

1 (2.00 pm)

2 LIEUTENANT GENERAL LOUIS LILLYWHITE

3 THE CHAIRMAN: Good afternoon and welcome to our witness
4 this afternoon, Lieutenant General Louis Lillywhite. We
5 are going to discuss issues relating to the Defence
6 Medical Services and the provision of treatment for
7 those injured in Iraq.

8 General Lillywhite, you served in a number of
9 relevant roles: from 2003 to 2005 as Director General of
10 Army Medical Services and from 2005 to 2006 as
11 Director General of Medical Operational Capability and
12 then from 2006 to 2009 you were the Surgeon General, the
13 highest ranking medical officer in the Armed Services.

14 You have provided the Inquiry with a full statement,
15 which we shall be publishing today, along with
16 a declassified document entitled "The Director General's
17 Medical Operational Capability" for which we thank you.

18 Now, I say on each occasion we recognise that
19 witnesses give evidence based on their recollection of
20 events and we, of course, check what we hear against the
21 papers to which we have access and which we are still
22 receiving, and I remind each witness on each occasion
23 that he will later be asked to sign a transcript of the
24 evidence to the effect that it is truthful, fair and
25 accurate.

1 With those preliminaries, I'll ask

2 Sir Martin Gilbert to start the questions. Martin?

3 SIR MARTIN GILBERT: General, I wonder if you could explain
4 to us the role of the Surgeon General?

5 LT GEN LOUIS LILLYWHITE: As I explained -- first of all, as
6 I explained in my witness statement, it has changed
7 since I have been in post. The original role was
8 restricted largely to actually setting policy and
9 setting standards with direct influence and control over
10 a small proportion of the Defence Medical Services,
11 those in the -- what was called the next steps agencies.

12 Over the period that I have been in office, that has
13 changed, so that the Surgeon General now has what is
14 known as an end-to-end responsibility. He is a process
15 owner, which means that he now has authority across the
16 whole of the delivery of healthcare, not health but
17 healthcare, including the means of actually ensuring
18 that his policies and standards have been implemented
19 and an ability to intervene should they not be so, and
20 that responsibility is directly to the Defence Board.

21 SIR MARTIN GILBERT: To whom did you report and who reported
22 to you?

23 LT GEN LOUIS LILLYWHITE: Again, it has changed. At the
24 beginning there was a Surgeon General and a Deputy Chief
25 of Defence Staff for Health, who kind of formed a team

1 of two. The relationship I think depended on the
2 individuals in office at the various times.

3 As I left the Deputy Chief of Defence Staff (Health)
4 post was being finished and it leaves now only
5 a Surgeon General, who reports directly to the
6 Defence Board in respect of healthcare. But I do
7 actually wish to emphasise that the Deputy Chief of
8 Defence Staff for Personnel is responsible for health,
9 health promotion, et cetera. So there is a difference
10 between health and healthcare.

11 SIR MARTIN GILBERT: Could you describe for us more
12 generally the role of the Defence Medical Services?

13 LT GEN LOUIS LILLYWHITE: Its core task is the provision of
14 healthcare on operations, to treat the injured, to
15 promote the health of the population that is deployed on
16 operations, that generally through providing advice to
17 the chain of command. Two, in peace, ensuring that all
18 individuals receive the appropriate healthcare for which
19 they are entitled, providing it in some cases directly,
20 and that is mainly in the primary and occupational
21 health areas, or ensuring it is provided by others,
22 which is the secondary care area primarily.

23 SIR MARTIN GILBERT: We heard last week from the former
24 Deputy Chief of Defence Staff (Health), who described
25 his role as delivering the outputs of the Defence

1 Medical Service. How did your role interact with his?
2 LT GEN LOUIS LILLYWHITE: As I said, I think it has changed
3 over time. I think if you actually look back, it
4 started as a partnership of two equals. I think then
5 a defence -- Deputy Chief of Defence Staff and
6 a Surgeon General of Defence, the Deputy Chief of
7 Defence Staff tended to take primacy.

8 Certainly in my time it has increasingly been
9 a partnership where I have taken responsibility for
10 actually ensuring that the healthcare was delivered
11 while the Deputy Chief of Defence Staff for Health made
12 sure that I actually had the resources necessary to
13 deliver that.

14 THE CHAIRMAN: It would help if you could slow down just
15 a little, please.

16 SIR MARTIN GILBERT: You say in your statement, which was
17 very helpful indeed that the post of DCDS (Health) was
18 abolished in 2009. Can you explain to us the reasons
19 for that?

20 LT GEN LOUIS LILLYWHITE: In order to explain that, one
21 needs to recognise why it was introduced in the first
22 place.

23 It was introduced in the first place because for
24 many years there had been disagreement within defence
25 about what the Defence Medical Services should be, in

1 terms of its organisation, in terms of its size, and
2 that disagreement had started to irritate the higher
3 echelons of the Ministry of Defence and they felt that
4 the best way to actually resolve it was to, in essence,
5 bring in an outsider from outside the Defence Medical
6 Services to actually resolve solve those internal
7 disagreements.

8 The reason why it has gone, I think, is because
9 finally, primarily as a result of the Top Structures
10 Next Steps study that I referred to in my statement, the
11 Ministry of Defence has now endorsed the size and shape
12 of the Defence Medical Services and the top-level
13 structures that should be in place, the responsibility
14 of the future Surgeon General, including, as I said, the
15 process ownership and responsibility to the
16 Defence Board.

17 SIR MARTIN GILBERT: Thank you. Can I take you back to 2003
18 to 2005, when you were Director General of Army Medical
19 Services. Can you describe to us what that role
20 entailed?

21 LT GEN LOUIS LILLYWHITE: That role entailed first of all
22 responsibility for recruiting to the Army Medical
23 Services. It was specifically for the Army, not for the
24 others. It involved providing a degree of assurance
25 that the units that deployed on operations were fit and

1 proper for purpose. And it included providing advice to
2 the Adjutant General in particular in respect of the
3 health -- the standard of health, of wellbeing, of Army
4 personnel.

5 SIR MARTIN GILBERT: That was entirely an Army --

6 LT GEN LOUIS LILLYWHITE: Entirely an Army.

7 SIR MARTIN GILBERT: And when you became Director General of
8 Medical Operational Capability, what was that role?

9 LT GEN LOUIS LILLYWHITE: That post was established in large
10 part because of a number of -- how do I put it? --
11 weaknesses, shortcomings, a need for modernisation that
12 I had identified as Director General of Army Medical
13 Services. It was decided that there was a need to
14 actually look specifically at operational -- medical
15 operational capability, and I was then appointed to do
16 that.

17 I was followed by a second individual who took over
18 from me, but again, having, as it were, completed the
19 task of reviewing the operational capability of the
20 medical services, having put in place implementation
21 plans, the post was folded and a new top structure has
22 taken its place.

23 SIR MARTIN GILBERT: If I can end by going back to your time
24 as Surgeon General, can you give us some idea of what
25 percentage of your time was spent with regard to Iraq?

1 LT GEN LOUIS LILLYWHITE: I have difficulty in actually
2 apportioning the time. By far the majority. Let me --
3 you said Iraq. By far the majority of my time, probably
4 something like 80 per cent, was related to operations,
5 whether they be Iraq or Afghanistan or both; but in many
6 ways they were indivisible.

7 SIR MARTIN GILBERT: What contact did you have as
8 Surgeon General with ministers?

9 LT GEN LOUIS LILLYWHITE: Frequent contact with ministers.
10 There were routine meetings, which, because of diary
11 clashes, which there was probably only once a month, but
12 there were frequent meetings in between to actually
13 address issues as they arose: issues that the minister
14 had wanted advice on or wished to debate or wanted to
15 give some direction on, or issues that I had that
16 I actually wanted to bring to ministers' attention or in
17 my turn wanted advice and direction on.

18 SIR MARTIN GILBERT: Thank you very much.

19 THE CHAIRMAN: Any particular a minister with a particular
20 interest in the medical services?

21 LT GEN LOUIS LILLYWHITE: Undersecretary of State.

22 THE CHAIRMAN: Right. Not the Minister for the Armed
23 Forces?

24 LT GEN LOUIS LILLYWHITE: Not -- occasionally --
25 I occasionally had contact with the Minister for Armed

1 Forces. I rarely had contact with the Secretary of
2 State. But the Undersecretary of State, of course,
3 I had quite a lot of contact with; not only was he
4 responsible for health but he was also, of course, the
5 Veterans Minister.

6 I'll turn now to Baroness Prashar.

7 BARONESS USHA PRASHAR: Can we look at the question of
8 medical personnel manning. It would be helpful if you
9 can describe the numbers and types of personnel deployed
10 in Iraq to provide in theatre the medical care.

11 LT GEN LOUIS LILLYWHITE: How do I summarise that?

12 BARONESS USHA PRASHAR: Give me an overall number, just
13 a general idea how many surgeons, nurses you had and so
14 on.

15 LT GEN LOUIS LILLYWHITE: It varied significantly --

16 BARONESS USHA PRASHAR: During the course.

17 LT GEN LOUIS LILLYWHITE: -- during the course. So what we
18 called Op Telic 1, there was the deployment of complete
19 hospitals, regular and Territorial Army, plus medical
20 regiments, plus what we call Role 1, which is the
21 battalion medical officers, and I cannot put a number on
22 that. I'm sure that, if you wish for numbers, we could
23 provide them or I could arrange for them to be provided.

24 Over time the Role 2, the medical regiments, were
25 removed because evacuation could then be from point of

1 wounding, from the battalion, straight to the hospital.
2 And of course with the finishing of the combat phase of
3 Op Telic 1, one was able to draw down the number of
4 hospitals.

5 So at the end there would have been in the order of
6 two surgical teams but with specialist surgeons as well.
7 So there would be four consultant surgeons plus one or
8 two more junior surgeons, for example, and associated
9 specialist staff like anaesthetists to support those.

10 The numbers varied over time in response to the
11 casualty load and indeed according to some of the
12 specialist requirements that were identified en route.

13 BARONESS USHA PRASHAR: Medical manning seems to have been
14 a problem particularly during the early stages of
15 Operation Telic and I think this was something that the
16 Defence Committee in the House of Commons said they were
17 alarmed at. What were the specific shortfalls and what
18 were the causes of these shortfalls?

19 LT GEN LOUIS LILLYWHITE: Again, one has to go back some
20 time before Iraq. The defence cost studies of the
21 mid-1990s, which abolished service hospitals, except for
22 Haslar, led to a major outflow of medical personnel.
23 Indeed, the House of Commons Defence Committee report at
24 that time did actually opine that the medical services
25 may have been beyond recovery. So we had dropped to

1 exceptionally small numbers. I think there were only 20
2 anaesthetists left, for example.

3 As you will be aware, training of medical personnel
4 takes a long time, particularly of specialist staff. In
5 spite of many attempts to directly recruit trained
6 specialist staff, in practice we have found that we have
7 to recruit internally for specialist staff. So even in
8 theory it would take 20 years to actually recover from
9 the mid-1990s to actually get up to full manning, and
10 indeed that is what in practice appears to be the case.

11 So by the time of the House of Commons Defence
12 Committee second report, we had more than doubled the
13 number of anaesthetists and indeed we were forecasting
14 almost another doubling of the number of anaesthetists
15 between then and 2012.

16 So what you saw was a shortfall due to a major
17 outflow due to a hastily implemented, in my view, study,
18 followed by a period of recovery, and of course recovery
19 in everything including medicine and organisations takes
20 time.

21 BARONESS USHA PRASHAR: And that happened before Iraq?

22 LT GEN LOUIS LILLYWHITE: Yes.

23 BARONESS USHA PRASHAR: What impact did this have on the
24 ability to deploy sufficient personnel to Iraq?

25 LT GEN LOUIS LILLYWHITE: It made it -- it made it more

1 difficult to actually meet the requirement. The
2 requirement was met. It was met by a variety of means:
3 making greater use of the reserves, even on mature
4 operations rather than simply on contingency operations,
5 which was the original intent of the reserves; and by
6 using international forces, so we had Czech surgical
7 teams, for example, deployed to Iraq to our hospital;
8 and to a lesser extent using contractors, although they
9 were primarily nurses, latterly neurosurgeons.

10 BARONESS USHA PRASHAR: So you had to rely on reserves,
11 contractors and international personnel?

12 LT GEN LOUIS LILLYWHITE: Yes.

13 BARONESS USHA PRASHAR: Did this shortfall result in breach
14 of the Harmony guidelines for some medical personnel?

15 LT GEN LOUIS LILLYWHITE: Yes, and probably continues to be
16 some breach of the Harmony guidelines, although the
17 number of times they are breached is reducing quite
18 significantly as manning improves. But, yes, there was
19 breaching of Harmony guidelines.

20 BARONESS USHA PRASHAR: But by 2007, the Defence Committee
21 were still concerned about manning.

22 LT GEN LOUIS LILLYWHITE: Yes.

23 BARONESS USHA PRASHAR: Because it said there were junior
24 staff deployed. I mean, why have these persisted for so
25 long? Because, you know, I understand there was a time

1 lag in terms of training but why have they persisted for
2 so long, over a period of five years?

3 LT GEN LOUIS LILLYWHITE: Certainly, if you actually look at
4 especially the more senior levels, which is the one that
5 concerned people, it takes seven or eight years to
6 actually result in a consultant. So from the end of the
7 Defence Cost Study 15 period which was about 1997, 1998,
8 1999, even in theory you would be talking about ten
9 years from there to when you could actually get to
10 full -- so it was to a large extent almost arithmetical.

11 But secondly, of course, it was also getting right
12 the ethos within the new organisations that had been put
13 in place. So the Ministry of Defence hospital units,
14 again which were set up rather hurriedly, initially did
15 not actually have what the individuals in those
16 hospitals, the military individuals in those hospitals,
17 felt were appropriate support structures. They felt, to
18 a large extent, as though they had been kind of excluded
19 from the mainstream military and it took time to put
20 that right.

21 So it was a mixture of almost an arithmetical
22 certainty -- it takes time to train -- plus having to
23 put right at the very beginning some of the shortcomings
24 of the systems that had been put in place post the
25 defence cost study.

1 BARONESS USHA PRASHAR: But what was the situation when you
2 left in 2009? Had that improved?

3 LT GEN LOUIS LILLYWHITE: Yes, indeed, there are significant
4 areas where we are getting concerned about overmanning.

5 BARONESS USHA PRASHAR: Such as?

6 LT GEN LOUIS LILLYWHITE: Orthopaedic surgeons, which had
7 almost disappeared at the end of Defence Cost Study 15,
8 not helped by the shortage of orthopaedic surgeons in
9 the NHS, which allowed an immediate outflow in finding
10 another job almost in the hospitals where they already
11 lived. So we went from almost two or three up to
12 a period now, when I left in 2009, we were concerned
13 with overmanning.

14 BARONESS USHA PRASHAR: But what about nurses and surgeons?

15 LT GEN LOUIS LILLYWHITE: Nurses, the numbers again had come
16 up to close to the numbers that we required. However,
17 there is an important proviso there: we still have
18 problems with specialist nurses, internally recruiting
19 our own nurses to actually be trained as intensive care
20 nurses, et cetera. So although the number of nurses has
21 come up in total numbers, that actually hides a shortage
22 in specialist nurses and that continues to be a problem.

23 BARONESS USHA PRASHAR: Were there lessons learned in terms
24 of forward planning, in terms of what's required. Is
25 there something to be learned from this particular

1 sequence?

2 LT GEN LOUIS LILLYWHITE: In terms of the numbers, a large
3 part of the defence -- or in parallel with the
4 Director General of Medical Operational Capability
5 report there was what was known as the PPSG study, that
6 actually identified the total numbers required to meet
7 what were then the government's defence planning
8 assumptions.

9 So the DG Med Op Cap work that I did, actually
10 a large part of it was coming to an agreement within the
11 Ministry of Defence, based on the evidence of the
12 current and previous conflicts and also of modelling by
13 people like DSTL, of what the future requirements should
14 be and what the personnel required for that -- to meet
15 that requirement should be. So -- and that was in due
16 course announced in Parliament and is in Hansard.

17 BARONESS USHA PRASHAR: Thank you.

18 THE CHAIRMAN: Thanks. I'll turn to Sir Lawrence now.

19 SIR LAWRENCE FREEDMAN: I want to look at the way seriously
20 injured personnel are treated in Iraq. Perhaps just
21 basically describe the nature of emergency medical care.
22 I'm interested in how you evaluate different approaches
23 to provide emergency medical care in operations.

24 LT GEN LOUIS LILLYWHITE: I think it is fair to say that the
25 early part of the Iraq campaign, we did not have the

1 data to actually allow us to undertake what I might call
2 an objective assessment.

3 As I think I said in my statement, to a large extent
4 that was a direct consequence of two things: one, the
5 Cold War approach, where one was actually managing
6 huge -- or planning to manage huge numbers of
7 casualties, where you did just what you could, and
8 therefore measurement in a sense wasn't actually going
9 to contribute anything other than being numbers; and
10 secondly, we had not yet fully introduced into the
11 operational area the new clinical governance environment
12 that one was actually seen post the Bristol Inquiry in
13 the National Health Service, although it was being
14 implemented at a local level by individual commissions.

15 However, individuals were still trying to measure
16 outcomes. The way that outcomes tend to be measured in
17 terms of emergency care is to use various scoring
18 systems that are internationally accepted. What that
19 means is if you take a casualty, you can actually look
20 at his mixture of injuries in an objective manner and
21 apply a score to that, and that gives you a probability
22 of survival, and you would hope to ensure that anybody
23 who has a greater than 50 per cent probability of
24 surviving does indeed survive, and you measure your
25 success by looking at how many people survive against

1 the score.

2 What we found before Iraq, in Bosnia, because there
3 was a number of clinicians who were doing it, was that
4 we were actually achieving a greater than expected
5 success rate. What we have identified subsequent to the
6 early Iraq data is that the number of survivors is
7 increasing quite significantly over and above what you
8 would expect in an equivalent system across the world.

9 SIR LAWRENCE FREEDMAN: Can you give us some idea of what
10 sort of numbers we are talking about? I think it is
11 normally done in terms of killed in action rates.

12 LT GEN LOUIS LILLYWHITE: There are two systems running in
13 parallel. If you actually look at killed in action
14 rates and died of wound rates, which you can actually
15 follow from the 1500s in fact, the killed in action rate
16 has remained quite constant over many centuries at about
17 25 per cent. We appear to have reduced that to
18 15 per cent in the later Iraq and Afghanistan conflicts.
19 So for the first time in many centuries we have made
20 a significant impact into the killed in action rate.

21 Those figures are yet unpublished in the UK data
22 set. They are available from the US and I expect the UK
23 to publish them in the near future.

24 SIR LAWRENCE FREEDMAN: You are confident that that's the
25 right number now?

1 LT GEN LOUIS LILLYWHITE: The numbers that I have seen that
2 have been worked out by DASA, the Defence Analysis and
3 Statistical Agency, supports us moving in exactly the
4 same manner as the United States have moved in the later
5 conflict.

6 The died of wounds rates initially went up amongst
7 the US forces, who were measuring the data earlier on
8 when we didn't have it, which is something that had been
9 found in previous conflicts like the Arab/Israeli
10 conflict. If you actually improve your killed in action
11 then your died of wounds, those who died in medical
12 units, goes up. The Americans found they went up before
13 coming down, as they learned how to manage those
14 casualties that previously didn't survive.

15 When we started measuring them, we could also
16 demonstrate that we were actually ensuring that those
17 who now survived from the point of wounding continued to
18 survive in our medical units. We did not see the blip
19 that the Americans had because we weren't measuring.

20 I know that the National Audit Office does actually
21 report in its report the specific numbers, but we are
22 talking about 20/25 -- they are small numbers because
23 most survive anyway -- but 20/25 people who are now
24 living who would previously have died just from the
25 Afghani campaign. I cannot give the exact numbers from

1 the Iraqi campaign.

2 SIR LAWRENCE FREEDMAN: That's very helpful.

3 Is there a relationship between treating people
4 where the incident occurs and evacuation?

5 LT GEN LOUIS LILLYWHITE: It depends if you are being --
6 where it occurs in the theatre of operations or if you
7 mean the point of injury.

8 SIR LAWRENCE FREEDMAN: I'm just looking at the report you
9 provided and there is some discussion there about
10 forward surgery in relationship to evacuation.

11 LT GEN LOUIS LILLYWHITE: I think there are two issues that
12 one needs to look at: one is where they are treated
13 within the theatre of operations, Iraq or Afghanistan;
14 and the second issue is the balance between treating in
15 the theatre of operations and treating back in the
16 United Kingdom.

17 So staying with the first one initially, as I said
18 in answer to your previous question, a treatment at the
19 point of -- survival at the point of injury has remained
20 obstinately constant for many centuries until the recent
21 conflicts. What we found in the later stages of Iraq
22 and now in Afghanistan was that the introduction of new
23 techniques, such as giving tourniquets to every single
24 soldier -- and tourniquets that worked, because it
25 transpired that not all worked -- giving them the new

1 what's called the Israeli dressing that is particularly
2 good at applying pressure over a wound, and introducing
3 new dressings that actually cause blood to clot at the
4 injury site, plus the training that was associated with
5 that and the introduction of individuals such as team
6 medics, those -- that combination has improved the
7 survival at the point of injury.

8 Again, as I indicated, from the American experience
9 and probably ours, although we didn't measure it, it is
10 no good saving those extra lives at the point of injury
11 if you do not actually sustain care subsequently. That
12 is where a debate continues, and it has been a debate
13 that has been going on since 1918, when the Australians
14 first developed -- deployed forward surgery in the Sinai
15 campaign.

16 There is a debate as to what extent you should
17 actually have surgery forward, where people say that
18 that is a misuse of resources and may be a wasteful one
19 if you cannot provide the ongoing care during
20 evacuation, amongst those who say, "Yes, but for 5 or
21 6 per cent of those injured it is essential", against
22 those who say it would be better to actually concentrate
23 on evacuation back to formal hospital facilities.

24 I think that the debate is a bit sterile because it
25 depends actually on the circumstances. Where you can't

1 evacuate casualties easily, forward surgery has a place.
2 Where you can evacuate casualties safely, they should be
3 evacuated straight to surgery and not have surgery
4 forward.

5 The latter campaign in Iraq and now in Afghanistan
6 has introduced a new concept of forward resuscitation,
7 rather than forward surgery. What you are seeing, of
8 course, mainly in Afghanistan -- by the time we had
9 thought about it, Iraq had withdrawn to Basra and the
10 distances were not so great -- but what we are finding
11 is that actually it is probably resuscitation that is
12 important forward rather than surgery. I know there are
13 surgeons that wouldn't like me saying that, but that is
14 where the evidence is leading.

15 So we are now deploying forward consultant
16 anaesthetists or consultant emergency medicine
17 physicians who can actually take these extremely serious
18 casualties whose lives have now been saved by the
19 techniques I mentioned and actually sustain their lives
20 until they actually get to hospital, even to the extent
21 occasionally of actually opening someone's chest, which
22 is a surgical procedure but not done by surgeons, to
23 actually sustain their circulation until they actually
24 arrive in the hospital.

25 SIR LAWRENCE FREEDMAN: Can you just explain to me what the

1 1:2:4 hour rule is?

2 LT GEN LOUIS LILLYWHITE: The 1:2:4 hour rule was a rule
3 that was developed in the immediate post-war period,
4 post-Cold War period, to actually provide some planning
5 guidelines for operational staff as well as medical
6 planners, which in essence said that -- it started from
7 the premise that you could not guarantee getting
8 somebody to surgery in the military context within the
9 hour, the so-called golden hour, and there was a need to
10 actually -- on the one hand. On the other hand, the old
11 rule from the Cold War of six hours to surgery was
12 clearly, we thought, unacceptable.

13 So it was a consensus -- a consensus meeting, which
14 I remember being at -- as to what was practical on the
15 one hand and, you know, what was not unacceptable on the
16 other hand. What the 1:2:4 hour rule says, in essence,
17 is: everybody who is seriously injured must have
18 resuscitation within an hour, they must -- the very
19 serious must have the opportunity for surgical
20 intervention within two hours and the serious should all
21 be in hospital within four hours.

22 So that was the 1:2:4 hour rule and that was what
23 was in existence at the time of the initial Iraqi
24 campaign.

25 Our thoughts are evolving as we see evidence from

1 ongoing campaigns and, of course, the rule has been
2 undermined, overturned, by that initial care at the very
3 point of injury. It is quite clear that -- what is
4 becoming clear from the evidence is that those very
5 seriously injured actually require resuscitation early
6 on, but the surgery appears to be quite capable of being
7 delayed to two or possibly longer hours.

8 So it is an old rule and interestingly, of course,
9 when we look at operations for the future, not in Iraq
10 and not in Afghanistan but future expeditionary
11 operations, we are going to have to address what
12 relevance that actually has in terms of that planning.

13 SIR LAWRENCE FREEDMAN: You mentioned before evacuation.
14 Were you using armed ambulances or mainly relying on
15 helicopters?

16 LT GEN LOUIS LILLYWHITE: In Iraq we spent -- we relied
17 significantly -- the first phase of the operation, we
18 were relying on ambulances. From the point of
19 wounding -- sorry, let me start again.

20 Op Telic 1, conventional deployment, regimental aid
21 posts, medical regiments, hospitals. We were using
22 armoured ambulances primarily to get from the aid posts
23 to the field -- to the medical regiments and we were
24 using a mixture of ambulances and helicopters to get
25 from there to the hospital.

1 Moving on to Op Telic 2 and beyond, we were using
2 helicopters from places like Al Amarah, straight back
3 from the regimental aid post or the point of wounding to
4 the hospital; from Basra City we were initially using
5 armoured ambulances and occasionally using helicopters
6 when it was felt to be too dangerous for armoured
7 ambulances. In Afghanistan now, like Al Amarah, where
8 the distances are long, it is almost entirely
9 helicopter.

10 SIR LAWRENCE FREEDMAN: Did you have problems with
11 helicopter availability?

12 LT GEN LOUIS LILLYWHITE: To my knowledge, no. I must be
13 careful in how I phrase this. I have no view as a medic
14 on whether there was sufficient helicopters or not
15 sufficient helicopters. What I do have a view on is
16 whether I personally or my medics get sufficient
17 helicopters. We always appear to have had our
18 helicopters when we want them. That, of course, may be
19 because there are sufficient overall or it may be
20 because commanders have prioritised them to medics.

21 SIR LAWRENCE FREEDMAN: All I'm concerned about is whether
22 you had at the moment.

23 LT GEN LOUIS LILLYWHITE: The medics have been lucky or the
24 commanders have given us the helicopters when we need
25 them.

1 SIR LAWRENCE FREEDMAN: You talked about a number of sort of
2 clinical developments. Perhaps you could say a bit more
3 about what we have learned about trauma care, for
4 example, as a result of operations in Iraq.

5 LT GEN LOUIS LILLYWHITE: That's actually -- interestingly,
6 you could have a complete symposium or multi-day
7 conference on what we are learning from Iraq and it
8 covers an increasing number of areas.

9 Clearly we have learnt how we can save life at the
10 point of injury. That is new. The contribution that
11 technology can make: haemostatic dressings, for example,
12 are based on a byproduct of the shrimping industry and
13 someone discovering that zeolite, which is from volcanic
14 rock, can react with blood. So that's the first point.

15 The second point has been that our data collection
16 has increasingly allowed us to analyse variation in
17 survival, which has pointed to what is important in
18 ensuring survival, so resuscitation and protocols like
19 the massive transfusion protocols that have actually led
20 to us using blood, but plus plasma and plus platelets,
21 contribute significantly to ongoing survival; something
22 which has clear relevance worldwide and not just in the
23 military.

24 So the whole of ensuring individuals' survival has
25 grown from that and increasingly massive transfusion

1 protocols will be seen within the civilian system.

2 We are also learning how to actually sustain the
3 quality of life of individuals subsequent to evacuation.
4 So as a result of what we are seeing on operations, as
5 one example, a lot of research is going on in what's
6 called -- I use it as an example -- something called
7 heterotrophic ossification. Who is writing it down?
8 But if you have lost a limb, for example, you get a lot
9 of new bone formation which interferes with stumps. So
10 there is a lot of research going into actually how that
11 minimises and actual identifying what are the factors
12 that are associated with that.

13 Plastic surgery is again starting to learn a lot
14 about how you can actually identify viable tissue from
15 non-viable tissue and that will actually have, again,
16 a relevance elsewhere.

17 Pain management has been a particular success. One
18 of the -- when you talk to our soldiers -- and I used to
19 hold those focus groups -- when you talk to soldiers
20 they would say as a generalisation they were very happy
21 with their care but they had pain, and it was almost the
22 universal adverse comment in the early part that pain
23 was not addressed.

24 We are introducing techniques such as continuous
25 infusion of local anaesthetics via catheters that we can

1 now sustain from the field hospital through the air
2 bridge into what was Selly Oak but which is now Queen
3 Elizabeth, as the new ward is open. Again it is
4 something that we have learned and we have also learned
5 the means to actually support that.

6 If you have a limb that is mashed, you can no longer
7 assume that the vein is where the nerve is because they
8 get separated, which is what you would do in civilian
9 life. So one has developed things like ultrasound
10 guidance to actually identify where the nerve is to put
11 in the local anaesthetic, which means that you can
12 actually abolish pain due to severely damaged limbs.

13 Again, it is but another example of where one has
14 learned.

15 SIR LAWRENCE FREEDMAN: That's very interesting. You
16 mentioned the massive transfusion protocol from plastic
17 surgery as having potentially wider clinical
18 applications in the UK. Are there other areas where
19 civilian medicine may be improved by what we have
20 learned?

21 LT GEN LOUIS LILLYWHITE: Oh, yes. I mean, we have -- I am
22 retired but I still say "we".

23 SIR LAWRENCE FREEDMAN: You are not the first witness to do
24 so.

25 LT GEN LOUIS LILLYWHITE: For example, it has been

1 discovered that somebody who has completely lost their
2 sight due to trauma, if you actually put a black and
3 white camera on their forehead and sensors on their
4 tongue, that they can train themselves to see again.

5 Experimental -- that is a US development, I think it
6 is Harvard or Massachusetts, but we have entered one of
7 our soldiers into that trial. Clearly if it is
8 successful, and it does appear to be successful, that
9 will be -- there will be benefit to anybody who loses
10 their sight due to a shotgun blast to the head, for
11 example.

12 There is a lot of research being undertaken by the
13 United States -- I think it is about £3 billion worth
14 a year -- into regenerative medicine, which clearly will
15 actually have benefits for medicine as a whole.

16 We are looking at noise-induced hearing loss in the
17 United Kingdom. There was a major symposium in December
18 which brought together civilian, academic and military
19 practitioners. Noise-induced hearing loss is an issue
20 for the civilian community as well as the military
21 community, and indeed one of the civilian charities,
22 Deafness Research United Kingdom, co-hosted that
23 conference.

24 So there are numerous areas where there will be
25 spin-offs for civilian medicine. That is not to say

1 that I endorse a view that you go to war to actually
2 enhance medicine, but it is a spin-off from war,
3 regrettably.

4 SIR LAWRENCE FREEDMAN: There will be other people who
5 benefit. It is important.

6 Another completely different question, my final
7 question, is just about how well prepared you felt for
8 other health problems, such as heat exhaustion, that
9 were found in Iraq?

10 LT GEN LOUIS LILLYWHITE: Heat exhaustion, the one you
11 mention, reasonably so. It is unfortunately one of
12 those lessons that has to be relearned by those on the
13 ground, although on this occasion I think that with
14 a few exceptions -- and there were some exceptions,
15 depending on the formation -- the procedures put in
16 place were entirely appropriate. Paradoxically, some of
17 them were so successful that we were actually having
18 problems the other way, in the sense that water intake
19 amongst a number of personnel appeared to be so great
20 that it was actually causing problems in itself. You
21 can actually drink too much.

22 So heat actually in a sense is a bad example of the
23 areas where we were not prepared.

24 There is no doubt, and the NAO -- National Audit
25 Office, yes -- the NAO report makes this clear, we have

1 not tackled to the same extent as we have in the trauma
2 area things like diarrhoea and vomiting and there seems
3 to have been an increasing prevalence or incidence of
4 minor injury and illness, mainly illness, that we do not
5 appear to have actually tackled appropriately.

6 I think it was quite reasonable that we actually
7 concentrated on the trauma. You have to put priorities.
8 But I think it is right to say that we do actually need
9 now to actually turn our attention much more to actually
10 reducing the amount of illness that one actually gets on
11 operations from infection, diarrhoea and vomiting, skin
12 disease, minor eye problems, many of which ought to be
13 amenable to preventative action rather than treatment.

14 But also we need to consider -- and I didn't answer
15 this part of the question from before; I can't remember
16 who asked it -- but the extent to which we actually
17 treat people in theatre as opposed to actually
18 evacuating to the United Kingdom; the problem being that
19 once you get them to the United Kingdom, the system
20 seems incapable of getting them back to operations
21 almost in spite of the efforts that the system makes to
22 do that.

23 SIR LAWRENCE FREEDMAN: Thank you very much indeed.

24 THE CHAIRMAN: That provides an agreeably elegant
25 transition. I wanted to get an understanding of the

1 treatment and rehabilitation of the seriously injured
2 once they get back to the United Kingdom.

3 Could you perhaps first just give a thumbnail sketch
4 of where people go when they are treated?

5 LT GEN LOUIS LILLYWHITE: Yes. As a preamble to that,
6 I think we need to recognise that the very complex
7 casualties are only just getting to the end of their
8 active treatment. It is a long process. So there are
9 questions that need exploring in respect of their care,
10 which I'm sure you will come to in due course.

11 But as a thumbnail, almost all casualties are
12 evacuated almost all casualties are evacuated to the
13 United Kingdom to the Birmingham area. A few will be
14 discharged as an airhead because they are so minor that
15 they actually go back to their units or to their local
16 area. But generally speaking, anybody who requires
17 hospital care will actually go into what was Selly Oak
18 but is now the Queen Elizabeth at Birmingham.

19 THE CHAIRMAN: Would that have been true all the way through
20 from Telic 1?

21 LT GEN LOUIS LILLYWHITE: Yes, it was. It is important to
22 recognise -- the historians will, I'm sure be aware of
23 this -- but the responsibility for the care of
24 casualties returning from operations has always been
25 with the civilian medical services. It has been the

1 exception that the military have looked after their own.
2 So whether it be the First World War, whether it be the
3 emergency services of the Second World War, whether it
4 be the planning for the Cold War, it has always been
5 assumed that the civilian medical services will take
6 care of casualties on their return; the military's core
7 responsibility being the care of the casualties in the
8 theatre of operations.

9 The responsibility for saying who does that is the
10 Department of Health now, and the Department of Health
11 allocated the initial responsibility to the West
12 Midlands Strategic Health Authority area. The West
13 Midlands Strategic Health Authority area allocated that
14 to Birmingham, where our Centre for Defence Medicine
15 was, so from early on, from Bosnia days, that was the
16 primary receiving hospital: was Birmingham, and in
17 Birmingham, Selly Oak.

18 The plan was that if Selly Oak couldn't cope, then
19 the Strategic Health Authority would designate other
20 areas in Birmingham to take the additional casualties
21 and if the Strategic Health Authority could not cope,
22 the Department of Health would allocate casualties to
23 other regions in the United Kingdom.

24 So there was the plan, and in practice casualty
25 numbers have been sufficiently low for Selly Oak to

1 actually manage them throughout the campaign.

2 There have been occasions when the university
3 hospital of Birmingham has had to make arrangements for
4 some of its local casualties to have been managed
5 elsewhere, but the casualties in essence go to
6 Birmingham.

7 Once they finish at Birmingham, they may be
8 discharged on a period of home leave, but in due course
9 you would expect that the majority would go to
10 Headley Court, which is the rehabilitation centre, and
11 the rehabilitation programme at Headley Court could be
12 short or it could extend over two or more years, not
13 continuously generally speaking, but in bursts of
14 a number of weeks. Again, in between times they go back
15 to their unit or go back on home leave, and in due
16 course Headley Court will discharge those casualties
17 either fully fit or to leave the armed forces or to the
18 care of their primary care service back in their
19 original units.

20 So theatre to Birmingham to Headley Court; discharge
21 from the services or go back to their unit.

22 THE CHAIRMAN: Thank you.

23 One or two points, perhaps more, of detail. But we
24 understand that from the 2008 Defence Committee report
25 that there was a period when the staff at Selly Oak from

1 the military managed ward were deployed themselves to
2 Afghanistan and I wondered what happened to returning
3 casualties during that period.

4 LT GEN LOUIS LILLYWHITE: Again, I fall back on the plan,
5 which was that the civilian medical services were
6 responsible for managing the military casualties. It
7 quickly became apparent that returning casualties
8 actually wanted to be looked after by the military. So
9 there was a period of time when there was discordance
10 between what the casualties and their relatives wanted
11 and what the policy was.

12 Although at no stage -- and I checked the care that
13 was actually undertaken at Selly Oak -- so that although
14 at no stage was there clinical care of casualties coming
15 back from Iraq compromised, there was an unhappiness
16 amongst the patients themselves and their relatives
17 about the lack of military involvement in both their
18 care, although actually much more so in their welfare
19 support.

20 So there was a period when the plan, which was
21 working, was not in accord with what people had expected
22 or wanted. So that led to a significant period of
23 adverse press and internal adverse press as well, whilst
24 both the medical services, but even more so the chain of
25 command, organised themselves to actually provide that

1 military bubble around the care in the hospital.

2 THE CHAIRMAN: I can see that there could be attitudinal
3 problems both by civilian patients in a general purpose
4 ward with young men with serious physical injuries
5 against people who might even be geriatric or in late
6 age.

7 Was it a two-way problem that needed to be resolved
8 and separated?

9 LT GEN LOUIS LILLYWHITE: I think it is a complex problem
10 which has, in many ways, been oversimplified.
11 Interestingly, some of the old people nursed alongside
12 some of the soldiers who actually -- the old people who
13 had Second World War experience or Korean experience
14 actually formed very close bonds with the soldiers
15 alongside whom they were nursed, whereas on the other
16 hand, the young motorcyclist aged 18 or 19 could
17 actually become quite anti--- or cause problems with the
18 soldier in there. So it is actually not quite as simple
19 a problem as with ...

20 There is no doubt that soldiers who have been
21 injured suddenly in battle, who often know nothing
22 between the time before they were injured and when they
23 wake up, prefer to have their like-minded people around
24 them and like to be -- and like to see their own people
25 looking after them. In the period before that was in

1 place -- found, I might say, by some disreputable press
2 involvement -- there was this significant period of
3 unhappiness but it was more complex than is perhaps
4 portrayed.

5 THE CHAIRMAN: Thank you. Just two short follow-up
6 questions on that aspect.

7 One is whether it is possible to judge how far
8 providing a military bubble around patient insist
9 hospital actually improves their recovery,
10 convalescences, or is it simply a matter of relative
11 contentment with conditions?

12 But the other issue is you have referred now twice
13 to negative press treatment and we read with interest
14 the House of Commons Defence Committee report, which
15 described much of the reporting about Selly Oak as
16 "inaccurate" and "irresponsible". Would you share that
17 judgment? Could it have been in any way countered
18 effectively?

19 LT GEN LOUIS LILLYWHITE: You have asked two quite separate
20 questions. If I might deal with the first one first,
21 which is the military bubble. It doesn't improve the
22 quality of clinical care but one should not
23 underestimate the beneficial impact upon recovery, upon
24 family dynamics, and upon psychological wellbeing of
25 actually being content.

1 So you could, on the one hand, say it does no more
2 than make the casualty and his family feel content, but
3 actually that is such an important element of the
4 recovery process that I think it is one of the main
5 lessons that the NHS have learned, we the Defence
6 Medical Services have learned, and indeed the chain of
7 command has learned: that we have to continue to
8 actually provide that military bubble, area of
9 responsibility, during that period of treatment.

10 THE CHAIRMAN: Indeed, you refer to this in your statement.

11 LT GEN LOUIS LILLYWHITE: Indeed, yes, and I think that we
12 have got that right now. I think that -- although
13 I have not been to the new ward yet, I think that that
14 will actually make it even better because the new ward
15 is purposely built to actually facilitate that.

16 How that would work were we to have to take
17 a significant number of casualties and go nationwide,
18 I think is another issue. Again, I emphasise that
19 I don't think the clinical care would suffer but
20 providing that military bubble for a different order of
21 magnitude of casualties could be difficult.

22 The media. It was interesting that except for
23 The Birmingham Post, when that House of Commons
24 Defence Committee report was published, that paragraph
25 in the House of Commons Defence Committee report was not

1 mentioned by a single newspaper.

2 THE CHAIRMAN: Thank you for drawing our attention to that.

3 LT GEN LOUIS LILLYWHITE: I have to say that I despaired at
4 being able to try and get across a countering message,
5 and I will give two examples.

6 I gave a press conference that actually did not --
7 during which time -- during the press conference I gave
8 or the questions I answered afterwards, the words "NHS"
9 or "National Health Service" did not pass my lips once.
10 Not once. The next day I was surprised to open a paper
11 to find in large headlines me being said to have
12 actually criticised the National Health Service. One
13 example.

14 A second example was that when that House of Commons
15 Defence Committee report was published, it was, in the
16 usual manner of things the government does, passed to
17 the press on the Friday as an embargoed version, prior
18 to its official release on the Monday. I was surprised
19 on the Sunday to see a report -- and I cannot remember
20 which paper it was in; it was one of the national
21 Sundays -- which said:

22 "Defence Committee or Parliamentary report released
23 tomorrow expected ..."

24 That's my emphasis:

25 "... expected to be critical of medical care."

1 My staff went back to the newspaper and said, "You
2 had the embargoed copy, you know, you knew -- why did
3 you report that?" And they said: well, it was expected
4 that the report would be critical, so we reported, quite
5 accurately, that report was expected to be critical.
6 Fair enough. So we said, "Well, but you had the
7 embargoed report. You knew it wasn't going to be
8 critical". The response to that was: you, oh
9 government, keep on telling us that we must not quote
10 anything in the embargoed report until the day of
11 publication, so we couldn't use it.

12 So there are two examples where, in spite of every
13 effort to the contrary, one could not just breakthrough
14 the view that existed at that time that things were
15 being done badly and wrongly. I rest my case.

16 THE CHAIRMAN: An eloquent piece of testimony. Can we move
17 on to rehabilitation. You have told us briefly about
18 Headley Court, which is, I take it, a fully military
19 facility.

20 LT GEN LOUIS LILLYWHITE: Yes, although, of course there are
21 civilian staff in there and it has treated civilian
22 patients at times when we do not actually have ongoing
23 conflict.

24 THE CHAIRMAN: You said in your statement, I think in
25 paragraph 15, that managing the rehabilitation workload

1 is a major risk area; that resources are being brought
2 into it. Headley Court stands at the centre of the
3 rehabilitation task but there are other resources as
4 well?

5 LT GEN LOUIS LILLYWHITE: We in the military have
6 a three-level approach. We have primary -- we have
7 primary rehabilitation, which is almost aligned to the
8 GP's surgery, to put it in civilian terms. We then have
9 regional units to actually look after cases that do not
10 require admission, although sometimes there is hospital
11 accommodation provided. Then you have Headley Court,
12 which is a centre of excellence, where real expertise
13 lies, and which actually deals with those complex cases
14 that actually needs admission or where rehabilitation
15 has failed elsewhere.

16 So, yes, Headley Court is in the centre.

17 THE CHAIRMAN: You have mentioned, as I have already quoted
18 to you, that it was a major risk area, but resources
19 were made available to meet that. Is that in terms of
20 ensuring there was sufficient capacity at Headley Court,
21 and that the regional and other facets were sufficient
22 for the task?

23 LT GEN LOUIS LILLYWHITE: It was a risk area. It was
24 a major risk area because there were many risks
25 associated with Headley Court.

1 Capacity was undoubtedly one. We were seeing far
2 more cases that needed inpatient care in beds that we
3 had ever seen probably since Korea, I suspect, and the
4 capacity of Headley Court was not sufficient to have met
5 it. Luckily, the building programme, the temporary
6 ward, the relationships with the local planning
7 authority, enabled us just to keep ahead of the
8 southern. A close run thing, I think, but we kept ahead
9 of the surge.

10 So the one issue of risk was capacity. That was
11 exacerbated by the fact that there is very little
12 inpatient rehabilitation capacity in the United Kingdom.
13 It is a major shortfall within the United Kingdom PLC.
14 There are places like the Wessex Rehabilitation Centre
15 but they are few and far between.

16 So that was the first area of risk. The second area
17 of risk was around the facility itself. Headley Court
18 is a fine listed building, which had in essence for many
19 years treated sports injuries, complex sports injuries,
20 but not open wounds. What we have started doing in this
21 conflict is starting rehabilitation ever earlier, with
22 significant success. But it posed risk in the type of
23 surroundings that they were being managed in, in that
24 Headley Court was not set up to look after cases that
25 were open wounds or complex medication that required

1 ongoing non-rehabilitation specialist care.

2 So Headley Court remained and possibly still
3 remains, the greatest area of risk in actually managing
4 casualties.

5 THE CHAIRMAN: Thank you. One last question from me and
6 then I'll turn to Sir Roderic Lyne and then I think we
7 will have a break after that.

8 My last one is really from something that
9 Bob Ainsworth said to us in evidence. He told us that
10 one of the concepts arising from the White Paper, the
11 command paper of 2008 that covered the White Paper, was
12 that in some areas:

13 "... special treatment is appropriate as a return
14 for sacrifice, mostly in regards to the injured."

15 Could you just perhaps comment on that remark?

16 LT GEN LOUIS LILLYWHITE: What we are seeing is this
17 complex -- this survivor that previously would have died
18 with complex injuries, a casualty that is not seen in
19 civilian life or is seen extremely rarely in civilian
20 life and for which the civilian medical services have
21 not been set up to manage, complicated by the fact that
22 care falls across the medical/social care divide, which
23 both the last and this government has recognised is
24 a weak point, and for which there is no experience.

25 So there are probably two reasons why returning

1 servicemen require a specialist approach. One is
2 because they are servicemen, where it seems to be
3 recognised that injury in the pursuit of this nation's
4 policy gives them an added entitlement to care on the
5 one hand, but there is the clinical argument on the
6 other hand that we are seeing surviving a type of
7 casualty that actually is going to need specialist
8 approach to. The.

9 Numbers are relatively small, 50/60 at the moment,
10 I would have thought, and no more, but spread across the
11 United Kingdom what one doesn't want to see, I would
12 submit, is everybody learning from what we call
13 "N equals 1". In other words, everybody everywhere is
14 learning on their casualty without the sharing of
15 experience, et cetera.

16 So there is a need, I think, to actually treat these
17 casualties as a group. How that is done, you might wish
18 to come on to later but I'll come back to that. There
19 is a third issue, though, and that is what we do with
20 some of the emerging research findings which are still
21 not endorsed for use in the National Health Service.

22 As you know, the National Health Service has quite
23 an effective and well thought of process for actually
24 assessing technological advances and new medicines, so
25 that they are not introduced until they are deemed

1 cost-effective and effective.

2 Yet I have already referred to what's called the
3 lingual sight, you know, the tongue and the camera. If
4 our American allies are having access to such care now,
5 should we delay giving our people that care until such
6 time as sometime distant, five or six years' time, it
7 has been using sufficiently often and gone through
8 a technological assessment process that actually leads
9 to its recommendation that it should be used in the
10 National Health Service.

11 Now, whilst they are in service, we can circumvent
12 that. But if we put a soldier who is blind -- we'll
13 take him as an example -- in some primary care trust
14 somewhere in an inner city, is that prime care trust,
15 who probably has many calls on its funding, going to
16 spend the money that it is short of on that soldier?

17 Even worse now is what is going to happen in the new
18 system, when we have GP consortia in England, as is
19 planned. What is their approach going to be to that
20 soldier? How are they going to make the informed
21 decisions about whether or not you should use this or
22 that in advance of it being recommended by NICE?

23 So that is the second reason why I think we need to
24 actually look at the severely injured soldiers as --
25 I don't like calling it a special case because I don't

1 think it is a special case. I think they are a group
2 with specific clinical needs.

3 THE CHAIRMAN: Thank you. Just a quick tailpiece before
4 Sir Roderic picks up.

5 I think I read in your statement that in theatre it
6 is possible to use some drugs prior to formal approval
7 by NICE. Really this is in part, what you have been
8 saying, an extension of that protocol into the home; not
9 theatre, the home base.

10 LT GEN LOUIS LILLYWHITE: Yes, except, like the soldiers we
11 send to trilingual sight, that is fine when they are
12 under my control. It is accepted -- not written down
13 but it is accepted -- that I as Surgeon General can take
14 that risk. Whereas if you were to actually put that
15 individual into a civilian setting, that would not
16 apply.

17 THE CHAIRMAN: I see. Thank you very much.

18 Roderic, over to you.

19 SIR RODERIC LYNE: You have already spoken of the way that
20 rates of survival have increased significantly. What
21 particularly has brought that about?

22 LT GEN LOUIS LILLYWHITE: The length of the campaign has
23 been a significant contributor to that because it has
24 allowed the collection of data over time that has
25 enabled variation to be analysed against survival. So

1 you have a data set and you see that some die and some
2 live and you explore that data set and you see that the
3 ones who die, there is a greater number of people who
4 had low body temperatures, for example. You can only do
5 that if your campaign is -- if the campaign is sufficiently
6 long. So the first thing is the duration of the
7 campaign.

8 The second thing is, I think, the enquiring mind of
9 those clinicians on the ground who, as a matter of
10 professional respect, integrity, bring that to the
11 battlefield from their civilian practice, where one is
12 always looking for ways of actually improving the care
13 you give.

14 The third thing latterly has been the
15 systematisation of that, in that we have introduced, you
16 know, more and more systems that actually identify what
17 leads to survival and what does not. So the weekly
18 conferences from Birmingham to Iraq initially, and Iraq
19 and Afghanistan lately, provides feedback to theatre of
20 where treatments have not worked properly, where things
21 have been missed, and therefore educates the clinicians
22 on the ground as to where to improve their performance.

23 Fourthly, there has been the money in the
24 United States and the UK that has been put into specific
25 research.

1 So it is a multi-factorial reason why survival
2 has improved, and that is supported then, of course, by
3 the procurement, the training, et cetera, et cetera.

4 SIR RODERIC LYNE: Now, obviously, the impact of this has
5 been a large increase in the number of people needing
6 a long period of rehabilitation back in the UK. We have
7 already talked about Headley Court and complex cases,
8 but this isn't just complex cases. To what extent have
9 the existing facilities been able to cope with this?

10 LT GEN LOUIS LILLYWHITE: So far, with the exception of some
11 slightly increased waiting times in some of the regional
12 rehabilitation units, they appear to have coped. That
13 has been facilitated by bringing in extra
14 physiotherapists, for example -- civilians, usually --
15 to actually complement or reinforce the military ones.

16 But so far it has coped, and indeed it has also
17 coped -- success as you know, breeds success, and as the
18 regional rehabilitation units have shown that they can
19 get people back to work quicker, so the referral rate
20 for ordinary injuries to the regional rehabilitation
21 units has increased as well. So there has been
22 significant pressure upon the regional rehabilitation
23 units to actually manage not only the injuries that are
24 coming back from Iraq and Afghanistan but also from
25 those from training injuries and sports injuries.

1 So they have coped, but it has coped because it has
2 managed and the capacity has expanded.

3 Another contribution has been the deployed
4 rehabilitation teams. We now send rehabilitation --
5 there is now a rehabilitation team in theatre, initially
6 in Iraq and also now in Afghanistan, that actually helps
7 hopefully prevent evacuation back to the United Kingdom.

8 SIR RODERIC LYNE: Have there been other challenges that
9 have had to be overcome as a result of increased rates
10 of survival?

11 LT GEN LOUIS LILLYWHITE: Yes. There is a clear issue about
12 how one transfers care to the National Health Service.
13 The theory -- the theory was -- and indeed the practice
14 was -- sorry, the practice was, the theory still is --
15 the practice was that we would actually care for them
16 until a point, at which point you would hand them over
17 to the National Health Service.

18 For various reasons we have been holding on to the
19 casualties for longer, and what that has -- what that
20 has demonstrated in a number of those cases that have
21 reached that point is that on the one hand we do not
22 have all the capability required to care for the
23 casualty at some point prior to handover to the NHS, and
24 I think from what you have been hearing from me from the
25 answers to the previous question, the NHS probably does

1 not have the ability to care for them on their own as
2 they are set up after we transfer them.

3 So a good example: you have a severely injured
4 casualty who has recovered sufficiently that he can go
5 home, but he still has wound care, he still needs -- he
6 needs speech therapy. He needs ongoing rehabilitation
7 locally. If he happens to be some place in the country
8 where his home is, where there is no military around,
9 how does one provide for that care?

10 You can't send -- we don't have district nurses
11 anyway and even if we had done, where would he or she be
12 sent from? We don't have speech therapists. Again,
13 even if we did, they would be some time distant. It has
14 become clear that one actually requires a partnership
15 with the local health authority or its equivalent in
16 order to provide that bit of the care that we do not
17 have in the military even while the individual is in the
18 military.

19 But, as I'm sure you appreciate, the National Health
20 Service does not have any responsibility, statutory or
21 otherwise for providing the primary and community care
22 to a serviceman while he is in the armed forces.

23 So arranging that care package requires individual
24 persuasion, discussion, debate, with the local
25 authorities in the place where that individual is at

1 home. Of course, the issue of funding can then come
2 into it. Where you are dealing with general practices,
3 who are independent contractors, not necessarily subject
4 to direction from the local health authority, unless it
5 is supported by statute, you can run into difficulties
6 there as well.

7 So the ongoing care of the complex casualty is
8 throwing up issues that we have not seen before.

9 SIR RODERIC LYNE: Is that what you had in mind when you
10 talked to the House of Commons Defence Committee about
11 the need to improve the quality of the outcome?

12 LT GEN LOUIS LILLYWHITE: No, because at that time we had
13 actually -- this had not been an issue. What I was
14 referring to then are the technical -- are the technical
15 and other clinical processes that we ought to introduce.

16 So let's take amputees as a good example. We will
17 discharge them from the armed forces with the best
18 prosthesis available, and indeed do so. If that
19 individual is 25 years of age, he will go with
20 a prosthesis. He will probably go with three
21 prostheses: he will probably go for one for showering,
22 he will go for one for walking and he will go for one
23 for running, if he is so minded.

24 If that quality of life is to be sustained, at some
25 stage he will probably want a cycling prosthesis some

1 years hence. Even us able-bodied people often move from
2 running on roads to cycling at some point. So we will
3 need a special prosthesis for that. If his quality of
4 life is to continue at a later stage, he will want an
5 electric wheelchair, and in due course he will want
6 special end of life care for amputation stumps that are
7 likely to be breaking down because the process of
8 ageing.

9 We therefore need to actually consider how one
10 actually ensures that that individual is going to get
11 the quality of care that ensures the quality of his
12 survival. Again, it is part of the issue raised before
13 about treating them as a group, but it is also the type
14 of things like the pain management. When I spoke to the
15 House of Commons Defence Committee, I think we had
16 actually identified that pain was an issue but not yet
17 addressed it.

18 Clearly managing pain is a quality of life issue
19 and, for example, we are finding anecdotally -- we do
20 not have the research evidence yet -- but it does appear
21 that because we are successfully managing pain from the
22 point of wounding now in those early stages, that
23 individuals are not getting the long-term pain that has
24 been associated with amputations in the past, something
25 called phantom pain, where you may have lost your lower

1 leg but it is still hurting a lot. We seem to be seeing
2 less of that, which we think is due to the good
3 management. So that is another quality issue.

4 So there are a whole host of quality issues that one
5 could use an examples in terms of taking forward the
6 care of the injured.

7 SIR RODERIC LYNE: Is psychological support part of that as
8 well?

9 LT GEN LOUIS LILLYWHITE: Yes. Do you want me to go into
10 mental health, as it were?

11 SIR RODERIC LYNE: I was thinking particularly of
12 psychological support for those who had suffered
13 life-changing injuries.

14 THE CHAIRMAN: We would like to go into mental health after
15 the break.

16 LT GEN LOUIS LILLYWHITE: Right, yes. Providing
17 psychological support certainly in the Armed Forces is
18 and should be subsequently.

19 SIR RODERIC LYNE: I think you have already described to us,
20 both in your statement and in your earlier evidence,
21 what you mean by "complex cases" and why it is that we
22 are having to learn how to handle them within the
23 civilian arena at the point at which they have passed on
24 from the military.

25 Can I be clear at what point the responsibilities of

1 the Ministry of Defence for complex cases ends and they
2 become the responsibility of the National Health
3 Service?

4 LT GEN LOUIS LILLYWHITE: The legal point is the point of
5 discharge. It is the day that you end up -- you finish
6 being paid by Her Majesty's forces and receive a pension
7 in lieu. At that point, legally, care transfers from
8 the military to the civilians.

9 SIR RODERIC LYNE: When does the discharge normally happen?

10 LT GEN LOUIS LILLYWHITE: I'm not sure that there is
11 a "normal" any longer and that's probably a good thing.

12 In the system prior to the current conflict, you had
13 a medical board that said that you were unfit for
14 service and there would be up to 18 months whilst you
15 carried out any remedial care and at which point you
16 were discharged, regardless of whether or not you had
17 fully recovered.

18 There has been very much an individual approach
19 taken these days. There has been a debate internally,
20 the extent to which that is appropriate. We certainly
21 have people still in service who quite clearly are not
22 going to be able to serve in any useful capacity.

23 Again --

24 SIR RODERIC LYNE: You mean any operational capacity? You
25 could be useful without being operational.

1 LT GEN LOUIS LILLYWHITE: No, in any useful capacity, who
2 have not yet been discharged. That has been done,
3 I think, as a compassionate response to, you know, very,
4 very serious injuries and sometimes difficult family
5 situations.

6 As I said, what it means is that we have moved from
7 something where there is firm policy to one where we are
8 now in a grey area and the debate is, you know, what is
9 appropriate. To what extent, you know, should we be
10 compassionate, particularly if it is against the
11 long-term interests of the individual? Because, for
12 example, delaying that break point can actually have
13 detrimental impact.

14 So there seems to be an ongoing debate which I'm not
15 sure has been fully resolved yet.

16 SIR RODERIC LYNE: But with regard to the 50 to 60 serious
17 complex cases you talked about, would I be right in
18 interpreting what you are saying as meaning that the MoD
19 is operating a degree of flexibility, is not insisting
20 on the fine-print of the legal point of discharge and
21 accepts a responsibility for those very difficult, very
22 severe cases that might go on for a much longer period
23 than 18 months?

24 LT GEN LOUIS LILLYWHITE: That is the case, yes. The extent
25 to which that is appropriate is a matter for internal

1 debate and I don't think there is a single answer to it.

2 SIR RODERIC LYNE: Thank you.

3 THE CHAIRMAN: Thank you very much. Let's break for about
4 ten minutes and then come back.

5 (3.20 pm)

6 (Short break)

7 (3.40 pm)

8 THE CHAIRMAN: Welcome back. Sir Lawrence Freedman is going
9 to start with his turn.

10 SIR LAWRENCE FREEDMAN: Yes, I want to talk about mental
11 health issues now.

12 Perhaps you can start by telling us what measures
13 were in place to identify mental health problems at the
14 start of Telic and what sort of problems were the main
15 ones you expected to see.

16 LT GEN LOUIS LILLYWHITE: I don't think that -- most of the
17 policies that are in place now were already in place at
18 the start of -- there are new ones, but I'll come back
19 to that later. But there is the -- the general
20 approach, which was well explored during the PTSD group
21 action trial, is one of --

22 SIR LAWRENCE FREEDMAN: That's the one that followed from
23 the Gulf War syndrome and looked back on the Falklands
24 and so on?

25 LT GEN LOUIS LILLYWHITE: The Falklands, correct, yes.

1 But in essence the Armed Forces seek, one, to
2 exclude individuals with significant psychological
3 disability, without doing -- going into detailed
4 screening, I would just hasten. They believe that the
5 training that they actually undertake, both initial
6 training and subsequent training, both will expose those
7 who do not have the ability to withstand stress and also
8 helps prepare people to withstand stress, the train-hard
9 fight-easy type concept.

10 They try and identify -- try and train commanders to
11 identify problems as they arise, preferably before they
12 arise, and we had just implemented at that time the
13 change from a single, central psychiatric hospital to
14 regional community mental health teams, plus our
15 traditional one on operations of deploying field
16 psychiatric teams to help identify those who had true
17 psychological disability, that actually needed care and
18 evacuation or simply support and return to duty.

19 So simplistically I think that is what we actually
20 had in at the very beginning.

21 SIR LAWRENCE FREEDMAN: How well did that do and what sort
22 of changes were developed over the course of the
23 conflict?

24 LT GEN LOUIS LILLYWHITE: The perennial problem for mental
25 health, whether it be civilian or military, British

1 military or any other nation's military, or indeed any
2 other civilian society, is of course stigma. So the
3 challenge has always been to actually overcome the
4 stigma of mental health.

5 A lot of effort has gone into educating both
6 commanders and individuals that psychological adverse
7 effects is not something that needs to be hidden. We
8 have not fully succeeded, nor has any other nation, and
9 neither has the civilian population. Mental health
10 continues to have a stigma amongst many that actually
11 inhibits its presenting for care early.

12 We have, over time, looked at ways of actually
13 minimising blatant psychological ill-health. There was
14 a period of time when we introduced critical incident
15 stress debriefing, before evidence emerged that it was
16 actually probably doing harm rather than good, and
17 certainly wasn't doing significant good; a lesson for me
18 that we need to be careful about introducing without
19 evidence procedures or processes or treatments just
20 because someone says they are appropriate.

21 We have started -- we then started -- and I can't
22 remember when we did this exactly -- we then started
23 introducing something called TRiM, which was a form of
24 debriefing any after incident but done by peer groups
25 not by an external counsellor but trauma risk

1 management, which was actually just to do a debrief
2 about what had actually happened. The person who was
3 doing the debriefing, we just took people through it,
4 taught to actually identify whether somebody was under
5 stress and might need referral elsewhere.

6 I think it was after the Iraq campaign was over that
7 we actually started third -- no, I think it was
8 during -- later part of Iraq, when we introduced
9 third-area decompression; that is stopping off in Cyprus
10 on the way home. So there have been developments
11 between then.

12 In response to what have we found, I don't think we
13 have -- I don't think we have actually found anything
14 that has surprised us. What we have, though, now is
15 evidence to support what perhaps we innately thought.
16 Post-traumatic stress disorder is not common; it can be
17 very severe in those who have it, but it is not common.
18 Common mental health diseases are common, and are common
19 amongst those in operations, and is the most common
20 manifestation, much more so than post-traumatic stress
21 disorder.

22 It has been demonstrated that alcohol misuse is an
23 issue, over and above that which you will find in
24 non-deployed troops, and evidence from around the world
25 has demonstrated that risk-taking behaviour increases

1 after you have been on a deployment.

2 You can understand that from a common-sense
3 perspective. You actually expect troops to take risk.
4 You can't suddenly say, "We have trained you and you
5 have taken risks; now you must take no risk". So there
6 is a period of acclimatisation back in the UK, I think,
7 before that risk -- lack of risk business disappears.

8 SIR LAWRENCE FREEDMAN: I know there was a major study done
9 at my college, King's College, I should say by close
10 colleagues of mine, who are monitoring the mental health
11 problems of servicemen and women in operations all the
12 way through. They found out, I think, that in some ways
13 those adversely affected, the numbers were lower than
14 might have been anticipated, and certainly seemed to be
15 lower than those in the United States.

16 Do you have any idea why that should be so?

17 LT GEN LOUIS LILLYWHITE: If I may just first of all pay
18 tribute to King's College. I know you are from there.

19 SIR LAWRENCE FREEDMAN: I'm happy to take it.

20 LT GEN LOUIS LILLYWHITE: They have contributed
21 significantly to the global knowledge on mental health
22 in servicemen. It has certainly been worth the
23 investment that the MoD have made and in fact have
24 repaid the investment that the Department of Defense has
25 made as well, from the United States, in the research

1 that has been conducted there.

2 Comparisons with other nations are an important
3 element of actually learning because variation gives you
4 the opportunity to actually explore why something has
5 occurred in one place but not in another. The
6 difference in the instance of -- or alleged difference
7 in the instance of PTSD, of mild traumatic brain injury
8 between the United States and the United Kingdom,
9 intrigues a lot of us both here in the United Kingdom
10 and in the United States.

11 The first thing that we need to be clear about is
12 whether there is a difference or not, and one of the
13 difficulties that one actually has is different
14 definitions; the second difficulty one has is the
15 application of those definitions, whatever they are; and
16 the third is the denominator, who you are actually
17 counting as the number under the fraction that gives you
18 the rate.

19 Added to that, there are differences between the
20 United Kingdom and the United States that undoubtedly
21 explain or could explain some difference. So, for
22 example, the proportion of reserves in the United States
23 is greater than in the United Kingdom that are deployed
24 on operations, and both the United Kingdom and the
25 United States have found that mental health problems are

1 greater in reserves than they are in regulars. So the
2 greater use of reserves in the United States would
3 explain some of the difference.

4 There is a greater proportion of officers in the
5 United Kingdom. Officers suffer less than other ranks,
6 so that would reduce the United Kingdom rate.

7 The United States has longer tour lengths than the
8 United Kingdom and -- perhaps more relevant -- have
9 tended to, at short notice, extend their tours in
10 theatre, and United Kingdom data demonstrates if you
11 extend tours, the rate goes up.

12 So there are a lot of variables that explain why the
13 United Kingdom rate appears to be significantly better
14 than the United States rate, but we are -- the jury, in
15 a sense, as to whether or not we the British are better
16 than the Americans is definitely out, and it could be
17 explained by the differences in obvious variables.

18 SIR LAWRENCE FREEDMAN: You mentioned there the impact on
19 reservists, and again, I think these studies showed that
20 they are more likely to suffer forms of mental stress.
21 Why do you think that is? Is it because they are
22 deployed individually, don't have the full support of
23 their colleagues?

24 LT GEN LOUIS LILLYWHITE: Again, I suspect it is -- there
25 are many factors. The first thing, of course, they will

1 not have had the full extent of preparatory training
2 over their career that the regulars will have had. So
3 they will not have been exposed repeatedly to the
4 stresses of training. So that's the first reason; that
5 could explain it.

6 The second reason may be that their families that
7 are left behind do not have the same supportive
8 environment that you will have in the regulars, because
9 the families are living in relatively close proximity to
10 each other in most cases and will actually have a system
11 of internal support. So that could be a second reason.

12 The third reason may be that the selection process
13 is not as robust.

14 The fourth reason might be that when they return to
15 the United Kingdom, they do not have the ongoing support
16 from their peers that the regulars have because the
17 regulars are still in the military environment. Another
18 part of that is that when they go back to work, the
19 people they go back to work alongside do not understand
20 what they have been doing and indeed sometimes think
21 that they have been on holiday, as opposed to in
22 life-threatening situations that have been very
23 stressful.

24 I think all of those contribute to the reservists
25 being at a disadvantage compared to the regular, which

1 actually manifests itself in greater stress and greater
2 psychological impact.

3 SIR LAWRENCE FREEDMAN: Such a range of possibilities, does
4 that make it harder to work out what extra help might be
5 given to reservists to mitigate these dangers?

6 LT GEN LOUIS LILLYWHITE: Yes, and in some cases it is
7 actually difficult to actually work out what you can do.
8 For example, you cannot make their workmates to be more
9 supportive. I cannot see an intervention that would
10 make that possible. On the other hand, it might be
11 possible to invest in greater support within their
12 Territorial Army units by providing a greater proportion
13 of regulars. But on the other hand, a reserve unit will
14 deploy so infrequently that the cost-effectiveness of
15 that will clearly be questionable.

16 So it is a difficulty, and again I note that the
17 United States have not addressed it; we have not
18 addressed it successfully either.

19 SIR LAWRENCE FREEDMAN: The charity Combat Stress has
20 suggested that had veterans can take an average of
21 14 years after being discharged to seek help for stress
22 resulting from an operational deployment. That suggests
23 there is a risk that there is a sort of time bomb that
24 will start to come in a few years' time.

25 Do you share that concern?

1 LT GEN LOUIS LILLYWHITE: No, I don't. The reason I don't
2 is that I see no difference between the type of events
3 that we are exposed to now, compared to the events that
4 people were exposed in Korea or in the early years of
5 Northern Ireland. Indeed, there were more people killed
6 I think in 1973 that the whole of the Iraqi campaign.
7 So I see no historical support for the claim that there
8 is likely to be a hidden tidal wave.

9 I think the 14-year point, it is increasingly
10 recognised, my experts tell me, that it is not 14 years
11 to PTSD occurring; it is 14 years during which the
12 individual has not come forward. In other words, it is
13 not 14 years, I have suddenly got PTSD; it is 14 years
14 and I have had it all the time but I have not been
15 prepared to come forward with it.

16 Hopefully the reduction -- the normalising of
17 psychological disability, the removal of stigma, which
18 although not successful, is occurring, will actually
19 result in people coming forward for care much earlier,
20 which would actually mitigate against that wait for
21 14 years. Again, as I said, the issue that -- the
22 psychological disability we see tends to be in
23 depression, anxiety, alcoholism, rather than in PTSD.

24 SIR LAWRENCE FREEDMAN: Does that suggest -- my final
25 question -- that what's required is perhaps a greater

1 awareness of colleagues, of family, society at large, of
2 the symptoms, so they may encourage people, help people
3 to seek support?

4 LT GEN LOUIS LILLYWHITE: Yes, and this is -- but again I'll
5 just come back to my very early point that this is
6 a society-wide issue in terms of mental health
7 generally. Mental health is not a disease that people
8 feel comfortable about declaring, you know. Things like
9 cancer now, whereas in the past no one would speak about
10 them, people are -- "happy" is the wrong word but are
11 quite prepared to expose the diagnosis. Mental health
12 is one of those that do not.

13 If I could make another comment, though, on mental
14 health generally, there are a large number of
15 organisations appearing or charities appearing that have
16 claims to actually successfully treat PTSD or something
17 else. It is a growth area within society that a lot of
18 people come forward and have success in this area and
19 one thing as Surgeon General that I kept on having to
20 repel was, you know, the new treatment which we have
21 been persuaded to introduce without evidence.

22 I know where King's College is important because
23 they can bring that intellectual rigour to actually
24 testing where appropriate whether or not an intervention
25 works or does not work. But CISD, the critical incident

1 stress debriefing that I mentioned at the beginning, is
2 good example of what you must not do, which is introduce
3 something without the evidence to support it.

4 SIR LAWRENCE FREEDMAN: You made an interesting point there.
5 What new treatments have emerged that you do think are
6 reliable?

7 LT GEN LOUIS LILLYWHITE: I don't think any new treatments
8 have emerged, other than some of the talking treatments
9 do appear to be shown to be more successful than perhaps
10 we realised and are being introduced.

11 It is the third-party decompression, it's the
12 preventative strategies, the TRiM, the trauma risk
13 management systems; that is what I think has been
14 successful.

15 SIR LAWRENCE FREEDMAN: Better to talk to your mates than to
16 a trained counsellor?

17 LT GEN LOUIS LILLYWHITE: In the first place, yes; and if
18 not, we do actually have people with the talking
19 therapies to actually provide the care.

20 SIR LAWRENCE FREEDMAN: Thank you very much.

21 THE CHAIRMAN: I'll turn to Sir Martin.

22 SIR MARTIN GILBERT: I would like to focus on military
23 health in the United Kingdom.

24 Can you describe to us how the MoD ensures that
25 healthcare for military personnel is provided

1 appropriately when it is beyond your direct control; for
2 example, how you interact with the National Health
3 Service?

4 LT GEN LOUIS LILLYWHITE: First of all, just to mention that
5 of course we do have to provide that care overseas as
6 well, and interestingly I feel that in some cases we do
7 it better overseas because we have firm contracts that
8 we can actually -- where we can actually quality-assure
9 in a way that it is quite difficult to do in the
10 United Kingdom because there it does not seem to be
11 sometimes the same external audit of care within the
12 United Kingdom that we are able to exert elsewhere.

13 Generally speaking, we rely upon the National Health
14 Service and its systems to actually continue to assure
15 that the quality of care provided to all those who are
16 in the hospital are appropriately cared for, but that is
17 moderated by the fact that we concentrate the care in
18 five hospitals only, the hosts for the MDHUs, the
19 Ministry of Defence Hospital Units, and upon primary
20 care and other specialists to point out what the care
21 that has been given might have been inappropriate; not
22 necessarily inappropriate because the quality is poor
23 but inappropriate because it is not appropriate for
24 a serviceman rather than a civilian.

25 So, for example, if you have something on -- if you

1 have an injury on your shoulder which requires
2 additional skin, if you are a civilian, you might have
3 what's called a split skin graft, which would be fine
4 for a civilian, but if you are a soldier and you want to
5 carry a bergen, you need to actually swing a complete
6 skin lap, so it is strong enough to withstand the
7 bergen.

8 So there are times when a particular approach is
9 better for the military than for the civilian.

10 SIR MARTIN GILBERT: You mention in your statement about the
11 important contributions of various NHS bodies. You
12 mentioned the National Blood Transfusion Service and
13 also the Health Protection Agency. How do you interact
14 with these?

15 LT GEN LOUIS LILLYWHITE: First of all, at my level, of
16 course, I interact with the chair or the chief executive
17 of those organisations and had regular meetings with
18 them and I either went to them or they came to me. At
19 a lower level there are -- there is within the
20 Ministry of Defence the kind of working level at the
21 policy level.

22 Then down at the very local level again there is the
23 interaction. So, for example, for the National Blood
24 and Transplant in Birmingham we have embedded people.
25 So that if we want blood in theatre, you have the

1 National Blood and Transplant people working alongside
2 ours, so that one actually has a seamless transition
3 from the blood collection that is done by the NHS to the
4 delivery and onward passage of the blood into theatre.

5 SIR MARTIN GILBERT: So it is an integrated system?

6 LT GEN LOUIS LILLYWHITE: Yes.

7 SIR MARTIN GILBERT: If I could turn to devolution, given
8 that healthcare is a devolved activity, can you tell us
9 how you react with the various devolved administrations?

10 LT GEN LOUIS LILLYWHITE: Again, it is at different levels.
11 They are represented on the partnership board that
12 brings together the Department of Health, MoD and the
13 devolved administrations. That is at kind of a policy
14 level. I would meet, from time to time, officials,
15 senior medical officials in the devolved administration.

16 Then if you take Scotland as an example, the
17 headquarters of the Army primary healthcare service in
18 Edinburgh, you know, interacts directly with the local
19 health authorities there. Indeed, for most of my tenure
20 there has been a military man actually embedded in the
21 Scottish Government or the Scottish Executive,
22 therefore -- actually doing a job for them but actually
23 allowing them to actually understand the military
24 perspective as well.

25 SIR MARTIN GILBERT: The House of Commons Defence Committee

1 in 2008 was critical of cooperation with Scotland. Can
2 you explain what the particular difficulties were in the
3 relationship with NHS Scotland?

4 LT GEN LOUIS LILLYWHITE: If I may be so bold as to say,
5 I think they sent unprepared witnesses in front of the
6 committee.

7 SIR MARTIN GILBERT: Were there specific issues on which
8 they were unprepared?

9 LT GEN LOUIS LILLYWHITE: I think devolution was relatively
10 new at the time and I think that the issues got clouded
11 by a debate between the House of Commons in London and
12 representatives from a devolved administration. That is
13 my take on it.

14 SIR MARTIN GILBERT: Can I look now at the service personnel
15 charities. Could you explain to us the nature of the
16 relationship with the MoD has with the charities, how it
17 is based and how it has evolved?

18 LT GEN LOUIS LILLYWHITE: I think it depends -- if I may
19 start that one has to be careful with the interaction
20 with charities. One has to recognise that charities need
21 to survive, and to survive they need funding, and one
22 has to always bear in mind, like any relationship with
23 anybody where there is a financial relationship, that
24 one has to take care.

25 That depends upon the charity. There are some that

1 rely more upon Ministry of Defence funds than others.
2 Combat Stress relies very heavily on Ministry of Defence
3 funds, for example, whereas the deafness -- the hearing
4 charities rely not at all. So one has to bear in
5 mind -- one has to bear in mind that that relationship
6 may -- where it depends upon money, there are governance
7 and other issues.

8 Also one has to recognise that sometimes there is
9 competition between the charities. Combat Stress is not
10 the only national charity in the mental health area.
11 Mind, for example, has a legitimate call to be heard by
12 the Ministry of Defence, as much as any other. So one
13 has to take that into account.

14 Having said that, I think that we all welcome the
15 involvement of charitable organisations. They all have
16 a desire to actually progress the care of servicemen but
17 sometimes they are not necessarily promoting the right
18 approach. So, for example, Combat Stress as an example
19 has relied for a long time on inpatient care in their
20 homes, whereas the best practice increasingly in the
21 civilian world, as well as in the military, is to rely
22 more and more upon community care.

23 So one has to take care again, even though the
24 charity may have the best interests of the patient and
25 the serviceman at heart, that they may not necessarily

1 be providing the most appropriate care.

2 But given all those provisos, generally speaking,
3 they actually contradict significantly to, one,
4 promoting the cause of particularly the ex-servicemen;
5 secondly, they are quite good at challenging us on what
6 we are doing or not doing; and thirdly, they often bring
7 a degree of expertise or approach that we might not
8 otherwise have recognised.

9 I mentioned before the big conference we actually
10 had in December, co-sponsored by Deafness Research UK
11 but also involving -- what is it? -- the National
12 Institute for the Deaf, you know, which I thought was an
13 excellent example of where one was able to synthesise
14 the expertise of the hearing charities and their
15 contacts with academia and with scientists on the one
16 hand against a need that we had on the other to actually
17 explore further why we were actually seeing a increasing
18 number of individuals with long-term hearing problems
19 when we had previously thought that we had actually
20 cracked it, as it were.

21 So it is a complex relationship but they are an
22 essential part, in my view, of our society in terms of
23 actually ensuring that veterans in particular, but to
24 a lesser extent, serving soldiers, get the appropriate
25 care that they require.

1 SIR MARTIN GILBERT: Following up on that, how do you decide
2 what should be funded and provided by the MoD, what
3 should be funded by the MoD and provided by the
4 charities and what should be left to the charities to
5 fund entirely?

6 LT GEN LOUIS LILLYWHITE: That's the most difficult question
7 so far. I'm not sure that we have an approach.

8 Generally speaking, if they are long-serving
9 soldiers, if we think this is appropriate, they will get
10 funded anyway. Anything that we deem necessary for a --
11 for the care of a serviceman will be funded, whomsoever
12 provides it. In general terms we are unable to fund
13 care by charities for those who have left because they
14 are the responsibility of the NHS and it would be using
15 funds inappropriately.

16 So it is probably more a question for the civilian
17 medical service, the National Health Service, than it is
18 for us in the Ministry of Defence because I will pay for
19 anything that is needed.

20 SIR MARTIN GILBERT: I would like to ask you now a data
21 question which I hope will be similar.

22 There are a number of entities, of course, involved
23 in delivering care to injured personnel beyond MoD and
24 Trevor Woolley told us in his evidence that in terms of
25 what the overall cost to the nation is, we don't know

1 the cost of caring for those injured in Iraq. The NAO
2 report 2010, this year earlier, suggests that one reason
3 for this is that the MoD doesn't centrally collate
4 accurate and complete medical data.

5 Should the MoD be Donald doing more to establish
6 accurate data, to help us understand the scale of the
7 problem?

8 LT GEN LOUIS LILLYWHITE: It depends on whose perspective
9 you are looking at it from. As far as care on
10 operations are concerned, it is effectiveness that
11 counts, not cost-effectiveness. As far as providing
12 care for servicemen was concerned, I was --
13 I personally, and I have to say ministers supported
14 me -- did not allow cost to be an issue. If it was
15 required, it was provided.

16 When one moves into what I might call a mature
17 theatre, that is when you are going to be there for the
18 next 20 years -- but we know we are not going to be
19 there for the next 20 years, but whether it be Germany
20 or Cyprus and Afghanistan until recently -- then there
21 comes a time when cost-effectiveness is an issue for the
22 medics as well, you know.

23 So from my personal perspective, during hot
24 operations, cost is not an issue and I'm not going to
25 spend much effort unless someone forces me to, and

1 I don't think I need to, actually cost anything from my
2 perspective. From my perspective, once we get into
3 mature operations, cost-effectiveness is important.

4 From a national perspective, and perhaps from
5 a broader Ministry of Defence perspective, then one
6 should know the cost of everything you do and therefore,
7 you know, it is important that perhaps we have better
8 data capture in terms of the cost.

9 Having said that, of course, it can be quite
10 difficult. There will be significant challenges to
11 capturing the real costs. How would we cost the recent
12 Danish element, which was 50 per cent/50 per cent of the
13 hospital in Afghanistan? How would we cost the Czech
14 contribution in Iraq? Would we cost the cost of care
15 that was provided to our servicemen by the US when they
16 ended up in an US facility? How would we address the
17 cost of US servicemen, French and others who ended up in
18 our own facility? So there will be many practical
19 challenges to actually identifying and attributing
20 costs.

21 SIR MARTIN GILBERT: Can they be left to the future
22 historian or are they in fact something we do need to
23 know as part of our onward planning?

24 LT GEN LOUIS LILLYWHITE: From a national perspective we
25 ought to know the costs of -- we ought to know the

1 costs. From a medical perspective, as I have said,
2 I have taken -- on ongoing operations I have taken
3 a fairly narrow view that it is effectiveness that
4 counts; whereas all my time in Germany,
5 cost-effectiveness counted.

6 So what I'm saying is, you know, there is
7 a difference. From a national perspective, if you are
8 planning other operations, then costs will actually help
9 you in your contingency planning.

10 SIR MARTIN GILBERT: Thank you very much.

11 THE CHAIRMAN: Right. Can I turn to Baroness Prashar.

12 BARONESS USHA PRASHAR: Can we move on to the question of
13 care for veterans now.

14 Who is responsible for healthcare provision for
15 veterans once they leave the military?

16 LT GEN LOUIS LILLYWHITE: It falls to those people who
17 provide care for any civilian. So it is slightly
18 different between the devolved administrations and
19 England and different between the National Health
20 Service and social services. But in essence it is the
21 civilian organisation that the government has declared
22 will provide the care that is responsible.

23 BARONESS USHA PRASHAR: So what kind of civilian
24 organisations?

25 LT GEN LOUIS LILLYWHITE: General practice is social

1 services, NHS hospital trust, just -- the same people
2 who are responsible for your care are responsible for
3 the veterans' care.

4 BARONESS USHA PRASHAR: So once they leave, they have no
5 special care? In a sense, they just fall into --

6 LT GEN LOUIS LILLYWHITE: Correct, yes.

7 BARONESS USHA PRASHAR: How are those who suffer
8 life-changing injuries supported when they are
9 discharged from the military?

10 LT GEN LOUIS LILLYWHITE: You are coming back to exactly the
11 point I made before. At the moment, in theory, exactly
12 the same as you are, if you had a life-changing injury.

13 What has been recognised or was recognised by the
14 last government -- and you will be aware that I left
15 before the change of government -- but what was
16 recognised by the last government was that there was
17 a need to actually consider whether that was appropriate
18 for the most complex.

19 BARONESS USHA PRASHAR: But what about the question of
20 principles that have been behind the priority access to
21 healthcare? How does that work? What are the
22 principles that apply?

23 LT GEN LOUIS LILLYWHITE: The direction given by the NHS in
24 England, and it has been copied certainly by the
25 devolved administrations in Wales and Scotland -- there

1 is an issue with Northern Ireland -- is that any
2 servicemen who requires access to hospital for
3 a condition related to service should be given priority
4 treatment.

5 BARONESS USHA PRASHAR: How does that work in practice?

6 LT GEN LOUIS LILLYWHITE: First of all, in practice it
7 frequently doesn't work at all because the patient
8 doesn't happen to mention that he has been in the Armed
9 Forces and/or the general practitioner doesn't know that
10 there is a right for priority access.

11 Secondly, frequently what that priority access
12 doesn't give is a trump card over somebody who has
13 greater clinical need. So it is only when people have
14 similar clinical needs that you would get the priority
15 access.

16 And thirdly, hitherto in the last few years, as
17 a result of the last government's initiatives, the
18 waiting times for hospital care have come down so
19 dramatically that the need has largely disappeared.

20 Where there is an issue, it tends to be where there
21 is an issue for the civilian population. So cognitive
22 behavioural therapy is difficult to access in the
23 civilian world, full stop. Capacity is far less than
24 demand. In practice, whether a serviceman will get
25 priority access over those who in theory psychologically

1 clinically have a greater need is very questionable.

2 BARONESS USHA PRASHAR: So what's the point of having this
3 in principle priority access if they themselves have to
4 identify themselves to their care provider? Do you
5 think that's the right approach?

6 LT GEN LOUIS LILLYWHITE: There has been long debate over
7 extent to which veterans should be tagged in order that
8 they may be given that priority access. As I said to
9 the House of Commons Defence Committee, we have to be
10 careful about that. There are some who have left the
11 Armed Forces who would rather not be known to have been
12 in the Armed Forces. So tagging without consent,
13 I think, is not a way to go.

14 There is also the practical difficulty that it is
15 quite difficult to tag anyway in the NHS. The new IT
16 system, if it is introduced, may actually allow that.

17 But priority access is great in theory; it doesn't
18 work as well in practice as the theory demands.

19 BARONESS USHA PRASHAR: Could they not be tagged by consent,
20 and those who don't want to be identified, that's fine?
21 Why can't you have a practice of those who want to be
22 tagged by consent?

23 LT GEN LOUIS LILLYWHITE: But again, we still have
24 a paper-based record in the NHS. So there are two --
25 what it would be quite useful to do is to start tagging

1 those records for those who leave proactively pending
2 the introduction of a summary care record, which is when
3 you could actually tag it electronically.

4 Nevertheless if you are in the National Health
5 Service where waiting times are low, if they remain low,
6 it is not going to actually give them much advantage
7 over anyone else. I mean, if you have four weeks to
8 cancer treatment, that's probably as quick as anybody
9 can cope with anyway. Having priority access is not
10 going to give you any advantage.

11 BARONESS USHA PRASHAR: So it is a notion in principle but
12 in practice it doesn't work. Do you think now something
13 more could be done to look at the care of veterans, the
14 healthcare of veterans?

15 LT GEN LOUIS LILLYWHITE: I certainly think that more is
16 needed to be done in terms of the more complex injuries
17 and I include amongst that more than the multiple
18 injuries; I include all the amputees, for example.
19 There are those who require access to treatment that
20 they would not otherwise get at all, where I think that
21 there is a need for something to be done differently for
22 veterans.

23 That is the area where I think that more needs to be
24 done. How it is done will undoubtedly -- will have to
25 be decided between the government and the NHS in England

1 and the four administrations, because I'm not sure
2 whether it means one system or five systems, but I think
3 something needs to be done in terms of the more complex
4 injured who have special needs that are quite clear.

5 Priority access, I wouldn't like to say that it
6 doesn't work at all. What I'm saying is that it has
7 limited utility to the individuals and then only if the
8 serviceman and the GP are actually aware that, one, it
9 is a veteran, and that he has a right of priority
10 access. So it is not a "no utility" but it is not
11 a greater -- it is not something that you join the Armed
12 Forces for, for example.

13 BARONESS USHA PRASHAR: Thank you.

14 THE CHAIRMAN: Can we turn for what I think is going to be
15 the last round of questions to Sir Roderic Lyne.

16 SIR RODERIC LYNE: Just a question or two on how military
17 medical personnel differ from civilian.

18 Firstly, what differs in their training?

19 LT GEN LOUIS LILLYWHITE: In terms of their basic training
20 there is no difference because they need to be trained
21 to work in the civilian environment, either whilst they
22 are still in the Armed Forces or in due course when they
23 have left, and our personnel need to actually have the
24 assurance that they are being treated by people who are
25 as good as any civilian. So the basic training has to

1 be the same, I think quite reasonably, as the civilians.

2 What do they need addition? First of all, they need
3 the military training to actually ensure that they can
4 actually survive on operations. That's non-medical. So
5 that if you are on board a ship that's on fire, you can
6 play your part in actually managing the fire; or if you
7 are in a forward operating base, you know, you can
8 actually feed yourself and dress yourself and keep
9 yourself free from infection, et cetera. So they get
10 the military training.

11 Then there is the additional specialist training
12 that is related to the particular speciality. General
13 practitioners in the Army need a lot more occupational
14 medicine training because they are dealing with an
15 occupational group as well as pure primary care. They
16 need much more training in preventative medicine than
17 their civilian peers would get. They need additional
18 training in psychological injury because it is a higher
19 priority in the Armed Forces. So that deals with the GP
20 equivalent.

21 The specialists that we have, we want them to be
22 much more generalist in their skills. If you deploy --
23 you don't want to have to have to be forced to deploy
24 six surgeons instead of one or two, which -- whereas if
25 you were in a civilian hospital and you came in with

1 your severe injury, if it was the chest you get an
2 thoracic surgeon; if it was the abdomen, you would get
3 a so-called general surgeon; if it was the leg, you
4 would get a plastic or an orthopaedic surgeon.

5 We actually need surgeons who can actually manage
6 the casualty initially with a limited but general range
7 of skills that is different from any range of skills
8 that a specific surgeon would have in the NHS. So they
9 actually need some specific additional skills in
10 addition to their basic skills.

11 So, for example, we may train a surgeon to be an
12 thoracic-abdominal surgeon so he could work in the NHS
13 in that role, but we would expect him to actually
14 undertake additional training that would actually enable
15 him to manage limb injuries were he deployed into the
16 field.

17 SIR RODERIC LYNE: When they are not deployed on operations
18 how do they maintain their skills?

19 LT GEN LOUIS LILLYWHITE: In terms of their primary skill,
20 they maintain that by working within the National Health
21 Service. The issue for us is the extent to which we can
22 actually sustain their additional skills. At the moment
23 that is not a problem because they are deployed to
24 theatre sufficiently; they are getting their refresher
25 training by doing the job of work for real.

1 The problem was before the current set of
2 operations, and it will arise again following the
3 current set of operations, when they will need to
4 sustain those skills in preparation for the next
5 conflict.

6 There are -- and we do that by having a variety of
7 courses that work on non-humans, so animal training,
8 training on cadavers and increasingly -- and I think
9 more so in the future -- using simulation. So we have
10 done a lot of work with the Royal College of Surgeons
11 and actually run a course in the Royal College of
12 Surgeons in London which is also accessed increasingly
13 by civilians that uses a combination of cadavers and
14 simulation to actually train the individual.

15 So, for example, in the Royal College of Surgeons we
16 have videoed operations in Iraq and Afghanistan and the
17 staff in the Royal College of Surgeons prepare cadavers
18 that have been donated for the purpose to actually
19 replicate the anatomy of those who have been seriously
20 injured and then operated on, and then the students
21 actually replicate the operations on the cadavers and
22 then discuss what they have done compared to what the
23 surgeons on the operations did, and we will be able to
24 continue that into the future.

25 Simulation is, I think, going to be increasingly

1 provided with the NHS anyway. The old medical model of
2 you know, see one, do one, teach one, has quite
3 reasonably gone out of favour, you know. Nobody wants
4 to be the one who is, as it were, learnt on. So I think
5 simulation is going to increasingly become important in
6 the civilian sector. Indeed, we have stimulated some
7 work with the Department of Health to actually look at
8 regional simulation centres, one of which would be in
9 the Midlands, for us to actually utilise as well.

10 SIR RODERIC LYNE: Could you explain --

11 LT GEN LOUIS LILLYWHITE: Can I just say, the problem will
12 be whether reservists will actually have the time to
13 actually access that. It is one of my main concerns.
14 It is not just a question of our funding being available
15 to provide the reservist with the extra man-days
16 necessary; it is actually the willingness of the
17 employer, in an increasingly efficiency-driven
18 National Health Service, to actually release them, in
19 spite of the money that is available.

20 So, for example, chief executives have said to me,
21 "No good giving me money. I need to treat patients,
22 I need to meet my 14-week rule, I need to keep my
23 waiting list down, and giving me money to take the man
24 away does not actually allow me to do that. So I don't
25 want your money, I want the man". So it is a problem

1 for reservists.

2 SIR RODERIC LYNE: Did it happen with the Iraq campaign that
3 taking reservists out of theatre disrupted operations of
4 the National Health Service and led to complaints from
5 NHS executives?

6 LT GEN LOUIS LILLYWHITE: Remember, I wasn't around on
7 Telic 1. It certainly did during the first Gulf War,
8 when I was around, that diverting resource to MoD
9 actually had an detrimental impact. And certainly chief
10 executives have said to me on a number of occasions that
11 their ability to actually release people does depend on
12 the goodwill of not only themselves but of the teams
13 within the hospital.

14 I have to say, though, that in spite of that
15 theoretical concern, the NHS has been very good at
16 continuing to release individuals in most cases. But
17 there have been one or two cases, where chief executives
18 have said, "I'm sorry, I just cannot afford to release
19 this man, regardless of the money that you might wish to
20 pay me, you know, in compensation".

21 SIR RODERIC LYNE: From what you say, this could become more
22 difficult in the future?

23 LT GEN LOUIS LILLYWHITE: That could become more difficult
24 in the future, yes.

25 SIR RODERIC LYNE: Finally, looking at the other side of the

1 equation, to what extent are the Defence Medical
2 Services dependent on having access to reservists and
3 particularly in specialised areas? You do refer to this
4 in your statement.

5 LT GEN LOUIS LILLYWHITE: It depends -- first of all, it
6 depends on the level of ambition of the United Kingdom
7 government as to how many and what extent of operations
8 it wants to sustain over time.

9 The regulars are sufficient in number for a short,
10 sharp operation of a reasonable scale, but anything that
11 is sustained over a significant period of time and
12 anything that is reasonably large is always going to
13 need access to the reserves; it always has and it always
14 will be. Indeed, it is quite important that we continue
15 to use reserves. That is the reason many of them join:
16 to be used.

17 So, one, there is going to be an ongoing
18 requirement; we will not be able to do everything as
19 regulars ourselves. Also, if we are going to actually
20 sustain a significant reserve component, we are going to
21 have to give them a job of work to do.

22 SIR RODERIC LYNE: You have now had a total of about
23 11 years of overlapping medium-scale deployment in Iraq
24 and Afghanistan, if you add the two together, and
25 Afghanistan is not yet concluded by a long way. Has

1 that severely stretched the medical resources and the
2 ability to access reservists?

3 LT GEN LOUIS LILLYWHITE: I have to say that there are two
4 type of answers to that question. One, sustaining the
5 level of clinical resources required on the ground has
6 taken an awful lot of management resource time and has
7 been achieved through using, as I think I said before,
8 multi-national assets and a small number of sponsored
9 reserves as well as the general reserves.

10 So there has been no doubt that we could not have
11 managed the peaks in particular just relying on -- or
12 could not easily have managed it just relying on the
13 regulars and the reservists we have. So we have
14 actually had to go elsewhere just to sustain the
15 capacity required, but we have done so and have managed
16 that.

17 In terms of the reserves themselves, generally
18 speaking they have continued to hold up in terms of
19 their willingness to deploy. That has been assisted by
20 us actually treating MoD -- treating medical reservists
21 slightly different from others. So the Ministry of
22 Defence has been prepared to actually deploy the medical
23 reservists for a lot shorter time than they have other
24 reservists. So we have been taking people for weeks at
25 a time rather than months at a time, and doing that has

1 been much more acceptable to the trusts from which we
2 have taken them.

3 There are disadvantages to that. There is an issue
4 about continuity and we have had to respond to that by
5 identifying regulars or indeed volunteer reserves who
6 are prepared to stay for longer to cover the continuity
7 issue. But with that exception, we have actually
8 managed by deploying people for far shorter time.

9 SIR RODERIC LYNE: Thank you.

10 THE CHAIRMAN: Just before we come to final reflections,
11 could you just explain for my benefit: what is this
12 system of sponsored reserves as opposed to the
13 Territorial Army?

14 LT GEN LOUIS LILLYWHITE: There have been, particularly at
15 the time when we were exceptionally short of regulars,
16 there have been various attempts to actually increase
17 the number of clinicians that we actually have access
18 to.

19 At the extreme right of arc, as it were, we
20 actually have the -- what's called ConDO, the
21 contractors on deployed operations, where we have
22 contracted with people like Frontier Medical to actually
23 provide specialist nurses. They, in essence, are
24 civilians, with no more than health and safety training
25 for that environment.

1 More towards the left end, towards the reservist
2 end, we have sought to see whether we could interest
3 particular organisations, such as hospitals, to actually
4 agree to provide a quantum of clinicians to actually
5 contribute to the overall capacity.

6 Neither have been particularly successful, in spite
7 of quite significant efforts to do that. It seems that
8 the tried and tested methods seem to be the best
9 methods: either a proper reservist or on proper regular.

10 THE CHAIRMAN: Thank you.

11 As a final question: looking at the duty, the debt,
12 the obligation that society as a whole, and expressed
13 through government and its public services, owes to
14 veterans, and not least those who have suffered injury,
15 is there a mismatch between the reality of the provision
16 of public services in the United Kingdom today, whether
17 for welfare or health or whatever -- which is not
18 perfect, it never can be perfect, but in civil society
19 there is probably quite a realistic acceptance that
20 things have limits and imperfections.

21 Is the military community, if I can put it that way,
22 aware of those realities in framing its own expectations
23 of what is owed to the military?

24 LT GEN LOUIS LILLYWHITE: I think it depends on who you are
25 in the military. I think we have increasingly -- not

1 "we" -- I think that politicians and generals have
2 increasingly promoted the military covenant.

3 That is actually quite a recent phenomena and
4 I think if you are actually at a relative junior level
5 in the Armed Forces now, you have come to believe that,
6 and I think we are selling to our younger soldiers,
7 sailors and airmen an expectation that may not be fully
8 deliverable. I think if you are more middle-ranking and
9 experienced with your family the National Health Service
10 and Social Services, that your expectation may be lower.
11 I think if you are the parent of a young soldier, you
12 too may be believing what the politicians and generals
13 and others, and indeed media, have said: that, you know,
14 the military covenant requires that they actually have
15 special care.

16 So I think there is an increasing expectation which
17 has been generated from more outside the Armed Forces
18 than within, but it has also been generated from within
19 the Armed Forces.

20 THE CHAIRMAN: Thank you. A cautionary comment.

21 Would you like to offer any further or final
22 registrations in addition to those that you have put
23 already in your full statement and in your evidence?

24 LT GEN LOUIS LILLYWHITE: I would just make four, just to
25 reinforce.

1 One, we have the Minister for Veterans. I must say
2 that I would much rather see him better supported from
3 other government departments. The Minister for Veterans
4 is within the Ministry of Defence but most of the work
5 that he needs to give effect to has to be done by other
6 government departments and it would be quite useful if
7 he was supported by an official from each of the
8 devolved administrations and the Department of Health
9 and the Department of Work and Pensions and possibly
10 Media and Culture.

11 So if the Minister for Veterans is going to be
12 effective, I think he needs greater support than the two
13 ministers that I worked for, who had tremendous
14 motivation to actually get things right but I felt had
15 to really fight hard because they did not actually have
16 the support from officials from those other government
17 departments.

18 So if I could make that at kind of a high level.
19 You asked me about my relationship with ministers: very,
20 very good, but their ability to influence the Department
21 of Health and others I thought was limited by not having
22 anybody from those departments. That's the first point
23 I would make.

24 I would reinforce the long-term care issue, if
25 I might. I think that there is a clinical necessity, as

1 well as the whole issue of the military covenant,
2 a clinical necessity to treat those patients who have
3 had significant injuries as a single group and
4 government needs to actually address how they have done
5 that, how they should do that.

6 I had general agreement when I was in office that
7 that was what was required, but it needs giving effect
8 to, and there are ongoing issues that can be only
9 addressed in my view by treating them as a group, like,
10 for example, giving them the advanced prostheses in the
11 future, giving them access to new techniques that are
12 becoming available as a result of research. That's the
13 second of the four.

14 The third, I think it is important that a number of
15 issues that I raised in my Director General Medical
16 Operational Capability report have actually been
17 resolved because of the ongoing conflict and training is
18 actually one of those. Our young clinicians can now
19 deploy to theatre in a training -- to actually help
20 their consultant colleagues and therefore gain
21 experience before they too become consultants. When
22 these operations finish, as inevitably they must, these
23 will become issues once again.

24 And the final point I will make is that we must be
25 careful, as historians will keep reminding us, to

1 remember that Iraq and Afghanistan are quite specific
2 operations. They are not necessarily the same
3 operations that we will do again in the future, which
4 may be very different, and we need to be very careful
5 about generalising from the specific lessons in Iraq and
6 Afghanistan to the future.

7 THE CHAIRMAN: A lesson for the defence and security review.

8 LT GEN LOUIS LILLYWHITE: Indeed. Those are my four points.

9 THE CHAIRMAN: Thank you very much. It has been a very
10 helpful session. You spoke in a point regarding
11 cooperation with the Scottish devolved administration
12 that the Defence Select Committee had the misfortune of
13 taking evidence from a witness not wholly prepared. We
14 have not had that misfortune this afternoon and we thank
15 you very much.

16 We are going to resume at 10 o'clock tomorrow
17 morning, Wednesday, when we shall hear from
18 Stephen White, who was the Director of Law and Order,
19 and the Senior Police Adviser to the Coalition
20 Provisional Authority in Basra between July 2003 and
21 January 2004.

22 With that, I will close the session. Thank you.

23 (4.40 pm)

24 (The Inquiry adjourned until 10.00 am the following day)

25

