



House of Commons
Committee of Public Accounts

Ministry of Defence: Treating injury and illness arising on military operations

Twenty-seventh Report of Session
2009–10

*Report, together with formal minutes, oral and
written evidence*

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The Committee of Public Accounts

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Powers of the Committee of Public Accounts are set out in House of Commons Standing Orders, principally in SO No 148. These are available on the Internet via www.parliament.uk.

Publication

The Reports and evidence of the Committee are published by The Stationery Office by Order of the House. All publications of the Committee (including press notices) are on the Internet at <http://www.parliament.uk/pac>. A list of Reports of the Committee in the present Session is at the back of this volume.

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Summary

A total of 565 service men and women have been seriously injured in Iraq and Afghanistan since October 2001.¹ Over the same time, some 125,000 troops who were based in Iraq and Afghanistan have sought medical help for minor injuries and illnesses, and a further 1,700 for mental health conditions. Medical care for troops injured or ill on operations is first provided by medical officers in the field. More serious conditions are treated at the field hospital at Bastion. Nearly all seriously injured troops who return back to the UK for medical treatment go first to the NHS hospital at Selly Oak and then to Headley Court for rehabilitation.

The Ministry of Defence's (the Department's) care of the seriously injured to date has been highly effective and the Committee welcomes the efforts of the Department in this area. The Department has developed a number of new medical techniques which have contributed to this. The Department's success is demonstrated by the rates of unexpected survivors, which are favourable compared to major trauma victims treated by the NHS. The Committee also commends the good work of the Department to support the families of seriously injured troops.

The main challenge the Department faces, should casualties increase significantly, is to ensure that all military patients will receive the same standard of care they currently experience at Selly Oak and Headley Court.

Some soldiers have suffered severe life changing injuries and will require specialist care for many years. This presents a further long term challenge not only for the Department who provide specialist care for them and support for their families while they remain in the Services, but also for the NHS and other government departments who will become responsible for the medical care and support of seriously injured soldiers after they leave the Armed Forces.

Minor injury and illness are a lesser issue but still have the potential to impact on the fighting strength and morale of our Armed Forces in Afghanistan and the increase in rates from 4%–7% since 2006 is of concern. The Department believes that increased reporting is in part responsible for this rise but cannot quantify the significance of any one individual factor.

On the basis of a Report by the Comptroller and Auditor General,² we took evidence from witnesses from the Ministry of Defence on its treatment of injuries and illnesses arising as a result of fighting in Iraq and Afghanistan.

1 As of 15 February 2010, Defence Analytical Services and Advice (www.dasa.mod.uk)

2 C&AG's Report, Session 2009–10, *Treating Injury and Illness arising on Military Operations*, HC 294

Conclusions and recommendations

1. **The Department's care of the seriously injured has been of a high standard and the Department provides a range of support for families when personnel are in hospital.** This report recognises the good work that the Department has done to date in the care for service men and women who have been injured on operations. Our recommendations therefore focus on the challenges that the Department faces to ensure that care remains highly effective in the future especially if numbers of casualties rise.
2. **The number of seriously injured patients who will need life-long care is growing but the arrangements for the support they will receive in the NHS once they leave the Armed Forces have not yet been widely tested, as very few have been discharged so far.** The Department has been working with the NHS to plan individuals' care once they leave the Armed Forces. The Department now needs to work with wider government to put in place an overarching system to ensure that soldiers' clinical care and support for their families is maintained in the longer term. This system should include a clear, costed plan to provide this care and support, and arrangements for monitoring the accessibility and standard of care for veterans.
3. **Should greater numbers of casualties occur, the Department relies on a voluntary NHS agreement to take the pressure off Selly Oak for five days by sending civilian trauma patients to hospitals elsewhere in the region.** This agreement needs to be formalised and built into the national agreement with the Department of Health.
4. **The Department does not have sufficiently detailed and robust contingency plans should Selly Oak become full. Injured military personnel should be treated in a military environment which is suitable for their needs.** If Selly Oak remains under pressure for more than five days there are arrangements for military patients to be treated in other hospitals across the UK, but these arrangements need strengthening. The Department needs to develop a more robust plan detailing:
 - a) Which NHS hospitals military patients will go to depending on their type of injury, and
 - b) How it will replicate elsewhere the important elements in place at Selly Oak for treating military casualties, including clinical expertise and experience in dealing with serious battlefield injuries, the creation of a suitable environment for military personnel and effective wider support for their families.
5. **Very few of the most seriously injured soldiers have been discharged from the Armed Forces to date and they are still receiving care at Headley Court. Given the UK's long term commitment to Afghanistan, patients will continue to arrive at Headley Court and its facilities are likely to come under increasing pressure.** The Department should model the potential through-put of patients at Headley Court to ensure that its expansion plans will provide enough beds. In conducting this analysis the Department should consider whether it will need to help the NHS provide some of the more specialist services its veterans from Iraq and Afghanistan will need.

6. **The Department's rates of minor illness and injury have increased from 4%–7% between 2006 and 2009. There are a number of possible explanations for the increasing trend and the Department believes that the increase is due in part to better reporting by medical officers in the field.** The impact on fighting strength and on morale mean that rates of minor injury and illness must be taken seriously. The Department should increase its vigilance in this area by:
 - a) Conducting a thorough assessment of why rates of minor injury and illness have risen and the adequacy of current prevention measures, while identifying areas for improvement, and
 - b) Researching how many of its troops may not be reporting illnesses and minor injuries so it can understand the full impact they have on the health of soldiers and the UK's fighting capability.
7. **The Department does not compare its approach to preventing minor injury and illness with the methods employed by other Armed Forces.** It should identify how it could most meaningfully compare its practices, and the rates of minor injury and illness experienced by UK forces, with those of other nations such as our allies in Iraq and Afghanistan.
8. **The Department is not sufficiently proactive in making sure Reservists who return from operations are treated for stress.** The Department has yet to demonstrate whether recent measures have successfully given Reservists sufficient access to mental health support on their return. The Department should assess systematically the effectiveness of these measures to guarantee that they identify the majority of Reservists who show signs of suffering from stress or are at risk of developing mental health problems.

1 Caring for the seriously injured

1. The Ministry of Defence's (the Department's) treatment of seriously injured casualties is good. Over the past 10 years it has focused its medical care on trauma and has developed a highly effective approach to caring for casualties from the time of wounding through to rehabilitation (**Figure 1**). Soldiers are surviving now who would never have survived in previous wars, despite sustaining some appalling injuries, and are referred to as 'unexpected survivors'.³ The number of unexpected survivors demonstrates the quality of the medical service the Department provides for its troops.⁴ The Committee congratulated the Department and its medical staff for achieving a level of performance which compared favourably with the best National Health Service (NHS) hospitals.⁵

Figure 1: The military approach to trauma care

STAGE OF CARE	MILITARY SYSTEM
PROTECTION	Physical protection such as body armour, contributes to saving lives.
FIRST AID	Troops are trained to give basic first aid from the point of wounding.
	Medical personnel deliver life-saving first aid, focused on controlling blood loss.
HELICOPTER EVACUATION TO THE FIELD HOSPITAL	Response teams bring the expertise of the emergency department to the casualty.
FIELD HOSPITAL	Casualties receive consultant-led care with surgeons in the emergency department team.
	Bastion field hospital in Afghanistan is a specialist trauma centre.
EVACUATION TO THE UK	Casualties are stabilised at the field hospital and then evacuated to the UK.
UK HOSPITAL CARE AT SELLY OAK	Military medical staff are integrated in the NHS hospital.
	Casualties have access to specialist care at other hospitals, such as for eye conditions.
REHABILITATION AT HEADLEY COURT	Provides unique rehabilitation facilities for soldiers with serious and complicated injuries.
WELFARE	Military patients benefit from being together on the military-managed ward at Selly Oak, in Headley Court and at recovery centres.
	The Department seeks to involve and support the family throughout hospital treatment.
	Accommodation is available for families to visit patients at Selly Oak and Headley Court.

Source: Qq 2, 6, 13 and 33–34; C&AG's Report, para 2.18, Figures 2 and 7

2. The numbers of military casualties are small relative to the total patients treated at Selly Oak.⁶ However, injured soldiers took up one-third of the hospital's trauma and orthopaedic ward beds in summer 2009, the highest period of casualties UK forces have

3 Q 3

4 Q 13

5 Q 12

6 Q 3

experienced in Afghanistan. The Department stated that so far, casualties under Operation Moshtarak had been lower than estimated.⁷ There are arrangements in place to help Selly Oak deal with high levels of casualties. If Selly Oak becomes full, it can divert civilian patients to other hospitals in the West Midlands. Soldiers could also be taken to other Birmingham hospitals. If demand then exceeds what the Birmingham area can deal with, arrangements can be activated which will allow military patients to be treated in NHS hospitals across the UK if needed. These UK-wide arrangements were tried and tested during the Iraq invasion and the Department is certain that they work.⁸

3. The Department was confident that under these arrangements, should Selly Oak become full, military patients would get the same high standards of treatment that they currently receive. By using first the regional then national NHS, it can access a much larger system than the military could provide by itself.⁹ The Committee was concerned that the Department's first level of contingency, to divert civilian patients to other hospitals in the West Midlands, is only a voluntary agreement that takes the pressure off Selly Oak for just five days.¹⁰ Furthermore, the Department has not defined where military patients should be treated nationally and there are a number of factors that it would have to recreate quickly if contingency measures were used. These include replicating the military culture and environment that exists now at Selly Oak. The Department admitted that a lack of military culture during hospital treatment had been an issue several years ago. The Department would also need to transfer the clinical experience Selly Oak has developed in treating serious military trauma and arrange support for the families of casualties.¹¹

4. The families of casualties are often very young and it is a traumatic time for them as well as the patient.¹² The Department recognised that families need to be seen as an integral part of patient care, and therefore provides financial and practical support for families such as transport to Selly Oak and accommodation close by. Families are briefed on what to expect before they visit the ward and the Department provides support to the nominated next of kin. For patients with no family, then the 'military family' comes into play, and the ward in Selly Oak can be busy with friends and commanders visiting and providing support to patients.¹³

5. The Department confirmed that very few seriously injured troops have left the Forces as many have not finished rehabilitation at Headley Court. The Army recently stated that injured soldiers can continue to serve if there is a worthwhile job for them to do.¹⁴ The Department acknowledged there would be a capacity issue in the longer term if many seriously injured troops stay in the Armed Forces. This issue relates to the availability of suitable roles for severely injured soldiers, and the need for the military to provide them

7 Qq 4 and 8

8 Qq 4 and 5

9 Q 62

10 Q 5

11 Qq 34 and 62; C&AG's Report, para 2.16

12 Q 13

13 Qq 34–38

14 Qq 60 and 61

with long-term medical care and rehabilitation while they are in the Armed Forces.¹⁵ The Department confirmed it was very conscious of future capacity at medical facilities and has plans to expand the capacity of Headley Court by up to 30 ward beds, subject to planning permission.¹⁶

6. Severely injured troops will need medical care for the rest of their lives. It is important that these individuals have a successful transition from military to civilian life. The Department recognised that effective transition is a real challenge and was concerned that society at large has not yet grasped the scale of the longer term care seriously injured troops will need.¹⁷ The Department is working closely with charities as they have a role in the longer term support of injured troops. It has recently established 'recovery centres', some of which have been built using charitable subscriptions, where injured soldiers can go after rehabilitation to help them back to work as swiftly as possible. For those that are too severely injured, these recovery centres will ensure that they are handed over properly to both health and social care providers. The Department stated that it had developed very positive working arrangements with the Department of Health and the NHS over the last few years, and is trying to bring local NHS providers into the process early enough, so that there can be a plan made for individuals three months before they leave the Services.¹⁸

7. The Department of Health has committed to provide the same level of modern prosthetics to injured troops as the Ministry of Defence, and that it will keep up with advancements.¹⁹ However, the Committee was concerned that future cuts in funding to the public sector, including the NHS, may affect the care that injured troops receive once they have left the Forces. It was also worried that the introduction of regional NHS trauma centres may not coincide with military treatment centres and therefore it will be harder for military medical staff to get the experience they currently get, in the NHS. The Department told the Committee that it is discussing trauma centres with the NHS to work out how they could best meet these concerns.²⁰

8. The Committee believed that the NHS could learn from the expertise of military medical staff in dealing with particular serious injuries. The Department said that learning best practice was a two-way process: it learns from trauma specialists in the NHS and believes that the NHS benefits from the military experience gained working in extreme conditions.²¹ NHS hospitals that will be designated major trauma centres in the future may benefit the most from military trauma experience.²²

15 Q 13

16 Q 3; C&AG's Report, para 2.22, Figure 11

17 Qq 12 and 13

18 Qq 12, 14 and 51

19 Q 50

20 Qq 50 and 52

21 Qq 16 and 17

22 C&AG's Report, para 2.12

2 Minor injury and illness

9. Minor injury and illness covers a range of conditions including digestive disorders, skin problems and musculoskeletal injuries such as ankle sprains. These conditions are minor in the UK but can become more serious in the extreme conditions of Afghanistan.²³ The Department recognised that these minor conditions impact on the morale of troops and this is why it takes them seriously.²⁴ The Department looks at trends, hotspots and specific problems in minor injury and illness to identify where it needs to put resources into prevention, such as hand washing, or improving accommodation.²⁵

10. Rates of reported minor injury and illness have gone up in Afghanistan from 4%–7% between 2006 and 2009. There are a number of possible explanations for the increasing trend and the Department singled out better reporting as a key factor, but it did not have the data to quantify the significance of this.²⁶ The Department acknowledged that capturing data on minor injury and illness had not been a top priority when forward bases were first established in Afghanistan. Data reporting had improved over time, particularly from 2008 onwards.²⁷ The Department acknowledged that there had been a real increase in rates although it was reassured that rates had stayed within its anticipated level of 10% in both Iraq and Afghanistan.²⁸ Reported rates may be lower than the actual level of minor conditions experienced as the Department believes that soldiers often manage with minor problems during busy periods of fighting and will seek treatment when it is quieter, if at all.²⁹

11. The Department acknowledged that it does not systematically compare its rates of minor injury and illness with other coalition partners. It advised that such comparisons need to be treated with caution as there may be differences in the motivation for reporting minor injuries and illnesses, for example in relation to access to subsequent veterans' benefits. However, it also admitted that these reasons for caution did not mean that it should not compare this data.³⁰

23 Q 9

24 Q 46

25 Qq 9 and 45

26 C&AG's Report, para 13

27 Qq 9 and 18; C&AG's Report, Figure 14

28 Qq 18 and 46

29 Q 45

30 Qq 42–45

3 Mental health

12. It may take a number of years for the full extent of mental health issues for troops who deployed to Iraq and Afghanistan to be known because it can take a long time for problems to emerge or for individuals to get help.³¹ Research suggests that overall rates of mental health issues are not that different between regular soldiers who have deployed and those who have not deployed, although symptoms of Post Traumatic Stress Disorder are 50% higher in deployed troops who have experienced combat.³²

13. Nevertheless, the Committee was concerned that mental health issues are not being picked up in troops. War is extremely stressful and the Committee was surprised that the reported incidence of mental health problems in the military is lower than that of the general UK population given the traumatic events some troops experience.³³ The Department recognised the importance of ensuring problems are identified, particularly given the stigma that is still attached to mental health, and provides services to support those soldiers who do seek help.³⁴

14. The Department has three community mental health nurses in Afghanistan to provide mental health support and a consultant psychiatrist visits every three months. The Department was confident that this was enough and would send out additional resources as required. The Department pointed out that those who have problems are brought back to the UK.³⁵ There are mental health professionals at Headley Court to help the seriously injured. There is no routine assessment of the mental health of other troops returning from Afghanistan although they can access outpatient mental health support at specialist military-run facilities known as Departments of Community Mental Health.³⁶ In 2008–09 soldiers were far more likely to be referred to mental health specialists in Iraq than in Afghanistan which the Department believes is due to the nature of the combat at various times. When troops are being shot at and can shoot back, it is a lot less stressful than when they are being bombed or suffering indirect fire.³⁷

15. Returning British Forces report lower levels of mental health symptoms than American and Canadian Forces. The Americans screen soldiers for mental health symptoms when they return from deployment, and some coalition partners do one-to-one interviews.³⁸ The UK does not medically screen because its research suggests it is harmful. The Department has built up a package of support within the military and uses general processes for managing stress instead of clinical screening. This involves more experienced soldiers on

31 C&AG's Report; para 4.4

32 Q 19; C&AG's Report, para 4.2; King's Centre for Military Health Research

33 Qq 20 and 21

34 Q 22

35 Qq 25–27

36 Qq 15 and 24; C&AG's Report, paras 4.6 and 4.7

37 Qq 22 and 23; C&AG's Report, Figure 23

38 Qq 19 and 24; C&AG's Report, para 4.7

the ground checking that fellow soldiers are okay and pointing to the availability of professional mental health services for those having problems (Figure 2).³⁹

Figure 2: Military stress management support processes

PROCESS	DESCRIPTION
TRAUMA RISK MANAGEMENT	More experienced soldiers provide support to those who experience a traumatic event, and help individuals to recognise if they need specialist help.
DECOMPRESSION	Mental health and stress management briefings are given to returning troops in Cyprus during a short period of relaxation.
POST OPERATIONAL STRESS MANAGEMENT	Line managers interview troops three months after they return.

Source: Q 15; C&AG's Report, Figure 24

16. The Department acknowledged that there has been a concern around mental health issues in Reservists who have been deployed.⁴⁰ Members of the Territorial Army may be back in their civilian life when mental health symptoms develop and so do not have access to the standard military support. The Department reassured the Committee that Reservists got as good treatment for mental health conditions as regular soldiers.⁴¹ However, the Committee expressed concern that there is less oversight of Reservists to identify those who develop mental health problems. The Department was confident that recent measures it had put in place, such as a pilot to give Reservists access to decompression systems, are closing the gap in oversight when Reservists return from Afghanistan.⁴² All troops who leave the Services can access mental healthcare through the NHS, mental health pilots or mental health assessment programmes for veterans. This relies on the individual or their family, friends or GP identifying that they need help.⁴³

39 Qq 15 and 24

40 Q 19

41 Qq 10 and 11

42 Qq 30 and 31

43 Qq 10 and 55–56

Formal Minutes

Monday 22 March 2010

Members present:

Mr Edward Leigh, in the Chair

Mr Ian Davidson
Nigel Griffiths

Mr Austin Mitchell
Dr John Pugh

Draft Report (*Ministry of Defence: Treating injury and illness arising on military operations*), proposed by the Chair, brought up and read.

Ordered, That the draft Report be read a second time, paragraph by paragraph.

Paragraphs 1 to 16 read and agreed to.

Conclusions and recommendations 1 to 8 read and agreed to.

Resolved, That the Report be the Twenty-seventh Report of the Committee to the House.

Ordered, That the Chair make the Report to the House.

Ordered, That embargoed copies of the Report be made available, in accordance with the provisions of Standing Order No. 134.

Written evidence was ordered to be reported to the House for printing with the Report.

[Adjourned till Wednesday 24 March at 3.30 pm]

Witnesses

Wednesday 3 March 2010

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Sir Bill Jeffrey KCB, Permanent Under-Secretary of State, **Lieutenant General Robert Baxter CBE**, Deputy Chief of Defence Staff (Health) and **Surgeon Vice Admiral Philip I Raffaelli**, Surgeon General, Ministry of Defence

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List of written evidence

1 Ministry of Defence

Ev 10

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Oral evidence

Taken before the Committee of Public Accounts on Wednesday 3 March 2010

Members present:

Mr Edward Leigh, in the Chair

Mr David Curry
Nigel Griffiths
Mr Austin Mitchell

Geraldine Smith
Dr John Pugh
Mr Alan Williams

Mr Amyas Morse, Comptroller & Auditor General, **Mr Robert Prideaux**, Director, Parliamentary Relations, and **Mr Mark Andrews**, Director, National Audit Office, were in attendance.

Mr Marius Gallaher, Alternate Treasury Officer of Accounts, HM Treasury, was in attendance.

REPORT BY THE COMPTROLLER AND AUDITOR GENERAL

MINISTRY OF DEFENCE: TREATING INJURY AND ILLNESS ARISING ON MILITARY OPERATIONS (HC294)

Witnesses: **Sir Bill Jeffrey KCB**, Permanent Under-Secretary of State, **Lieutenant General Robert Baxter CBE**, Deputy Chief of Defence Staff (Health) and **Surgeon Vice Admiral Philip I Raffaelli**, Surgeon General, Ministry of Defence, gave evidence.

Q1 Chairman: Thank you very much for coming to a very important hearing of the Committee of Public Accounts because today we are considering the Comptroller & Auditor General's Report on *Treating Injury and Illness Arising on Military Operations*. We welcome back to our Committee Sir Bill Jeffrey, who is the Permanent Under-Secretary to the Ministry of Defence. Sir Bill, perhaps you would like to introduce your two distinguished colleagues.

Sir Bill Jeffrey: On my right, Chairman, is Lieutenant General Robert Baxter, who is the Deputy Chief of Defence Staff (Health) and covers the whole of this area from the policy point of view. On my left is the Surgeon General, Vice Admiral Philip Raffaelli.

Q2 Chairman: Obviously, Sir Bill, on behalf of the Committee I would begin by paying tribute to our troops in Afghanistan, who are obviously doing a wonderful job and, sadly, on occasion sustaining appalling injuries. I would like to note, also, right at the beginning that the Report makes quite clear that your performance compares favourably with the best NHS hospitals, so all your staff should be congratulated on that. Obviously, we want to try and press you a bit further on how you are going to maintain your standards in the future, particularly if there is a rise in the number of casualties. Perhaps I could start by addressing my questions to the Surgeon General because obviously he is the expert in this area but you may wish to pass the questions around. Vice Admiral, what are the main factors that have led you to achieve this good performance, do you think?

Surgeon Vice Admiral Raffaelli: It has been a good ten years, I think, since we moved into Kosovo, that we have really realigned our deliveries to focus on

trauma management. What we have evolved over that period is an end-to-end approach on how we care for casualties. It starts at the very point of wounding, where we train our soldiers, sailors and airmen to buddy-care to a remarkably high standard. We have next to them Combat Medical Technicians or Leading Medical Assistants who provide immediate life-saving first aid, and we use a slightly different paradigm than is used in civilian life, where our focus, given the understanding of the likely injuries, is very much on controlling the potentially catastrophic circulation and blood loss. We focus on that with some novel techniques, using things like combat tourniquets and special clot mechanisms that stop the bleeding and allow us to save life at that point. I would add, of course, that the actual protection that the body armour, etc, would provide to people these days is itself contributing very much to the fact that we have people whose lives we can save. The next part in the system that delivers very positive effect is our forward helicopter emergency response team, the Medical Emergency Response Team, which not only extricates these people but takes to them a clinical capability. We have a consultant deployed which equates to the front end of an emergency department, so they receive high-level treatment on the route back to the receiving hospital facility at Camp Bastion. Once they get there, we have completely integrated our surgical teams with our emergency department teams, so we have these combined teams working with a consultant-led capability to deliver the best care in a very integrated fashion. The facility in Bastion from the outside looks like a big shed, frankly, but once you are inside it, you could be in any high-level trauma centre anywhere in the world.

Q3 Chairman: Obviously, people are surviving now who would never have survived in previous wars and they are going to have to receive treatment for the

 Ministry of Defence

rest of their lives. They come to Selly Oak and then they go on to Headley Court. How are you going to cope with the increasing numbers in Headley Court so that people are not pushed out into civilian facilities? As I understand it, and perhaps you could confirm this, the military, the ordinary soldiers, are very much of the opinion that they want to be with their own kind in their own place; they do not want to be pushed out of places like Headley Court. How you going to cope with a long-term war and people having to remain perhaps under some sort of care for the rest of their life with very severe injuries?

Surgeon Vice Admiral Raffaelli: It is a big question, is it not? There are a number of points there, if I may. If I can just start with Selly Oak, the whole of what we call the Role 4, which is the axis between Birmingham and Headley Court, it is of course the NHS at UHBFT, University Hospital of Birmingham Foundation Trust, that is responsible for the care but we have provided a large number of our own medical people there to supplement and support their capability. We have with them a ward that is very much a military managed ward, so we employ that military envelope round the casualties and patients. It is worth pointing out however that if someone comes with an injury that requires perhaps an ophthalmic surgeon's intervention, then we have another relationship in that area where these people are dealt with. It is also worth noting that a number of our people spend considerable amounts of time in theatre in that environment. It is not a just us in Selly Oak; it really is a combined NHS and DMS support.

Sir Bill Jeffrey: Might I add a word to that, Chairman. One of the key issues which we are very conscious of is future capacity: if there is an increase in casualty rates in particular, are we ready to deal with it? I would distinguish between Selly Oak and Headley Court. The benefit we get at Selly Oak is that we are a very small part of a large hospital trust. We have an extraordinarily close relationship with the NHS and provided we observe the military's preference, as you say, to be dealt with in a military environment, which we can do with the trust, as we have shown—

Q4 Chairman: Sir Bill, you say that you are a small part but as I understand it, a third of Selly Oak's A&E trauma¹ is taken by the armed forces. That is quite a lot. So say you get ten more men coming in as a result of the present operation, can you give us an assurance that they are not going to be pushed out to another hospital, a civilian hospital?

Sir Bill Jeffrey: The point really is that there is the flexibility there in our relationship with the trust first of all to put our people into other hospitals in the area if the need arises but, secondly, if one is talking about a very large increase, to activate the arrangements that are mentioned in the Report called Reception Arrangements for Military Patients, which brings in the entire resources of the National Health Service.

Q5 Chairman: But you have this voluntary agreement with the NHS, have you not, and that takes the pressure off Selly Oak for five days, is that right?

Sir Bill Jeffrey: It does, and if at that point the increase in demand exceeds what can be dealt with within the Birmingham area, then we move into these UK-wide arrangements, which were tried and tested through the Iraq invasion and which do work.

Q6 Chairman: General, could I ask about Camp Bastion? That is nearly full to capacity, is it not?

Lieutenant-General Baxter: You have to understand that the system is a managed system, with people flowing through it. You would look at Bastion and at any time only about 40% of the casualties through there are UK military; that is fact one. The other piece to realise is that we keep people in Camp Bastion for a short period of time until they are stabilised ready to be aeromedically evacuated back to the United Kingdom. The other thing to take on board is that for every operation that takes place there is an estimate process that goes on, and part of that estimate process is estimating the casualties, and on the basis of that estimate we either reinforce or reduce the staffing.

Q7 Chairman: What has happened, for instance, in the recent offensive? Have they coped all right there? Have they had enough resources? Have you put in more resources?

Lieutenant-General Baxter: My understanding is that certainly they have coped so far and they are coping.

Q8 Chairman: Has there been a significant increase in casualties going through as a result of the recent offensive?

Lieutenant-General Baxter: I am not superstitious but it is good that the casualty estimates are higher than the actuality.

Q9 Chairman: Can I ask you, either Admiral or General, about so-called minor injuries? They may be minor injuries or illnesses in our terms but in the extreme conditions of Afghanistan, the extreme heat, they can become very serious very quickly. Do you have significant resources to deal with this as well?

Surgeon Vice Admiral Raffaelli: Yes. The Report rightly identifies that early on in the Afghan campaign the actual level of what we call DNBI, disease and non-battle injuries, was far below what our estimates were, that is both in peacetime and in long term, which is up to 10%. It was running at 3 or 4%. We were aware however at that point in the campaign, when we were very much expeditionary, if you like, that we were not capturing all the data that we perhaps would wish to have had. Frankly, when you are on the ground doing that kind of business, it is not the top priority. They have since come up to still well within the estimate level, between 6 and 7% when the NAO were there, and it has remained at that level, which is well within planning assumptions. The spectrum of diseases are very

¹ A third of Selly Oak's 90 trauma and orthopaedic ward beds were taken by the armed forces in July 2009, the highest period of UK casualties so far.

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much dermatological, musculoskeletal, some gastrointestinal, so our focus is on where we can prevent some of these things by good practice in accommodation, hand washing, etc. Whilst we would never be complacent at all, we are very comfortable that the resources we are putting in and the levels we are achieving are well within the planning assumptions, which are very historical and very reproducible.

Q10 Chairman: General, the last question is about combat stress, what in my father's or grandfather's time would have been called shellshock. Would members of the TA get as good a service as the regular army, do you think? Obviously, they go back to civilian life and some of these symptoms may take more time to develop.

Lieutenant-General Baxter: That is why the mental health pilots are in place—you may have heard of the mental health pilots, they are mentioned in the Report—and also as a safety net there is the Chilwell facility for people to be referred by general practitioners. There are a number of levels: the mental health pilots, the safety net, the mental health assessment programme and the stress management that is mandated for all servicemen, which is perhaps the most important thing. In the long term we have these mental health pilots, so if someone is out there, perhaps have left the Territorial Army, there are these to catch them, and the mental health assessment programme, and then, to try and minimise that happening, there is a set of policies and operational stress management which exist to identify people who might be susceptible and then refer them early.

Q11 Chairman: The answer to my question whether the TA gets as good a treatment is yes?

Lieutenant-General Baxter: I think the answer is yes.²

Q12 Geraldine Smith: Can I add my congratulations to the work of the staff in those battlefield hospitals? It is not just the Report that recognises this but also people have told me that have had direct knowledge of it. It really is a credit to those people who work in very difficult conditions that they provide such a high standard. My concern is also what happens long term. Young men and women who have had their life transformed in the most appalling way through serving their country—what can we do that we are not doing presently to improve the situation when they return?

Lieutenant-General Baxter: I suppose the answer is you can always do better. I think it would be complacent if you did not try and learn lessons and do better. There is a lot of activity in place, and there was an announcement some weeks ago about the Army Recovery Capability, and before that about Hasler Company, the Royal Marine equivalent, which is there really with two roles. One is to help returning people to service as swiftly as possible to make sure—young men are sometimes not the most

reliable—that they go to hospital appointments on time and that kind of thing, but also for those who may be discharged at some stage to make sure, for the very badly damaged, that they are handed over properly in terms of both health care and social care, in the case of NHS England to the appropriate primary care trust, in the case of the devolved administrations to the appropriate pieces there. So we do do a proper job of handing people over.

Sir Bill Jeffrey: Could I add a word to that, if I may, which is that I think personally that this longer term issue is one that society at large has not quite grasped the scale of yet. The most we can do is what we are trying to do, which the General referred to, which is most importantly, I think, to work exceptionally closely with the Department of Health and the National Health Service. The key thing for these people as they leave our Service and beyond is that they should find it easy to access the best that the NHS has to offer. What we have been trying to do, through the protocol that the General referred to, is to bring local NHS providers into the process early so that there can be a plan made for individuals three months before they even leave the Services. Joining all that up I think is the means by which we can best address this issue longer term.

Q13 Geraldine Smith: It must be very important for them to be with other soldiers in similar positions who have suffered similar injuries, because only they can really understand what they have been through. What do you do to make sure there is that contact when people need it, and also support for the families?

Surgeon Vice Admiral Raffaelli: It is a very important point but I think there is a two-phase part to that. First, within Service we absolutely focus on providing that environment, be it at Headley Court or be it the Army Recovery Capability or Hasler Company. It is not just medical although that is very important. It is all to do with the regimental support, the regimental family, and the Army Welfare Service and the rest. That is very much the wrapper that is put round not just the patient but the patient's family, who are often very young, and it is a very traumatic time for them as well. I think we are doing remarkably well in getting a lot of these people not just better but back to work and retaining them in the Service, and that is of course an issue because there is a capacity issue in the longer term, and there have been announcements on that. It is the next phase I think that the whole of UK society needs to get round. If you are a young man who has had a life-changing, traumatic event like this, your destiny is going to be the NHS and working in the civilian world as well. Effecting that transition that is the real challenge for us, the military working to get them to the very best, get them prepared financially, mentally, in whatever way we can, and effecting a very well-observed handover, with both sides of that partnership, us and the NHS or the social work departments, to take that on. We have also, of course, a longer term, not so much medical interest at that point, but an ongoing regimental and veterans' interest into which a lot of focus is being

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put just now. We have got to help them make that transition so they look forward not to what they are limited by because of their injuries but the best they can do for life and the way ahead, for those who are badly injured outside the Services.

Q14 Geraldine Smith: Yes, and obviously charities like Help For Heroes must be very important.

Sir Bill Jeffrey: Just on that point, we are sometimes represented as being in some sense at odds with Help For Heroes. The truth is that on this we have been working extraordinarily closely with them and the Personnel Recovery Centres that were the subject of an announcement a week or so ago have been built from the subscriptions of those who have contributed to Help For Heroes, and they will be managed by the Royal British Legion and the Army jointly. So there is a very close interface.

Lieutenant-General Baxter: Sir Bill mentioned the Royal British Legion, and if you look back in history to the role it played to provide that social place where you could come and gather, I think you are going to see something of a renaissance. It had become just like another pub, but I think you will see something of a renaissance in things like the Royal British Legion, regimental associations, various Service associations, to produce that long-term context.

Q15 Geraldine Smith: Can I just ask as well about the mental trauma that people face. I spoke to the mother of a young soldier. He came back really quite traumatised. What help and assistance is available to Service personnel?

Surgeon Vice Admiral Raffaelli: In Service we have what we call the Departments of Community Mental Health run currently by the three Services but it has been taken under an Army lead service so we can really focus delivery. We have an arrangement also with the Staffordshire Trust³ where we can take in-patients if required. For those who are traumatised and end up being retained within the Role 4 I talked about between Birmingham and Headley Court, we have additional psychiatric resources to focus on those patients as well, so we do not forget that side of the business. We also, generally, for all of our deployed people have a system called TRiM, which is not delivered by medical people although we are part of the training and audit and oversight of it. That we invest in senior leaders, be that Warrant Officer or Sergeant level and officer level, to give them the skills to recognise when an event could have led to trauma and some mental problems related to that. They do a review of that without actually getting into treatment to reassure people that what they are going through and the responses they are feeling are part of the normal response but also to help them recognise if they are having difficulties with that how they can then be brought forward and taken early on for professional intervention if required. We monitor this part of the business very closely. We do that internally with data

³ In-patient treatment is provided by a consortium led by South Staffordshire and Shropshire Healthcare NHS Foundation Trust.

collection but we also have Professor Simon Wessely at King's College, who is doing a longitudinal study, and we have I think very good evidence base on the levels of mental health difficulties that are pertaining and particularly PTSD and the good news is those are actually quite low considering what we are going through and certainly low in comparison to the Americans.

Q16 Geraldine Smith: Can I ask as well, on a more positive note, the staff in your hospitals deal with such horrific injuries and they get very specialised at dealing with terrible injuries like that. What can the rest of the National Health Service learn from them? What experience can they give?

Lieutenant-General Baxter: From a mental health point of view?

Q17 Geraldine Smith: No, the doctors and nurses who actually treat patients. I remember in Northern Ireland there were cases where some of the people dealing with the terrible injuries and things from bomb explosions were able to use their expertise in other fields, for example, for victims of car crashes.

Sir Bill Jeffrey: This is very much two-way traffic. We learn from the best that the National Health Service has to offer and their trauma specialists. The nature of our experience in recent years is such that they are learning from us as well. I know the Committee has a hearing with the Chief Executive of the NHS in the next few weeks which covers similar territory. I think he would tell you that the NHS benefits greatly from the experience of the quite extreme conditions that our people are accumulating at the moment.

Q18 Geraldine Smith: Can I just ask a final point, again going back to minor injuries and illnesses? Can I ask why they have actually gone up in Afghanistan from 4% to 7% from 2006 and 2009? Is there any explanation for that and is there any connection with the living conditions?

Sir Bill Jeffrey: Our view is that it has something to do with reporting rates because in the earlier part of that period, as the forward operating bases, which are sometimes in quite remote and difficult parts of Afghanistan were being set up, some of the more minor complaints were just not being reported, but there is something real there as well and we are keeping an eye on it. The key point to bear in mind is, as one of my colleagues said earlier, that we are still operating within the 10% that we assume for that sort of minor illness or injury and, as a matter of fact, since the NAO did their study work, the level has remained pretty constant at between 6 and 7% so it does not appear to be getting worse although we are very conscious of the risk that it might.

Q19 Dr Pugh: Can I follow through on the mental health issues. I noted and I think you just referred to the fact that, in terms of diagnosing mental health issues we seem to pick up fewer in the British Army than the Americans or the Canadians do. That is the case, is it not?

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Sir Bill Jeffrey: It is. I think we would all be cautious about the figures on this partly because, as the Report brings out, it is not easy to make international comparisons and also because a lot of the studies on Post Traumatic Stress Disorder suggest that it takes a lengthy period in some cases to become obvious. Subject to that, the analyses that have been done, by King's in particular, suggest that the rates are first of all not that different as between deployed and those who are not deployed. If anything, the area of concern is actually around deployed reservists.

Q20 Dr Pugh: The concern I have really is that clearly there is a rate of referral but there may be numbers of cases that may not actually be referred. I think we would all accept that war is extremely stressful and people see some horrid, fearsome things that would disrupt the psychology of almost anybody. What surprises me is that the referral of the Forces appears to be lower than the referral rate of the population as a whole. Is that not intrinsically implausible? You would have thought there would be more mental health issues amongst a population of people who see quite traumatic scenes than amongst those who do not.

Sir Bill Jeffrey: My colleagues may want to comment on that, Dr Pugh. What the studies do suggest is that the incidence of mental health problems among the military is not significantly different from among the population at large.

Q21 Dr Pugh: It is actually lower than the population at large. In other words, it would appear to be the case that in the confines of Committee Room 15 we are far more vulnerable to mental health stress than people in the operational theatre of war. That is what I find implausible.

Sir Bill Jeffrey: I do not know. Maybe it is something to do with the population that one starts with.

Q22 Dr Pugh: They are more robust?

Sir Bill Jeffrey: What is undoubtedly an issue for us is to ensure that mental health problems are identified and, given the stigma that still attaches to it, that people do come forward and when they come forward we have the services to support them.

Q23 Dr Pugh: If we were doing it faultlessly, we would expect similar patterns of referral in Afghanistan and Iraq when in fact we get quite different patterns of referral. You are far more likely to be referred in Iraq than you are in Afghanistan. I cannot think of a good reason for that. Can you think of one?

Lieutenant-General Baxter: I think you have to look at the nature of the combat at various times. One thinks back to Ireland. When you are being shot at and you can shoot back, it is a lot less stressful than when you are being bombed or suffering indirect fire. There are quite a number of factors you have to put in to explain why there are the differences. You mentioned the difference with the Americans. If you look at our tour intervals, typically six months, American tour intervals are 12 months or more.

There are a number of factors there that you need to put into the balance to try and explain the differences.

Q24 Dr Pugh: One of the factors, crucially, if you look at the diagram on page 40 at the bottom, is that the Americans do a lot more screening than we do. If you look across at paragraph 4.7, it says, "Research funded by the Department has shown that typical self-completed questionnaires used for screening are imprecise and open to manipulation. Other coalition partners with smaller deployed forces undertake one-to-one interviews with personnel following deployment." This is leading to an impression on my part—and you can correct me if you wish—that we are just not as good at monitoring mental health as other forces are.

Sir Bill Jeffrey: The judgment that is reported in the NAO Report is based on research undertaken at the King's Centre for Military Health Research, which suggested that sort of process was not effective and could well be counter-productive. My colleagues may be able to enlarge on why we decided against it but it was a conscious decision.

Surgeon Vice Admiral Raffaelli: Very much so. It is not a trivial point whatsoever but all screening is harmful, and particularly in the mental health area there is very good evidence that it can actually almost lead to the problems. The other point is that for what you do screen for, the tests that are used are terribly non-sensitive and non-specific. The trick, if you like, is to monitor your people and ensure that those who are having difficulties are identified without using a tool that may cause them harm. The focus that we have used in the UK is very much to use the command leadership and that whole package of support that we have built up within the military. What General Baxter referred to as the post-operative stress management, POSM, is each of the single services, be it for regular or reserves, have a mechanism whereby after deployment, without getting into medical screening (which is what is used by the Americans in particular), they look to meet with people, ensure they are okay from a command welfare perspective and, if there are difficulties, then through that and the TRiM follow-up stuff we believe we will identify if there are problems. We are not being complacent about it but a lot of the work that King's are doing in a longitudinal study is drawing from personnel deployed in Iraq and Afghanistan, and they refreshed that work and are drawing more people into that cohort. They are identifying through that process at a very high level of scientific validity, what the actual rates are without in any way getting involved with that and they are demonstrating that those rates are comparable.

Q25 Dr Pugh: Certainly you are doing some serious research into the topic at the moment but I do point out, and I think you are not going to dispute, the fact that the Americans have already done the research ahead of us in some respects, because you are actually using some of their results of some of their pilots on battlemind and things like that. Just going

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on to the level of support, mental health support in Afghanistan is provided by three community mental health nurses, according to the Report. Is that enough?

Surgeon Vice Admiral Raffaelli: Yes.

Q26 Dr Pugh: Is it?

Surgeon Vice Admiral Raffaelli: That is not the total capacity that we have in theatre. We deploy regularly also consultant psychiatrists, both to do audit and the rest. I was out there two weeks ago at the same time as the Professor of Military Psychiatry was out there with one of his consulting assistants, who are looking right across the whole area. We flex out additional resources as they are required but the people who have problems, of course, at that level or who have sustained trauma are brought back.

Q27 Dr Pugh: You are happy with the level of provision where you have three community health nurses and a consultant psychiatrist visiting every three months?

Surgeon Vice Admiral Raffaelli: Yes.

Q28 Dr Pugh: Is it the same consultant psychiatrist or is it different ones?

Surgeon Vice Admiral Raffaelli: It is a number of them.

Q29 Dr Pugh: Would it not help to have the same guy go out all the time? He might develop a level of expertise dealing with the particular kind of problems you are getting out there.

Surgeon Vice Admiral Raffaelli: All of our military psychiatrists, the reason they are in uniform and we do not simply buy it in or use NHS consultants is that very point you are making, that it is important that these people are fully experienced in the military way of life, military support, and that includes what happens on operations. I would suggest it is equally important that we maintain a pool of people who have the skills and experiences you are referring to.

Q30 Dr Pugh: Would you like to comment on page 42, paragraph 4.8, where it says, “There is inconsistent access to non-medical stress management processes on return to the UK for Reserves.” Are you comfortable with that?

Surgeon Vice Admiral Raffaelli: I think it was absolutely a correct statement at the time. What General Baxter was referring to are the measures that have been put in place to try and address that area, which had been a concern, which I think we are beginning to close; that small gap that was rightly recognised. This month, for example, we are running a number of studies, with King’s again, to look at piloting—not research but piloting—additional support to reserves and individual augmentees—to see how much they would benefit from the decompression systems that we go through, which are also referred to in the Report, to see whether that would provide an additional level of support and monitoring for these people.

Q31 Dr Pugh: When will the King’s study be completed?

Surgeon Vice Admiral Raffaelli: These pilots, this month, March, and we will have the work back early April. The thing about decompression that is interesting: we are all convinced—

Q32 Dr Pugh: On that last point, is it possible we could get this research before completing our report here?

Surgeon Vice Admiral Raffaelli: It will be pilot work, the effectiveness of the pilot. I do not know what the exact timetable is but it should be available in early April, I would think.⁴

Q33 Mr Williams: The number of unexpected survivors, people who have survived injuries which no-one would normally have expected them to survive is in fact a tribute, as the NAO has said, to the service you are providing for our troops. Equally, the family must be very important in terms of morale, perpetuating the will to live. What do you do to maximise the benefits the family can offer?

Sir Bill Jeffrey: This mostly comes into play, Mr Williams, when those who have survived, in some cases unexpectedly, come back to this country, are dealt with initially at Selly Oak, but then in many cases—and I have seen them for myself—end up at Headley Court receiving rehabilitation, intensive physiotherapy, the kinds of things that Headley Court does, and at that point there is a very intensive effort to involve families. There is a facility in which families can live in order to spend quite a lot of time with their son, in most cases. I would recommend to the Committee individually to visit Headley Court because it is quite an inspiring facility for that very reason, that it is the point at which the families visibly start to get involved with the recovery process.

Q34 Mr Williams: Is there any structured support and help or advice service for families to enable them to be of maximum benefit to their sons or husbands?

Sir Bill Jeffrey: I believe there is. One of my colleagues might want to say more but certainly I have seen guidance.

Lieutenant-General Baxter: The very reason we refer to the thing we call “the patient group” is to make explicit the point that it is not just the patient; it is the family, loved ones, that group that has to be looked at as part of the clinical activity almost. That might sound not very good. It is to make sure that people recognise that the family are an integral part, that they are looked after. There are flats at Selly Oak where people can stay very close to the hospital just to enable that whole piece where the family can be together during what is a very difficult time for them.

Q35 Mr Williams: That is very encouraging and to be commended. Are the families given any practical support, such as financial assistance in getting there?

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They may have to travel from remote parts of the country. What are the guidelines here on financial support to go and see a son or a husband?

Lieutenant-General Baxter: Travel will be either facilitated, i.e. they will be given transport or they will be paid to get there.

Q36 Mr Williams: How widely is “family” interpreted in that sense?

Lieutenant-General Baxter: I would have to give a written reply to that. It would be the nominated dependants, next of kin, who are nominated by the individual soldier, sailor or airman.

Sir Bill Jeffrey: My recollection is that there is some guidance that takes account of the fact that these days families are what would in the past have been seen as unconventionally composed. I think the General is wise to suggest that we offer the Committee a note on that, if you would like to have one.⁵

Q37 Mr Williams: For far too many families they are seeing injuries they never, ever thought of seeing. What is done to help them deal with the shock of what has happened to a loved one?

Lieutenant-General Baxter: A very important part of looking after the patient group is to make sure when they first come there that they are briefed as best you can on what to expect. Equally, they are briefed on what to try not to do to make things worse. It is easy to tell somebody what they are about to see and to suggest to them how they might behave. The reality of what then happens is perhaps different but the whole point of having clinical staff and nurses there, certainly when the family, the loved ones, the extended family, are there, making sure they know what to expect is a very important part of this.

Q38 Mr Williams: For those who do not have family, is there any way you can replace the emotional support that the family gives other injured troops?

Lieutenant-General Baxter: That is where the regimental/squadron/commando family comes in. If you visit Selly Oak, the ward can be somewhat busy, shall we say, because usually round the bed you will find five, six, seven, eight or nine people. There will be a point that their friends, commanding officers, Colonel Commandants of various sorts will be there visiting.

Q39 Mr Mitchell: Why has there been such a steep increase in minor injuries and illness between Iraq and Afghanistan: 41,900 in Iraq but 83,299 in Afghanistan? Why is that? What is the ratio to troops deployed?

Sir Bill Jeffrey: We need to do the analysis. I am not sure there is in practice over the period we are talking about, given the numbers that were deployed at the time, that much difference. I think the Iraqi rates probably relate to the latter part of the campaign, when we had between 4,000 and 5,000 troops

deployed, whereas in Afghanistan we now have 9,500 troops deployed. It may simply be the volumes. I am not sure. We could check that.⁶

Q40 Mr Mitchell: Is it not worthwhile doing the analysis? I see from paragraph 3.2 that there are a range of possible factors for the increasing trend, including the intensity and basic living conditions of operations. If you do not know what is causing it, and you do not seem to, how can you deal with it?

Surgeon Vice Admiral Raffaelli: If I could suggest, if you look at page 29 of the Report, figure 13, where it has the two graphs, one of Afghanistan and one of Iraq, they are perhaps slightly misleading in that the axis on the left-hand side are on different scales, so it makes it look like there is a considerable difference between Iraq and Afghanistan but, in fact, if you look, you will see that in both cases per thousand personnel per week, it is around between 50 to 100 per week. It is actually, within the terms of the scale of things, very similar. There is of course that earlier difference we talked about when you had at the beginning of the Afghanistan campaign a lower rate, but where we are now is very comparable on rates rather than actual numbers.

Q41 Mr Mitchell: Thank you for that. It is not that the conditions are so much worse in Afghanistan; the trends are the same?

Surgeon Vice Admiral Raffaelli: I think that is true, yes.

Q42 Mr Mitchell: Why do we not do comparisons with particularly the Americans but other troops in the coalition, first of all about this increase in minor injuries and, secondly, about the effectiveness and the speed of treatment, ours compared to theirs?

Lieutenant-General Baxter: I do not want to drive a wedge between ourselves and the Americans but some of the motivations for reporting things are perhaps higher in the case of US forces. When you try to make comparisons you are on quite dangerous ground because having a medical condition ascribed to an operation is very helpful in getting you Veterans' Administration Benefits, so people are perhaps more punctilious about ensuring that those things go in and are recorded for the future, whereas when people come back here, either the NHS or what-have-you will pick up that loading, and of course, America does not have our health care system.

Q43 Mr Mitchell: That might indicate that Americans are softer than our troops and ours are braver and more inclined to bear injuries without complaint.

Lieutenant-General Baxter: I would not say that. I think there is an incentive mechanism perhaps operating that is not operating for us.

Q44 Mr Mitchell: You do not say it with any assumption of British superiority?

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Lieutenant-General Baxter: Absolutely not.

Q45 Mr Mitchell: Do you have routine comparison of injury levels and treatment levels? I would have thought they would be invaluable in aligning us with whatever is the best.

Sir Bill Jeffrey: We do talk to the Americans but what I am not sure about, unless either of my colleagues can answer immediately, and we perhaps ought to check, is just how systematically we compare figures.⁷ There are lots of reasons, and the General has just offered one, for treating such comparisons with caution. That is not to say we should not do it.

Surgeon Vice Admiral Raffaelli: I think at one level, the high-level trauma, we have two, not the same but comparable systems called trauma registry comparisons and they use similar but again not exactly the same models. We have good information on comparability of the high-level trauma, the unexpected survivor arguments, and we spend a lot of focus on it because that is in some ways the high end of the business. When it comes to the disease and non-battle injury parts, it is important in overall terms, and certainly the regional medical commanders as part of the coalition forces maintain an overview, so if there is a peak or something occurs in whatever country's area, they will direct resource to look at that. Part of the problem is that it is a very nondescript bit of business. I know and we keep good records of what the major things are, and I have already said musculoskeletal, dermatological and gastrointestinal things but, for example, one of the peaks was during a quiet time when individuals came forward in the UK forces to have an H1N1 vaccination. That was recorded as 150 attendances and that added to the numbers then. Of course, if you are very operationally busy, then people do go on working with minor irritations or rashes or problems. It is when you are in a quiet time you go and get your cream for your rash. Sometimes the peak is actually reflecting the opposite of what you would think. It is a non-troublesome period. So I think our overall professional view is that to get into too much detail will not be particularly helpful. It is important however to identify trends, hotspots and specific overall problems so if necessary we can put resources either to identify a prevention problem or some additional treatment resources.

Q46 Mr Mitchell: Thank you very much. That is very interesting. Is there any indication of any correlation between minor injuries and morale? Both Iraq and Afghanistan are very difficult areas to fight in and in a very difficult situation climatically, in terms of relations with the people and in terms of the kind of tactics used against our troops. Do we have any indications of an increase in minor injuries and a fall in morale?

Sir Bill Jeffrey: Morale is certainly one of the reasons why taking minor injuries seriously is important. I am not sure that we could draw any direct correlation of the kind that you describe but it is one

of the reasons why, although the trend is somewhat upwards, the fact that we are well within what previous experience would lead us to assume would be the minor injury and illness rate is quite reassuring in itself.

Q47 Mr Mitchell: The Admiral mentioned unexpected survivors, which is a curious term, but I see that there is a lower percentage of unexpected survivors in NHS hospitals than in military treatment. Is that because of different measurements? I gather in NHS hospitals it is arrival at the hospital door that counts but, in terms of your calculations of unexpected survivors, it is sustaining the injury on the battlefield and everything that follows.

Surgeon Vice Admiral Raffaelli: You are right that there are differences in how we finally calculate and assess them that does make it hard to draw very hard comparisons. They are all based on different forms of what is called International Injury Severity Scores, which are a standard benchmarking system which focuses however on anatomical trauma. So there is a—flaw is the wrong word because it is important that we use a standardised benchmarking mechanism— but it does not necessarily capture the wide range of things that our chaps sustain when they are injured and some of the massive physiological challenges that come along with it. In order to then make sense out of what is a relatively uni-dimensional scoring system, all of us, be it our forces deployed, the NHS or the Americans, then use a peer review mechanism which takes into account the overall experiences and capabilities. There is a bit of calibration within that but I think we are all comfortable that in each of the areas we are doing the best. At the NHS review, which the NAO reported on and is before the PAC in a few weeks time, they will identify that there are some areas where the scores are different.

Q48 Mr Mitchell: Have there been any problems with helicopters and evacuations in this survival issue? We had two soldiers from Grimsby killed in that “rogue policeman” incident and they were in a fairly remote checkpoint where it took time for medical help and support to arrive. Have we had any problems because of the remoteness and the lack of helicopters?

Sir Bill Jeffrey: My recollection is that on evacuation, the Report's conclusion is that we are performing well in terms of timeliness. What the Report picks up in one or two areas is where helicopter availability has affected other things, like the movements of medical practitioners around theatre, and our general efforts, which are well known, to increase the number of helicopters in theatre and their availability are, I hope, easing that. We have since 2006 almost doubled the number of helicopters and more than doubled the number of helicopter hours available to operational commanders in theatre in Afghanistan.

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Q49 Nigel Griffiths: This Report is very praiseworthy of what you have done for our Armed Forces. There seems to have been a very good improvement over the previous Report and many satisfactory outcomes for what is a tragedy and trauma for people. Can I ask you, have you read reports that our Service personnel who lose limbs are getting the best in the world, state-of-the-art limbs as replacements, with all the training and back-up that is needed for their use?

Sir Bill Jeffrey: I believe so. I think the prosthetics, the quality of what is done, particularly at Headley Court, is extremely high. There are one or two cases which have been reported on where individuals have chosen to go elsewhere. I do not know if either of my colleagues would like to add comment. I was impressed certainly by what I saw at Headley Court and I believe it to be as good as is available.

Lieutenant-General Baxter: We are continuously looking at what is going on, particularly in America, where there are many more casualties, for things to develop on and where there are techniques that appear to be useful. There is one that may be reported shortly, something called lingual vision, which the Surgeon General can explain, but it is basically helping someone who is blind see, albeit in black and white. We are always looking around to see if there is something new and better we can do. There may well be circumstances where something pops up in another country and we just have not seen it yet but it is something we are very active in and I hope we are not complacent in.

Q50 Nigel Griffiths: Have you seen the reports that I have seen that amputees who leave the Forces and then require replacements, perhaps after 36 or 48 months, are not getting and are not offered the same high level of limb or the maintenance of that limb?

Surgeon Vice Admiral Raffaelli: There was a communication issued by the Department of Health, Minister O'Brien, about two weeks ago, I think. He gave an absolute commitment that not only did the NHS seek to provide the same level of modern prosthetic that these chaps are being issued with today but they would keep up with whatever advancements are delivered through Headley Court.

Q51 Nigel Griffiths: Was that in response to criticisms that has not been the case to date?

Surgeon Vice Admiral Raffaelli: I am not aware of anybody who has been in that particular position. I think this was just part of the very positive working together of the Department of Health and the Ministry of Defence that has been developed over the last few years in particular.

Q52 Mr Mitchell: I just wondered, given the fact that there is a prevailing mood of economy in the NHS, and certainly considerable efficiency savings are being expected, how far is this going to impinge on you? I do not know what the financial arrangements are but certainly the physical arrangements if you are going to have a series of designated trauma centres

which may not coincide with your treatment centres, is that going to cause you problems? What is going to be the effect of the reorganisation?

Sir Bill Jeffrey: There are two distinct issues. One is NHS resources, where we will need to carry on working very closely with the NHS as we go through the coming period, when we will all be under financial pressure of one sort or another, but I would say that our relationship with the NHS and the Department is stronger than it has ever been. The other is the one that is picked up in the Report, which is whether the plan to have regional trauma centres will make it harder for our people to get the experience they currently get in a number of NHS centres around the country. There are discussions going on now between ourselves and the NHS about how, given that they have yet to select these centres, we can best meet that concern.

Q53 Chairman: Two or three more questions just to tidy up the hearing. General, you gave various reassurances to me about Camp Bastion but I am right in saying, am I not, that it was the MoD's own review, not the NAO, that concluded that Bastion is close to capacity?

Lieutenant-General Baxter: We would expect it to operate efficiently and to capacity and the Commanders Medical in theatre, if there are unexpected peaks, can load-balance between the hospitals in the theatre of operations.

Q54 Chairman: So the fact that it is close to capacity is an aspect of good management, you think?

Lieutenant-General Baxter: I would say it is an aspect of good management.

Q55 Chairman: You recall I asked you about the service that the TA people were getting. Am I right in thinking that the mental health pilots and medical assessment programme require reservists to seek help themselves? What are you doing to identify reservists who may have a problem?

Lieutenant-General Baxter: When you say seek help themselves, yes, if someone says, "I am unwell," if their family identifies something that is adrift, if the general practitioner identifies that something is not quite right, then they can refer to these various capabilities.

Q56 Chairman: But of course the MoD is not set out to identify these reservists. You would presumably say how can you?

Lieutenant-General Baxter: In the operational stress management, when a reservist comes back to the unit, there is a policy of debriefing, making sure that someone is taken through, that the unit is actively aware that a person has been there and is on the look-out for anything. If someone then leaves the reservists, leaves the Territorial Army, and there is not that unit around them, then you are relying on family, friends and GPs.

Sir Bill Jeffrey: Then, as we said earlier, it comes back to the question of ensuring easy access to the general services of the NHS.

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Q57 Dr Pugh: A final question on the mental health issue: do you keep statistics of suicide rates amongst both military personnel and ex-military personnel?

Sir Bill Jeffrey: We keep suicide rates among serving military personnel and they are lower, generally speaking, than for the general population.

Q58 Dr Pugh: In some ways one might expect that.

Sir Bill Jeffrey: It is harder, because we are talking about a large population of people, many of whom left many years ago, to track through into the general population. I am not aware of studies that have done so, although my colleagues may be.

Q59 Dr Pugh: Would you be able to say, for example, two to three years after people leave the Services the suicide rate was such and such? You do not know?

Surgeon Vice Admiral Raffaelli: We cannot. It is not unique to mental health. There is a real challenge that the NHS does not flag veterans separately, so we cannot capture that information. Clearly, through some other routes, we may identify the odd one but that is as far as we can go. We are working currently with NHS England to look at a mechanism trying to put that into place but there is the Data Protection Act and other problems. The nearest we can do at present is the work we are doing with King's, which is this longitudinal study, which is not designed to look solely at people who commit suicide but clearly, should that tragedy happen, it will pick that up.

Q60 Chairman: Admiral, a last question for you: do you know how many people have left Headley Court and what their experience has been?

Surgeon Vice Admiral Raffaelli: Of the serious trauma group?

Q61 Chairman: Yes. They have left for civilian life. Do you track what their experience has been?

Surgeon Vice Admiral Raffaelli: Yes. None as of yet⁸. You will have heard a couple of weeks ago, when the Army restated its approach to medical discharges at the same time as the Army Recovery Capability had been put in place, from the current conflicts, and certainly Afghanistan, they are all still in service with us if they have higher trauma levels.

Q62 Chairman: A last question for you, Sir Bill. Obviously, Selly Oak is providing an excellent facility. Can you assure the Committee that if it becomes full, our injured military personnel will get just as good treatment elsewhere in the NHS?

Sir Bill Jeffrey: I believe I can. I think, as I have said earlier, that one of the great virtues of doing this in close partnership with the NHS is, first of all, that we have access to the best that they can provide clinically but, secondly, that we have access ultimately to a much larger system than we could possibly sustain ourselves. The arrangements for flexing into wider capacity in the Birmingham area and then nationally are ones that I feel confident in. What we would have to do, and do as rapidly as we could if there was a sudden expansion, is to look at the issue that did cause us some problem several years ago, which is the confidence with which we can create an adequate military ethos within the wards in which our people are held, because that was an issue several years ago. It is now, through a lot of hard work on the part of our people and NHS managers, being well dealt with but if we were to expand quickly, we would have to address it again.

Q63 Chairman: Thank you very much. Gentlemen, that concludes our hearing. Perhaps lastly, Admiral, you would convey our thanks to your staff for the wonderful work they do.

Surgeon Vice Admiral Raffaelli: I would be delighted. Thank you.

⁸ *Note by witness:* Research within MOD that is being prepared for publication in peer-reviewed medical literature has identified that from the start of conflict in Afghanistan in 2001 to 1 September 2008, a total of 53 UK service personnel sustained amputations as a result of deployed operations in Afghanistan and Iraq. Review on 1 April 2009 showed that 44 subjects remained in the Services, with 7 in full-time rehabilitation; 33 had returned to work. 9 personnel had left the Services (both Regular and Reserve) by that date. The Department will place a copy of the research paper when published in the Library of the House.

 Supplementary memorandum from the Ministry of Defence

Questions 10–11 (Chairman): asked about combat stress, and whether members of the TA get as good a service as the regular army.

Acute stress reactions and operational stress injuries are treated in theatre or when people return from deployment, whether regular or reservist. Whilst mobilised, TA (and all mobilised Reserve) personnel get the same access to care as regular personnel. Once demobilised, they are able to access the Reservists Mental Health Programme based at Reserves Training and Mobilisation Centre, Chilwell. This offers assessment and treatment if appropriate at one of our military departments of community mental health. This programme is open to reservists who have been mobilised and are concerned about their mental health related to operational service since 2003. Additionally, veteran reservists (and regulars) who have seen operational service from 1982 onwards can attend the Medical Assessment Programme (MAP) at St

Thomas' Hospital, London, for a specialist mental health assessment by a consultant psychiatrist with extensive military experience. The MAP does not provide treatment but a treatment recommendation is made after the assessment. The cost of attendance and travel is met by the MOD.

Questions 31–32 (Dr Pugh): about the timetable for the publication of the King's study.

A “decompression” trial for Individual Augmentees is planned during March 2010. The trial will consider whether Individual Augmentees can benefit from decompression as formed Units currently do. All Individual Augmentees in Afghanistan who are due to depart during the trial period will participate in the trial. Quantitative data will be collected and assessed by our Academic Centre for Defence Mental Health with results expected by the end of May 2010. We intend to publish the results and place a copy in the Library of the House as soon as practicable after that date.

Question 36 (Mr Williams): asked about how widely the family is interpreted in the sense of support given by the Department to families in getting to Selly Oak.

Accommodation and travel at public expense for members of the Patient Group including nominated “significant others” are governed by the Dangerously Ill Forwarding of Relatives (DILFOR) scheme.

The Joint Casualty and Compassionate Centre (JCCC) will authorise DILFOR for up to five members of the “Patient Group” to visit the bedside irrespective of where the family resides or where hospitalized. In exceptional circumstances, additional members to the Patient Group can be authorised centrally.

The patient must be listed as Very Seriously Ill or wounded (VSIL), Seriously Ill or wounded (SIL), have an incapacitating illness or injury (III) or have a clear medical recommendation that a visit from close family is in the best interest of the patients' recovery. In applying the policy, the definitions are: immediate family means a spouse/civil partner; close family means a parent; step-parent; parent in-law; legal guardian; non-dependant child; grandparent; sibling; including half and step-sibling; or person nominated as Emergency Contact (EC).

Question 39 (Mr Mitchell): asked about the steep increase in minor injuries and illness between Iraq and Afghanistan and the ratio to troops deployed.

Figure 3 of the NAO Report shows raw numbers of patients seeking medical treatment for a variety of medical conditions on operations in Iraq and Afghanistan, but this must be put in the context of the number of troops deployed.

The Surgeon General, in his response to Mr Mitchell at Q40, explained that the graphs shown in Figure 13 on page 29 of the NAO Report do give the rate of minor injury and illness per 1,000 troops. Noting that the axes on both graphs are different, it can be seen that the rates are broadly similar; if anything, the trendline values in Afghanistan are lower over the periods under comparison.

Question 45 (Mr Mitchell): asked about making a comparison between ourselves and the Americans of injury levels and treatment levels.

The UK and US military medical services have separately established quality assurance systems for their seriously injured. Whilst there is overlap in some aspects, there are also important differences in content and the analytical models used. The UK uses internationally recognised mathematical models of trauma system performance combined with expert peer review of all survivors of major trauma in order to determine “unexpected survivors”. The US do not use these system performance measures, and direct comparison is therefore not possible.