House of Commons

Defence Committee

Medical care for the Armed Forces: Government Response to the Committee's Seventh Report of Session 2007–08

Sixth Special Report of Session 2007–08

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The Defence Committee

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Sixth Special Report

The Defence Committee published its Seventh Report of Session 2007–08 on *Medical care for the Armed Forces* on 18 February 2008, as House of Commons Paper HC 327. The Government's response to this Report was received on 22 April 2008. This is appended below.

Government response

The Government welcomes the House of Commons Defence Committee's report on Medical care for the Armed Forces. We note that the report pays tribute to Defence Medical Services (DMS) personnel, and their NHS colleagues, who together provide world-class care, and that the Committee concludes that the clinical care provided for Servicemen and women seriously injured on operations is second to none.

We welcome the Committee's recognition of the excellent work carried out by DMS and NHS staff at Selly Oak Hospital, and that rehabilitation services, especially at Headley Court, are recognised as exceptional, making an enormous contribution to the welfare of injured Service personnel. The Government echoes the HCDC's condemnation of the irresponsible reporting of the treatment provided to our injured Service personnel at the University Hospital Birmingham Foundation Trust.

We are pleased that the Committee commends the MOD's sound decision to base its secondary care around units embedded in NHS Trusts, allowing military clinicians to maintain and develop their skills, with a case load and mix that could not be matched by stand-alone military hospitals. We hope that this will close the debate on Service hospitals and the future of Royal Hospital Haslar.

The Government's response to the Committee's conclusions and recommendations as set out on pages 35–39 of the report are as follows:

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

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

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

4. (Recommendation 4) We acknowledge the progress which has been made at Selly Oak in terms of creating a military environment, to take advantage of the healing

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

We are pleased that HCDC has recognised our achievements, working with UHBFT, in developing a military managed ward at Selly Oak Hospital. We shall be building on those achievements when we take this concept forward in the Trust's new hospital. We shall of course continue to keep the HCDC informed of progress.

We attach a high priority to the welfare of military patients and their families. Current patient family accommodation is contracted for until 2011. Officials are now working on plans for the family accommodation that will be required when the Clinical elements of the Royal Centre for Defence Medicine move to the Birmingham New Hospital. This planning phase will also consider the means of provision of welfare facilities, for which there are several options. We are most grateful to SSAFA-FH for their generosity in offering to provide a "home from home" in the area, for patients' families.

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

The Government shares the Committee's view on the improvements in welfare provision, and takes this opportunity to place on record its own appreciation for the work of welfare and charitable organisations. It is entirely appropriate for the continuing generous support of charities to sit alongside the provision of facilities from public funds, as is the practice in many walks of life. Charitable assistance is a welcome and tangible demonstration of public support for the armed forces. The Government welcomes an open debate about the respective roles played by the Government and by charities and voluntary groups. The forthcoming Service Personnel Command Paper will be an important part of that debate.

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

The Government agrees that improvements should continue to be made as part of an ongoing lessons learned process. We continue to address lessons to be learned in all aspects of the patient care pathway for injured service personnel, through in particular the work

that was initiated by the appointment of a Standing Joint Commander (Medical), to which the Committee referred in its report. Ministers are advised regularly by the Deputy Chief of the Defence Staff (Health) and the Surgeon General on the progress of that work, and aspects of it have been reviewed as necessary by the Chiefs of Staff and the Service Personnel Board. There is also regular liaison and review with NHS staff through the University Hospitals Birmingham NHS Trust Clinical Governance Committee.

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

The Government welcomes the HCDC's endorsement of our plans to develop the Defence Medical presence in the Midlands. It remains the intention of the Midland Medical Accommodation project to co-locate key elements of the Defence Medical Services at Whittington Barracks, Lichfield. These elements are expected to include the HQ of the new Joint Medical Command (currently located at Fort Blockhouse, Gosport) and the new Strategic Medical HQ that is being developed.

The project is still in the Assessment phase, but we hope to reach a decision on the next steps before the summer. We shall provide the Committee with details of our plans when they are decided.

Lest there should be any misunderstanding, it should be noted that there never has been any intention to establish MoD secondary care facilities or accommodation for patients or their families at Lichfield. However, we are considering plans for accommodation for families of military patients being treated at Birmingham, as explained in our response to paragraph 4.

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

The new hospital project of the University Hospital Birmingham NHS Foundation Trust will deliver a range of new facilities, including for the Royal Centre for Defence Medicine (RCDM), from 2010 onwards and is making excellent progress towards completion by 2012. The RCDM is in discussion with the Trust about the MOD's detailed requirements and the timetable for the occupation of the proposed military areas of the new hospital. We shall advise the Committee once conclusions have been reached and provide subsequent up-dates as necessary.

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

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

The Government welcomes the Committee's recognition of the achievements of the staff and patients at Headley Court. We are in the process of reviewing what our future requirements for rehabilitation are likely to be. This involves not only the Defence Medical Rehabilitation Centre (DMRC) at Headley Court, but also our Regional Rehabilitation Units (RRUs). We expect the review to be completed shortly and will make the outcomes available to the HCDC.

Capacity at the Defence Medical Rehabilitation Centre at Headley Court was increased by the opening of a 30-bed ward annex last May and will be further enhanced later this year, by the building of a new staff and patient accommodation block.

We expect to continue to invest in Headley Court for the foreseeable future and our current review will encompass how we might best target additional investment. In addition to public investment, we welcome all offers of charitable support for our wounded Service personnel. The MOD works together with a number of charities in this field. We consider this to give the public a good opportunity to show their support for the Armed Forces.

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

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

visited and are satisfied that they deliver high quality care to military and civilian patients. (Paragraph 61)

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

This is an area which the Government had already identified as a priority, and which it is committed to developing further, for example through regular meetings between MOD and Health Ministers, the MOD/Departments of Health Partnership Board and the Medical Research Council. The MoD already has a number of processes in place to ensure that best practice is shared between the Defence Medical Services and the NHS.

When not deployed overseas, DMS medical personnel who work in secondary care maintain their clinical skills in the NHS, ensuring cross-pollination of the skills they develop while on deployment and NHS best practice. Similarly, NHS reservists bring the clinical and crisis management skills they learn on operations back into the NHS.

The MOD also shares the results of defence medical research. DMS personnel undertaking research publish their papers in the wider scientific press, and deliver presentations at both national and international civilian clinical conferences. An expert symposium comprising international experts (including from MOD) was convened in London last year to produce best evidence guidance on clinical practice following a blast incident. From this, best practice guidance was issued to the NHS in December 2007.

Advances in military emergency medicine have influenced recommendations from the Joint Royal Colleges Ambulance Liaison Committee. Also, DMS' Royal Centre of Defence Medicine is hosted at University Hospital Birmingham Foundation Trust, a centre of excellence for polytrauma medicine, and the closest cross-fertilisation exists between them, and with field hospitals in theatre.

DMS also shares best practice with the Medical Research Council, for example to increase awareness of our recent enhancements in battlefield medicine that may have wider A&E applicability. The MOD has also engaged with Dame Carol Black's review of health in the workplace, where our rehabilitation programmes are seen as leading the field in getting severely injured people back to work. Such work is taken forward within an overall framework that is overseen by the cross-Government MOD/UK Health Departments Partnership Board.

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

The MOD indeed aspires to have a "genuinely tri-Service DMS" and the recent creation of the new Joint Medical Command, which has wider responsibilities than the former Defence Medical Education and Training Agency, is an important step towards such a

goal. In addition, secondary healthcare DMS personnel are frequently deployed and gain considerable experience on operations on a tri-service basis. We are also looking at how to make MDHUs more tri-service. We are, for example, planning to open up more senior posts within the MDHUs to all three Services and the Joint Medical Command is reviewing the arrangements made for military medical placements with the NHS and examining the assumptions behind the current structures of the MDHUs. However, it is important to recognise the practicalities imposed by the geographical presence of the single Services in the vicinity of the MDHUs, and the fact that most DMS personnel will spend the majority of their career based with their parent Service. This means that it is inevitable and by no means undesirable that the DMS personnel at an MDHU will be drawn more from one Service than the others, just as the military patient population using that MDHU will be predominantly from the same Service. This does not represent any reduction in capability.

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

There are three separate schemes for obtaining faster than normal access to treatment for Service personnel or veterans. To clarify, the arrangements are:

> **Accelerated access** for Service personnel—Service personnel are of course entitled to access local NHS secondary care by referral from local (military or civilian) GPs. In addition, the MOD will in some circumstances purchase accelerated access from a small number of NHS providers at additional cost, for any medical condition, in order to meet operational requirements. These providers are the NHS Trusts hosting Ministry of Defence Hospital Units[1] (MDHUs) and University Hospital of Birmingham Foundation Trust (UHBFT).
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> **Orthopaedic "fast track"** programme for Service personnel—The MOD has also developed a specific orthopaedic fast track programme to meet the relatively high incidence of musculo-skeletal cases within the military population. For Service patients with these conditions the MOD arranges rapid access to diagnosis and—for the minority who are then found to need it - surgery in NHS facilities. Those needing only physiotherapy/ rehabilitation treatment (the majority) are treated in MOD's own Regional Rehabilitation Units (RRUs). Typically, these patients will start physiotherapy within 4-6 weeks of the decision on their treatment path. If surgery is necessary (for the minority of cases) the MOD arranges fast access to surgery from the MDHU Host Trusts, other NHS Trusts and in the past from the independent sector within 6 weeks of the decision on their treatment path.
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> **Priority treatment** for war pensioners and veterans—Where a veteran in England, Wales and Scotland has a disorder accepted as due to service under either the War Pensions or Armed Forces Compensation Schemes, there is entitlement to priority treatment—including assessment, treatment, aids and appliances for accepted

[1] Derriford, Frimley Park, Northallerton, Peterborough and Portsmouth

conditions. Priority is decided by the clinician in charge based on clinical need. NHS priority treatment has recently been extended to all veterans in England and Scotland, whose injuries or ill-health are suspected of being due to their service, and will be extended to veterans in Wales on the same basis soon.

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

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

The MOD maintains regular contact at both working level and the highest official levels with counterparts in the health departments of the Devolved Administrations to ensure that health issues affecting Serving personnel, their families and veterans are given the consideration they deserve.

The Under Secretary of State for Defence chairs the Veterans Forum where he meets regularly with officials from the Devolved Administrations to discuss and address issues of concern to the veterans' community. He also meets Ministerial counterparts where issues of concern justify engagement at this level; he most recently met with the Scottish Government Minister with lead responsibility for veterans, Stewart Maxwell MSP, on 3 December 2007.

The MOD/UK Departments of Health Partnership Board, chaired at senior official level, typically meets 3 times a year and is a forum designed to strengthen further the working relationship between the Department of Health, the Devolved Administrations, NHS and MOD. The Partnership Board has established 3 working Groups with representation from the devolved administrations to take individual workstreams forward between Partnership Board meetings. The focus of the forward work programme is on tackling key strategic issues in order to produce real improvements in the quality of health and healthcare provision for Service personnel, their dependants and veterans and in the delivery of deployable operational capability.

There are also numerous contacts at working level between officials in MOD, the Scottish Executive and with the Welsh and Northern Ireland administrations on various issues of concern to Service personnel, their families and veterans. There has for example been close discussion of the arrangements for meeting the mental health needs of veterans.

The Government understands that the Scottish Executive has provided a separate response to the Committee. We welcome the fact that Scotland has extended NHS priority treatment to all veterans for conditions which are likely to be related to their service. This came into effect on 29 February 2008

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

For the purposes of establishing eligibility for priority NHS medical treatment a veteran is anyone who has served for at least one day in HM Armed Forces (Regular or Reserve) or the Merchant Navy Seafarers and Fishermen who served in a vessel at a time when it was operated to facilitate military operations by HM Armed Forces.

The Department of Health, which is responsible for meeting the health needs of veterans in England, consulted with the Devolved Administrations before the Secretary of State for Health announced his decision to extend priority treatment for veterans in England. Both the Scottish Executive and Welsh Assembly Government have also announced the extension of NHS priority treatment for war pensioners to all veterans in Scotland and Wales, on the basis of clinical need for health conditions related to their service. This came into effect in Scotland on 29 February 2008.

Priority treatment for war pensioners was not introduced in Northern Ireland because historically, Northern Ireland retained a dedicated hospital for war pensioners. We have been informed by the Northern Ireland Government that it is committed to providing excellent public services for all its citizens.

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

Having extended NHS priority treatment to all veterans in England, the Government is aware that it needs to raise awareness of the provisions. Steps have already been taken: for example, the new guidance on priority treatment for veterans was sent to all NHS Trusts, foundation trusts and GPs in England and the forthcoming Chief Medical Officer Update includes an item on priority treatment; in Scotland a generic leaflet on entitlement to NHS priority treatment is to be distributed to all current members of veterans associations in Scotland, citizens advice bureaux, general practitioners and NHS hospital outpatient

clinics. The Welsh Assembly Government will also be issuing guidance to remind clinicians about the extension of priority treatment for war veterans.

MoD has also asked the various veterans' agencies to publicise the provisions through their communications with veterans. The Department of Health, the Scottish Government and the Welsh Assembly are all considering further means of raising awareness and will keep this issue under review.

We have considered carefully the Committee's proposals around tracking of veterans in the NHS.

The Government believes that that there could be significant issues from a security viewpoint in flagging the medical records of veterans. The fact that someone was a member of the armed forces is sensitive personal information. It would be cumbersome under current arrangements to flag up a veteran's status to a GP while giving that personal information sufficient protection. In addition, we would need to respect that some individuals may not wish it to be known, for whatever reason, that they have previous Service experience.

Moreover, because of the large numbers of veterans in the UK a retrospective solution would not be viable.

In the Government's view, however, the introduction of the English NHS National Programme for IT (NPfIT) through the Connecting for Health initiative—and the Defence Medical Services' connectivity with the NPfIT—should allow greater integration between the NHS in England and MoD, improving the provision of care to Armed Forces personnel with the protection of strong security measures. Work is also in hand with the devolved administrations to allow a similar level of integration in the future.

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

All individuals leaving the Armed Forces are given a summary of their medical records, which they are advised to give to their new civilian GP when they register. If the GP wishes, they can request a copy of the full medical record from the appropriate single Service.

For medical discharges that require an ongoing medical care plan to be put in place, the military consultant in charge of medical care arranges the handover of care to his civilian counterpart, much in the same way as a handover of care is arranged for civilians moving from one primary care trust to another. The transfer of medical records forms an integral part of the process.

MOD's new IT system for the Defence Medical Services, the Defence Medical Information Capability Programme (DMICP), will allow the sharing and transfer of medical records electronically in future. The programme is being introduced incrementally and is now in use at 140 medical centres in the Army and the Royal Air Force in the UK. It will continue to be introduced at Royal Navy shore locations, the Defence Dental Service and to all our Armed Forces in permanent bases overseas, such as those in Germany, Cyprus and Gibraltar, throughout 2008 and should be complete by early 2009. The system will also be deployed to our Armed Forces on overseas operations and to HM ships beginning later in 2008.

The system is compatible with the English NHS National Programme for IT (NPfIT). Work to effect an interface between DMICP and the NPfIT has been approved by the MOD and the Department of Health and has already begun. It is due to be completed in 2010. There is a need to protect patient confidentiality, including their military history, and to comply with each patient's decision on whether or not their medical record could be shared. Subject to this it is intended that detailed records could be transferred electronically to their new GP when Armed Forces personnel retire and that a summary record could be made available to the NHS during service. It is also intended that the Defence Medical Services will be able to use the NHS Choose and Book system for their patients in England. Defence Medical Services are also actively engaged with the devolved administrations to establish a similar electronic exchange of information in the future.

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

The Government entirely accepts this conclusion. The Department of Health has continued to make progress in terms of health care for the armed forces, their families and veterans. Last November the Department of Health announced the extension of priority treatment to veterans for conditions related to their military service, and the establishment of a number of pilots to look at the best way of meeting the needs of veterans with mental health problems. In December 2007 the Operating Framework for the NHS in England for 2008/09—the document which sets the NHS's key priorities—was published, which included: making sure that the NHS provides the right services to meet the needs of armed forces and their dependants who move frequently; reminders that the NHS should support staff who want to be volunteers in the Reserve Forces; and reminding the NHS about the priority treatment provisions and their extension to all veterans.

The Scottish Executive has also extended priority treatment to all veterans in Scotland, on the basis of clinical need for health conditions related to their service, with effect from 29 February 2008 and is working with the MOD on the establishment in Scotland of a community-based pilot to examine the best way to address the particular mental health needs of veterans. Each NHS Board in Scotland has been asked to appoint a senior member of staff to have overall responsibility in ensuring the implementation and monitoring of the extension of priority treatment for veterans. The Scottish Executive intends to hold a workshop for those individuals, representatives from the veterans' organisations in

Scotland and representatives from Citizens Advice Scotland to establish and promote a general understanding of what is meant by NHS priority treatment.

The Government accepts that support for veterans and the families of Service personnel plays an important part in the retention of Service personnel and works hard to ensure that support from all relevant departments in the UK works as well as possible. In particular, work on medical and health support is undertaken between MOD and the UK health departments through the Partnership Board and its supporting working groups.

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

The Government agrees with the Committee that Service Personnel and dependants are entitled to high-quality medical services to NHS best practice standards where practicable. It is important that policy and resource initiatives to improve the health of the UK population are also extended to Service Personnel and their families in the same way. The MOD and Department of Health have agreed to work closely together, and with HM Treasury, on this issue in the run up to future Spending Reviews.

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

The Ministry of Defence will be reviewing the provision of Secondary Health Care (SHC) in its Permanent Joint Operating Bases (PJOBs) in Cyprus and Gibraltar to Service personnel and their dependents. The project team, involving all key stakeholders, will consider a range of options, including the use of local health providers and the development of partnerships with UK health trusts to ensure that the MOD continues to meet its obligation to provide appropriate care to its personnel. This will be a challenging undertaking, and sufficient time must be allowed to ensure that we deliver the right outcome. We will need to investigate the most effective relationships between ourselves, health providers and other stakeholders. This will also need to address quality assurance and capacity. We will, of course, ensure that our personnel in Cyprus and Gibraltar are kept fully informed about the future provision of SHC in these locations

24. (Recommendation 24) We acknowledge that the healthcare of Service families in the UK is the responsibility of the NHS. However, the MoD has a part to play, and should be doing more to support Service families during the transition from overseas postings to reliance on NHS healthcare. There should be better cooperation between the MoD and health departments across the UK. The Scottish Executive also has a responsibility to improve its procedures in this regard. Providing this sort of support is a vital part of maintaining morale among Service personnel themselves and their

families, which has such a profound effect on the retention of experienced Servicemen and women. (Paragraph 89)

The Government accepts that support for the families of Service personnel plays an important part in both the delivery of operational capability and retention of Service personnel. This is a fundamental aspect of the Service Personnel Command Paper, which in itself demonstrates the commitment for cross-Government efforts to ensure support from all Departments works as well as possible. But work is already undertaken on these issues between MOD and the UK health departments through the Partnership Board and its supporting working groups. This has proved an effective mechanism for cooperation and has led to important work on, for example, specific guidance on support for Service families in the NHS Operating Framework and identification of best practice through primary care trusts that serve significant Service communities in England and Wales.

The MOD also provides a range of support for families that are relocating, including the HIVE Information Service. With about 165 HIVE offices worldwide in every significant Service location plus a remote web-based service, every Service family can access relocation support specific to their circumstances. This includes healthcare, with detailed information on the options for GP and dentist registration at the future location. The Relocation Guide—available through HIVE, online and via Families Federations—and specific pages in the Service Community area of MODWeb provide information and guidance on a range of issues, from transfer of current care to the necessary contacts for any follow up with key organisations, particularly if facing any difficulties. Nevertheless, the MOD will look for further ways in which the advice, guidance and specialist support available can be better communicated to the Service community.

25. (Recommendation 25) We consider that the MoD provides adequate mental healthcare for serving members of the Armed Forces. We have been told on visits that there is a culture of individuals 'bottling things up' inherent in the Services, but we note with approval the steps which have been taken to attempt to prevent problems through 'decompression'. This should be an integral part of the procedures for all personnel returning from operational tours. It is also important that the problems which can arise are recognised throughout the Services, so that early warning signs can be spotted and dealt with before problems get worse. We believe it is sensible to approach mental healthcare from community-based provision, delivered in conjunction with local military units, in-patient treatment being a last resort. The MoD should also review its contract with the Priory Group to assess its effectiveness. (Paragraph 97)

"Decompression" is part of the package of operational stress management that is delivered to Service personnel before, during and after their operational deployment. It is our policy that mental health issues should be properly recognised and appropriately handled and that every effort should be made to reduce the stigma associated with them. The Ministry of Defence recognises mental illness as a potentially serious and disabling condition, but one that can be treated. Diagnosis and treatment of mental illness in the Armed Forces is performed by fully trained and accredited mental health personnel.

Our mental health services are configured to provide community-based mental health care in line with the guidelines and standards set by the National Institute for Health and Clinical Excellence and the National Service Frameworks.

We do this by providing outpatient assessment and treatment at our military regional Departments of Community Mental Health (DCMH) centres sited in military bases with care provided by either military mental health care professionals or civilians employed by the MOD. This means that serving personnel usually remain with their units and receive outpatient care in a military environment.

In-patient care, when necessary, is provided regionally in specialised psychiatric units under a contract with the Priory Group.

Close liaison is maintained between local DCMHs and the Priory Group to ensure that all Service elements relating to in-patient care and management are addressed. This has worked very successfully, with appointed Service Liaison Officers regularly attending Priory facilities where Service patients are admitted. They attend consultant ward rounds and influence the care plan of these patients. The aim is to stabilise and return the individual to the community for onward management. This has helped limit the length of stay for the majority of patients.

The Priory Group won a competitive bidding process as its bid best met our requirements for access to high quality care without delay, providing regional care within easy reach of unit, base or home. The contract with the Priory Group was extended for two years under the provisions of the original contract, but is due to expire at the end of November 2008. In line with commercial practice a competitive tendering exercise is now being conducted to place a new contract.

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

The MOD is the single biggest contributor to Combat Stress. Last financial year we paid them £2.5 million in fees for the care of individual veterans with a mental health condition accepted under the War Pension Scheme as due to service. On 4 October 2007, the Minister for Veterans announced a further increase of 45 per cent to be phased over the year to reflect the build up of staff to deliver the enhanced capability required to treat war pensioners. This substantial increase represents a significant boost to the charity's finances and demonstrates the Government's continuing commitment to help Combat Stress play an appropriate part in treating veterans with mental health problems, and we will work with them to ensure that the model of care is the most appropriate. We are working closely with Combat Stress on the pilot schemes that are currently being undertaken in six locations across UK which will assist in determining the best model of care.

As we explained above in our response to the Committee's Recommendation 5, the Government welcomes an open debate about the respective roles played by the Government and by charities and voluntary groups. The forthcoming Service Personnel Command Paper will further inform that debate.

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

The Government is committed to ensuring that those who have served in our Armed Forces receive the most appropriate mental health care. In particular, we need to ensure that NHS mental health services are better able to recognise the link between service and later mental ill-health. We also need to ensure that veterans themselves are encouraged to come forward in the confidence that their concerns and background will be understood. The current piloting of a new expert veterans service within the NHS, with funding support from the MoD, should teach us a great deal about how to improve access and take-up. Once there has been an opportunity to evaluate these pilots, the other NHS Mental Health Trusts will be encouraged to develop their own plans to meet these needs, building on this model.

In addition, the Department of Health's current work to improve the response of NHS services to mental health problems resulting from trauma of all kinds, as well as the increased availability of the skills necessary to deliver these services through the Improving Access to Psychological Treatment Programme, will better equip NHS Mental Health Trusts to respond to the needs of veterans.

On the former, the Department of Health is currently taking the lead in working with the World Health Organisation to establish an agreed framework for the management of those affected by trauma and the best way of ensuring the resilience of all emergency services to traumatic events. When agreed, expected to be early summer of this year, the Department of Health will develop a regional plan for enacting this framework and, as well as implementing this in the English Regions, will make the work available to the devolved administrations.

On the latter, on top of the significant investment in mental health services over the past decade, the Government has made available an additional, initial, investment rising to £173 million by 2011 to improve the provision of evidence-based psychological treatment in the NHS. This provision will be for people with common mental health problems such as depression and anxiety disorders, conditions often experienced by veterans.

There is an ongoing debate about the efficacy of screening Service personnel for psychological problems. Current MOD policy is to conduct health surveillance of Armed Forces personnel returning from deployment so that any signs of psychological distress are detected and treated appropriately. However, research published by the King's Centre for Military Health Research (KCMHR) has found inconclusive evidence that screening personnel for possible future mental health problems is helpful, and there is evidence that it can cause problems due to the number of false positives and stigma associated with a diagnosis. We have commissioned the KCMHR to carry out a continuing major cohort study of physiological and psychological health of UK Service personnel who were

deployed to the Iraq in 2003 compared to personnel who were not deployed. This study looks at Regular and Reserve personnel. Many of their findings have already been published. The MOD has recently commissioned an extension to the study to look at the health consequences further down the line, and following deployment in Afghanistan and other theatres.

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

We are pleased to note that the Committee recognises the major contribution that Reservists make to the requirement for medical personnel. The MoD recognises that Reservists provide both additional manpower and specialist expertise using skills gained in their civilian employment and they provide personnel across a wide range of medical care specialisations. The NHS in particular provides a talent pool of qualified specialists. The military training they receive and involvement on operations provide the environment to gain skills not necessarily found in civilian life and these skills and experiences can usefully be used in their civilian employment.

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

The MoD is not complacent and strives for better integration of its reserves not only on operations but throughout Reservists' careers. The responsibility for recruitment and retention is managed by the single Services and the front line Commands responsible for force generation now attempt whenever possible to integrate Reservists' pre-deployment activity with that of Regulars at the earliest opportunity. Employer supportiveness is an important retention component for the Volunteer Reserves. SaBRE (Supporting Britain's Reservists and Employers) is a MOD campaign that provides support by providing information and advice to Reservists and their employers. Through a national marketing programme and a network of regional representatives SaBRE explains to employers the benefits, rights and obligations associated with employing a member of the Reserve Forces. The MoD recognises its obligations to mitigate the disruption caused to employers if an employee is mobilised and above all understands that the only sustainable approach is one which balances the requirements of the Government, the Reservists and the employer.

The NHS is a supportive employer of Reservists, and the MOD actively engages with the NHS to further encourage and support NHS reserves. The Chief Executive of the NHS in England visited Afghanistan recently, where he saw for himself the contribution that NHS reserves make to the DMS medical support to operations.

There are a number of initiatives being taken forward by the MoD/UK Health Department Partnership Boards and key areas include encouraging reserve service and developing the Sponsored Reserves concept. The MoD recognises the support the NHS could provide in specialist clinical areas and that developing the sponsored reserves concept could enhance the manning option available. The Sponsored Reserves concept is already being successfully used in other non-medical military cadres and a supporting legal and employment framework is already in place. Under the Defence Career Partnering (DCP) concept there is a proposal to develop a collaborative relationship between DMS and the NHS. Conceptually DCP is an arrangement between the individual, selected employers and the MoD, in which the parties co-operate to mutual advantage to enable continuous service in the Defence community, and which allows for a two-way flow of individuals between military service and civilian employment.

When Reservists terminate service they are entitled to the services provided by the Service Personnel and Veterans Agency. In addition, the MOD recognises that it has expertise to offer in certain specific circumstances, and in November 2006, it launched, in partnership with the NHS, the Reserves Mental Health Programme (RMHP). Under RMHP, the process of self-referral can be initiated by the Reservist or the individual's GP and an offer of assessment follows. If diagnosed to have a combat-related mental health condition, the MOD offers out-patient treatment via one of the 15 UK DCMHs. If more acute cases present, the DMS will assist access to NHS in-patient treatment. The MOD is working with the UK health authorities to ensure that GPs across the UK are aware of this initiative.

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