346 **John Spellar:** People do want to join, but they are being held up for a year. Understandably, they are then going for those civilian jobs. Why, after all these years, has it taken so long for the Department to even start to scope the problem and get a grip of it?

Mr Ellwood: Well, the flash-to-bang time was a concern. The time it took for people to indicate that they would like to step forward to actually signing up or ending up in phase 1 training was too long. That is the first thing the Defence Secretary recognised, and work has been done. General Nugee will expand on that.

Lieutenant General Nugee: The report also says that the Army and Capita have made significant changes to their overall approach to recruitment and that we have gripped the problem and are making significant changes. Last week somebody went through our recruiting process in 22 days, which shows it can be done. That was on the pilot that we are running, which will report in January. We have now had more than one person. Somebody went through in 39 days and someone in 22 days. We have had five people go through in about 45 days. If we can get this time of flight right and we deem the pilot to be successful in January, we will roll it out across the whole piece.

We have changed the process. We have changed the standards, in terms of making it easier for the medics to understand them, rather than physically changing the standards. We still require high standards from our people, as you would expect. We have changed everything we possibly can about this. We have changed the centralised approach, which is what we introduced with Capita in 2012, so that we now have a lot of young role model soldiers going out and doing a piece that helps nurture those individuals who want to join the Armed Forces.

Mr Francois: But, Richard, you are still thousands short every year. You have been telling us all this stuff for two years, and the numbers of enlistments are not improving.

Lieutenant General Nugee: So—

Q347 **Mr Francois:** No, wait a minute. They are still not improving, and the NAO were very clear on that. On this contract, it is not so much that the Emperor has no clothes; the Emperor is stark bollock naked, frankly. For six years, Ministers have done nothing. When are you going to do something about the fact that you have a fatally failing contract, which is undermining the operational effectiveness of the Armed Forces? All you

do is make excuses for these people.

Lieutenant General Nugee: I disagree that it is fatally undermined. If you look at the figures of applications, Army briefings, people attending the assessment centres and enlistments, there is a bow wave coming through. It will take a bit of time, but it is coming through. From April, the applications have been significantly larger than they were 12 months before. They have been consistently larger from April. Army briefings have been consistently larger since June—that is when applications got through to the Army briefings. Assessment centres have been significantly larger since the autumn, and enlistments started growing in November. What we are not seeing yet—it will take time—are those coming out of our phase 1 basic training. That will take a bit of time, because we are only just seeing that bow wave come through the system. That bow wave has been entirely consistent since April, and applications have been up on the year.

Q348 **Mr Francois:** Last comment. Capita said that they will only hit the target in the last year of the contract. They will only actually perform to the contract in its 10th and final year. Isn't that disgraceful?

Lieutenant General Nugee: The Chief Executive, Jon Lewis, who I understand will go in front of the Public Accounts Committee, has made it a personal crusade to make sure this contract works. He has only been in a relatively short time, and he has every intention of following that through. He believes that they will hit the target next year.

Mr Francois: That's not what the CDS said two weeks ago.

Q349 **Ruth Smeeth:** We could do a whole session on Capita, given that they have met seven of their 240 KPIs, according to the NAO. That's a bit of a challenge. Minister, I am interested in the comments that were made about Joint Forces Command. We have waited a year for the MDP to be published. It is six months late. What we saw today was an announcement of a further review of a core function of our joint forces. What do you mean by a review? Is it going to be cost-led? Is it resource-driven, or is it actually about redeployment of resource? How long does it last? When will we see it? Is it CSR? Is it SDSR 2020? Are we still having SDSR 2020?

Mr Ellwood: The General has been close to this.

Lieutenant General Nugee: The JFC review is a review that builds on the success and strength of the JFC. It is designed to look at what we did six years ago in creating the JFC and ask whether it is still fit for purpose, given all the Minister spoke about, in terms of the changing form of warfare. We are looking at making sure its functionality is coherent. We are making sure the bits in the JFC are still coherent as part of the JFC, and identifying other things that are changing because the situation has changed.

It is taking an increasing role in the two new domains that the Chief of the Defence Staff said are in the MDP—space and cyber. How do they fit into the rest of the JFC? The JFC is changing because the situation around us is

changing. The idea of the review is to look at what its strengths are and how we can build on them, and make sure we have a JFC that is completely fit for purpose for the next phase of the way war is going.

Q350 **Ruth Smeeth:** But I asked specifically when we will have it. How long is it going to take?

Lieutenant General Nugee: I believe—I can check for you, obviously—that the report is coming out in the spring.

Q351 **Ruth Smeeth:** Who is leading on the report?

Lieutenant General Nugee: A senior civil servant is running the JFC review, but obviously it will go to the Chief of the Defence Staff, who is taking an extremely keen interest in this, and the permanent secretary.

Q352 **Ruth Smeeth:** So CDS is overseeing the full process.

Lieutenant General Nugee: Yes, and he is intimately involved.

Q353 **Graham P. Jones:** Whenever I speak to our Armed Forces personnel, they always tell me that morale is low. You have mentioned that retention rates are appalling at the minute. They cite things like pay, but particularly pensions, as exceedingly demoralising. That we do not reward our staff is their view when I speak to them. It is clear that the shortfall probably is an indicator, as in any market, that this is not an attractive vocation for the rewards that are offered. Do you accept that, Minister? Do you think that we should be improving the pensions and pay of our Armed Forces personnel in order to resolve the recruitment and retention issues?

Mr Ellwood: I agree with much of what you say. Pensions is not an issue. We speak to the families federations and use them as an important yardstick, along with other sources, to get an understanding of what the morale across all three services is. Pensions is not one that actually comes up. There are other aspects that prompt individuals to want to leave the Armed Forces. Pay absolutely is an issue.

Those who join the Armed Forces don't actually join because they want an awful lot of money. They don't do it for that; they join for other reasons. We don't want pay to become a reason why they won't join, and I believe we are reaching that point. Again, this fits into our case to be made in the spending review as to why the Defence budget should increase. We have a tendency to talk about operations, equipment and procurement, but the slice of the budget that the General and I are very much engaged in is the people piece. That means the accommodation and the shower blocks. It means the family units as well. It means the harmony guidelines. It's all these aspects that will actually allow somebody not only to enjoy the operational side of things, but to enjoy the life of the Armed Forces. What we are seeing is the importance of not forgetting that. This is why we are working hard—so that when we make the case that the budget needs to increase, it isn't just the operations and the kit that are on people's minds.

Q354 **Chair:** Before we move back to the main subject, I want to raise one

other point. Minister, you summed up in a recent debate on the Armed Forces Covenant where I and others raised the issue about the small cohort of war widows who lost their war widow's pension when they remarried and who have not had it reinstated—although, if they were to divorce the person they subsequently married, it would be reinstated, and, if they were to remarry that person, it would not be taken away. This is an extreme injustice, and I read out some pretty heart-breaking accounts of what it meant to the ladies in question. I don't expect a definitive answer from you this afternoon, but can you just assure the Committee that this matter—this dreadful anomaly—is being given active consideration both in the Ministry and in the Ministry's dealings with the Treasury, which is where I suspect the problem actually resides?

Mr Ellwood: I have hunted high and low to try to find the civil servant who came up with the idea that somehow if you divorce your—

Chair: But it's a logical consequence of the policy.

Mr Ellwood: This is what's mad. We cannot have a situation whereby if you divorce and remarry, you are suddenly able to gain the very pension that you have been seeking. You have raised this a number of times. You have raised it on the Floor of the House as well. I have met with the association on a number of occasions, as has the Defence Secretary. He has taken this issue to the Treasury to see what can be done to support change. We are still waiting for a response from the Treasury. I am grateful to you for raising it again. It is important that we keep this issue alive until we get a definitive answer.

Chair: I think that's the best we could hope for today. Thank you very much. We will move on at last—I would like to thank Jackie and Kate for their patience—to the main subject on the agenda. If you want to blame anyone, blame the MoD for bringing out a statement like that on the same day that one of their own Ministers was supposed to be talking to us about another subject. Leo will start off.

Q355 **Leo Docherty:** We turn now to the provision of mental health care to serving personnel. Minister, why are some of your Departments of Community Mental Health failing CQC inspections, and what are you doing to improve them?

Mr Ellwood: The inspections that you are talking about I think refer to Clyde, Brize Norton and Digby and Marham—is that correct?

Leo Docherty: Yes.

Mr Ellwood: Yes, you are correct. There have been some questions over the Care Quality Commission reports. The most concerning was that at Clyde. Having looking into this in detail, it is not so much about the direct support itself; it was more to do with an infrastructure issue, and to do with a manning issue. We are now turning the corner here by addressing that particular issue, but it does reflect badly. It is not the level of care that we would want to have, but, as I say, it has been drawn to our attention and we are rectifying the matter.

Lieutenant General Nugee: The important thing is that in every case the care has been deemed good; it is the piece around it that is not good, and was not adequate in the case of Clyde in March 2018. There has been a huge amount of work to try to improve all these issues as a result of the CQC reports.

We are very grateful to the CQC for pointing this out, and we are looking at a different way of doing business to try to make sure that this sort of thing does not happen again. We welcome CQC reports coming in to identify areas where things are lacking, but the most important thing is that the care itself was deemed good. I think that is something that we should bear in mind.

Q356 **Leo Docherty:** Staying with you, please, General, how do you monitor the contracted-out care for psychiatric bed provision?

Lieutenant General Nugee: Obviously, we pay very close attention to everybody. We put out to various organisations within the NHS, if they are not part of our own organisation, and we keep very close tabs on our individuals to make sure where possible that they stay—obviously we are talking about Service personnel—as part of the serving community.

Q357 **Leo Docherty:** Is there adequate mental health care support for personnel deployed outside of their own units?

Lieutenant General Nugee: Yes. They have access in exactly the same way as every other person does to a medical centre, or they can go direct—we are piloting self-referral—to the community mental health centres. If there is an issue, or somebody else refers them to it, they can go straight to a DCMH, if they do not go to a medical centre that refers them to it. The fact that they are not part of a unit should not preclude that. Everybody has a medical centre that they report to regardless of whether they are in a unit, or are outside the unit in a headquarters, or something like that.

Mr Ellwood: Could I add a comment on that, Mr Docherty? You raise an important issue regarding whether individuals are aware of what support is available. Historically, mental health has not been something that we have addressed correctly. The effort that we are now dealing with to make people conscious of where support can be found should they need it has changed fundamentally thanks to the defence people mental health strategy 2017.

In the circumstances that you are suggesting, I can easily see somebody who is going to a new unit, or perhaps doing an individual posting somewhere, not being familiar with where help might be found. We should recognise that a third of all of us during our lifetimes may experience some form of mental ill health. It is so important, whether you are in the Armed Forces or not, that you know where help can be found.

Q358 **Leo Docherty:** Does that care apply to civil servants who might be deployed to conflict zones?

Mr Ellwood: Yes, it does.

Q359 **Chair:** I just want to be clear about this—when you contract out care in relation to in-patients, for example, they go into NHS beds. Is that correct?

Lieutenant General Nugee: We provide additional support, and we pay for it, but we use the facilities that are available that are closest at the time.

Q360 **Chair:** So we are talking about the civil sector.

Lieutenant General Nugee: Yes.

Q361 **Chair:** Which would be NHS beds, or possibly private beds.

Lieutenant General Nugee: Yes. We do not have a very large in-patient capability within the DCMHs.[1]

Q362 **Chair:** This is where I hope we can bring in the civilian side to comment. We know that when someone gets grievously injured abroad, there are national trauma centres for these terrible physical injuries to be rehabilitated by specialists. Can I ask Jackie and Kate to explain what facilities there are within the NHS or, to the best of your knowledge, within the private sector that could approach this level of care for people who are grievously mentally injured?

Jackie Doyle-Price: I guess this will always be driven by clinical need. I am reading into your question a suggestion that there should be some kind of national centre.

Q363 **Chair:** I am wondering. Given the very specific nature of the trauma that Service personnel may undergo as a result of the terrible things they see when they are on deployment, is there not a case to be made, within either the military framework or the civilian sector, for specialists on a par with the specialists who deal with the grievous physical injuries sustained by military personnel?

Jackie Doyle-Price: We would invest in clinical specialisms relevant to mental health, and we would see it as a mental health specialism. Running through all our treatment is the idea that the best hope for recovery is where those who are suffering mental ill health have access to support networks. Most of the time, that is their families. We would look at where the person is going to be treated, rather than having a national centre. That said, you are absolutely right, Chairman, that there are particular challenges with PTSD and the trauma that comes from serving in operational theatre. It is fair to say that we still need to develop our understanding about that.

Q364 **Chair:** We have had evidence from individuals who said that when they started to explain what caused their trauma to civilian psychiatric staff, they ended up having to comfort the staff, because it was so upsetting to people who had no appreciation of the terrible events that had caused the trauma in the first place. General Nugee, do I see you straining at the

[1] Clarification from MOD: The MOD does not have an in-patient capability within the DCMHs, as set out in written evidence.

leash a bit? Wasn't there previously an acute in-patient facility within the military for this sort of thing?

Lieutenant General Nugee: That I don't know. It is before my time, I think. We have a contract with eight specific NHS trusts for this outsourcing. The analogy I would draw is with the wings of German hospitals. When we got rid of all our medical hospitals in Germany for the reduced number of troops that we had there, those wings had to speak English, and they had to understand the military. I would absolutely assume that these eight NHS trusts, which are led by the Midlands Partnership NHS Foundation Trust, will develop the experience and understanding of what it is to be military, so it will get significantly better. I read the transcript of those who said that they had had, in effect, to comfort those who were meant to be counselling them. Part of this is that we haven't suffered from this sort of trauma for a very long time. Therefore, what we need to do is make sure people are more aware of it. I think it will get better as more experience comes through.

Jackie Doyle-Price: As a follow-up to that, I think there is a genuine challenge, with regard to civilian mental ill health, caused by trauma. Trauma can be caused in other circumstances, too. I am thinking specifically about victims of sexual violence. We are having to really up our game to make sure we have that trauma-informed care running through the system when we are dealing with severe cases of mental ill health.

Kate Davies: Just answering the question about mental health needs and support for currently serving personnel, as Richard said, there is a current provision that is part of contracting. We have a number of trusts that support the care of serving personnel—both physical and mental health. One of the things that we have to review—we are reviewing it—is that we have more cases and presentations of people serving, where there are needs relating to mental health and trauma support. In many respects, that is a good thing. It is really positive that the culture of serving personnel and their families is shifting to saying, "I'm not coping. I have seen things that are giving me real concern for my health and my mental health."

I think it is also important to say that the Defence and National Rehabilitation Centre, as well as addressing the physical trauma of the wounded, injured and sick, also works on mental health and trauma. That probably has not been emphasised.

However, in all the commissioning that we are doing in the NHS and the work that has been explained in answer to other questions, we are completely taking on board that we need to commission services that are absolutely NHS, so far as mental health clinical standards are concerned, but that are also military—they speak Armed Forces. The majority of the services that we are commissioning and the work that we are developing in partnership with the MoD is about bringing together the strengths of the NHS to look at those unique issues for serving personnel. It was a serving question, so I will come back later on veterans.

Q365 **Chair:** But you do not have a specialist centre for the most acutely traumatised military personnel, whether they are serving or veterans. That is something that you would presumably expect the military services to supply.

Kate Davies: Not as a residential mental health requirement. As part of low, medium and highly secure facilities, there will be staff and there will be elements within that. I and Dr Leach, as my medical director for the Armed Forces, have done a lot of work on how we can increase the knowledge and support for particularly complex cases of serving personnel and veterans.

It is a debate that we have had. We are aware that, in the private sector, there are residential services that cite that they are specialists in treating serving personnel and veterans. That is to be welcomed. However, we do not want services that do not have regulations around their NHS and clinical care for veterans, as they would for anyone else.

Q366 **Chair:** But almost by definition, the ones who need beds—who need to be in-patients—will be the most severely traumatised. You would think that there would be a specialist unit somewhere within the medical universe, whether within the MoD framework or the NHS framework, to cater for such people.

Kate Davies: Within our low and medium-secure facilities for the NHS, we have certain facilities with more specialised areas for serving personnel and for veterans.

Q367 **Chair:** Where are they?

Kate Davies: Certainly, one of the low and medium-secure facilities in the East Midlands has a particular number of beds for serving personnel and veterans. It does exist. However, we do not have a national mental health residential rehabilitation centre that is exclusively for either serving or ex-serving personnel.

Chair: I've got Martin, and then Madeleine will come on to the question of how many uniform specialists we have.

Q368 **Martin Docherty-Hughes:** I will follow Leo's question on the DCMHs, specifically regarding Clyde. I know the Minister will say that overall care was good, but the big red flag that we have said previously in Committee is leadership, which was at that point "inadequate".

The CQC report says: "The management structure was not being adhered to at Faslane so that leadership roles were unclear. Morale was poor at Faslane and some staff were displaying destructive interpersonal relationships within the management and staff team. This was undermining performance and was not managed at any level." My first question is: what has changed about the leadership at Faslane since the report was published?

Secondly, the Lieutenant General talked about links with NHS trusts. Can you tell those of us from the other nations about the NHS structure and

connections—if they exist—with NHS boards such as Greater Glasgow and Clyde?

Mr Ellwood: The Lieutenant General can come back with the details of the steps we have taken. I do not know if it is the other way around. I think the overall label was "inadequate", but the tag for the caring domains was "good". That is why I touched on other aspects that lowered the band down from that perspective.

Q369 **Martin Docherty-Hughes:** It is a pretty important one.

Mr Ellwood: I do not dispute that at all. I also do not dispute the urgency of the requirement for us to get it back up to the standards that our Armed Forces deserve, which is what we are now doing.

Lieutenant General Nugee: Key concerns related to the structure, as I said, but also to staffing. A management action plan was put in place in Scotland to address that specifically. We asked the CQC to come back and look at it again after all the staffing changes we made there, to make sure that those criticisms that you rightly pointed out no longer applied. We await the report from the CQC and we will of course share it with you, if you wish, when we get it. I don't know when it is due, but that is up to the CQC.

Q370 **Martin Docherty-Hughes:** Given that there are major plans for investment in staffing in Faslane, what are the connections with the NHS structure in Scotland?

Lieutenant General Nugee: That I am not sure about, and I will write to you.

Q371 **Mrs Moon:** There seems to be a real problem with the offer you are making to uniformed mental health nurses and psychiatrists. According to the figures we have, in the last two years 25% of posts for uniformed mental health nurses were not filled. For uniformed psychiatrists, the figure has ranged between 55% and 70% below par in the last decade. What is going wrong? Why are we not attracting the people we need? What have been the consequences of providing civilian locums and personnel?

Mr Ellwood: The first thing to say is that the numbers are getting better. You said it is 25%, but it was greater than that in the prior two years. The trend is for us to improve, but you are right that we need to do better than this. The consequence of whether we are meeting our targets, such as the 15 working day target, is also important to look at, asking what impact it is having on those who need treatment. Again, it was 75%, but that has now crept back up to 91%. That is still not good enough. Our target is 95%, and that is why a plan is now being put in place to ensure that we get the necessary employment in place. Lieutenant General, do you want to add anything?

Lieutenant General Nugee: I would add only one thing, which is that there is a national shortage of mental health professionals. The NHS would recognise that as much as we do. We made one change to our recruiting

mechanisms in where we recruit. Previously we recruited in competition with the NHS. Now, we are recruiting with the NHS. It is proving to be more beneficial. By working in partnership with them, we have increased the number of people coming through into the military as a direct result of a different approach with the NHS on recruiting. There is a national shortage, and we need to be alive to that. We are doing our very best and it is improving, but we are not there yet.

Mr Ellwood: Can I just respond with a general comment? As we speak more about mental health as a society—not just in the Armed Forces—it means that more people are willing to step forward, which then places further pressure on the system itself. The system cannot therefore sit still. It has to respond to that, and that is exactly what we expect. I don't know whether you agree with that, Jackie.

Jackie Doyle-Price: I quite agree. It is great that we are raising awareness and tackling taboos, but that is generating a spike quicker than we can recruit qualified staff to deal with it. However, the direction of travel is going in the right direction.

Q372 **Mrs Moon:** But we also have increased numbers coming forward with high levels of need who are not being offered, and are not able to access, the help they need. I have the figures in front of me. We were doing quite well in 2010-11 in terms of uniformed mental health nurses. It starts to go down in 2011-12. It goes up again in 2012-13. It is now, in 2017-18, not looking good at all, but we have never been doing well at employing uniformed psychiatrists, so what is going wrong with the offer? It is not good enough that we are putting people into high-pressure, difficult situations without providing them with the service that they need within the service. We know they have a better response if they can speak to uniformed personnel about their mental health difficulties. What is going wrong with the offer? I appreciate the competition, but that means we should be even cleverer and even better with the offer we need to be making. What is wrong with the offer you are making to attract those people into the Armed Forces and keep them there?

Mr Ellwood: I do not think there is anything wrong with the offer as such; it is about not being able to keep up, as Jackie said, with the sudden change in people stepping forward. In addition, we have an issue to do with competition, and that has now been rectified as well. I heed what you say—we need to improve on this—but the direction of travel is positive.

Lieutenant General Nugee: Perhaps I can give you one statistic. In 2010-11, we had in the reserves a requirement for 20 mental health nurses. We now have a requirement for 70. That has gone up substantially in just six or seven years, and keeping abreast of that is quite difficult. That shows that people are coming forward, and that we need to have many more nurses, but it is also about ensuring that they are qualified and come to us. That is why we have changed our recruiting with the NHS, to try to ensure that we get the maximum out of that.

Q373 **Mrs Moon:** What level of experience are you looking for in the personnel

you employ?

Mr Ellwood: That depends on the rank, the band and the appointment.

Q374 **Mrs Moon:** At what level are you at your weakest? Are you weakest at new entry, newly qualified level, or are you weakest in terms of experienced consultants, for example?

Lieutenant General Nugee: That I don't know at the moment.

Q375 **Mrs Moon:** Perhaps you could come back to us with a table.

Mr Ellwood: We can do some analysis on the tables that have been put forward, and we can provide the information for you.

Q376 **Mrs Moon:** Thank you, because it is not enough to have capacity to recruit newly qualified doctors, psychiatrists and mental health nurses. You need people who are experienced in working with the most complex of needs. If we are not offering that, we are clearly failing quite dramatically.

Mr Ellwood: I agree, but the goalposts have also shifted, as the Lieutenant General just said. There is now a requirement for more nurses, and the base of support that is required is growing. We therefore have to respond to that as well.

Q377 **Mrs Moon:** Hopefully, people are coming forward earlier, so you will be offering a different level of need and treatment. That is fine—I understand that. Our concern is that those with the highest level of need are not necessarily receiving the quality of care and support they need. Sometimes, people are even being discharged from the Services, and end up being passed into civilian mental health services that are not equipped and do not understand the trauma that many people may have experienced and which led to their mental health difficulties.

Mr Ellwood: I think that the crossover we are now doing with the NHS and the MOD has rectified that, but that was a concern to raise. The fact that we are here together is a reflection of that as well, and our target of seeing 91% of those who are required to be seen shows that even though we are pressed on the manning, at least the support we are providing is there.

Q378 **Mrs Moon:** Have you improved on provision for those reservists who come back from service—people who have been deployed and then go back to their community, where perhaps those mental health problems begin to be experienced? Are they getting the help and support, as reservists, that they should be having, and are you tracking the mental health needs of your reservists?

Mr Ellwood: Whether they are reservists or regulars, the studies we are doing on those who served in Iraq and Afghanistan mean that they are contained in that study. So absolutely, yes, they are. They go through exactly the same programme of decompression and being checked up on 12 months afterwards, or perhaps they are on a programme anyway. People remain reservists unless they have signed off, and even if they

have signed off they are still a veteran as such, in which case they are part of the programme. We have three or four programmes that look rather similar, depending on whether someone is an active regular member who has not been to the frontline, someone who has been to the frontline, a reservist who has or has not been to the frontline, or someone who has moved into the veterans space. Each area will have a process to ensure that if mental health provision is required, it is there. I think we need to focus more on ensuring that individuals know where to go to get that support.

Kate Davies: The question of reservists is really important. It is one of those areas where we have had to be more proactive, particularly as part of the services we are commissioning within the community for civilians, and it is about what that means for men and women who are reservists and who also access generic GP services. Some of our work on primary care is to emphasise the needs of families and reservists, because sometimes that is not necessarily as well understood. Certainly, as Mr Ellwood was saying, the cross-pollination around some of the men and women working in defence medical services as reservists, and those working in the NHS as clinicians, has been really important, not only as part of helping with their own personal needs, but in how that helped us with some of the training and correspondence. Certainly, you have challenged me when I have been in front of you before about how we communicate to make sure that generic NHS services are much more aware. We have been doing a push for reservists particularly.

Q379 **Mrs Moon:** Thank you for the recognition of the support that is needed within families, who are often the first to realise that there is a problem. Giving support to those families is absolutely vital. Thank you also for recognising the particular need for NHS medical staff, and reservists and full time, in medical services on the frontline.

Kate Davies: I completely agree. Often, we hear from the families first, particularly in general practice. It is often the coaching and the support that then mean that other men and women, whether they are reservists, veterans or on leave, and while serving as well, are accessing different supports. We work very closely to support those people.

Q380 **Mrs Moon:** May I clarify something? Whenever we went to Camp Bastion and we went to the hospital, the services there were stunning—they were excellent. You could not have asked for better quality medical care. It was superb. What about the mental health support in theatre? Is it now there?

Secondly, do you practise when you are taking part in training exercises? Are mental health services available there? Do you follow it through so that people are aware in training that mental health services should be accessed even when you are on operations, and are they physically there on operations?

Mr Ellwood: What you saw in Camp Bastion was quite exceptional. It was created over a number of years of us being committed there.

Mrs Moon: And also in the Queen Elizabeth.

Mr Ellwood: It is unusual compared with the field hospitals in the process that you would go through from picking an injured person up and then moving them through the various stages until they finally get to a CASEVAC situation. There, they are whisked off the battlefield. Often, normally, they would have died, but they are kept alive because of those amazing facilities that you saw there.

The same support is provided—was provided—from a mental perspective, so we had psychiatrists out there as well. Without going through the details, which you might be familiar with, there is now an awful lot of pre-op preparation and there is also a decompression period that comes afterwards. There is the support available to deal with those aspects to do with the mind as well as the physical injuries. Lieutenant General, do you want to add anything?

Lieutenant General Nugee: All three Services are working extremely hard on mental resilience right from phase one training so it becomes part of what we have called mental fitness. You do physical fitness and mental fitness at the same time during training. It is introduced, with each of the Services having their own operation—OP SMART, OP SPEAR and, in the Navy, REGAIN—to try to build a complete environment whereby they understand that mental health is important and they know where to go if there is an issue. We top that up just before deployment.

We recently looked at mindfulness, as a direct result of Tim Boughton, who I understand came in front of you, coming and chatting to us. We are going to try to introduce mindfulness in the right way across defence. That is work in progress; we have not got there yet. We are trying our hardest to try to get resilience—mental resilience—into our initial training and our pre-deployment training.

Q381 **Graham P. Jones:** What criteria do your clinicians use for deciding when personnel who are provided with mental health care can return to duty?

Lieutenant General Nugee: It depends on each individual. We need to make sure that they are signed off as mentally fit in order to be able to return to duty. It depends on each individual as to what the criteria would be, but every individual is signed off as mentally fit before they go back to duty.

Q382 **Graham P. Jones:** But what criteria do you use—in a bit more detail? They are fit for duty, but how do you assess them?

Lieutenant General Nugee: There are medical standards that I am not particularly familiar with.

Mr Ellwood: Would you like a copy of the medical standards?

Graham P. Jones: I would suggest that you send them to the Committee. That would be helpful. With the approval of the Chair, of course.

Chair: *indicated assent.*

Q383 **Graham P. Jones:** To press you, what care is provided to those who are identified for discharge as a result of their mental health conditions?

Lieutenant General Nugee: The most important change that we, and the NHS, have made is the TIL— Transition, Intervention and Liaison— Service, where we, as early as we can but at least six months before, warn the NHS that there is an individual who has mental health issues, so that they can link directly to the local NHS trusts or the local GP. That is the first bit of it, but actually quite a lot of our people do not know where they are going to end up, and so sometimes that bit is less than six months.

Most importantly though, once they have discharged, the NHS has picked them up. The NHS has absolute ability to come back to us for six months, and they have the ability to go to a DCMH for two years, working in conjunction with the NHS.[i2] We have tried to create at least a year of seamless transition between us and the NHS for any service person who is leaving as a result of mental illness.

Mr Ellwood: There is the personal recovery unit, and something we call a personal recovery plan for individuals who we know will be affected for a long time. They are given particular attention and monitored. Their records are also transferred directly across to the NHS to make sure that they are not lost in the system. I am afraid that we learned this the hard way, when those coming back from Iraq and Afghanistan did disperse into the civilian streets, and they were not getting the necessary support that they deserved.

Graham P. Jones: I was going to come to that issue. How many people do not fall into the safety net? How many people do not make a smooth transition to the NHS, and what do you do for those who are not in the safety net that you provide?

Lieutenant General Nugee: One of the most important things is that a Service person who has been part of the Defence Medical Services and therefore is not part of the NHS is registering with a GP, and making sure that they bring alive to that GP when they register that they are a veteran. That is something that we are working on. I recently saw some extremely good documents from the NHS about how to get the most out of your GP if you are a veteran, and I have just asked that that goes to every single Service leaver as they leave, and also in the Service leavers' book.

We have to make sure that all our Service leavers register with their local GP, and then the NHS knows about them, but it is not compulsory for members of the general public to register with a GP. It would be very difficult for us to make it compulsory for our Service leavers to register with a GP because it would be against the whole way the general public are dealt with. However, we very strongly encourage it.

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[2] Clarification from MOD: Service leavers have the ability to go to a DCMH for up to six months post-discharge, working in conjunction with the NHS, as set out in written evidence.

Mr Ellwood: Jackie might want to add to this, but there are now more and more GPs who call themselves "veterans friendly". They are more familiar with the veteran environment, therefore anybody who has Armed Forces connections should obviously migrate that way.

Jackie Doyle-Price: It is also worth reflecting that we have introduced this service as part of the five-year forward view on mental health. It has been running only since 1 April 2017. We recognise that in the past we have not always been great at this, but so far we have had 4,500 people leaving the Service going through the system. I am confident that we are getting better at it, but that is not to say that I am complacent. We owe it to our people leaving service to put the right foundations in place for them.

Kate Davies: It is important to say that the Transition, Intervention and Liaison Service was developed because Service users, patients—both serving and ex—and their families said to us that what was missing was that connectivity when you are still serving, and what that meant when you know that you are going to be a civilian. Also, quoting many of those people, and I spoke to a gentleman only last week, it is quite scary to come out of serving and into "civvy street", not knowing what to do about a GP, and not knowing what to do about some of the elements that you have had done for you before.

Though it is rightly focusing on transition, it is also going back to colleagues' questions about what happens if they fall through that safety net. We are finding that many of the men and women who are coming forward, and we need to state also that 7% of that number are women, are coming forward in two years, usually—well, I suppose we are not even into two years, but they are coming in much sooner.

When we modelled the service, we said that we would know that we were successful when we were getting much less distance between someone who is non-serving, ex-serving, and someone who is leaving. That is absolutely one of the things that we are monitoring at the moment, and we find that the more complex cases are also particularly in a certain age group and coming through when they have served less time per se—that is, they are discharged sooner. That is something that we are really conscious of as part of the complexity.

Q384 **Graham P. Jones:** So 4,500 people have been through. What numerical assessment have you made of the success so far?

Kate Davies: That is a really important question. None of our NHS services is contracted without that data. This is the first time that we have numerical data but also some of the elements we are developing around output and tracking of individuals. So we are absolutely aware that, of the referrals that came through the front door in the first 18 months of transition, intervention and liaison—or TIL, as we call it—73% have been seen as appropriate for assessment and referral. For some of those men and women, it may be a question of brief interventions or advice or support. They go on to a face-to-face assessment. We know exactly how

many of those are now attending our face-to-face assessment and then how many of those are part of long-term co-ordinated care packages. We also have the breakdown of how many receive clinical appointments, so we will be very aware of the number of clinical appointments that are being attended and how that has affected patient discharge.

Those are numbers; those are statistics. What is really important is the quality of the services. The other thing that we have done is to set up a robust lived-experience patient and public involvement group.

I will just say, because this was brought up by my colleagues earlier, that one of the things we designed in was how military records were to be shared as part of the transition. Some of the guys I have been speaking to in the last couple of weeks have been saying, "We don't know why our military records are being shared. We're actually a little bit cautious about our military records being shared." So we are also looking at how we explain that better within the initial assessment period. Some people feel a little bit sceptical about it, and we realise that we may need to just restructure some of that communication.

Mr Ellwood: I am holding two of the flyers that you now get in hospitals—I can leave these or get copies to you—which explain to veterans the 12 steps in order to gain better treatment and recognition of their background, as well as an understanding of what the Transition, Intervention and Liaison Service, in addition to the mental health Complex Treatment Service, can provide. So it's spelled out, to those who may not be aware, that there is this support available. Again, it's one of those things where, from a mental health perspective, you may not be aware of what has gone on and may have ignored the requirement for mental health support until way after you have left, so providing this material and having better engagement with the hospitals and GPs is, I think, a huge step forward.

Q385 **Graham P. Jones:** You are quite perceptive about my line of questioning. I wanted finally to press this point home. What do you do for those who turn up rough sleeping, who turn up dishevelled at a community drop-in centre and who are perhaps living a dysfunctional or marginal existence? I think you gave the figure of 73%. Isn't part of the 27% at the sharp end of this? What are you doing for those who are not within the transition between the Armed Forces and the NHS and have, effectively, dropped out? What efforts are you making to reach out to the very last person?

Kate Davies: Our figures very clearly show us, and quite rightly—I am quite a stickler for this—that the service is there for anybody. It doesn't matter if someone is 20 years ex-serving. Quite often people are fine and then they might hit a blip because of a relationship breakdown or employment issues. Absolutely those services are there for all people in all circumstances.

It is really important to say, as you are questioning me on what that means around some of the complexities, that we are absolutely aware that

the capacity coming through to those services is something that we didn't expect, and some of the complexities are at a higher number than we expected as well. That is why, as Jackie said in her opening statement, through the long-term plan we have recognised that there needs to be additional investment but also the increase in the framework of services, including crisis intervention and intensive services, for some of those men and women who may be at more risk personally and also who come to us because of blue-light services or because of their personal circumstances. That is absolutely part of our developments going forward.

Q386 **Graham P. Jones:** You touch on those who are probably at greater risk—perhaps those in specialist roles in the Armed Forces, such as special forces and bomb disposal units—and their access to mental health care. What are you doing to support those people once their career comes to an end? They are at great risk of developing some mental health issues or flashbacks from their experiences during their years of service.

Kate Davies: Many of those men and women come forward, and we do not know that. They come forward with their personal stories and we are then aware of their situation, maybe as snipers or as bomb disposal or in special forces. Actually, I was going to highlight in my answer to the previous question that my team are currently doing work with special forces to look at the model of care and pathways of care, because it is really important that we look at where there are different elements; where people's time and employment may affect the way that they then access services. I am sure you understand the sensitivity of that, but that is something that we are also doing that is unique to the needs of some of the people who have served and their experiences.

Mr Ellwood: May I invite the General—because I know he has been close to this—to talk about the Marines' pilot scheme? It touches very close to what you are talking about.

Lieutenant General Nugee: In terms of self-referral, we are trying to encourage people to find any avenue to be able to bring concerns to somebody's attention. Whether they go to a GP, a DCMH, or whatever it is—wherever that individual feels comfortable presenting and saying, "I've got an issue"—we will try to push it through to the right position.

There is, I would argue, a slight misperception that people are unwilling to talk about it because of security issues. Most soldiers, in my case, would know what is a security issue and what is not, and if they have a mental health issue, they do not necessarily not come forward because of a security issue. They will leave that to one side and they will still come forward with mental health issues, but we are trying to make it as easy as possible to find as wide a funnel as possible to get people into understanding where mental health can be dealt with.

Q387 **Chair:** I think it was the great Second World War commander Viscount Slim who made a radio broadcast saying that even the bravest of individuals has only a certain amount of resilience and reserve mentally, and if you are not properly rested, you can only overdraw your account—

as it were, using a banking analogy—to a certain extent. Otherwise, the bravest people will go under. That then raises the question of whether or not, just as we allow people who are physically exhausted a period to rest and recover and sometimes even pause their career, we should do the same for serving personnel who are mentally exhausted.

Lieutenant General Nugee: I am a strong believer in Lord Moran's well of courage, which he talked about in the Second World War. That is another way of putting the same point: if you draw too much water out of the well, you will absolutely end up exhausting somebody and their resilience will break, however brave they are. I absolutely agree with that as a sentiment.

Q388 **Chair:** So what do we do structurally to allow for that and make sure we do not lose some of the best people?

Lieutenant General Nugee: The irony is that in mental health circumstances, sending somebody to recover at home is probably one of the worst things you can do, because they need to have a degree of continuity. You rotate them out if that is necessary; we aeromedded people out of Bastion. Interestingly, they were very reluctant to do that. That is why we have allowed this idea of self-referral straight to the DCMH: some people do not want to self-refer in those circumstances, because they know they will be aeromedded out and they do not want to leave the theatre and let their mates down.

There are complications here with a mental health issue which there are not with a physical health issue, but as you are well aware, we are introducing flexible working come 1 April. Should that be the answer, that will be another opportunity to allow people a slightly lesser work rate in order to be able to recover, but still keep them in work, because that is seen to be a good thing for their mental health.

Q389 **Chair:** Are you satisfied that the message has got through to some of the bravest and best people in uniform that if they come forward and say, "Look, I can tell that I am overdrawing my well of courage"—mixing the bank metaphor and the other one—they can do so without permanent detriment, or indeed any detriment, to their military careers?

Lieutenant General Nugee: The Royal Foundation and the princes have done an enormous amount about stigma. I think there is less stigma, but that does not mean that there is no stigma. People are still nervous of it. Despite every protestation that they will be looked after and their careers will not be damaged, people still believe that their careers might be damaged and therefore they will be nervous about doing so. Whatever we do, we must continue to communicate that message.

Q390 **Chair:** Here is your chance to broadcast that message loud and clear to all the members of the Armed Forces. If you feel yourself overloaded in this way, what should you do?

Lieutenant General Nugee: You should go to the medical centre or you should go to a DCMH and you should be checked out, if you are serving personnel. If you are a veteran, you should go to the NHS. You should go

and seek help—that is a very strong message—and you should be properly assessed as to what the situation is.

Q391 **Chair:** If it is simply the case that you are in need of a respite, that will not harm your future career.

Lieutenant General Nugee: We put people on light duties for a sprained ankle, or whatever it is, in the physical sense. We can and do do exactly the same for mental issues. We need to make sure that that message is understood both by our doctors and by the individuals.

Q392 **Chair:** Is it clearly understood throughout the various units of the Armed Forces that they should have this regime in place and that they should not disadvantage anyone who comes forward?

Mr Ellwood: We promoted this at every single level in all three Services all the way down, including every ship's captain and every platoon commander, to say, "Look out for each other. It is okay if you are not okay. You can go and get support for that without any detriment to your potential career, promotion prospects and so on." That is different from General Patton's view of life. He had a very different approach to all this.

Chair: Indeed. He was a great man, but not in that respect.

Q393 **Martin Docherty-Hughes:** Having Kate here is great, but it places a few of us around the table at a slight disadvantage. I am looking for some expansion in terms of the Service transition booklet and ensuring that there is appropriate signposting to how you transition in the other nations of the UK. Kate, you might have an answer to this. How are you working with your colleagues in the other NHS structures? I can only speak for Scotland in terms of the approach to the mental health action plan for long-term delivery. Are you able to add anything to that? Does the MOD even know about it?

Lieutenant General Nugee: On the first question, I checked whether we could produce something exactly the same for the NHS in Wales, Scotland and Northern Ireland. The answer was, "Yes, we can, but we need to do the work to ensure that it is properly received when we get there, because this was an NHS England initiative. It was not our initiative." We need to ensure that the other NHSs are properly identified and can help us on that.

Q394 **Martin Docherty-Hughes:** First, it was the NHS that came to you; it was not the MOD that recognised that there might be an issue in terms of transition back into civilian life.

Lieutenant General Nugee: No, that would be a misunderstanding. The Transition and Intervention Liaison Service is an NHS system, but one of the great things about this strategy is that it was written in very close co-ordination with the NHS and the Department of Health and Social Care to ensure that it was agreed by both of us, rather than it being just an MOD thing thrown over the fence to the NHS or vice versa. I was referring to the two pieces that the Minister held up, which is a specific thing about how to get the most out of your GP from an NHS perspective. That is an NHS document that I am now saying we must give to every individual who

leaves the Armed Forces. Obviously, that document is an NHS England initiative. We therefore need to ensure that it is relevant in Scotland, Wales and Northern Ireland, too.

Mr Ellwood: It is an important point. If you are in Kinloss, Lossiemouth, RAF Valley or Brize Norton, you need to know where the support will be, 24/7.

Kate Davies: The good news is that we have had an Armed Forces Partnership Board for the past four years, and it includes Devolved Administrations. The national Government has rightly made sure that the equity and the needs of all MOD personnel are part of how we work across Devolved Administrations. We have done a lot of work with our Welsh colleagues, sharing information and supporting what that means. There are very different issues because there may well be a smaller access point or a different way of commissioning those services, particularly from the Welsh health board.

That is something that we have done year on year, particularly for Scotland. I have worked very closely, as have my team and Dr Jonathan Leach, with the past Scottish Veterans Commissioner. In fact, we were joint writing a lot of our plans and strategies and sharing them, going backwards and forwards. We had a very productive meeting in Glasgow only a few months ago, and other teams have been up.

New commissioners have just been appointed and I have set up a new meeting for early in the new year. What is really important is that we do not reinvent the wheel when there are things that work and things that we can share. It is really important. Again, going back to the family point, it is the families that tell us more than anything else. There are no boundaries when it comes to where people are based or where they might be being re-based from, and that is something we have had to do very much across the Devolved Administrations. And my colleagues ask me questions, particularly on Northern Ireland in the past, which I know is pertinent.

Q395 **Ruth Smeeth:** I want to take us back to continuity of care for people who have been militarily discharged for mental health reasons. How do you ensure that care continues across from the military into the NHS? How do you make sure people do not fall through the cracks as they transition?

Mr Ellwood: It depends on whether they are leaving with a mental health concern.

Q396 **Ruth Smeeth:** If they are discharged for mental health reasons.

Mr Ellwood: I touched on that before. It is an individual recovery plan that will stay with them. They will be looked after for a period of time by the MOD and then handed to the NHS to make sure that care continues.

Q397 **Ruth Smeeth:** But what if they have not been discharged for mental health reasons and symptoms start to appear afterwards? Help for Heroes has published evidence that suggests people first start to ask for help 12 months after discharge, so that does not help with the six

months where they have a level of support from the military. How do you make sure they access the right level of support?

Mr Ellwood: Twelve months after, we touch base with them. We are doing that much more proactively to see how they are and whether they have shown any signs whatever. We are now making it clear that we want to catch up with everybody who departs: 14,000 or 15,000 or so each year. We now get back in touch with them after 12 months.

Q398 **Ruth Smeeth:** How? Talk me through the process. If I am 12 months into being ex-Service personnel, how do you contact me?

Lieutenant General Nugee: If they have consented—not all do, because some do not want anything more to do with us at all, and I understand that—we use the latest address that we have for them, either email, telephone or physical address, to get in touch with them through Veterans Welfare UK, which is an MOD responsibility, to ask them if they are okay and to see whether there is anything we can do to help them. We write to them effectively either electronically or physically after 12 months. We give them as much as we can—if you need to get in touch with us, please come back to us with whatever your issues are.

Also, the Veterans' Gateway are about to start a proactive programme of going out to people that they are aware of who have come to them with issues and who have given their consent, and they say, "Are you still okay?" What I would like to do, but we have not done yet because it is a pilot, is be able to do that for everybody. We changed the law with GDPR to allow us to access the contact details of everybody who has left in order for us to be able to build a regular reserve that actually had teeth, and in order to be able to answer the MDP, which the Minister talked about earlier.

We have not yet broached that with HMRC, but we could use that because we have access to those details. We could broach that with HMRC to allow us to access those details for other reasons as well, apart from just the regular reserve, but we changed the law for the regular reserve.

Q399 **Ruth Smeeth:** My concern would be that a letter from you 12 months after I have left the Services will not necessarily inspire me. If am just beginning to display mental health challenges, that is not how I will access support from the military.

Mr Ellwood: Like anybody, as a civilian you have the option of talking to your GP as well, and referring yourself in that sense. Again, people now leave with a greater understanding—I illustrated some forms and so forth—as they re-engage with the civilian world of where support can absolutely be provided. It would be great to have a service that is far more hands-on, but given the scale of what we need to manage and the fact that we have a civilian NHS capability that is second to none, we have to utilise that.

Q400 **Ruth Smeeth:** You speak to as many ex-Service personnel as I do. As soon as they access NHS services—Kate and I have had this

conversation—they view themselves as in competition with people who are going through other trauma. There is absolutely no way that a former Serviceman or woman, if they think that they are in competition to access resources with a child who is having a mental health breakdown or someone who has been raped, will not immediately—because this is what we train them to do—think, "Those people should be in front of me."

That is my concern. The new system is yet to be tested, really, to see whether it is working or not, but all former serving personnel I have spoken to—obviously, most of them who we all communicate with are well past two years—believe themselves to be alone as soon as they have left. If it is directly via their GP, they do not believe that they have this support network around them. That is my concern—the transition from one to the other.

Jackie Doyle-Price: Recognising that is where we have got to with this service, actually. We know that we need to create a bespoke culture that makes veterans realise that we have services directly for them, to take away that competition. However, with the greatest will, that needs to become embedded so that people view that as business as usual.

Kate Davies: The commissioning of the Complex Treatment Service has been key. It has only been going for six months. It is very new, and we will undoubtedly increase the capacity for that service, and the capacity for intensive support and care. That was something that was being evidenced to us very quickly. Of the 300 people who have been seen in under six months, 96% have been seen as appropriate for complex treatment. That is a very high percentage.

We also need to be clear that the Complex Treatment Service is about mental health and complex problems. It may be depression and anxiety; it might be PTSD; or it could be rape or other complex issues, particularly around alcohol and drugs where it is also related to former serving. There is something there that is particularly for those men and women. That is something that has been influenced by those conversations.

Q401 **Ruth Smeeth:** My experience of the veteran communities is that they are much more likely to access service provision through a local tri-Service veterans centre, and through the third sector. How are you communicating with the third sector? It is very easy just to deal with the national charities. They are all brilliant—I do not want to dismiss their role at all—but in my community you are much more likely to go to your local tri-Service veterans centre to access help, and then be escalated up to the national charities, than the other way around. How are you ensuring that comms are spread at the ground level in communities?

Kate Davies: I am very pleased to say that NHS England, which takes our commitment to the Armed Forces and ex-serving communities very seriously, are now commissioned to have a specialised comms support, which has been invaluable when I have been challenged on how that message gets out. That has been very proactive.

I also have to say that family networks are really important. One of the things in the long-term planning is increasing the amount of local family networks and local networks, because I think that is crucial, as well as working with Help for Heroes, the RBL, SSAFA, Combat Stress and so on.

The other bit is that all of our service commissioning is a collaboration with the third sector. Although they are contracted as the prime providers to an NHS trust, they are also, as part of the specification, in collaboration with the third sector. That has been invaluable, and we need to grow that over the next few years, because the employment, housing and relationships element is often best served when you get a collaborative multi-agency approach. You do get, "I feel someone understands my situation." However, you are also living in Hull, Bristol or Stoke on Trent, and you need to know where those local connectivities go.

Jackie is right: this is early days. We are not going to pretend that it is not. I want to also say, on the question of people coming back after 12 months, we need to accept that some people come back because it is distance from the military and it is distance from the Armed Forces. Some of our patients absolutely want to have that anonymity and some of that distance. It is absolutely important to have the understanding. It is also important to sometimes make quite sure that people have that distance and their own confidentiality.

Q402 **Ruth Smeeth:** I have one final question for the Minister. It is difficult having two Ministers. It is for Tobias. On the issue of Armed Forces compensation awards, there has been a great deal of concern that if you are trying to access for mental health issues it is almost impossible to get any funding from it. Is it under review, to make it easier? This could be for Lieutenant General Nugee. Is it under review to make sure that we have parity?

Mr Ellwood: Yes, it is. A recent submission has come through, so I am just confirming. Can I write to you with more details of what is going on? I came close to this myself in my own personal experience as well, so it is something that it is important to get right. If I may, I will write to you.

Q403 **Ruth Smeeth:** Parity of esteem has to be parity of esteem for this purpose.

Mr Ellwood: Completely, yes.

Lieutenant General Nugee: The only other point on that is that because of the comorbidity between mental and physical, all medical discharges automatically consider an ill health pension award, which includes mental health. They consider that as part of the piece. I think we are learning. We are getting better, but I accept your point.

Q404 **Gavin Robinson:** I apologise because I shall have to withdraw. I will piggyback on the question. Kate, drawing on your comments about the partnership board, I personally find it unsatisfactory—not about you but the process—that we get strong evidence from NHS England or a Minister who is directly responsible for NHS England and the same is not the case

for our devolved nations. You have a close working relationship with them. Can you offer us any indication whether during that partnership board you have had the chance to probe or challenge—or to share your work—in a way that would bring an end to a situation where even a nine to 52-week period for assessment and treatment of someone with a mental health issue is not being met? The Royal College of Surgeons briefing suggests that there is a high number of cases in Northern Ireland of individuals waiting beyond the 52 weeks before they get satisfactory treatment.

Kate Davies: Obviously, I cannot speak for the treatment and commissioning services in Northern Ireland, but we have had conversations and recent correspondence, because of the partnership board, in the last six months. What is really also very important is that there is a different community access point and feel for some of the personnel and families, particularly in Northern Ireland. What we have done—this is alongside the answer I gave to Martin Docherty-Hughes—is share the work we are doing around GP accreditation and hospitals and Veteran Aware. How do you increase the baseline knowledge of generic services to support the needs of ex-serving personnel and the families of serving personnel? Certainly, our Northern Ireland counterparts are interested in supporting the GP accreditation programme and looking at it in more detail.

Q405 **Gavin Robinson:** Obviously, Minister Ellwood, you are responsible for implementation of the Armed Forces Covenant. I know it is a requirement or a duty that you take seriously, but I am struggling because we are trying to get a similar standard of service. That is why we are providing this scrutiny and attaining accountability. You could hear from that exchange the difficulty in ensuring the satisfactory delivery of mental health provision for veterans in Northern Ireland. You will also remember that I shared with you before the policy of the last Minister of Health in Northern Ireland that the Armed Forces Covenant does not apply here. During this inquiry we have had evidence from Combat Stress who, when I challenged them on the proportionately low service they provide in Northern Ireland—one clinical psychologist and three community psychiatric nurses—answered, "The LIBOR funding we get isn't for Northern Ireland, and actually we use our contributions to give support to the Province." How do you, as the Minister responsible for veterans across the United Kingdom, ensure that there is parity of LIBOR funding and parity of service, and that we have the ability to rigorously challenge the mental health provision and the health provision in Northern Ireland?

Mr Ellwood: That is a really good question. As you are aware, I have been engaged in what is going on in Northern Ireland. Having served there myself, I am pleased with how it has advanced and the support that is provided for our veterans, but there are a unique set of circumstances that you will be more familiar with than anybody else.

In my visits, we have worked on a bottom-up approach, which seems to be successful. It is a challenge, because there is no Assembly for us to work with at the moment, but in meeting the Covenant team, they made it

very clear that anybody requiring the necessary support should get in touch with them and they can make it work on a local basis through the new council structures and so forth.

What I have promised to do as well, to follow up further conversations with some of your colleagues, is to return back to Northern Ireland to see what more we can actually do to advance the process to make sure that LIBOR funding, which was never going to be around for a long time—people use this term and forget where it actually originated from; you cannot keep fining banks for what happened in perpetuity—

Chair: Why not? *[Laughter.]*

Mr Ellwood: Invite the Chancellor here and you can ask him that. The purpose, though, is that the funding was always going to be limited, and it was always important that wherever it went to, it was seen that it would be capped and that there had to be a plan of continuity once the funding had ceased. That absolutely applies no matter what project you are doing in whatever part of the country. I am more than happy—I think we will do another visit in the new year—to explore that further as to what more we can do to help.

Q406 **Gavin Robinson:** Thank you for that. I think you recognise that I have questioned you previously on ensuring that there is continuity of funding for services beyond LIBOR. That is important. In a hearing where I share a report that indicates that even the 52-week target for assessment and treatment is not being met, I am sure you share the same level of respect I have for that report. Given that you share that, is the answer simply that you need to contact RFCA Northern Ireland? Is the answer simply that if you want to obviate that—

Mr Ellwood: I will let Kate explain the details of it. In the more general aspect of the Covenant process, that would be the advice. There was a bit of frustration that some of the politics of what is going on in Northern Ireland is overshadowing the good work that is taking place. You just need to know how to access it.

Kate Davies: On the issue around mental health services, although LIBOR funding has absolutely been very supportive, it is NHS England that has funded the mental health services. Actually, when we are looking at clinical support as well as therapeutic and multi-agency pathways, it is for Devolved Administrations—I know this is something that Scotland has been doing as well—to look at where they are not relying on services that are not necessarily being commissioned through clinical contracts.

Lieutenant General Nugee: May I make one point really clear? The Armed Forces Covenant does apply to Northern Ireland, and I put that on record. Therefore, the Armed Forces Covenant trust fund provides specifically for Northern Ireland and has done a number of projects there. That is in perpetuity, or that is how it was set up. Although it came out of LIBOR, it was in perpetuity, and Northern Ireland has access to that.

Chair: I will make a couple of housekeeping points, because we lost the

first 30 minutes on other areas that we felt we had to deal with today. We will not reach the end of our allotted series of questions, so we will have a number that we will write to you about afterwards. I hope that is acceptable. What we will do is consolidate about four more topics in just over a quarter of an hour, albeit we may run over by a few minutes. I will take Martin next, then Madeleine, then Mark and then myself. If time permits, I will, as I usually do, invite the members of the panel, if there is any particular last point or two that they would like to put over to us, to do that as well.

Q407 **Martin Docherty-Hughes:** I have a specific question. We have heard that a trigger event for the mental health of some veterans could be the anniversary of a particular attack on their unit, say one that led to multiple casualties. What are you doing to identify and support such groups, who might be at more risk at particular times of the year?

Lieutenant General Nugee: We became aware of what I have called a cluster—it is a clinical term—around a particular unit. Using that as a mechanism, I have asked that we identify what units would be particularly susceptible at particular points of the year. We are gathering that information at the moment. Once we have that information and we work out what units would be most susceptible at certain times of the year for particular operations or particular incidents, we will work out how we deal with that. I do not have an answer for what we are going to do. We have started the process of amassing the evidence on how much, what and when, and then we can start to work out what we are going to do about it.

Q408 **Martin Docherty-Hughes:** Would anyone else like to comment?

Mr Ellwood: I think the Lieutenant General did brilliantly, so I will leave it there.

Q409 **Martin Docherty-Hughes:** Once that has concluded, could you write to the Committee to let us know how it has gone?

Lieutenant General Nugee: Yes, but I do not know how long it will take to amass the evidence.

Q410 **Martin Docherty-Hughes:** Kate, if I could go back to the Transition, Intervention and Liaison Service, do you believe that it has been operating effectively in the 18 months since it started?

Kate Davies: What has been really important is bringing in the Complex Treatment Service. Without that, the pathway of some of those more complex needs, and NHS England's commitment under the mental health five year forward view to having more complex treatment available close to home for an unlimited period of time, depending on individual care packages, would have been a greater challenge.

There are challenges: first, to support the number and the demand; secondly, to have more of a local network for the services that we have commissioned, originally across four regions, which is certainly our focus going forward; and thirdly, how to integrate those with the whole

pathways around hospitals and GPs, but also particularly family support, because we want to pursue earlier intervention.

My personal challenge, and the challenge for many of us, as part of leading this on behalf of NHS England—Jackie and I have talked about it on a number of occasions—is also the level of suicides and what we are doing to support the intense needs around crisis intervention. I think it actually goes back to your question before, although not totally, about pertinent times in people's lives during which we are not aware that they may well be more vulnerable and how we can support the support structures around those services.

We are very much committing to a framework of services that are particularly focused around mental health and the different needs, some of which are acute. That particularly covers families but also particular areas such as veterans in the criminal justice system or issues around rebasing and so on. Those will be our moves going forward. We have learned a lot from the first 18 months of the Transition, Intervention and Liaison Service, mostly from the patients, who tell us how to support and improve it as we go forward.

Q411 **Martin Docherty-Hughes:** Finally, either for yourself or Jackie, are the regions of England where you have been delivering this now all meeting their waiting time targets for both assessment and first treatment sessions? If not, when will you expect them to meet them? Also, on the experience of those utilising the service, I think it is important to recognise that sometimes that lived experience can really inform practice.

Kate Davies: We gave a commitment, which I know has been said to the Committee, to offer 14-day assessments as part of that. That has been challenging. We currently meet an average of 20 days. We have had spikes where that has been nearly as much as 40 days, which is not good enough. However, we have had a whole-systems approach, working with a GP or offering a triage intervention.

The distance travelled by some of our service users is one of the other issues. The investment in the long-term plan will certainly help to support that. The last thing is around mainstream services. We have 35,000 veterans that also access the IAPT — Improving Access to Psychological Therapies—services. That is probably not widely known but is a really important element in waiting times.

Jackie Doyle-Price: As a follow up to that, I am not the sort of person to accept targets that are easy rather than challenging. I think we need to be as ambitious as possible for this cohort of people. They deserve it.

Q412 **Mrs Moon:** I will pick up on a couple of things, particularly with Lieutenant General Nugee, although some will come under Jackie's bailiwick, I am afraid. You were talking about picking up the issues related to significant anniversaries, and there are particular issues related to suicide, as Jackie will know. What are you doing to track suicides among ex-personnel to ensure that, where anniversaries are leading to

deaths, you are monitoring those for whom the anniversary would be significant—perhaps where the death of a comrade may be significant? One of the things that comes home to me whenever I meet ex-personnel in the veterans community is how they are all still connected—they are all still talking to each other on Facebook, for example. There are repercussions that we are perhaps not always picking up on. Could you say a bit about that?

Lieutenant General Nugee: Suicide is something that we are putting quite a lot of effort into, as you would hope. We had a review of suicide by the Defence Safety Authority, and we have implemented all their recommendations, in terms of getting a closer idea about suicide among serving personnel. As far as veterans are concerned, we are doing what I understand is the largest non-NHS to NHS comparison of records—between all those who served in Iraq and Afghanistan from 2001 onwards, which is a very significant number, and the suicide records that the NHS have. That study was announced in October, but it started in July, and will hopefully deliver by the spring on what the overlap is between those who have served in Iraq or Afghanistan, those who are serving and those who have committed suicide. We are understanding that.

The University of Manchester is doing a study into exactly the question you are asking, which is: what is the trigger for somebody who has committed suicide? If we know of a veteran who has committed suicide—obviously, it is quite difficult to predict suicide—they are looking back at those who have committed suicide and saying, "What was the trigger that did that? Are there any trends, patterns or particular anniversaries that led to that particular suicide?" The University of Manchester is starting to do that in the new year. I don't know how long that study is going to take, because it is something that we need to be unbelievably sensitive about, as you will appreciate. It is going to be done very carefully to try to analyse whether there are trends or particular anniversaries that make a difference.

The only other thing I would say is that, although a veteran who commits suicide is, of course, a veteran, not all veterans commit suicide because of what has happened to them during their service. Anticipating anniversaries that we may absolutely not know about—it might be the death of a partner, a parent or something like that, which has got nothing to do with their service—will be quite difficult. I very much doubt we will get this all right. It won't be totally predictive.

Q413 **Mrs Moon:** Before you come in, Tobias, nobody in this country "commits" suicide. Can we just get that absolutely clear? You commit a burglary, because it is a criminal offence, but suicide is not a criminal offence. Therefore, nobody commits suicide. People may take their own life, but they don't commit suicide, because it is not a criminal offence. I am sorry; it is just one of those things that causes great offence to families.

Lieutenant General Nugee: I apologise; it is common parlance. I am sorry.

Mrs Moon: Thank you.

Mr Ellwood: I just want to add that service does not make you immune from suicide. I would say that you are less likely to take your life if you have served. The statistics show that. I am interested in working with the Ministry of Justice to see whether we can use coroners' reports—independent reports. I am working with the Justice Minister on database issues and other things, but we are progressing. I just wanted to let the Committee know that there have been calls for better understanding about the cohort of people who have taken their lives, from a military perspective. We are absolutely engaged with that to find a solution to it.

Jackie Doyle-Price: As you and I have discussed before, Madeleine—

Mrs Moon: Many times.

Jackie Doyle-Price: The biggest vulnerability that we have with all suicides is that two thirds of people who take their own life are not in contact with any kind of mental health service. Straight away, that is my target group to get to. In the sense that we have now got TILS, we would hope that we are putting a package of care around people so that a veteran is never going to get to that moment of crisis, because we will have that up-front support early on. But I am not complacent about that in any way and emphasise that it is still early days in making clear this early intervention and it will take a lot of time to become embedded.

It will also take some time—more than anything else, I think—before veterans who have had that experience feel comfortable about seeking help early. Everything that makes our serving personnel brilliant—they have better skills of mental resilience that equip them to deal with issues—makes them, as Ruth Smeeth says, less inclined to seek help when they need it. But we know that recent theatres of war have seen episodes that will have caused trauma, and as you will know, that takes time to surface. We need to encourage cultural change to enable people to ask for help. Again, you and I have talked often about the specific need to encourage men to feel that they can ask for help when they need it.

I am not complacent about any of that. Obviously, we will be looking, through Kate's team at NHS England, at specific areas as they affect veterans; and, through our suicide prevention plans, we will be looking at three particular pilots to see whether there are any real lessons we can draw from the veteran community.

Mrs Moon: Loneliness and isolation can sometimes be a problem for veterans because there are few people in their civilian circle who have that experience. That can also be a trigger.

Chair: Can this be the last question, Madeleine?

Q414 **Mrs Moon:** Yes, I'll be very quick. Ms Davies, you talked about the assessment and first treatment targets that you have across England. Are those targets also being applied in Wales; are they also there?

Kate Davies: They are not the same identical targets in Wales. I cannot speak for my colleagues in Wales, but we have had an Armed Forces partnership board with our Welsh counterparts and Scottish counterparts in the room, and certainly we are comparing those targets. We are comparing, obviously, how we get early access, particularly through the way we commission targeted services. And certainly I am aware that Wales is doing the same piece of work to have services that have a whole pathway to get people into an area of support. But obviously I am here for NHS England, so I would not want to go into the numbers or the details. I feel unable to really answer that question.

Q415 **Mr Francois:** Let me turn to the MOD first. Gentlemen, what degree of involvement did you have in managing the defence programme?

Mr Ellwood: Sorry, the defence programme?

Q416 **Mr Francois:** The MDP—the thing that's just come out. To what degree were you both involved in that?

Mr Ellwood: I had no involvement.

Lieutenant General Nugee: I was involved in the people area of it, completely.

Q417 **Mr Francois:** Sorry, you are the Veterans Minister and you had no input into it?

Mr Ellwood: I can only give you an honest answer: I had no involvement in it.

Q418 **Mr Francois:** Tobias, we all know that if you tell us that, it's true. And you had some input, General?

Lieutenant General Nugee: I had input in the people space, yes.

Q419 **Mr Francois:** Okay. I'm not being rude, General, but I have managed to flick through this in the course of the hearing. I have been listening, but I have managed to flick through it. Of the 25/26 pages, people—our greatest asset in defence—get half a page. There is no mention at all of veterans. There is no mention at all of medical care. There is one reference to families, but it is to families of technologies, not to Armed Forces families. Why have people been so deprioritised in this review?

Mr Ellwood: What I would say, in defence of this document, is that a wider document has been produced, which I think is more than 26 pages—I'll have to check now, having said that. That is the Veterans Strategy. I think you have not touched on the consultation and I was hoping that that might be a question from you as well, because what we have launched, through a consultation, is where we want to take and look after our veterans over the next 10 years: what are the responsibilities; what duty of care does the nation actually have? That is the detail that will show our commitment and our continuity of care after they have left the Armed Forces. That is separate to it being included in—

Q420 **Mr Francois:** I think that is a fair answer. I am just surprised to see that

people generically, whether they be veterans or serving personnel, are referred to in this review almost as an afterthought.

Lieutenant General Nugee: The word "transform" is relevant to people as well. I have a transformation programme that we are building to transform our people. One of things that I am trying to get out of that transformation programme is to make sure that it is not only transformation of our people but transformation of the understanding of how important our people are within defence.

Q421 **Mr Francois:** Turning to the NHS, Ms Davies, you have painted a picture of trying to expand the TIL service to provide more capacity for veterans who need help, but from the evidence that the Committee has taken, it is very much a postcode lottery. There are parts of the country where there is little or no provision at all and it is a matter of luck whether you get early treatment. We have had multiple examples of veterans who have been diagnosed as seriously mentally ill, and they have been diagnosed relatively quickly—the medics have said, "This person is really not well"—but it takes them a year or more to get into a treatment programme.

They are not all people who have fought for their country, but many are, and that is why, unfortunately, they are suffering a mental illness. Do you think it is acceptable that someone who has fought for their country and who is mentally ill has to wait for over a year to be helped by the national health service?

Kate Davies: I do not think it is acceptable for anybody to wait, obviously, whether they have fought for their country, or it is my daughter or anybody else who needs that support when they need it. That is why I am proud to be part of NHS England, which has put a lot of time and energy into supporting the decades' worth of mis-investment or lack of investment into the NHS. The mental health five-year forward view, the work that we are completely committed to and the ambition, as my Minister has outlined, for what that means for veterans and their families, are completely not only a moral obligation but now a resourced obligation. I accept—

Q422 **Mr Francois:** Sorry; we do not have a lot of time, so I am going to challenge you. I completely accept your Minister's commitment, because I have been with her to lots of military events down the years in her constituency. I am completely sold on that. The Secretary of State still needs some convincing, I think.

We are talking about how effective the system is in reality—what the military call the ground truth. We took evidence from an articulate veteran called Andy Price, who served in the Minister's old regiment. This is what he said about TIL: "Then you've got the TIL service, which is absolutely brilliant, but in the county where I live they haven't got a therapist any more. The therapist that they did have was coming across from Somerset," — he lives in Dorset — "and has now left because of the pressure she was under trying to support veterans countywide. Now we have a void. Off the back of that, we had a guy who tried to kill himself the other day because he doesn't know how he is going to push on now

that there is no therapy available, and they've turned around and said it will be five months until they can find a replacement for that lady." That is the ground truth of how the NHS looks after veterans with mental illness.

Kate Davies: That is our commissioned service and I am aware of where there have been some pressures in getting recruitment—we have talked about that already—but actually, I would happily take that outside this meeting to look at it.

The second point that I was coming back to is that the investment absolutely needs to support the demand. The demand locally also needs to ensure that we have many more staff, including psychiatrists, therapists, nurses and GPs.

What we are doing, and what we have done in the last six months, is commission a care co-ordination part of that service. Often, it is about how we put an individual care co-ordinator around those individuals. That is the feedback that we have had from people like that gentleman, which has really helped to move people forward when there have maybe been some changes or deliberations in the system.

I completely understand your frustration and the question. That is why we are really making quite sure that the £10 million investment supports that capacity issue and supports where there have been some cases that have not been good enough.

Q423 **Mr Francois:** Forgive me, because we are tight for time, but £10 million is not going to make a dent in it. These people have seen their friends blown to pieces in front of them. They have seen horrible things that, hopefully, no one in this room will ever have to bear. They have been wounded in the service of their country, except they are mentally wounded rather than physically wounded. If they are physically wounded, I would contend that the treatment they now get is world class. We can look the Americans in the eye on that—on Genium prosthetics or anything like that, we are world standard. When it comes to the mental health of the wounded who leave the military and come under your care in the NHS, we are not even beginning to get anywhere near it. It is a disgrace how we treat these people, and it is your Department that is asleep on the bridge. What are you doing about it?

Kate Davies: I am sorry you feel that way, but I can absolutely—

Mr Francois: This is what these people are telling us.

Kate Davies: I absolutely assure you that it is our absolute priority. That has been why the investment is absolutely key. It is also why we are constantly working to support and to improve a new service, and to improve it across all localities, and to work with our GPs, our hospitals and our commissioning systems, within social care as well as in mental health, because it is absolutely a priority. NHS England has demonstrated that this is one of its biggest commitments over the last few years, but we still have a place to go.

Q424 **Mr Francois:** My last point. These witnesses have been telling us that people have been in danger of taking their lives while they have been on your waiting list, waiting to get treated. If they were in the military they would be prioritised, but because they are in the NHS with everybody else, even though they fought for their country, they stand in a queue, and then unfortunately they get worse and worse while they are queueing. Our beef with you, if I can use that phrase, is that you do not seem to value these people in the way that we do.

Jackie Doyle-Price: I think that is unfair, actually. My opening statement was that we address the tension between the clear expectation that we need to do right by people who have given military service and served their country—

Mr Francois: But you're not, Jackie.

Jackie Doyle-Price: Let me finish. We also need to give access to healthcare on the basis of need without fear or favour. We are discharging that obligation by commissioning these specific services. I am not satisfied with where we are any more than you are, but I will say that what we have had in place for the last 18 months has started a direction of travel that is the right one. We need to continue to be challenging in making sure that the commitments we have in terms of TILS are delivered. I am more than happy to take away that case and really satisfy myself as to what has happened.

Mr Francois: My last word—I think the Chairman wants the very last word; that is his right. I am not trying to be personal, Minister, because we are friends.

Jackie Doyle-Price: Yes, I know.

Q425 **Mr Francois:** But I contend that your Department is not really honouring the Covenant in a way that other Departments—

Jackie Doyle-Price: In the way that you expect.

Q426 **Mr Francois:** No, forgive me—in the way that the veterans expect. Not me. In the way that the people who have worn the uniform and fought for their country expect. They expect to be decently treated. You are not dishonouring me; you are dishonouring them.

Jackie Doyle-Price: No, no. My commitment, and the NHS's commitment, is to give care at the point of need, regardless of who it is. We have commissioned these specific services for veterans in order that we can honour that debt.

Q427 **Mr Francois:** Then why are so many killing themselves?

Jackie Doyle-Price: I do not accept that premise, actually. What I do accept is that we can and must do better, and that is what we are trying to do.

Q428 **Chair:** In the time available I want to finish with one very specific issue, which has been brought independently to the Committee by two separate

organisations, one being Blind Veterans UK and the other being the National Centre for Trauma, which is at the moment a fairly skeletal organisation with close links to certain experts and university departments. Both of them have impressed on us that there is a major overlap between the symptoms caused by PTSD and caused by mild traumatic brain injury, particularly cumulative mild traumatic brain injury, which often results from blast, given that the signature weapon of the campaigns in Afghanistan and in Iraq were IEDs.

I want to ask you whether this particular problem of potential misdiagnosis of people who have suffered mild traumatic brain injury as suffering from PTSD—or even if they have both, which is frequently the case, as suffering from PTSD only—is causing concern. In particular, there are only two specialist scanners in the country—one at Aston University imaging centre and one at Nottingham University imaging centre—that are capable of picking up the slow bleed in the brain that is caused by the blast injury. Normal scanners are not capable of doing that.

Are you aware of this potential problem, which could be killing people slowly and can certainly be driving them to suicide, and what are you planning to do about it? Is it not crying out for a national centre of excellence for trauma, such as they have in the United States, where they routinely screen people who have been potentially hit by blast injuries?

Lieutenant General Nugee: Certainly we are aware of it. We have an organisation called the Independent Medical Expert Group—the IMEG—and they have looked at this twice to try and really get to the detail of understanding exactly what it is. Their evidence to date is that this is a very significant issue in the US, but there is not the same level of issue in this country. Now, that may well be lack of evidence, as opposed to—

Q429 **Chair:** If you only have two scanners that can pick it up, of course there is going to be a lack of evidence.

Lieutenant General Nugee: It is done on proportions, I think, but it is absolutely understood by IMEG as an issue that they need to fully understand, and they are keeping it under review. Now, that is not "they are going to do something about it", because at the moment they do not know what it is they need to do something about, because it is so difficult to diagnose, exactly as you described it. What they are trying to do is get all the evidence from all the medical expertise possible in this Independent Medical Expert Group to understand it, and therefore be able to do something, if that is the right course of action.

Q430 **Chair:** I do not wish to be unduly alarmist, but it was put to us that at least some of the people who suffer these blast injuries, once they are diagnosed, will possibly have as little as 15 years of life left before those injuries prove fatal. It is surely a matter of the greatest concern and the highest priority that if people have been injured in this way in the service of their country, we should have a screening process in place so that we at least know what has happened, and they are not misdiagnosed.

Lieutenant General Nugee: I would not be able to comment on what the outcome is of what the IMEG is looking at at this point in time.

Q431 **Chair:** All right. We have to stop now, but before I ask you to have your last words, I would just like to explain that when I went to visit Combat Stress 12 days ago, I met somebody—his name is Harry—who served for a considerable number of years as a regular and then volunteered to continue serving as a reservist. Despite all his campaigns in Afghanistan, he was actually injured because he was too close to a mortar when it was fired, and he suffered a blast injury. As a result of that and the effect it had on him, he was later court-martialled for seizing a weapon and running off with a view to doing away with himself, and he was sentenced to five years in prison, of which he served two and a half.

The only good thing that came out of it all was at least the people in the prison he was sent to recognised that he was injured, rather than guilty of anything of a criminal nature. Does that not show how far we have yet to go, that someone like Harry should be put through that ordeal, so much so that he actually presented me with his Afghan campaign service medal—which the Committee will keep safe for him—because he does not wish to wear it anymore?

Mr Ellwood: I am very sorry to hear that. All I can do is apologise for all he has had to go through. He has served his country, and continued as a reservist as well. He is now working with Combat Stress as well—a fine organisation. If I may offer through you to meet him, I would be happy to apologise in person.

Q432 **Chair:** Thank you. Any last words? Kate, any last observations that you would like to make?

Kate Davies: As in the case you just highlighted, it is essential that the NHS continues to take the challenge on, certainly with the work we are doing with veterans in the criminal justice system, some of whom should not be there, as you put it, and how we support people's needs as part of early interventions. Also, the NHS in England is quite rightly there to support people's needs regardless of their circumstances and regardless of their mental health or physical health needs. I am very proud that we have done an awful lot to increase that over the past few years. That is something we will continue to fight very hard on—we will take the challenges on.

Lieutenant General Nugee: I will just make one comment, which is really to take your good office, if you like, and make the point you asked me to make earlier. That is to broadcast as loud as possible that people who have a mental health issue or feel they have a mental health issue should present to the chain of command, to their medical or to the DCMH—wherever they feel is appropriate—in order to get help. We will support them, and that is our firm commitment.

Jackie Doyle-Price: I emphasise that genuinely we are in the midst of a transformational programme in terms of how we address mental health need across the board. Obviously, what we do for veterans and their

families is part of that. It will be a long time before I am in any way complacent about the challenge.

Mr Ellwood: Chair, can I say thank you to you for helping scrutinise us to make sure that we raise the bar and identify gaps—areas for improvement—as well as the general direction of travel? I join my colleagues in saying that this is a journey. We need to advance. We are getting better at it, but there are huge things we need to do differently as we move forward.

Can I also simply say thank you to all those who are serving and have served? We owe a duty of care to you, and to your families, too. You have done an astonishing job for the Armed Forces, and a mark of any advanced nation with Armed Forces such as ours—the most professional in the world—is how we look after people once they have packed up their uniform for the final time and slid it back across to the quartermaster. I am grateful for today. We have learned a lot, and we continue this journey.

Chair: Thank you very much indeed. You would normally have been the final panel, but because of the clash with the statement on the modernising defence programme, we have had slightly to reverse things. Unusually, we have one more witness, who will take the chair now. I thank you all very much indeed.

Examination of witness

Witness: Johnny Mercer MP.

Q433 **Chair:** We now move to the final panel. This is a slightly unusual configuration. In a previous inquiry, the Committee was able to take evidence from the Chair of another Committee—the Foreign Affairs Committee—because our colleague, Tom Tugendhat, had very relevant experience on which to give us evidence. This time we are drawing on the expertise of one of our own members.

Johnny, you often complain about the Ministry of Defence marking its own homework—I think that is your signature phrase—so you will fully understand that you will not be able to mark your own homework and that, by giving evidence to us because of your personal expertise and experience, you will be stepping aside from the compiling of the Report.

Johnny Mercer: Sure.

Chair: You made a great impression with your maiden speech when you entered Parliament. I regarded it as a privilege to sit there and listen to what you had to say about your service and, more importantly, about the service of your comrades and why you felt it necessary to come into Parliament. I would like to start off by asking you a general question about whether you feel the provision of mental health care during your period of service was good enough. Was it three tours that you did in Afghanistan?

Johnny Mercer: Yes. I served in Afghanistan in 2006, 2008, 2009 and 2010. It is fair to say that veterans' mental health care has come a long way from where it was at the beginning and is certainly in a better place now. The point in all this is the contrast between what you have just heard, which sounds great, and fitting for a first world military nation, and what we have heard in other sessions. I think the fundamental problem in this country is the way we view this. It's often how much we put into the system rather than how it feels for those going through. The reality is that for far too many still going through the system, a lot of the things that we have heard this afternoon are not a reality. I wish they were. As Mark Francois touched upon, these are young, brave, fit people who do not want to be casualties of a conflict that we all volunteer to go to. They don't want to be in such a position. If it was as easy as accessing some of the healthcare that has been laid out this afternoon, I think we would be looking at a different problem.

Q434 **John Spellar:** Johnny, would you say that there was sufficient guidance and support as you left the armed forces?

Johnny Mercer: I only left four years ago. It's different for different units. As always with these situations, too much of it depends on the personality of the command chain. At the weekend I saw an incident where a soldier left 1 SCOTS after 23 years of service. He was marched out of camp and made to feel like this was the end: a big deal for him. When I left it was completely different. I still don't have all my operational medals. You go from serving one day to the next. What really struck me was that you go and pick up your medical notes and they get given to you in paper format, and that is still the case today. You could just chuck them in the nearest bin and nobody would ever know. This idea that you sign up to a GP just doesn't exist. What is frustrating is that that is so easy to sort out. That could be part of your leaving process. You get, basically, paid money for attending classes to write your CV and things like that. You could say, "Show us that you have signed up to a GP and you will get your next instalment." It's as easy to fix as that. The problem is that you have heard all these experiences, but they could all have been said six years ago.

Q435 **John Spellar:** Is that a failure of the system or of implementation?

Johnny Mercer: The system has been slow to hear the stories of those who have, for example, taken their own lives, which I have spoken about in this House before. It's great to hear that over the last 18 months progress has been made, but these stories started coming out 10 or 11 years ago. People have died, and they need not have died had the support been as easy or as accessible as it's made out to be. That's the reality. The difficulty for the veteran community is the difference between how it's presented at the strategic level, which is understandable—and of course they would say that, but it's how it feels for the veteran community. Frankly, it still feels like we don't really matter. Mark Francois made the point about people being in the MDP plan. If you look in the veterans strategy, I can't find it where they talk about mental health.

Q436 **John Spellar:** From your observation and experience, are there

differences in the way it's handled and also in the way that it's perceived between those who serve for a limited number of years and those who go either to a full term of service or a very substantial term of service?

Johnny Mercer: Largely, in my experience, there seems to be no correlation between the type of incident you are involved in and whether or not you suffer mental health problems. Similarly with length of service. It genuinely appears to be as simple as whether or not you get a physical health condition. I have been involved in incidents where people have ended up in psychiatric units and others have not thought about it again. The problem is that because the Government have not applied themselves to genuinely understanding PTSD, it has got out of control.

Now, the idea that you can have PTSD as a blanket term for all manner of illnesses is really dangerous. If you try to treat somebody for PTSD and they actually have substance abuse problems or depression, they will never get better. Similarly, those who need the help for PTSD—including some of my friends, one of whom I was with today, who genuinely need the help—do not want to come forward because they do not want to be part of this gang. But similarly, it is tough to access the treatment. Why should somebody wait a year to access help for PTSD? We can say it is unfortunate and Ministers will say they will look into it, but it has been like that for 10 or 11 years, I'm afraid.

Q437 **Ruth Smeeth:** What has changed since you left?

Johnny Mercer: I think there is more of a strategic focus on it now, and on delivering something that means tangible change to people, but I am afraid the progress just is not fast enough. When I first made that maiden speech in 2015, it was still the beginning of the process where mental health was not really talked about. It is talked about a lot now, and a lot of celebrities and so on will talk about mental health. It is one thing to talk about it, but when it comes to getting your hands dirty and intervening in the practices and what works best for those in our most vulnerable communities who access mental health, I am afraid the conversation stops and runs a bit dry. There are some brilliant provisions out there, and you can get better with mental health treatments, but the reality is that accessing and navigating them remains very difficult. In some ways people talking about it has got better, but accessing that care is enormously difficult. Sitting here today as an MP, I would find it hard to access that care, and you would have thought I should know, so if you are in one of our most vulnerable communities or you have served, you do not really have a cat in hell's chance.

Q438 **Ruth Smeeth:** Johnny, I desperately wanted to use the unique opportunity of you sitting in front of us to make fun of you after your post-service employment, especially with Dove, but I actually just wanted to say I'm really proud of you.

Johnny Mercer: Thanks, Ruth—you're lovely. Thank you.

Q439 **Mr Francois:** Dove or no Dove—ditto, Johnny. I have read your book, and it is true that we now talk about mental health stigma—largely,

though not entirely, down to the princes, in a completely different way—but you wrote very frankly about some of the challenges you had had in your earlier life, which had had quite an effect on you. We have residential centres for people who are physically wounded. We have had Headley Court, we now have the DNRC and we have the rehabilitation centres, such as Tedworth House, that Help for Heroes and others have run. One of the benefits of that is the comradeship and being in the same boat as other people who have the same challenge as you. Do you think there is any merit in having some kind of national residential centre for people who have been suffering from mental illnesses as a result of serving?

Johnny Mercer: If I am honest, I feel that the clinicians' view on whether that helps is really important, particularly touching some of the evidence we have heard of individuals having to then sort of comfort their psychiatrist as they tell them. That is ridiculous, right? Clearly, we have not gone far enough in creating a correct environment for individuals to access treatment and get better. Whether or not residentials work, I think the evidence isn't really there at the moment. With the Americans it obviously has worked with the Walter Reed centre and things like that, but the truth is that the clinicians rule the roost as to whether or not it would increase the chances of people accessing care and getting better. I think it would be down to them.

Mr Francois: I am not trying to put words in your mouth, Johnny, because I know it would not work anyway, but if there was a place where guys who were seriously mentally disturbed as a result of military service could go and get decent, proper, professional help, I think the nation would think that that was a good thing, and I suspect many of the veterans would, too.

Johnny Mercer: Yes. The symbolism here is very important. We probably would not be having this conversation if the nation genuinely felt that it had got this right in the first place. Members of the veterans' community do not want to be poorly or come back and struggle in life; they genuinely want to get on. If, despite all these efforts, they still feel, as far too many of them do, that the Government just do not get it when it comes to veterans' care, then we have to look at why that is. Symbolism is a big part of it. Your point earlier about defence people is very important. The gap between what is said in this place and the reality for so many of our veterans in this country is so wide that sometimes it is personally quite difficult to engage in this process.

Q440 **Mr Francois:** You have been a combat veteran and I have not, and I respect your service. When I was the Veterans Minister, I formed the impression that armed forces personnel and veterans do not necessarily want sympathy, but they do want respect. I just worry that the system is not respecting these people in the correct way, which in a sense adds to their trauma, because they feel, "I've done all this—I've put my life on the line, and nobody really seems to pay much attention to that."

Johnny Mercer: When I first came here in 2015, I gave that speech and then I wrote a three-pager for David Cameron on what we could do about veterans, and he read it. Interestingly, a lot of that is now in the Veterans Strategy—it has not really moved on in the three years since then. He said, "Johnny, what do veterans actually want?" I said, "Look, they just want someone who cares—not someone who pities them or feels sorry for them, but who just cares."

Just let them get on with their life. There will be some who struggle, and maybe we should give them a hand. They want to feel like the nation goes beyond the amazing scenes at Armistice and stuff like that, and that the public genuinely get what service was like—what it's like to fly out to a very unpopular war six hours away and lose your friends, and then come back to a country that is busy partying at Glastonbury and getting on with their summer. There is no complaint, because we volunteered for that, but let's be honest about the challenge that represents to some of our servicemen and women, and we should always be cognisant of where the military recruits from. People don't like talking about it because sometimes it is uncomfortable, but we recruit from a specific demographic to join the military sometimes. Let's be grown up and cognisant of that and understand that that contrast will present a significant challenge to some of our young people, and let's meet that challenge.

Q441 **Mr Francois:** The Minister Jackie Doyle-Price's heart is absolutely in the right place—I've known Jackie for years—but it is true that in an era of tight public spending, there is a lot more money going into mental health in the NHS, which is a good thing. With the £20 billion-plus, there will be even more. Hypothetically, if you had control over that money, how would you like to see it best deployed in the NHS to help veterans? What would be the most effective way of spending that cash?

Johnny Mercer: The thing with veterans care in this country is that there a lot of good services. The problem is that, as we know, it is very difficult to access them. If you were to spend that sort of money, you should really spend it on trying to sort out what is already there—for example, if you kitemark charities and say, "Right, if you're going to have access to veterans out of the veterans gateway, then you must adhere to some very basic things, like you must have your accounts audited or you must practise evidence-based care." That way, you start to bring the standards up, so that we stop hearing so many of these horrible stories about people not accessing care.

A single point of entry works. It was hoped that would be the veterans gateway, but the charities do not want to drop their helplines, which is where a lot of their front-door work comes in. That collaboration and organisation is the only place where you need to spend money in veterans' care. You really don't need to spend that much, because it is already there. It's all about political will and the ability to jump from talking a good game—paying respect, treating veterans with deference and all the rest of it—to delivering something that works, means something and changes people's lives out in communities.

Q442 **Mr Francois:** You mentioned charities, but what more could the NHS specifically do?

Johnny Mercer: If you look at GP surgeries up and down the land, people's experiences of accessing them are very different. GPs get a lot of public money—rightly so; they do an amazing job—but with that should come some sort of understanding that some common parlance or treatment of veterans is not that difficult, if you get someone in and find out they are a veteran. That has started; don't get me wrong. I don't really understand, though, why it cannot be mandated. If it is public money, with that should come some sort of responsibility to look after these people.

Chair: Before I bring Madeleine in, I think Ruth wants to come back briefly, possibly to shower you with a little more praise.

Johnny Mercer: I doubt it.

Q443 **Ruth Smeeth:** Oh no, his ego is fine. I am interested in your views—I have spoken to a lot of veterans recently who are slightly older and are either from Kosovo or the Falklands. They feel that they were abandoned in terms of the support provision they got when we had significant numbers of service personnel return from Afghanistan and Iraq. That was specifically by certain charities. The veterans were lost in the system. Now they feel they cannot really access veteran support. What do you think we should be doing better to answer that? That is a missing part of the conversation we have been having.

Johnny Mercer: There is no doubt that the operations in Iraq and particularly in Afghanistan, which were some of the heaviest fighting we have seen since Korea, changed the dial on veterans care. Those who were injured and mentally affected before that undoubtedly felt that they were not looked after in the same way. One charity in particular changed their covenant and the way they were set up to enable them to reach those people.

Why were Help for Heroes and other things set up after 2005 and 2006? It was because of the huge demand. Some of our veterans will feel like that, and it is particularly pertinent around Northern Ireland, because it was a very different conflict from Afghanistan. Some of the trauma that went on out there is clearly significant. The situation is getting better, but when too much of this is left to the third sector—the third sector has a massive role to play, but if you just chuck the whole thing into the third sector and think that is your bit done, you will get problems like that. Certainly Help for Heroes have changed some of what they do, and that is to be welcomed, but it is tough for charities. They are set up on a mandate. They set out their clear aims and objectives and what they are going to raise money for. They then raise that money and feel they have to spend it in that way. I understand that. I think it is getting better. A rising tide lifts all ships. That is certainly the case with veterans' care.

Q444 **Mrs Moon:** Johnny, I want to take you back to what you said about the demographic that we recruit from. Some people within that demographic

are individuals who have had adverse childhood experiences. Many of them do very well within the military, because it is a new family that surrounds them and gives them all the support and the comradeship—everything that they have looked for. Often they have exemplary service. Those adverse childhood experiences and relationship fractures and difficulties do not go away, though. Are the military doing enough to recognise their responsibilities, in all that training they do, to also look at a different form of resilience—emotional resilience to not only the trauma experienced in battle, but the trauma experienced in life—particularly to prepare people for transition back into the wider civilian world, where the collective arm of the military is not around you, and to deal with the loneliness and isolation, which goes back to those adverse childhood experiences? I hope you followed all that.

Johnny Mercer: I did. It is a very fair point. It is something that we have shied away from politically over the years, for a number of different reasons. The short answer is yes. Resilience training has now become a much bigger part of training within the military. It started within the Royal Marines, which has always been slightly better at this stuff than the Army, in fairness. There is someone who we used to call the "nod whisperer" down at Lympstone. Essentially, he was a civilian psychologist who used to come in and talk to the recruit troops going through. The effect this guy had on these troops and their pass rates came out in the data. That is now part of their training and is much more part of the Army's training. I think it has got better as the mental health debate has evolved, but it comes back to what I was saying before about the personalities of the individuals involved. I was with somebody today who presented with a mental health problem and was immediately cut off by his commanding officer. That was only last year. You can have all the structures around them you like, but while you still have individuals who do that, it comes down to personal command decisions.

In that regard, one of the fundamental changes—this is a discussion for another day—is the way that the Army reports: everything is top-down, there is nothing about what it is like to serve in someone's regiment, platoon or company. I think it is an interesting way of looking at it. No one is marking that CO's homework, as to how that company commander feels having had said to him, "Look, I think I am going to have to take some time off." He is his only line out, if you like. If he is not interested, where does he go? That is where you start to see the beginning of this process that ends in someone leaving thoroughly disenfranchised and maybe slipping into substance abuse, or whatever it may be.

Q445 **Chair:** To wrap up, if and when that day comes, and the call is received from No. 10 Downing Street saying, "Mr Mercer, we want you to become Veterans Minister in the Government of national unity," or whatever fanciful structure—

Johnny Mercer: Under John Spellar?

Q446 **Chair:** You could do a lot worse. What would be your top three priorities, if you had carte blanche?

Johnny Mercer: One of the problems is that in this country veterans care is given to a junior Minister. The single biggest factor that improves a veteran's life chances is having a job, and that is nothing to do with the Veterans Minister. A lot of the issues around housing have nothing to do with the Veterans Minister either. We are the only Five Eyes nation that does not have singular body that pulls together all the functions of Government to deliver for veterans. We now have the Veterans Strategy in the Cabinet, which is a start, but we don't have a commissioner, we don't have an ombudsman and we don't have a Department. That is the single point of failure we have seen. If you could do that, you would be able to extrapolate all of the other things that veterans Departments do, such as points of access, kitemarks, and things like that.

Q447 **Chair:** We heard earlier about the United States and how it has, for example, the comprehensive screening programme for the possibility of mild traumatic brain injury. What do you think are the best features of the US system, if you are acquainted with it, which we could try to import into the UK?

Johnny Mercer: The best thing—I don't understand why we haven't done it for a long time—is data. The policy has to be driven by the data. In terms of veterans suicide, we have heard that starting, largely as a result of pressure that you have personally put on the Department to start recognising these things. If you have a Department or a body that holds everyone to account, you will get data and then be able to drive policy and improve these people's lives. The trouble at the moment is that it is a kind of fire and forget missile. You have the covenant flying out there. You have the covenant reference group. You have all those things going on but there is no one in this country who is the final accountable arbiter of whether a veteran is looked after. Until you have that, you will always have one Department that says, "Well, you know, if Health had done it better," or "If the DWP had done it better." I understand the arguments for why people do not want another Department or whatever that may be, but ultimately, if you are going to have a safety net that pulls all functions of Government together, with one person responsible, it needs to be Government-led, and delivered by charities, because they have absolutely the best methods of delivery. You have to organise them and get rid of the ones that are no good. You have to have a single point of contact. You have to have a common needs assessment, for example, so veterans are not telling their stories all the time. You have to harbour that charity group, but the responsibility must lie with Government. At the moment, there is not a single person there at the top of the tree.

Q448 **Chair:** Is the only way to do that to have a separate Department?

Johnny Mercer: There are different ways. You could have a very small Department; nothing like the Americans, because you are not talking about delivering services, but about controlling what goes on in Government, so maybe a small Department. You could have an ombudsman, or you could have a commissioner, like they do in New Zealand. Somebody has to take responsibility. That comes back to what Mark Francois said: what do people want? Ultimately, they just want

someone who cares, and who is going to be able to hold Government to account on their behalf.

Why do we have such a cohort of really proud young people who have served their country, who at the moment feel quite bitter about the way that they are treated by the Government? They are not wired to feel bitter like that. They are wired to be proud of what they have done. They want to move on and get on with a new life. They do not feel like that because they do not really feel like we care. I know that is not true, because there are people sat here before me who do care, but they need the systems in place to enable them to show that.

Chair: Johnny, thank you very much for being their spokesman today. That concludes the session.

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