



House of Commons
Defence Committee

**Mental Health and the
Armed Forces, Part Two:
The Provision of Care:
Government Response
to the Committee's
Fourteenth Report of
Session 2017–19**

**Eighteenth Special Report of Session
2017–19**

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The Defence Committee

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Eighteenth Special Report

On 25 February 2019, the Defence Committee published its Fourteenth Report of Session 2017–19 [HC 1481] Mental Health and the Armed Forces, Part Two: The Provision of Care. The response from the Government was received on 21 May 2019. The response is appended to this report.

Appendix: Government response

During Service

Recommendation 1. We are deeply concerned that the Ministry of Defence is not consistently providing the quality of mental health care to its Servicemen and women that they deserve. We welcome the Department's invitation to the Care Quality Commission (CQC) to inspect the care provided by Defence Medical Services. However, two of the four Departments of Community Mental Health (DCMHs) inspected failed CQC standards. Service personnel have reported a wide range of experiences of military mental health care provision, including problems with speed of, and access to, treatment. This situation is completely unacceptable. (Paragraph 17)

We continue to strive to improve the quality of Mental Health Care for our Armed Forces. In September 2018, Defence Primary Healthcare implemented a new care pathway for Service personnel with common mental health disorders, with the aim of enhancing the care provided by the MOD General Practitioner (GP) and revising the referral pathways into DCMHs. The MOD Joint Medical Group (JMG) expect to see resulting improvements in care, and to have the data to support this, by the end of 2019.

In April 2019, the MOD will begin the roll-out of a national Outpatient Service Contract with Midlands Partnership Foundation Trust through a number of NHS Partners. This contract aims to provide improved access and additional capacity for high-intensity psychotherapy. JMG have also introduced a new Cognitive Processing Therapy service, specifically focused on improving care for those with combat-related post-traumatic stress disorder (PTSD).

The Care Quality Commission (CQC) inspection programme is fundamental to our quality improvement programme, and as we learn lessons from the inspections, they are implemented. Of note, none of the sites requiring improvement were because of substandard care.

Department of Community Mental Health (DCMH) Scotland has been re-inspected. While some areas were noted as still requiring improvement, progress had been made in key areas of concern and we are continuing to address the issues raised by the inspectors. The re-inspection of the second failed DCMH, at RAF Brize Norton, took place on 2 and 3 April 2019.

Recommendation 2. We recommend that the Ministry of Defence should fully review how it manages military mental health services in order to understand why there are such variations in the care offered to Servicemen and women. The Department should

also set out what it is doing to ensure that the other DCMHs are up to the standards necessary to pass future Care Quality Commission inspections and how best practice is being shared across all its mental health centres. (Paragraph 18)

We agree with the recommendation and Defence Primary Healthcare has already begun a process of assessing mental healthcare provision. The findings from this review have been implemented and are due to be re-assessed in the summer of 2019. In addition, the Defence Healthcare Delivery Optimisation Programme will further address the provision of healthcare in the Firm Base, including mental health.

The management of the mental health service remains under review to ensure that it is optimised for service delivery. We have introduced new management tools to assist with departmental performance management and will run management training sessions for DCMH staff in 2019. We continue to undertake routine governance visits, led by the Defence Consultant Advisors in Psychiatry and Psychology.

Recommendation 3. We are disappointed that the Department continues to struggle to address its longstanding shortages of mental health staff. With continued 50% shortfalls in some mental health posts, it is no surprise that some serving personnel are not being seen sufficiently quickly and a few are having to take the drastic step of funding their own care elsewhere. If recruitment does not improve, we recommend that the Department should review what it can offer in pay and other benefits to attract people into military mental health roles, either as Regulars or Reservists. (Paragraph 23)

We agree with the recommendation and have already specifically prioritised recruitment over the last six months and recruiting has improved. This is set against the context of a challenging national recruiting environment that sees the MOD, the NHS and the private sector competing for a limited number of suitably experienced mental health specialists.

Despite these challenges, advances have been made, resulting in an improved overall staffing picture of 79% at March 2019 against an April 2018 figure of 76%. In Consultant Psychologists (where the deficit was three against a requirement of six), the number required has increased to 8.5 and the deficit reduced to two against the new requirement. Work continues to address recruitment in cadres that have traditionally proved difficult to fill and this includes an examination of pay and allowances to ensure that the remuneration package offered is comparable in the market. The pay scales for MOD Clinical Psychologists are in the process of being realigned to better match those on offer in the NHS.

There are also initiatives in place to improve the recruitment and retention of MOD civilian healthcare professionals. Through these, it is expected that we will further stabilise the staffing levels, including those of mental health staff. Overall, outflow figures are low and improving. Among civilian Mental Health Nursing we gained 16 personnel between January and November 2018 while losing only five, and this trend of net gains through reducing outflow is demonstrated across mental health.

Such initiatives, designed to attract, recruit and retain the right people, are expected to result in continued and sustained improvement over time. While significant improvements have been made, this will continue to be a challenging area.

Recommendation 4. Early intervention can be crucial in preventing mental health problems from developing into more severe conditions. However, despite significant improvements in how mental health issues are perceived in the Armed Forces, the fear of damaging their career remains a significant barrier to Servicemen and women coming forward for help, with the level of support often being dependent on individual commanding officers. As we reported in Part One, we support the Department in campaigning against the stigma surrounding mental health issues and promoting help-seeking. Yet it is obvious that more still needs to be done. (Paragraph 33)

We welcome the Committee's acknowledgement of the Department's progress, and agree that we will continue to work hard to improve the mental fitness and wellbeing of our serving personnel, reduce stigma and encourage personnel to come forward.

The majority of mental health issues are both manageable and treatable and, with the recent review of Medical Employment Standards, there is now a greater understanding across Defence regarding the impact of mental and physical ill health on employment status. More than 70% of those who do present to DCMHs are returned to full fitness and can continue a productive career. Of those who do not, many are satisfied with the outcome of leaving the Armed Forces; less than 4% of personnel are medically discharged as a result of a mental health problem.

However, we agree that there is more to be done. While the stigma associated with mental health issues is not a challenge unique to Defence, we recognised that attitudes towards mental health are a cultural and societal issue and a key factor in ensuring that people feel able to come forward. As such, under the Defence People Mental Health and Wellbeing Strategy 2017-2022, we have undertaken a comprehensive overhaul in our approach to mental health and tackling stigma is one of the highest priorities. The Strategy is introducing standardised mental health and wellbeing education and training throughout a serving person's career, with better communication about what help is on offer and specific pathways available as they transition out of the Armed Forces.

Research has shown that 'positive perceptions of leadership' and 'better unit cohesion' are significantly associated with lower stigma levels and a willingness to discuss mental health matters. As such, we are introducing specialist mental wellbeing training for commanders and senior officers to equip them with the knowledge and understanding they need to role-model and embed mental health-positive leadership and management practices in their commands. The Senior Leaders Mental Fitness and Resilience Training programme, led by the Defence Academy of the United Kingdom, has been piloted and is being launched in late spring 2019 for 1 – 4* military personnel and Senior Civil Service equivalents, and a similar programme for officers (OF 3-5) will be developed in 2020. The programme will encourage and equip senior officers and leaders to create a culture of open discussion that 'normalises' how we talk about mental health and wellbeing in Defence and to develop awareness of leadership and management practices to promote mental wellbeing including during times of stress.

To assist in promoting positive attitudes towards mental fitness and to equip personnel of all ranks with tools to enable good management of their mental fitness, the single Services have introduced their own mental fitness and resilience training. The Royal Navy has developed Op REGAIN (a peer-to-peer support Royal Marine programme) and runs Stress Management Training; the Army is developing OP SMART and initiatives such

as FIRST (Fitness Integrated Resilience Skills Training) and Mental Resilience Training; and the RAF runs SMART, a resilience model for all RAF stations, using insights from the evaluation of their SPEAR programme to inform its development.

Defence is also working with the Royal Foundation to develop a campaign and a suite of training resources to promote the concept of 'mental fitness' in the Armed Forces. This will seek to reduce stigma by championing active maintenance of good mental fitness as opposed to solely focusing on 'mental illness' and encourage personnel to view mental health, like physical health, as a spectrum where poor health harms individuals and hinders performance, while good mental health maximises effectiveness and is vital to overall wellbeing.

Recommendation 5. We also appreciate that the Armed Forces medical services have an occupational health role focused on returning Servicemen and women back to full duties. However, this needs to be balanced against the time and care that an individual might need for recovery, and medical discharge should be only a last resort. (Paragraph 34)

We agree with the recommendation and welcome the Committee's recognition of the ultimate importance of maximising operational capability. We also take very seriously the duty of care we owe to our people, and this extends to ensuring that personnel are supported to return to duty over an appropriate timeframe.

More than 70% of those who present to DCMHs are returned to full mental fitness and can continue a productive career. Defence Medical Services will, as appropriate to a serving person's needs, keep periods of sick leave short as it is well recognised that being away from the work environment or not being in an employed role is detrimental to mental health and recovery. However, mental healthcare can at times be a long and complex care pathway which can span months and, in some cases, years.

If an individual does not respond to a number of care pathways and they remain in either a reduced working capacity or a non-working capacity for a long period, their ongoing/future employment will be considered at a Medical Board. At the Medical Board, their care to date will be carefully considered using a full psychiatric report from their consultant psychiatrist as well as all other medical information following which recommendations will be made to continue treatment and extend their downgrading period and time in Service, or a decision will be made to recommend their exit from Service. A career break can be requested by the individual, and this will be considered on a case-by-case basis.

Parallel to medical treatment and occupational health support provided by the Defence Medical Services, the Defence Recovery Capability ensures that the appropriate level of welfare support is provided to Service personnel designated as Wounded, Injured or Sick. This support is tailored individually to ensure a return to duty in the appropriate timeframe, or to allow preparation for life after medical discharge including employment, re-training and education opportunities.

The capability is delivered through single Services Recovery Pathways backed by the resources of single Service-led Personnel Recovery Units (PRU). Personnel Recovery Centres (PRC) run in partnership with Service charities, and specialist centres (such as the Battle Back Centre).

The Recovery Pathways are aligned with clinical treatment and rehabilitation, but do not deliver mental or physical treatment or rehabilitation. In parallel to the Recovery Process, medical boards take place as early as possible. These determine an individual's likely recovery outcome and focus the Individual Recovery Plans accordingly, based on case specific assessment and need.

Early medical board decisions provide clarity to the individual and a timeframe for those designing recovery and further support and enable the external agencies that will take over the care to make suitable arrangements. Service Manning Authorities ensure that decisions regarding employability and discharge dates are either informed by, or undertaken concurrently with, an assessment of an individual's broader needs. The core principle is one of "informed decision making" so that the discharge date is based on the recovery and resettlement needs of the individual and not simply on entitlements to resettlement and terminal leave.

In order to deliver the necessary consistency of outcome, the MOD asks five questions of transition in order to determine that the right decision is being made on behalf of the individual; no-one will leave the Armed Forces until they have reached a point in their recovery where leaving the Armed Forces is the right decision.

Less than 4% of personnel are medically discharged as a result of a mental health problem, and many of these are satisfied with the outcome of leaving the Armed Forces.

Recommendation 6. We recommend that the Department should clearly demonstrate to Servicemen and women that mental health problems are taken seriously, and their reporting does not lead to the end of their careers. This could be done by publicising examples of senior officers or non-commissioned officers (NCOs) across a wide range of Armed Forces specialisms who have sought mental health help previously without adverse effects upon their careers. (Paragraph 35)

We agree with the Committee that wholehearted endorsement of open dialogue on mental health and wellbeing by the chain of command, including amongst senior personnel, is vital in encouraging people to come forward. It is also the case that more than 70% of serving personnel who present to DCMHs are returned to full fitness and will continue a productive career and only 3 to 4% of personnel are medically discharged as a result of a mental health problem.

Help-seeking among serving personnel has increased in recent years. However, we know that there is more to do to ensure that serving personnel are confident to come forward for help and are undertaking a number of initiatives to reduce stigma and to instil a culture of positive mental wellbeing that is leadership-led.

The MOD continues to evolve its Mental Health Communications Plan which aims to counter misconceptions about the mental health of the Armed Forces and Veterans, demonstrate the support available for current and ex-Service personnel who do require support and to reduce the stigma around mental health issues. The MOD is working in close partnership with single Service colleagues across Defence, the Devolved Administrations, the Department of Health and Social Care (DHSC) and NHS England to deliver this communications activity.

The MOD has proactive Mental Health Champions, one for military personnel and another for civilians, who engage across the organisation regularly including providing constructive challenge to policy makers. In summer 2018, the Defence Mental Health Network was launched – with over 500 members, it is the largest of the staff networks and has an integrated Whole Force approach ensuring both military and civilian personnel are represented. We are also contributing to and promoting national mental health promotion campaigns such as Time to Talk Day and Mental Health Awareness Day. Further, the Senior Leaders Mental Fitness and Resilience Training programme, led by the Defence Academy of the United Kingdom, has been piloted and is being launched in late spring 2019 for 1 – 4* military personnel and Senior Civil Service equivalents, and a similar programme for officers (OF 3-5) will be developed in 2020. The programme will encourage and equip senior officers and leaders to create a culture of open discussion that ‘normalises’ how we talk about mental health and wellbeing in Defence and to develop awareness of leadership and management practices to promote mental wellbeing even during times of stress.

Recommendation 7. We also recommend that the Department must provide better mental health awareness training to officers and NCOs so that they can respond effectively and sympathetically to anyone in their unit coming forward to seek help. (Paragraph 36)

We agree with this recommendation and are taking steps to address it. The first Strategic Aim of the Defence People Mental Health and Wellbeing Strategy 2017-2022 is a leadership-based approach to mental health and wellbeing that recognises that the promotion of mental wellbeing and the prevention of mental ill-health is primarily a non-medical leadership responsibility, and we recognise the journey to embed the cultural and behavioural changes necessary to achieve the Committee’s recommendations.

Currently Officers, Senior NCOs and Junior NCOs are routinely trained in methods of stress management, and increasing operational use is made of Trauma Risk Management (TRiM), which is a unit-led model of peer-group mentoring and support. All three Services provide briefing on mental health issues prior to deployment, including such issues as how to recognise signs of potential mental health issues and what to do if personnel have concerns.

In addition to these existing measures, as part of our Mental Health and Wellbeing Strategy, we are introducing Defence-wide, standardised, mandatory and evidence-based mental health and wellbeing education and training, including specialised training for Officers, NCOs and senior military leaders.

The Senior Leaders Mental Fitness and Resilience Training programme, led by the Defence Academy of the United Kingdom, has been piloted and is being launched in late spring 2019 for 1 – 4* military personnel and Senior Civil Service equivalents, and a similar programme for officers (OF 3-5) will be developed in 2020. The programme will encourage and equip senior officers and leaders to create a culture of open discussion that ‘normalises’ how we talk about mental health and wellbeing in Defence and to develop awareness of leadership and management practices to promote mental wellbeing even during times of stress.

We are also working with partners to further enhance the ability of the chain of command to provide effective support to personnel as required. Defence is in partnership with the Royal Foundation to develop online resources and training products that will promote good attitudes towards mental fitness including the management of good mental health, as opposed to waiting to react to poor mental health. This will include bespoke materials for Command-level personnel (Officers, NCOs, and Senior Officers).

The Samaritans, working closely with the Defence and funded by a LIBOR award from HM Treasury in March 2016, are developing training for personnel in suicide prevention, including managing situations where there is risk of suicide. Defence is also working with the Big White Wall, providing serving personnel access to a digital mental health and wellbeing service offering safe, anonymous online support, 24/7 and 365 days a year.

Furthermore, to assist in promoting positive attitudes towards mental fitness and to equip personnel of all ranks with tools to enable good management of their mental fitness, the single Services have introduced their own mental fitness and resilience training in addition to Defence level programmes. The Royal Navy has developed Op REGAIN (a peer-to-peer support Royal Marine programme) and runs Stress Management Training; the Army is developing OP SMART and initiatives such as FIRST (Fitness Integrated Resilience Skills Training) and Mental Resilience Training; and the RAF and are using insights from the evaluation of their SPEAR programme to inform development of new RAF-wide resilience training.

During the Transition to Civilian Life

Recommendation 8. We agree with the many Veterans who believe that the Armed Forces are not doing enough to support and follow up with them once they have left the Services, leading them to feel that they had been abandoned. The Department has transition support programmes in place and, at least in England, there is now potentially greater coordination with the NHS for someone who is being discharged. However, there is little follow-up to establish what else might be needed once a Veteran has begun to adapt back to civilian life or to identify any development of mental health issues. We recommend that the Department revises its follow-up policy, so that there is regular engagement and offer of further support to Veterans for at least five years after discharge, including a formal medical health check for each leaver a year on. This engagement should ideally be supplemented by personal contact, for example a phone call, rather than just a derisory email. (Paragraph 48)

We acknowledge the issues that the Committee has raised and looking at the best way to follow up on support once an individual has left service.

In order to ensure to the greatest possible extent that transition into civilian life is as painless and smooth a process as possible, we are introducing a holistic Transition Policy as part of the Veterans' Strategy. The MOD already provides or facilitates various avenues of support across 'holistic transition', including: employment; health and wellbeing; welfare; housing advice; financial information and chain of command pastoral guidance. However, these are not currently coordinated under a single policy. The purpose of the new single coordinated policy which will be launched later this year is to ensure that the MOD, in partnership with others, better prepares and transitions its Service personnel and their families to successful civilian life at the end of their Service career.

The new policy will include a new bespoke Transition Service to be known as the 'Defence Transition Services' which will become operational once the policy is implemented. It will provide a "helping hand" for those Service leavers who are identified as facing the most challenges when leaving the Armed Forces. The aim of the new 'Defence Transition Services' is to provide positive support and to resolve issues and to develop an individual's personal resilience and independence. This will supplement and enhance the resettlement employment support already available through the Career Transition Partnership.

The Defence Transition Services will be provided by a new separate organisation within Veterans UK, which is part of the MOD and already operates a telephone helpline providing assistance on many issues including benefits, housing and welfare to Veterans and their families. Veterans UK also provides the Veterans Welfare Service (VWS), which provides one-to-one support where required to Veterans via a national network of welfare managers across the UK.

The MOD's Service Leavers Guide advises Service Leavers to register with an NHS GP and to identify themselves as a Veteran if they wish. Rather than wait for symptoms to progress and only reporting this at a routine health check, any Veteran with mental health concerns should, in the first instance, seek help from their GP, and in doing so be explicit that they are ex-military.

While the best option is to register with an NHS GP to ensure continuity of care and GP referral to veteran-specific health initiatives.

In England, NHS England's Veterans' Mental Health (VMH) Transition, Intervention and Liaison Service (TILS) is available to Service Personnel approaching discharge, during the transition period and as Veterans afterwards and sits in addition to full access to the Veterans' NHS GP and any local or regional mental health (or other) services that may be required. It is imperative that all Veterans register with an NHS GP and tick the GP registration form box that states they have served in HM Armed Forces. This is to ensure that any continuity of care and access to the right care can be put in place, should it be necessary. Veterans are also able to self-refer directly to the NHS's mainstream Improving Access to Psychological Therapies (IAPT) and to the specialist VMH TILS and Service Leavers have access to DCMHs for up to six months after discharge from the Armed Forces

The MOD has funded the Veterans' Gateway to trial a new outreach service for Veterans, by proactively calling Veterans who have previously been in contact with the Veterans' Gateway to ask for support. The trial identifies vulnerable Veterans who have contacted the Veterans' Gateway helpline and have given their consent to receive calls from the Veterans' Gateway. As part of the trial, trained call handlers get in touch to make sure that the Veterans are receiving the support they need. Veterans receive calls from the same adviser and can decide how often they hear from the Veterans' Gateway so that they are supported in a way that suits their specific needs.

It should be recognised that not every Veteran seeks to be identified as a Veteran and to access services due to their Veteran status, nor for their previous employer to continue to keep in touch with them we explicitly ask Service Leavers that we can remain in touch through the Joint Personnel Administration System (JPA).

Recommendation 9. The significant difficulties that some Veterans, especially those with more complex conditions, have faced with the Armed Forces Compensation Scheme is one particularly glaring example of why Veterans feel unsupported once they have left the Services. We welcome the Department’s work to improve the scheme but clearly more needs to be done and we look forward to receiving the results of its expert group’s follow-up review and the Department’s subsequent response. (Paragraph 52)

We welcome the Committee’s acknowledge of the work that we have done in this area and are committed to further improvements. The 2016 Quinquennial Review (QQR) of the Armed Forces Compensation Scheme (AFCS) concluded that the Scheme was fundamentally sound and should not require future amendment especially as the Independent Medical Expert Group (IMEG) provides ongoing independent assurance that scheme policy and decision-making reflect contemporary medical understanding of the causes and progress of disorders and injuries. The QQR raised specific issues on mental health and referred them to IMEG. Subsequently comments were included in the Fourth IMEG report dated December 2017.

In the Report, drawing on clinical insights from the literature and discussion with senior clinical colleagues, both military and civilian, working in traumatic psychological injury, led IMEG to recommend that, exceptionally and applicable to a small number of cases there should be a Level 4 mental health award. This has been accepted by the MOD and from 8 April 2019 the highest award for severe mental health disorder increased from £144,200 to £289,870 with, in addition, a 100% Guaranteed Income Payment (GIP), tax free and paid from service termination for life.

The 2019 Fifth IMEG report will include an update on the 2013 report on mental health including sections on mild traumatic brain injury and suicide. All AFCS awards include an element for mental health symptoms with around 5% of total awards paid for discrete diagnosable mental health disorders. Data confirm that of the almost 4,000 current AFCS awards for mental health, a higher percentage than for traumatic physical and disorder include a GIP, acknowledging long-term adverse impact on post service function and employability. The AFCS provision to make interim awards or payment on account before a disorder has reached a treated stable or optimum state has been subject to criticism and misunderstanding which IMEG and Defence have previously tried to address.

There remain many gaps in understanding of mental health disorders. In the context of interim awards, a particular issue is early prediction of response to treatment. In the current Review, IMEG will explore contemporary understanding of early indicators that mental health disorders may become chronic or treatment resistant.

We are also working with Veterans’ UK, who administer the scheme, to see where processes can be streamlined, modernised and, where appropriate, delivered digitally.

Statutory Provision for Veterans

Recommendation 10. The lack of civilian medical practitioners’ understanding of military culture and military mental health issues remains a significant barrier to Veterans accessing and receiving effective treatment for their mental health conditions. We welcome the work being done to improve the understanding of civilian medical

practitioners, such as the creation of Veteran-friendly GP surgeries. However, this remains small-scale and much more still needs to be done to stop Veterans feeling let down by the health care system. (Paragraph 67)

The DHSC agrees that, whilst there has been significant improvement in civilian practitioners understanding the needs of Veterans, we are still at the stage of building understanding the system. Whilst the issue surrounding the lack of military knowledge amongst clinicians is rapidly being addressed, the DHSC and NHSE recognises the vital importance of ensuring that momentum is not lost. The MOD will continue to work with the DHSC and the NHS across the UK to increase awareness among Service Leavers including making use of the Veterans' ID card.

As part of rapidly addressing the issue of improving military knowledge amongst clinicians, military and veterans' health is now an established part of the national curriculum for GPs across the United Kingdom. This has been part of the qualifying examination for membership of the Royal College of General Practitioners (RCGP) for over four years. New GPs qualifying will be better versed in understanding the needs of Veterans but, we also need to ensure that the many thousands of doctors already working in NHS are similarly versed.

NHS England is also engaging with the Royal College of Psychiatrists, the Royal College of Nursing, the College of Emergency Medicine and the College of Paramedics to extend Veteran awareness. More than 150 GP practices in the West Midlands have signed up to become Veteran-aware accredited practices in recent months and the initiative will be rolled out across England over the next few years.

The Government also publishes the Service Leavers Guide, which offers information and advice prior to and after leaving Regular service including registering with a GP. The next iteration of the Guide is due to be published in April and will contain a more expansive section on the services available to Veterans and how to access them.

The Veterans Trauma Network, the Veterans Covenant Hospital Alliance and the Armed Forces Community e-learning modules also seek to make sure NHS healthcare providers and staff, not only clinicians, are fully aware of their duties and help to improve understanding of, the needs of all members of the Armed Forces Community not only Veterans.

The Welsh Government updated their Armed Forces Covenant - Healthcare Priority for Veterans (WHC (2017) 41) guidance to health boards and NHS trusts in September 2017. The guidance updates and clarifies guidance on priority treatment and healthcare for Veterans and reaffirms the commitment to the Armed Forces Covenant. It calls on Chief Executives of health boards and NHS trusts to raise awareness of the Armed Forces Covenant among all those working in the NHS in Wales and of the commitment, when making referrals for diagnosis or treatment or arranging waiting lists, to provide priority treatment for Veterans suffering from health conditions directly related to their Service, subject to clinical need. The guidance also provides information on the process of identifying, recording and referring Veterans eligible for priority healthcare. E-learning modules of Veterans' healthcare are available to all NHS staff in Wales, including those in primary care.

In Scotland, NHS Champions for Armed Forces and Veterans are in place in every health board; their role is to act as a Veterans' advocate and to help ensure fair and equitable treatment for Veterans. The Scottish Government have communicated the policy on priority treatment for Veterans to all NHS Boards, and the Champions for Armed Forces and Veterans are responsible for ensuring the implementation of these guidelines. In addition, updated material, which includes guidance for GPs, has been provided to healthcare practitioners and to each NHS Board Veterans Champion to raise awareness of Veterans' healthcare needs.

The Scottish Government are also actively engaging with the RCGP to encourage and improve the level of understanding of Veterans' needs for civilian medical practitioners. Scottish Government officials have also worked with the organisation Veterans Scotland and NHS 24 to update online information about Veterans' health services on NHS Inform, improving access for Veterans and those about to leave the services. Furthermore, the Veterans First Point model in Scotland which provides specialist Veteran mental health services includes the use of peer support workers who are Veterans or have experience of military culture. Each of the six centres across Scotland are resourced by peer support workers in addition to a dedicated clinician.

In Northern Ireland, Armed Forces' families and Veterans have access to mental health services within the NI Health and Social Care system on a similar basis to other members of the Northern Ireland population and access to health care services is based on clinical need.

Recommendation 11. We recommend that the Department of Health and Social Care updates us within six months on progress in improving civilian practitioners' awareness of Veterans' mental health, including how this has been measured and what other actions it has since taken or plans to take for further improvement. The Department should also update us on the work to exchange best practice with the other nations in the UK. (Paragraph 68)

The DHSC agrees with the recommendation that assessing activities to improve civilian practitioners' awareness of mental health issues among Veterans is important and propose to employ already established and robust reporting mechanisms available through their support for the Armed Forces Covenant.

The DHSC provides regular updates to the Cabinet Office-led Covenant Reference Group and the MOD-led Covenant Working Group. Both groups feed into the Ministerial Covenant and Veterans Board and the publication of the Armed Forces Covenant Annual Report.

The DHSC will report to these groups on the progress of the RCGP Veterans Awareness and publish figures annually as part of the Armed Forces Covenant Report. The DHSC will also include data on other awareness initiatives including the Veterans Covenant Hospital Alliance.

Best practice in this area is shared via the MOD/UK Departments of Health Partnership Board and its relevant sub-groups. Further, NHS England's Armed Forces team are visiting the Veterans First Mental Health team in Scotland later in 2019 and the DSHC will encourage similar visits between the four nations. The Contact group also facilitates joint working across all nations in the UK.

NHS England's Armed Forces team host biannual clinical fora to share best practice between mental health services, including statutory, charity, bespoke and general, that treat Veterans.

An outstanding example of sharing best practice is the work of the NHS England Veterans Trauma Network (VTN) and NHS Wales on developing a Welsh version of the VTN which will provide the basis for a more UK-wide pathway and will help to reduce service variation for Veterans and their families.

The Welsh Government funds the Veterans' NHS Wales service. This operates on a hub and spoke model based in Cardiff and Vale University Health Board with spokes in five other health boards. This has enabled the service to provide equitable, National Institute for Health and Care Excellence (NICE)-approved evidence-based psychological therapies across Wales.

In Scotland, Veterans have access to a range of evidence-based treatments through mainstream NHS services, including specialist and mainstream mental health services.

The Scottish Veterans Commissioner's report 'Veterans Health and Wellbeing – A distinctive Scottish Approach' of April 2018 is the main driver to delivering better health outcomes for Veterans in Scotland. The Scottish Minister for Mental Health announced in her annual statement to the Scottish Parliament on Veterans in September 2018 that the Scottish Government accepted all the recommendations and they are now proceeding towards implementation. One of the recommendations from the report was for the Scottish Government to look into establishing a Managed Clinical Network (MCN) which is currently being explored through the NHS National Services Division as a potential longer-term approach to coordinated health services for Veterans. Networks are a well-established way of driving improvement in the quality of care through a coordinated approach to things like service mapping; improving care pathways; tackling inequalities; developing standards; training; awareness raising; data support. The MCN would allow the support to Veterans to have at its core a common approach across Scotland.

Recommendation 12. The differences at both local and national level in the availability of statutory Veteran-specific services have led to wide variations in the care a Veteran might receive. The worst affected are Veterans living in Northern Ireland as there is no statutory provision for many of them. The four UK health departments have the responsibility for ensuring consistency within their nation and for meeting increasing demand. However, as we concluded in Part One, even though health care is devolved, the Department cannot abdicate its responsibility for ensuring that all Veterans receive comparable care regardless of where they live. (Paragraph 76)

The DHSC agrees with this recommendation. We recognise that variation in care does exist as health is a devolved matter and therefore mental health provision can vary between nations and localities for all mental health services not just those specifically aimed at Veterans. Variations are also as much a part of the differences in the Veteran population as they are in service provision. However, whilst these variations exist, we agree with the Committee that they should not amount to a disadvantage to Veterans in the quality of care they receive based on where they live.

The MOD has never had primary responsibility for Veterans' healthcare, which has been the responsibility of the NHS since its launch in 1948 as it has for all members of the general population. The MOD continues to play a vital part in advocating for our Veterans across all Government Departments.

A number of initiatives are underway across England and the Devolved Administrations to ensure quality treatment for Veterans wherever they live in the UK. The DHSC is working on a paper with the Devolved Administrations on how we can ensure a joined-up approach to providing mental health support in the UK. The paper will set out proposals for how we can work towards a joined-up approach, within the framework of self-determination that devolution presents. This paper is due to be presented to the Ministerial Covenant and Veterans Board in May 2019.

In Northern Ireland, Armed Forces' families and Veterans have access to mental health services within the NI Health and Social Care system on a similar basis to other members of the Northern Ireland population and access to health care services is based on clinical need.

The newly-formed NI Veterans Support Office is helping to better co-ordinate the efforts of the Veterans Support Committee with other departments and health trusts across Northern Ireland. They are already linked into the Veterans' Champions in each of the 11 local authorities in Northern Ireland, as well as UK-wide initiatives, including the Veterans' Gateway.

£300,000 has been allocated over five years to improve the capacity and capability of Local Authorities and other service providers in Northern Ireland to apply for Armed Forces Covenant funding. The Fund has seen an increase in the number and quality of applications from Northern Ireland as a result. For example, two significant projects to tackle serious stress in Veterans, carers and families have recently been announced:

Inspire - Recovery Together

The portfolio will bring together a range of innovative wellbeing and support services across Northern Ireland, safely case-managed and clinically governed. The portfolio will offer services delivered within a stepped care model from low through to high intensity support interventions, to enhance the support for Veterans, their families and carers across Northern Ireland.

Ely Centre - Veterans Support

The project will provide a Veterans and family crisis response support project which will deliver a crisis intervention and de-escalation service to Veterans and their families or carers who reside in County Armagh, Fermanagh and Tyrone. This will include health and wellbeing support interventions, intensive psychotherapy within a holistic approach to health and wellbeing and benefits/pension advice for Veterans and their immediate families.

The Veterans Support Office, the Reserve Forces & Cadets Association Northern Ireland (RFCAN I) and HQ 38 Brigade have local contacts which they are very effective at using to ensure the best outcomes for Service personnel, Veterans and their families in Northern Ireland. Successful projects range from the creation of health and wellbeing hubs to helping injured Veterans overcome physical, mental health and social isolation barriers.

The MOD, through the Army, also funds the Ulster Defence Regiment (UDR) and Royal Irish (Home Service) (HS) Aftercare Service (ACS). The ACS currently provides welfare advice and medical support including psychological therapies. Engagement is by specialist trusted medical service providers with experience of treating ex-Service personnel, and in some cases their families. Once eligibility is confirmed then there is a clinical assessment. All former UDR and Royal Irish (HS) soldiers that served during Operation Banner (1970 to 2007) and their families are eligible where appropriate treatment is not available through normal statutory services within a reasonable time.

We will continue to review and progress Veterans' services in Northern Ireland and report progress through the Armed Forces Covenant Annual Report to Parliament.

Recommendation 13. We recommend that the Ministry of Defence works with the health departments of England, Scotland and Wales, to address urgently the gaps in Veteran-specific provision across the UK. We also repeat our recommendation from Part One on the development of a shared set of methodologies for collecting and analysing Veteran mental health data across the UK. This should include outcomes so that best practice can be identified and shared across the four nations. (Paragraph 77)

Both the MOD and DHSC agrees with this recommendation and, as mentioned in the response to Recommendation 12, the DHSC is currently working with the Devolved Administrations on a paper that looks at ways to join up mental health provision across the UK. As part of this, the DHSC and the Devolved Administrations are looking at ways in which data collection and sharing best practice can be improved. Whilst the complexity of dissimilar services with differing access times brings challenges for shared methodologies, we do not believe these challenges are insurmountable.

The NHS in England are seeking to understand the gaps in Veteran-specific and mainstream mental health provision and as well as collecting data from the priority services, Veterans are identified in the IAPT and Mental Health Data Set.

National Records of Scotland propose including a question in the 2021 census to provide robust statistics on the size, location and profile of the Scottish Veterans' population. The final decision on the content of Scotland's Census 2021 questionnaire will ultimately be made by the Scottish Parliament and the legislation to allow this will be laid before the Scottish Parliament in early 2020.

As discussed in the response to Recommendation 16, the Departments are aware of work by the Contact Group in seeking agreement on common measures and the MOD/UK Departments of Health Partnership Board will look to see how this can be supported.

Recommendation 14. We also recommend that the Department sets out how it will help Veterans living in Northern Ireland to access Veteran-specific mental health treatment available to those living in the rest of the UK. (Paragraph 78)

In the United Kingdom the provision of healthcare, including mental healthcare, to the general population, including Veterans, is devolved but best practice is shared. It is for each of the four home countries to decide how best to provide appropriate healthcare to their local populations. In Northern Ireland, Armed Forces families and Veterans have access to mental health services within the Health and Social Care system on a similar basis to other members of the Northern Ireland population and access to health care services is based on clinical need.

The newly-formed NI Veterans Support Office is helping to better co-ordinate the efforts of the Veterans Support Committee with other departments and health trusts across Northern Ireland. They are already linked into the Veterans' Champions in each of the 11 local authorities in Northern Ireland, as well as UK-wide initiatives, including the Veterans' Gateway.

£300,000 has been allocated over five years to improve the capacity and capability of Local Authorities and other service providers in Northern Ireland to apply for Covenant Funding. The Fund has seen an increase in the number and quality of applications from Northern Ireland as a result. For example, two significant projects to tackle serious stress in Veterans, carers and families have recently been announced:

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The portfolio will bring together a range of innovative wellbeing and support services across Northern Ireland, safely case managed and clinically governed. The portfolio will offer services delivered within a stepped care model from low through to high intensity support interventions, to enhance the support for Veterans, their families and carers across Northern Ireland.

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The Veterans Support Office, the RFC NI and HQ 38 Brigade have local contacts which they are very effective at using to ensure the best outcomes for Service Personnel, Veteran and their families in Northern Ireland. Successful projects range from the creation of health and well-being Hubs to helping injured Veterans overcome physical, mental health and social isolation barriers and extends to larger projects such as the creation of a Veterans and family crisis response support project to deliver crisis intervention and de-escalation services to Veterans and their families or carers.

The MOD, through the Army, also funds the UDR and Royal Irish (Home Service) Aftercare Service (ACS). The ACS currently provides welfare advice and medical support including psychological therapies. Engagement is by specialist trusted medical service providers with experience of treating ex-service personnel and in some cases their families. Once eligibility is confirmed then there is a clinical assessment. All former UDR and Royal

Irish (HS) soldiers that served during Operation Banner (1970 to 2007) and their families are eligible where appropriate treatment is not available through normal statutory services within a reasonable time.

Recommendation 15. The creation of Veteran-specific services has meant that Veterans should generally be able to access mental health care more quickly than the general population. However, it can still take far too long for Veterans to be able to access care when they need it, with missed waiting list targets meaning Veterans could be waiting up to a year. In many cases, this is because capacity cannot keep up with demand. When Veterans seek help for their mental health issues, some may need immediate treatment to prevent the problem from quickly worsening. Failure to do so can lead to serious, and even fatal, consequences. (Paragraph 85)

The DHSC agrees with the Committee that Veterans should receive priority access to mental health treatment for service related conditions. We agree with the Committee that long waiting times for Veterans are not acceptable. However, health is a devolved matter and different Administrations have responsibility for determining policy on the treatment of Veterans. Veterans that need immediate mental health treatment receive it through mainstream crisis/home care teams, or psychiatric liaison services in A&E departments like other members of the general population. As stated in our responses to recommendations 12 and 13, DHSC is working with the Devolved Administrations on how a joined-up approach for mental health services for Veterans can be delivered. In addition, there is work already underway across the UK to reduce waiting times for Veterans.

In England, waiting times for services for Veterans and for the general population (which Veterans benefit from) have been significantly reduced. Over 20,000 Veterans are utilising mainstream mental health services with very positive outcomes, often better than the general population.

Veterans benefit from shorter waiting times for Veteran-specific services, with an average wait of 18 days. Capacity is being increased in line with the increased funding from the NHS England Long Term Plan announced on 17 December 2018 to ensure that access targets are achieved. It is noted that the targets which have been set for delivering care are sometimes shorter than is clinically appropriate for Veterans to be ready to start therapy. The targets have helped provide the necessary momentum for delivering services to Veterans with urgency and raise the profile of the needs of Veterans in the NHS.

Veterans' NHS Wales operates an open access referral allowing GPs and other NHS practitioners, third sector stakeholders and the Veterans themselves or their families to refer online, via email or telephone. Where a Veteran is in need of a rapid response, therapists will use their clinical discretion to expedite them to therapy. Veterans' NHS Wales provides management information to the Welsh Government on the number of referrals and waiting times across Wales. These are not formal targets, but Veterans' NHS Wales has agreed to provide information against 28 days opt-in to assessment and 26 weeks assessment to treatment. These are similar to other Welsh Government referral to assessment and access to psychological therapies targets. In November 2017, the Welsh Government announced an additional £100,000 recurrent funding to Veterans' NHS Wales for additional Veterans Therapists to mitigate against a rising demand for the service and to bring down waiting times.

Veterans in Scotland receive priority treatment for ongoing health problems that are a direct result of their service subject to clinical need. Everyone in Scotland has access to a range of person-centred mainstream NHS services. Should a Veteran need immediate treatment then they will receive the required treatment through the appropriate pathway. If treatment can be provided through the services at Combat Stress or Veterans First Point, then the individual would be referred for treatment subject to clinical need.

Recommendation 16. We repeat our Part One recommendation that the Ministry of Defence and the four UK health departments, alongside charities, must develop a common understanding of demand for Veteran mental health care and ensure that enough resources are allocated to meet demand so that waiting time targets are fully met. (Paragraph 86)

The DHSC agrees with this recommendation, as the science of measuring and analysing demand for services is not well understood as help-seeking behaviour and presentation of illness vary significantly from individual to individual.

As mentioned in the response to Recommendation 12, the DHSC is currently working on a paper with the Devolved Administrations that looks at ways to join up mental health provision across the UK. Determining patient need and demand to meet those needs will be part of this work. In addition, the paper will look at ways in which data collection and sharing best practice can be improved. The Departments are also aware of the work of the Contact Group in seeking agreement on common measures and the Department will look to see how this can be supported.

The provision of further funding by the MOD to the Veterans' Gateway will enable creation of a phone application based on Northumbria University's "Map of Need" work, which will be badged under the Veterans' Gateway branding and will enable Veterans to understand what support is available to them locally.

The Contact Group of mental health charities is developing a metrics template, which will endeavour to identify top level trends in demand across the Armed Forces Community, including unmet need, through sharing data and information, together with initiatives to inform and populate the developing "Map of Need" with mental health data. Contact also expect to receive increasing levels of feedback from their work to enable them to develop a common assessment framework and improve case management; both of which will improve understanding of demand across the Armed Forces community. This will be further supplemented by other new sources of data including the expanded Combat Stress Helpline and Contact's proposed crisis text line. It is anticipated that this range of initiatives will help to identify gaps in service delivery, which will in turn allow discussion between the NHS in England and the Devolved Administrations and service providers in the Service Charity sector and wider third sector.

Recommendation 17. We expressed significant concerns about the confusion surrounding priority treatment in our Part One inquiry, and it is clear that many Veterans are not receiving priority treatment for their service-related injuries, with civilian medical practitioners' lack of knowledge of this principle of the Armed Forces Covenant— and indeed of the Covenant itself—being a key factor. We welcome the work by the Ministry of Defence and Department of Health and Social Care to establish a clearer definition of priority treatment by 2019–20. However, this must be

accompanied by a clear strategy to ensure that the definition and its consequences are understood and implemented across the NHS and that best practice is shared with the devolved administrations. (Paragraph 91)

The DHSC agrees with the Committee's recommendation that a clear strategy is needed and development of this is a priority. In line with the Defence People Mental Health and Wellbeing Strategy and the *Five Year Forward View for Mental Health in the NHS in England*, the MOD will work with the DHSC and in consultation with the Devolved Administrations to develop a clear definition of priority treatment and work together to develop a simple clear guide that outlines the Veterans' specific services that are available across the UK and practical steps to put clinical priority into action for Veterans with service attributable conditions whilst ensuring fairness to all NHS patients.

The DHSC are keen to share and work with the Devolved Administrations and suggest that the MOD/UK Departments of Health Partnership Board has final sign-off on the definition and guide.

As mentioned in the response to Recommendation 10, military and Veterans' health is part of the national curriculum for general practitioners across the United Kingdom. This has been part of the qualifying examination for general practitioners, membership of the RCGP for over four years.

Knowledge of the Armed Forces Covenant is increasing and the greater emphasis on encouraging Veterans to register with an NHS GP and identify themselves as a Veteran after discharge will help further. The new Veteran ID card will ensure the process of validating service is as straightforward as possible, so that ex-Service personnel can access support for issues related to their service quickly, where needed and will be detailed in the guidance issued with the Veteran ID card.

Recommendation 18. We repeat our recommendation from Part One that the Government should ensure that once it has set out how priority treatment should be implemented in practice, this clarification is cascaded down to both NHS staff and Veterans and their families across the whole of the UK. For example, it may be that the only way to prioritise service related mental health conditions is to have separate specialist facilities at which to treat them, but this approach needs to be made clear to all. (Paragraph 92)

The DHSC agrees with this recommendation that a new definition and practical advice surrounding implementation should be shared with health professionals and put into a format that is suitable and meaningful for members of the Armed Forces community.

As part of our developing work for priority treatment discussed under Recommendation 17, the MOD will work with the Department of Health and Social Care and in consultation with the Devolved Administrations to develop a clear definition of priority treatment and work together to develop a simple clear guide to outline the Veterans specific services that are available across the UK and practical steps to put clinical priority into action for Veterans with service attributable conditions whilst ensuring fairness to all NHS patients.

There are already a number of bespoke priority services that are available to Veterans including VMH TILS, VMH Complex Treatment Services (CTS) and the Veterans Trauma Network and the guide and supporting documents will include information on these and other services and how Veterans and their families can access them.

The Welsh Government's reissued Armed Forces Covenant - Healthcare Priority for Veterans (WHC (2017) 41, dated 4 September 2017, clarifies that Priority Treatment applies only to conditions which are service-related, and Veterans will not be given priority over other patients with more urgent clinical needs. In Wales this would apply primarily to physical health conditions as those with a service-related mental health problem would be referred to Veterans' NHS Wales. Through Veterans' NHS Wales, as a bespoke service, Veterans are not 'competing' with the general population and as such can be considered to be receiving 'priority' treatment.

The Scottish Government note that specialist Veteran services should be embedded as local services within Partnership areas; and it is the responsibility of local Health and Social Care Partnerships to deliver long-term sustainable services. The Scottish Government have made significant funding available to NHS Scotland and expect local Partnerships to make future funding decisions for their areas that reflect Veterans' priority and the needs of their own local populations. Local areas have the right to determine the best approach for their areas, and the Scottish Government respects that right.

In Northern Ireland, Armed Forces families and Veterans have access to mental health services within the Health and Social Care system on a similar basis to other members of the Northern Ireland population and access to health care services is based on clinical need. Our response to Recommendation 12 provides information regarding the provision of services and support to Veterans and their families in Northern Ireland.

Recommendation 19. The new Transition, Intervention and Liaison and Complex Treatment Services were created, not just to help Veterans but also to try and get around the dichotomy whereby the Ministry of Defence and the Armed Forces Covenant argue that Veterans should receive priority treatment in the NHS, whereas the Department of Health and Social Care traditionally prioritises strictly according to clinical need. The creation of a bespoke service for Armed Forces Veterans is very much to be welcomed. Nevertheless, it is scandalous that in an NHS budget of over £150 billion UK wide, less than £10 million per annum (0.007%) has been allocated to this service, which is swamped by the scale of demand. Health Ministers need urgently to recognise this deficiency and use part of the very significant increase in NHS funding envisaged under the new NHS Ten-Year Long-Term Plan to increase substantially the resources provided to the TIL and CT services, in order to make them truly fit for purpose. Those who have worn the uniform of their country deserve no less and NHS Ministers must be prepared to be held firmly to account on this matter. (Paragraph 98)

The DHSC agrees with this recommendation and welcomes the Committee's championing of the importance of appropriate resourcing to the provision of quality services for Veterans. The MOD also welcomes this and notes that the provision of long-term care for Veterans is not within the remit of, or resourced by, the MOD.

The further £10 million announced for Veteran's health as part of the NHS England Long Term Plan on 17 December 2018 increases the overall funding for VMH TILs and its associated VMH CTS to £16.4 million. This provision is in addition to the increase in funding for adult mental health services, which Veterans can also access to receive care.

Looking ahead, NHS England has committed to mental health receiving a growing share of the NHS budget, worth in real terms at least a further £2.3 billion a year by 2023/24 over current levels, which is planned to reach a record £12.1 billion in 2018/19.

In this time, NHS England is committed to expanding its support for all Veterans and their families as they transition out of the Armed Forces, regardless of when they left the service. Local transition, liaison and treatment services provide support for a range of healthcare and social needs. By 2023/24, these services will expand access to complex treatment services as well as targeted interventions for Veterans in contact with the criminal justice system.

It is also noted that the Committee's Report refers only to expenditure in England. In November 2017 the Welsh Government announced an additional £100,000 recurrent funding to Veterans' NHS Wales, bringing total annual funding to £685,000. The Scottish Government's Programme for Government 2018/19 announced an additional £250 million of investment in mental health over the next five years, to introduce a package of measures to improve services for children, young people and adults, and embed support for good mental health across our public services. Veterans in Scotland have access to a full range of community, hospital and specialist NHS mental health services.

Each NHS Board has a Veterans Champion to act as the Veterans' advocate and to help ensure fair and equitable treatment for the ex-Service community in order to meet the intent of the Armed Forces Covenant, in that "those who serve in the Armed Forces, whether regular or Reserve, those who have served in the past, and their families, should face no disadvantage compared to other citizens in the provision of public and commercial service". Across Scotland, a range of evidence-based treatments are available, including for PTSD, determined by individually assessed needs. Individuals with PTSD can also have other mental or physical health needs, and the NHS provides a holistic approach to care and treatment.

The funding package for the Scottish Government Programme for Government comes in addition to the £150 million investment over five years that is already underway to support delivery of the Mental Health Strategy, of which many of the key themes and commitments will impact positively on Veterans and their families. In addition, the Scottish Government co-fund Veterans First Point with local health boards and provides funding to Combat Stress to provide specialist and community outreach mental health services for Veterans and their families in Scotland at their facility in Ayrshire. Altogether, the Scottish Government will spend £5.8 million in total on Veterans' Mental Health services between 2018–19 and 2020–21.

The Contact group of mental health charities already works to identify best practice and promulgate it between the four national health Departments. In addition, it is also working to improve the consistency and continuity of case management across the UK, which remains patchy. This seeks particularly to smooth the passage between different levels of support for individuals and to ensure that statutory and charitable provision can

work better together. A workshop is scheduled for mid-June in Edinburgh to develop this further. Contact also note that data from NHS England's VMH TILS and VMH CTS on referrals, waiting times, and onward referrals will inform understanding of the demand trend, and that these services are a significant step forward and provide a superior structure for the third sector to be plugged into where capacity constraints require it.

Recommendation 20. We are very concerned by the insufficient provision of long-term statutory care of Veterans with complex mental health conditions. Time limits on treatment—which anyway may not be effective for the most complex cases—mean that those with the greatest need have nowhere to go. We recommend that the Ministry of Defence, in conjunction with the four UK health departments, set out how it will develop long-term care provision for Veterans with complex mental health conditions. (Paragraph 99)

The MOD notes that long-term and complex care for Veterans is the responsibility of the DHSC, the NHS in England and its equivalents in the Devolved Administrations. The MOD is not responsible for the provision of healthcare, including mental healthcare, for Veterans but works collaboratively with statutory services to advocate for Veterans.

The DHSC agrees with the Committee that long-term care provision for Veterans with complex mental health conditions needs to be fully embedded within the English health system. The Veterans Mental Health Complex Treatment Services (CTS) in England are still very new and there has not yet been enough time to determine the capacity or duration needed for the services. However, these determinations are a priority for NHS England to ensure that the VMH CTS is meeting the needs of Veterans with complex mental health issues across England.

NHS England's VMH CTS was launched in April 2018. On 17 December 2018 NHS England announced that the capacity of the VMH CTS will double providing treatment for up to 1,000 Veterans with complex mental health needs. This will provide more time to determine the capacity or duration needed for the service being provided. VMH CTS will be reviewed as part of normal contract review and consideration given to a higher intensity service. The NHS England Long Term Plan commits to expanding access to complex treatment services, as well as targeted interventions for Veterans in contact with the criminal justice system, by 2023/24.

There is no set time limit on Veterans' NHS Wales sessions. While a clinical need remains and both the therapist and patient feel progress is being made, treatment will continue. Veterans' NHS Wales has established a common care pathway of trusted expert partner organisations, which includes Change Step who provide peer mentors with a military background and a lived experience of poor mental health or addiction. Between assessment and treatment, Veterans have access to a peer mentor to offer support on a variety of often complex psychosocial problems.

The Scottish Government's Mental Health Strategy 2017-27 highlights the Scottish Government's support for the ethos of the Armed Forces Covenant and, as set out in *Renewing Our Commitments*, that no one should suffer disadvantage as a result of military service. Many of the key themes and commitments in the Strategy will impact positively on Veterans and their families, which has improving access to services and supporting

earlier intervention at its core. In supporting efforts to meet the needs of Veterans and their families, the Strategy encourages local partnerships to consider how best to provide services locally for them.

Recommendation 21. Far too many Veterans, whose relationships have broken down and who are in crisis, having already been diagnosed as suffering from severe conditions, such as PTSD, are having to wait up to a year to enter into a suitable treatment programme. This is utterly unacceptable. Many of these Veterans only see their condition deteriorate further whilst waiting for access to treatment and, in the most extreme cases, they take their own lives whilst awaiting help. To prevent this, patients must be continually monitored and reassessed during the gap between initial diagnosis and the commencement of treatment. (Paragraph 100)

We are working hard to reduce waiting times across the UK recognising that variations are in part due to health being a devolved matter, where different Administrations have responsibility for determining policy on the treatment of their local population, including Veterans.

The DHSC agrees with the Committee that Veterans in crisis should not face long waiting times for treatment. As previously mentioned in the response to Recommendation 15 in England, over 20,000 Veterans utilise mainstream mental health services with very positive outcomes. Evidence suggests that the longer waits are in seeking help, rather than in access to services. In England waiting times for services for Veterans and for the general population (which Veterans benefit from) have been significantly reduced and bespoke Veterans' services have an average wait of 18 days. It is noted that the delivery targets are sometimes shorter than is clinically appropriate for Veterans. Capacity is being increased in line with the increased funding from the NHS England Long Term Plan announced on 17 December 2018 to ensure that access targets are achieved.

Evidence suggests that the longer waits to receive care are the result of Veterans delaying in seeking help or not knowing where to find help, rather than in access to services. DHSC and NHSE agree that more must be done to assist and encourage Veterans to access mental health services, so those in crisis get help sooner.

As noted in the response to Recommendation 20, Veterans' NHS Wales impose no time limit on sessions and treatment continues while there remains clinical need. Veterans' NHS Wales has established a common care pathway of trusted expert partner organisations, which includes Change Step who provide peer mentors with a military background and a lived experience of poor mental health or addiction. Between assessment and treatment, Veterans have access to a peer mentor to offer support on a variety of often complex psychosocial problems.

In Scotland, the average wait for Psychological Therapies is six weeks and it is recognised that some individuals wait too long for treatment. Patients waiting over a year for treatment may have complex needs that require multi-agency co-ordination, which takes longer to arrange.

The Scottish Government is determined that the standard (for 90% of patients to be seen within 18 weeks of referral) across Scotland, is met and is investing £54 million over four years (2016-2020) to help Boards improve access and recruitment/retention. The Scottish

Government also set out plans in the 2018/19 Programme for Government to utilise technology to extend access for adults to a range of support services, and to reaffirm the importance of meeting Waiting Times Standards.

Recommendation 22. There needs to be a highly professional place of safety to which these Veterans can be sent as soon as they are diagnosed, in order to be stabilised and to begin to receive assistance for their recovery. Following residential treatment, they should then be discharged directly into a TILS/CT programme back in their own locality but without any discontinuity of treatment or gap in their care pathway. (Paragraph 101)

The Committee raises an important point through its recommendation. The DHSC agrees that when a Veteran needs a place of safety, that need is urgent and a high standard of care is needed to help stabilise them.

The NHS in England strives to ensure that professional places of safety are available for those that need them, as close to the individual's home or community as possible. Veterans who need immediate mental health treatment receive it through mainstream crisis/home care teams or psychiatric liaison services in A&E departments, like other members of the general population.

The Serious Case Review into Winterbourne View care home, published in 2012, highlighted the problems individuals face when located in care far away from their families and a familiar environment. Since the publication of the report, the focus of the NHS has been on ensuring that as many Veterans are treated at home and in the community as possible, because this represents best evidence-based practice. The NHS report of the engagement exercise for developing mental health services for Veterans in England also showed that care provided at home or in the community is what Veterans and their families want. Facilities provided in this way enable the NHS to react quickly, facilitate safeguarding, maintain employment and relationships and avoid expense.

The DHSC will work with NHSE to review the existing arrangements for the urgent mental health care needs of Veterans, to see how the arrangements can be strengthened as recommended by the Committee. In particular we would want to ensure that residential care was as minimally disruptive to a Veteran's life as possible and without any break in service once they return home.

The Scottish Government will allocate £1.4 million per year until 2021 to NHS Ayrshire and Arran in order to facilitate treatment within Combat Stress community-based and residential treatment programmes for Veterans residing in Scotland.

If required, for Veterans with mental health related needs, a recommendation will be made for a clinical assessment, conducted by a Community Psychiatric Nurse, Occupational Therapist, or Combat Stress Therapist. Where appropriate, Veterans will be referred for treatment within a Combat Stress residential/community-based psychological treatment programme. Alternatively, Veterans may be advised to make a self-referral to a GP in order to access mainstream NHS mental health. Combat Stress may also make referrals to a range of other health and social care services (both statutory funded and third sector organisations).

Dedicated research in Wales by Professor Jonathan Bisson points to community-based treatment as the most effective method of treatment for Welsh Veterans. Services should take into account NICE guidelines, which are also clear that the evidence base suggests that PTSD should be treated in the community. An independent report published in 2013 by Professor Rosemary Kennedy CBE, Colonel Commandant, Queen Alexandra's Royal Army Nursing Corps, concluded that Wales does not have a critical mass of Veterans with PTSD to make a residential centre viable within Wales.

In Northern Ireland, Armed Forces' families and Veterans have access to mental health services within the NI Health and Social Care system on a similar basis to other members of the Northern Ireland population and access to health care services is based on clinical need.

Recommendation 23. The Committee strongly believes that it makes sense for such a centre to be collocated with the new state-run Defence and National Rehabilitation Centre (DNRC) for physically injured serving personnel at Stanford Hall. The DNRC evolved from Headley Court, which rightly established a world-class reputation for the treatment of the physically wounded from conflicts such as Iraq and Afghanistan and it should be a national aspiration to establish a similar world-class centre for the treatment of mental injuries relating to service as well. The NHS should urgently consult with the Ministry of Defence and the DNRC in order to establish this facility with an initial operating capability within the next 12–18 months. (Paragraph 102)

The MOD and DHSC welcomes the Committee's recommendation that the DNRC presents an opportunity for establishing a world class centre of excellence for Mental Health care services for Veterans and the public. We would like to explore this option further in the months ahead.

The Committee's recommendation sets out the importance of having ready access to a centralised source of expertise in order to deliver the best possible care to men and women who are serving or have served their country. We agree that wherever serving personnel, Veterans, families or carers are in the UK, those who are struggling with mental health issues should be able to access high quality care quickly and in an environment that understands their culture and the context of their needs.

A lot of work has been done over the past decade to move mental health services to the local delivery model. The Committee's recommendation has prompted the DHSC and the MOD to work with NHS England to take stock of how we ensure best practice on complex mental health conditions is developed and disseminated to the NHS, both in England and across the UK. We recognise that not every local mental health service will have the necessary experience in dealing with specific complex mental health cases in Veterans or will know who to turn to for advice.

The DHSC and the MOD will work with NHS England to take forward these issues, and to explore options for making changes to support, advice, training and research for complex and combat-related mental health conditions within the time-frame set by the Committee. In particular, we will explore how we can collaboratively use and develop the resources and expertise available to us to best effect. This will include consideration of how the exciting developments for rehabilitation being pioneered by the DNRC project could be applied to mental health.

Recommendation 24. The Government has a duty to not treat patients incorrectly as a result of misdiagnosis. Post-Traumatic Stress Disorder (PTSD) and mild Traumatic Brain Injury (mTBI) share some similar symptoms, which increases the risk of misdiagnosis of these conditions in serving personnel and Veterans. We recommend that the Ministry of Defence and the four UK health departments support further research work into mTBI, including the testing of methods for clearly identifying this condition. (Paragraph 108)

We agree with the Committee that the Government has a duty to not treat patients incorrectly as a result of misdiagnosis. The December 2017 IMEG report included a substantial section on Traumatic Brain Injury (TBI), a leading cause of death in young adults in developed countries.

There remains no agreed definition of mild Traumatic Brain Injury (mTBI). It is clinically heterogeneous in both presentation and outcome, and the diagnosis is by history and exclusion of severe and moderate traumatic brain injury. In the military context, mTBI occurs as result of sport (in the UK usually called concussion) and combat associated with blast. In that context it is much less frequently diagnosed in UK personnel compared with US personnel.

Case studies on head injuries suggest that severe head injury accounts for about 3% of the total, moderate accounts for 22% of the total and mild for the remaining 75%. TBI reduces life expectancy in those who survive the acute stages. Although there are no published civilian or military longitudinal studies, about a third of patients who reach hospital and are admitted after a severe head injury will die during the first few weeks. Those who survive a severe head injury but remain immobile with high dependency will survive about 15 years, while those recovering mobility and some independence, and those with moderate or mild head injury, have normal life expectancy.

Although there is no published civilian or military study of long duration, the ADVANCE Study by Imperial College aims to gain knowledge of the long-term outcomes of British battlefield casualties over a 20-year period and, using the knowledge gained, help support and plan the best care possible for present and future generations of injured Service Personnel. Most patients with mTBI recover completely within months to a year post-incident and achieve overall return to pre-injury function and employability. There remain a minority of patients with persistent symptoms and functional disability. mTBI studies with different patient characteristics, definitions of mTBI and short follow-up times vary widely. The studies are unable to clarify whether outcomes relate to brain damage, psychosocial factors or both. Evidence does suggest that patient education and specific intervention (e.g. for headaches) can reduce symptoms and disabling effects.

Current imaging techniques do not infallibly detect mTBI. Standard CT and MRI scans do not exclude diffuse axonal and vascular structural changes seen in mTBI. These can be demonstrated by a range of more advanced, but not yet clinically routine, structural imaging techniques. These include functional and metabolic imaging modalities such as positron emission spectography (PET), single photon emission computed tomography (SPECT), functional magnetic resonance imaging (fMRI), and as referenced in the Committee evidence session, magnetoencephalography (mEEG). These detect cellular and metabolic change but there is to date no simple robust method of identification. There are both specificity and sensitivity issues. Psychiatric disorder may be present before

injury, making mTBI more likely with long-lasting disability. Treatment of the psychiatric disorder may improve functional prognosis, but the evidence base is inconsistent and presently underdeveloped.

Differentiating mTBI and PTSD is not a new challenge. Ten percent of British casualties in the First World War were diagnosed with shell shock, accounting for about a third of medical discharges if physical injury was excluded. In the period after the war there was much debate about whether shell shock was physiological or psychological. By 1939, the matter was unresolved, with most clinicians favouring a psychological explanation.

In the recent conflicts where mTBI and a psychological diagnosis co-exist, a challenge for clinical management and compensation is separation of overlapping symptoms. Where there is a documented episode of mTBI and a preponderance of physical and neurological symptoms, such as headache, balance problems, confirmed cognitive impairment, the balance will favour mTBI as the primary diagnosis, while nightmares and hyperarousal avoidance will make PTSD the main diagnosis.

Noting that research into how best to prevent and treat PTSD and combat-related PTSD has increased dramatically in recent years, the Welsh Government agrees that further research into this area would be beneficial. As part of activities to ensure a consistent approach to management of people with PTSD and combat-related PTSD across Wales, the Welsh Government is currently considering a proposal for an All Wales Traumatic Stress Quality Improvement Initiative which takes a whole system, consistent approach, and is informed by the current evidence base and the experiences of the Cardiff and Vale University Health Board and the Veterans' NHS Wales service.

Recommendation 25. We welcome the Department's work on improving its identification of Veteran suicides following our recommendation in Part One, including working with the Ministry of Justice and Department for Health and Social Care. We look forward to receiving an update on progress as part of the Government's response to this report, including the results of the study into suicides by Iraq and Afghanistan Veterans. We recommend that the Department considers options for regular statistical releases on Veteran suicides once sufficient data is available and includes these options as part of its response to this report. (Paragraph 114)

We welcome the Committee's recommendation and acknowledgement of the steps being taken by the MOD on this issue. The Department's new study in partnership with NHS Digital will investigate the mortality rates and causes of death, including suicide, for all military personnel who served between 2001 and 2014, which will include those who deployed to conflicts in Iraq and Afghanistan. The study will cover personnel who are still in service and those who have transitioned to civilian life. The first publication is expected in 2019.

The study will enable Defence to respond to concerns that Service personnel and Veterans who deployed to Iraq and Afghanistan experience any excess of ill-health due to potential exposure to local conditions and also address media and public concerns about the number of suicides among Veterans of these operations. It has been claimed that 75 Veterans took their own lives in 2018 which MOD is not able to refute due to lack of evidence.

The study will build on links with both the ongoing research by King's Centre for Military Health Research at King's College, London (the longitudinal health and wellbeing study for personnel deployed to Operations Telic and Herrick) and the ADVANCE Study by Imperial College sharing information on deaths and cancers for both cohort studies. The ADVANCE Study aims to gain knowledge of the long-term outcomes of British battlefield casualties over a 20-year life course and using the knowledge gained to help support and plan the best care possible for present and future generations of injured Service Personnel.

If the study identifies an excess of deaths, for any cause, Defence Statistics will undertake a more detailed analysis of the data to understand what the drivers might be. Some of the variables that Defence Statistics will consider are Service and cap badge. They may also be able to look at roles on operations within high level groupings such as combat, combat support and combat service support. Defence Statistics advises that there are two caveats to this:

Prior to the introduction of JPA (The Joint Personnel Administration HR IT system) between 2005 and 2007 there is only a record of Service personnel deploying and not when they deployed, so analysis might be limited to Afghanistan and not the early phases of Iraq;

Assumptions would have to be made on the role based on their cap badge as 'role on deployment' is not consistently recorded in the same way by all three Services and as there are so many different roles Defence Statistics would struggle to generate any meaningful analysis.

Defence Statistics publishes annual statistics on coroner-confirmed suicides in the UK Regular Armed Forces since 1 January 1984 with the latest publication for the 20-year period 1998 to 31 December 2018, published 28 March 2019. The UK Regular Armed Forces have seen a declining trend in male suicide rates since the 1990s and suicide among serving personnel remains a rare event. The rate in each of the services is low, evidenced by the small number of deaths in each year.

For the 20-year period 1999-2018, 310 coroner-confirmed suicides occurred among UK Regular Armed Forces personnel (292 among males and 18 among female personnel) and the male suicide rate for the UK Regular Armed Forces was statistically significantly lower than the UK general population.

Defence Statistics publishes studies of the causes of death, including coroner-confirmed suicide and open verdict deaths, of two cohorts of Veterans: those of the 1982 Falklands Campaign and the 1990/91 Gulf Conflict. For these groups of Veterans, the risk of suicide and open verdict deaths is statistically significantly lower compared to the UK population.

Armed Forces Charities

Recommendation 26. Armed Forces charities play a significant role in the provision of mental health services to Veterans and we highly value the work that they do. However, some Armed Forces charities exist only because of a gap in statutory provision and Veterans report going to charities for their mental health issues because of poor NHS experiences or because they do not know where else to go. This emphasises the need for the four UK health departments to improve their statutory provision as we have

already set out. Where it is more cost-effective to do so, however, we agree that the health departments should be working closely with and help fund Armed Forces charities to provide the services that are needed. (Paragraph 131)

The DHSC agrees that gaps in statutory provision of mental health services should be addressed and, where they are not, it is imperative the NHS works with charities to ensure services are as comprehensive as possible. In England, the establishment of TILS and CTS has already improved statutory provision of mental health services for Veterans in England and reduced gaps in provision. NHS England works closely with the third sector, and charities are encouraged to bid to deliver NHS England services – some have successfully done so.

Veterans' NHS Wales has established a common care pathway with trusted third sector partner organisations, including Change Step. A successful Covenant funding bid for 'Change Step' will enable them to provide peer mentoring service for the next two years.

The Scottish Government have made record funding available to NHS Scotland and expect Partnerships to make future funding decisions for their areas that reflect the Veterans 'priority, and the needs of their own local populations. The Scottish Government have positive relationships with Veterans' charities and representative groups and use these to gather evidence and feedback in their work, for example, in progressing towards the recommendations of the Veterans Commissioner in the 2018 report, 'Veterans Health and Wellbeing – a distinctive Scottish Approach'. In addition, the third sector is represented on the Joint Group on Armed Forces and Veterans Health, which will drive forward progress towards the commitments to meeting the health needs of Armed Forces personnel and Veterans.

Furthermore, the Scottish Government continue to fund Combat Stress through commissioning arrangements with NHS Ayrshire and Arran with £1.4 million per annum until March 2020 to provide specialist and community outreach mental health services.

Recommendation 27. Veterans and their families continue to struggle to navigate the complex landscape of mental health providers across the UK, particularly in crisis situations when the Veteran needs help the most. The Department established the Veterans Gateway to address this problem, but as we reported last year in our Armed Forces Covenant report, we await Government statistics to show whether the Gateway has been effective. (Paragraph 132)

We welcome the Committee's recognition of the role of the Veterans' Gateway.

Veterans' Gateway was launched in 2017. Veterans' Gateway headline statistics as at February 2019 are:

- 24,800 contacts to the team at Connect Assist, leading to over 3,500 referrals to partners for direct assistance, (with the contact centre advisers being able to answer the remaining requests for information);
- 472,000 visits to the web site and over 1,162,000 pages read;
- 86,775 social media sessions created;
- 73,000 self-referrals made through the on-line self help guide hyperlinks

- Over 2,500 users of the geo location tool in January and February 2019, that adds further granularity to the Northumbria University Mapping of Need data in terms of location and category of enquiry.

The Veterans' Gateway works closely with providers of mental health provision, including the NHS, Combat Stress and MIND, all being listed and accessible from the web platform.

In addition, a separate external evaluation of the Veterans' Gateway funded by the Royal British Legion is currently being undertaken by Ulster University, who will submit their final report at the end of August 2019.

It is imperative that all veterans register with a GP and tick the GP registration form box that states they have served in HM Armed Forces as Service Leavers are advised in the Service Leaver Guide. This is to ensure that any continuity of care and access to the right care can be put in place, should it be necessary. Rather than wait for symptoms to progress, any Veteran with mental health concerns should, in the first instance, seek help from their GP, and in doing so be explicit that they are ex-military.

Recommendation 28. Furthermore, like the care provision provided by Government, there are issues with the services that Armed Forces charities offer. In particular, demand often exceeds their capacity which means that Veterans either have a lengthy wait or miss out entirely. Where and how Veterans can access a charity's service is also geographically dependent, with Northern Ireland particularly lacking in charity provision. As we set out further below, it is critical that there is greater coordination of services and resources across the sector to ensure a greater consistency of care provision, regardless of where a Veteran is in the UK. (Paragraph 133)

We welcome the Committee's recommendation and will work with stakeholders to continue to advocate for the greater coordination of services and resources. The UK Armed Forces charity sector plays a significant role in supporting the Armed Forces Community of serving personnel, Veterans and families. In 2014 it was reported that there were some 2,200 Armed Forces charities in the UK including welfare charities, Service Funds, Armed Forces Associations and mixed-type charities, Armed Forces heritage organisations and Cadet Forces organisations. In 2014 there were 409 UK Armed Forces charities registered in the UK providing welfare support to the Armed Forces Community with each charity having its own eligibility criteria to determine whether support can be provided. It is generally considered that the Armed Forces charitable sector shows greater collaboration and co-operation than other charitable sub-sectors with examples of partnership-working in welfare provision as well as financial co-operation with the grant-making process of the benevolent funds highly coordinated and flexible in responding to the needs of beneficiaries.

The establishment of the Veterans' Gateway funded by the Armed Forces Covenant Fund, and established by a consortium of Armed Forces charities, led by the Royal British Legion, is an example of how a high level of collaboration is improving ease of access to support for those seeking it. The Veterans' Gateway was created as a single point of contact for Veterans and their families unsure of where to access the services they need. It is both a 24/7 phone line and an interactive website. Many of the helpline call handlers

are Veterans themselves and aware of the issues faced by Veterans and their families after leaving the Armed Forces, in both the short and long-term. Statistics about contact with the Veterans' Gateway are at Recommendation 27.

The Veterans' Gateway is supplemented by the University of Northumbria Covenant funded 'Map of Need' project which has helped to build a full picture of the needs of the Armed Forces Community by providing an evidence-based analysis of what services are being sought and where. As new data-sets continue to be added and previous data re-visited, the project is helping to better identify the emerging needs within the Armed Forces Community to support the development of programmes under the £10 million per annum Covenant Fund and is of wider use to both the Government and the charitable sector.

Cobseo (the Confederation of Service Charities) provides a single point of interaction with government including local government, the Devolved Administrations, private sector as well as other members of the Armed Forces Community. Membership of Cobseo is open to charities and other organisations that promote and further the welfare and general interests of the Armed Forces Community, subject to fulfilling certain membership criteria. Cobseo has almost 300 members with funding predominantly derived from membership subscriptions.

Collaboration is achieved at operational level when charities work together to provide effective support to beneficiaries. This includes use of Cobseo's Casework Management System which is used by many of the Armed Forces charities to centrally co-ordinate support to beneficiaries reducing duplication and meeting client needs more efficiently. In addition, there are groups collaborating across themes to co-ordinate support for specific cohorts of Veterans; for example, the Wounded, Injured and Sick Veterans Employment Group focuses on the combined issues of employment and health for these Veterans. This makes effective use of the Cluster Groups formed in 2009 by Cobseo as part of its desire to enhance collaborative working and to ensure that issues could be raised, solutions identified, and subsequent actions taken or recommended to implement such solutions.

Cobseo also resources and oversees the Northern Ireland Veterans Support Office (NI VSO) supporting Veterans in Northern Ireland. The NI VSO provides a focal point for advice on support available to Veterans and on how application to the Covenant fund can be made. It also provides solutions to those Veterans in NI whose needs are not being met by statutory bodies such as health trusts or the charitable sector. It has trained and is overseeing the network of Veterans champions in each of NI's 11 local authorities through whom individual referrals can be made. It also facilitates the meeting of the Northern Ireland Veteran Support Committee (NIVSC) comprising Armed Forces charities and acts as an information best practice exchange body. The NI VSO works to find solutions to individual Veteran's needs through its own networks in NI, through the NIVSC, or elsewhere where practical. The NIVSO is linked to the Veterans Gateway to ensure common and accurate exchange of information.

The metrics template being developed by the Contact group of mental health charities will be further supplemented by other new sources of data including the expanded Combat Stress Helpline and a proposed crisis text line. Provision of services in Northern Ireland is more complex and must take account of a range of constraints, not reflected elsewhere in the UK and a framework is in place to address this. This range of initiatives

will help identify gaps and provide consistency in service delivery, which will in turn allow discussion between the NHS and service providers in the Service Charity sector and wider third sector.

The Contact group have proposed broadening their reporting remit to provide the Ministers of the four nations responsible for Health and for Veterans with data and this is being considered.

It is recognised that there is always more that can be done and through the Ministerial Covenant and Veterans Board and underlying boards there is now an established structure to co-ordinate services across Government, the Devolved Administrations and the charitable sector to achieve the best outcomes for the Armed Forces Community. It is hoped that better co-ordination of services may smooth out some of the geographical differences in experiences.

Recommendation 29. Mental health care provided by Armed Forces charities is not necessarily accredited or quality assured, leading to some providing treatments that are not evidence-based and potentially even harmful to patients. We recommend that the four UK health departments work with the charity sector to identify and implement an enforceable form of regulation so that treatment is evidence-based or that the Veteran is fully aware of the risks if not. This could include reviewing whether current legislation regarding the scope of the Care Quality Commission should be revised to extend its remit to charities. Such consideration should also include how to help smaller charities to comply with the regulations and to publicise them to Veterans so that they are aware that mental health treatment is regulated. (Paragraph 134)

We welcome the Committee's recommendation.

It is noted that the remit of the CQC is confined to England only; the Devolved Administrations have their own inspection arrangements. The scope of CQC's regulation is determined by the activities carried out by a provider (referred to in Legislation as 'regulated activities'), rather than by the 'type' of provider. Third sector providers and charities who provide regulated activities are legally required to be registered with the CQC.

The DHSC has a commitment to keep the scope of CQC regulation under review and is grateful for the Committee in bringing the issue of regulation in this sector to our attention. We will take the Committee's recommendation into consideration as part of future reviews.

If it becomes clear that providers currently outside the scope of registration should be brought in (or providers presently within scope taken out), then the Department will take the necessary action through legislation following public consultation.

Cobseo membership provides assurance through its application process but this will be further improved by accreditation based on evidence-based treatment, which the Contact group supports. At the Contact group meeting on 28 March 2019 it was agreed to further develop options with the Royal College of Psychiatrists, which operates a number of accreditation schemes UK-wide. However, making such arrangements mandatory would still leave considerable financial and practical problems to resolve.

If a way is found to fund an accreditation scheme, it will allow a simplified kite mark to be used and this will need to be accompanied by a straightforward explanation of the implications of using accredited service providers or not. In summary, accreditation will ensure standards are upheld throughout the sector and service users receive the treatment they expect and deserve.

The regulation and registration of charities is devolved through the Charity Commission for England and Wales, the Office of the Scottish Charity Regulator (OSCR) in Scotland, and the Charity Commission for Northern Ireland in Northern Ireland.

Recommendation 30. We were disappointed to hear that there was no long-term vision for the use of LIBOR funding. As a result, although we noted in our Armed Forces Covenant report in June that the funding had delivered positive results, an opportunity has been missed to have used the funding for long-term investment in areas such as Veterans’ mental health services. Instead charities continue to compete for short-term funding from both Government sources and public donations, risking the closure of services if future funding is lost, restricting their ability to plan long-term and with the possibility of resources not going where they might be most needed. (Paragraph 144)

We strongly feel that health services for Veterans should predominantly be funded by the NHS. However, we also recognise the role that the third sector play and the advantage of providing choice to our Veterans. In his Autumn Budget 2018, the Chancellor of the Exchequer announced £10 million to support Veterans’ Mental Health and Wellbeing needs which will be delivered by the independent Armed Forces Covenant Trust Fund. The budget is being used to fund two programmes: the Positive Pathways Programme has a ring-fenced budget of £9 million, which will include projects delivered by veterans for veterans, and will open for applications in May 2019, while the Strategic Pathways Programme, which opened for applications in December 2018 with a £1 million budget, has now closed.

The decision made by the then-Chancellor of the Exchequer in 2012 that LIBOR funds would support Armed Forces charities and good causes, was later expanded in October 2014 to include “Armed Forces and Emergency Services charities and other related good causes that represent those who demonstrate the very best of values”. It has always had this vision and purpose, and a wide range of organisations that support the Armed Forces Community including those providing mental health services for Veterans have benefited from this funding. The impact is to be evaluated and the results published in 2021 when the grants have finished.

Recommendation 31. The lack of coordination of mental health care funding and services across the UK continues to demonstrate the lack of strategic direction and accountability from the Government on the Armed Forces Covenant. It has structures in place for cross-government working, such as the Veterans Board, and the Contact Group has been formed specifically for coordinating the mental health sector. However, their effectiveness is questionable and some Veterans see only a disjointed system that fails them when they need it, not least by repeatedly forcing them to retell their story as they move from provider to provider. We will continue to urge the Government to improve its governance of the Armed Forces Covenant, as part of our annual inquiry, to ensure that the Covenant is being fully implemented across the UK. (Paragraph 145)

We welcome the Committee's acknowledgement of the cross-government governance structures in place. The Ministerial Covenant and Veterans Board agrees priorities and coordinates activities to enable the best outcomes for the Armed Forces community. This is in addition to other holding to account measures which cover Veterans in the same manner as any other member of the general population, for example the Local Authority Ombudsman.

In its first year the Ministerial Covenant and Veterans Board commissioned the Veterans' Strategy, which was published in November 2018. Reviews of The Veterans' Strategy in 2022 and 2025 will enable the Veterans Board and the Armed Forces Covenant Annual Report to hold Government departments to account against the commitments of the Strategy and ensure that it delivers consistent aims and principles over time and throughout the UK. It is also noted that the larger Service charities sit on the External Reference Group, which enables high-level co-operation between the UK Government and the third sector.

The Board has also encouraged members to introduce further metrics to provide a more detailed picture of delivery and outcomes for the Armed Forces community.

The Contact group has a key role to play bringing stakeholders together to facilitate closer cooperation, work across boundaries, develop best practice, and take forward specific initiatives in the provision of mental health services for the Armed Forces Community. Contact has put in place a programme of work aimed at meeting these objectives and exerts influence across the Service charity sector. This includes work to improve the consistency and continuity of case management across the UK, as this is acknowledged as patchy. The Group's work on mapping and common language will also assist in this regard. These strands of work seek particularly to smooth the passage between different levels of support for individuals and to ensure that statutory and charitable provision can work better together.

Recommendation 32. We recommend that the Ministry of Defence works with the other partners in the Contact Group to ensure that it develops into an influential body, effective at coordinating funding and service provision across the whole mental health sector. This should include bringing more of the smaller charities into the Group and increasing stakeholders' awareness of its work. (Paragraph 146)

We welcome the Committee's recommendation to work with Contact to develop it into an influential body. The Contact Group has a key role to play bringing stakeholders together to: facilitate closer cooperation; work across boundaries; develop best practice; and take forward specific initiatives. Contact already has a programme of work aimed at meeting these objectives, including associate members for smaller charities and exerts influence across the Service Charity Sector. However, it is a voluntary body of like-minded organisations, and it is the view of Contact that it is not well placed to co-ordinate funding or service provision beyond the current objectives the Group has in place.

Recommendation 33. Charities are of course sovereign bodies, many of which wish to do the right thing—but only on the understanding that they will do it their way. Ministers have no formal power, other than via the Charity Commission which deals only with governance, to compel charities to do anything against their will. Nevertheless, given the stovepiping and lack of joined-up working clearly identified in the charitable sector within this report, Ministers should be prepared to work with COBSEO and the

Contact Group to do whatever they practically can to “knock heads together” in the charitable sector to try and provide a far more joined-up service, which is to the benefit of the Veterans rather than the charities themselves. (Paragraph 147)

We agree with this recommendation. MinDVP regularly brings Service Charities together to provide a more joined up approach. The MOD is highly supportive of the work of Cobseo and the Contact group, and works closely with them to facilitate closer co-operation between statutory providers and charities, and between charities themselves. Improving collaboration and co-ordination are two of the key cross-cutting factors identified in the Veterans’ Strategy, and Ministers both in the MOD and more widely will work in partnership with the third sector to achieve this, building on the success of initiatives such as the Veterans’ Gateway and the Cobseo-led Case Management System.

Improving the consistency and continuity of case management as set out in the responses to Recommendations 16 and 19 will assist in better joining up a Veterans’ experience as they navigate through both statutory and charitable providers.

Families

Recommendation 34. We are very concerned by the lack of Armed Forces’ family-specific specialist mental health care in the UK, including the very limited provision within the Armed Forces charity sector. As we reported in Part One, the mental health of families can be just as exposed to the stresses of Service life, especially if they are living with serving personnel or Veterans who have complex mental health issues. Yet many may be reluctant to seek help, perhaps because of the perceived stigma or because civilian medical practitioners would not understand their situation as an Armed Forces’ family member. (Paragraph 156)

The MOD and the DHSC agree that more support for family members is needed and we are exploring options to deliver this. NHS England has strong links with the Family Federations and they are represented on the National Clinical Reference Group. The views of the Federation have been considered in how the NHS provides services, for both physical and mental health. They are also represented on the NHS Public Patient Participation Group where they can contribute into the design and delivery of NHS services in England.

In England, both the TILS and CTS support family members. While these specific services do not offer direct treatment, they can offer support and treatment where it would assist in the treatment of the Veteran. In addition, they can refer on to other services and family members are able to make use of all the other mainstream NHS mental health services available. The NHS England Long Term Plan sets out developing an enhanced service that will look to support these family members further.

It should be noted that work by Health Education England and the RCGP is helping to raise awareness amongst all health professionals not just clinicians. This means that the number of practitioners that have knowledge of the issues members of the Armed Forces Community can face is increasing.

Health Education England’s specific training and courses on Armed Forces community awareness are intended to support clinical professionals and families. The e-learning programme is designed to highlight both the similarities and the differences to allow

healthcare personnel to understand both the context of military life and also how to appropriately respond to patient need. The programme is broken into three broad areas – the NHS care of current serving personnel, the NHS care of the families of military personnel and Veterans, and finally Veterans themselves. Access is not restricted to NHS staff; various professional groups, including students as well as staff working in social care in England, can register to access the content.

As noted in the response to Recommendation 10 NHS England is also engaging with other health institutes for example the Royal College of Psychiatrists to extend Veteran awareness. More than 150 GP practices in the West Midlands have signed up to become GP accredited in recent months and there are plans in place to roll this initiative out nationally in conjunction with the RCGP. It is recognised however that greater awareness amongst the NHS workforce is needed on the specific health needs of the families of serving personnel. Whilst NHS England has already developed educational material which is freely available on the care of military families it is in the process of developing guidance and top tips for GP practices and clinicians and staff across the wider NHS that provides information on the health needs of this patient group and key considerations and actions to undertake when caring for them. Furthermore, information is being developed for the families of serving members of the Armed Forces to help ensure that they are aware of their rights in terms of accessing NHS health care, the range of services available to them and top tips for ensuring they get the best care.

The Covenant Fund has run the Families in Stress Programme which has awarded £4.35 million in grants; families will also benefit from the £4.4 million awarded under the Tackling Serious Stress in Veterans, Families and Carers programme. Furthermore, the Map of Need, which plots existing data on uptake of public and charitable services by Armed Forces community, will give clearer evidence on the geographically-based areas of need for the Armed Forces Community. Funding from the Covenant Fund has enabled expansion of geospatial research to incorporate Armed Forces Families and reservists along with Veterans.

Defence Primary Healthcare are scoping “Veteran-friendly” practices where families are under care and is examining how transition can be improved at practice level in other areas.

In addition, as part of the Government’s response to its 2018 consultation on the mental health of children and young people, 25 trailblazer sites were launched in schools in December, where the first wave of the Mental Health Support Teams will be based. The MOD was closely involved in the consultation to ensure the needs of Service children were captured.

Veterans’ NHS Wales ensure that Veterans’ families are signposted to appropriate services if required. The service has a Forces in Mind funded partnership with TGP (Tros Gynnal Plant) Cymru, a leading independent Welsh children’s charity working with some of the most vulnerable and marginalised children, young people and families in Wales. TGP are working with Veterans from the Cardiff and Vale area who have a family with children potentially affected by a Veteran’s mental health. This pilot is being evaluated by Cardiff University to determine whether a bespoke family service would provide a useful addition to Veterans’ NHS Wales by improving the communication and mental health in families living with the affected Veteran.

In Scotland, families of Armed Forces personnel have access to a full range of evidence-based treatment through their local NHS Board, access to which would begin with their GP practitioner. We are aware that in some areas the MOD have commissioning arrangements in place with local NHS Boards in areas with a high population of serving personnel to provide dedicated support; these are at the discretion of the local NHS Boards.

Recommendation 35. We repeat our recommendation from Part One that the Ministry of Defence, in conjunction with the health departments of the four nations, should place a greater focus on service and Veterans’ families as part of their mental health care provision. This should include providing additional funding to statutory services, such as the Transition, Intervention and Liaison Service in England, to assist families. We also recommend that the Ministry of Defence, alongside the four health departments, review what assistance can be provided to family members of serving personnel and Veterans with mental health issues. (Paragraph 157)

The Departments agree that identifying gaps in provision for service and Veteran’s families is important and will explore what more can be done. As outlined in the response to Recommendation 34, NHS England has an effective relationship with the Family Federations enabling their contribution into the design and delivery of NHS services in England.

Currently, both the NHS England VMH TILS and VMH CTS do have some support for families and assist family members in England access support. Providers are expected to support the families of Veterans and provide specific support where it would assist the Veteran. They are also expected to refer on, especially to other services such as IAPT where appropriate. It has been shown that that interventions which indirectly support Veterans provided to family members can be shown to have a positive impact on help-seeking and therapeutic outcomes for the Veteran, such as psycho-educational interventions. The enhanced services outlined in the NHS England Long Term Plan will be developing ways of treating family members of both Veterans and serving personnel. Furthermore, regional networks will be established, together with Family Federations, to ensure that there is support for families and carers with links into local community service provision and expert bespoke care where there is a need.

As noted in the response to Recommendation 34, Defence Primary Healthcare is already looking at “Veteran-friendly” practices where families are under care and is examining how transition can be improved at practice level in other areas.

In Scotland, families of Armed Forces personnel have access to a full range of evidence-based treatment through their local NHS Board, access to which would begin with their GP practitioner. Veterans families also have access to the clinical support available at the six Veterans First Point centres across Scotland.

Veterans’ NHS Wales ensure that Veterans’ families are signposted to appropriate services if required. The service has a Forces in Mind funded partnership with TGP (Tros Gynnal Plant) Cymru, a leading independent Welsh children’s charity working with some of the most vulnerable and marginalised children, young people and families in Wales. TGP are working with Veterans from the Cardiff and Vale area who have a family with children potentially affected by the Veterans’ mental health. This pilot is being evaluated by Cardiff

University to determine whether a bespoke family service would provide a useful addition to Veterans' NHS Wales by improving the communication and mental health in families living with the affected Veteran.