Cynulliad Cenedlaethol Cymru
The National Assembly for Wales

Y Pwyllgor Iechyd, Lles a Llywodraeth Leol
The Health, Wellbeing and Local Government Committee

Dydd Mercher, 20 Hydref 2010
Wednesday, 20 October 2010

Cynnwys
Contents

Cofnodir y trafodion hyn yn yr iaith y llefarwyd hwy ynddi yn y pwyllgor. Yn ogystal, cynhwysir cyfieithiad Saesneg o gyfraniadau yn y Gymraeg.

These proceedings are reported in the language in which they were spoken in the committee. In addition, an English translation of Welsh speeches is included.

Aelodau'r pwyllgor yn bresennol
Committee members in attendance

Lorraine Barrett	Llafur Labour
Peter Black	Democratiaid Rhyddfrydol Cymru Welsh Liberal Democrats
Andrew R.T. Davies	Ceidwadwyr Cymreig Welsh Conservatives
Irene James	Llafur Labour
Ann Jones	Llafur Labour
Helen Mary Jones	Plaid Cymru The Party of Wales
David Lloyd	Plaid Cymru The Party of Wales
Val Lloyd	Llafur Labour
Darren Millar	Ceidwadwyr Cymreig (Cadeirydd y Pwyllgor) Welsh Conservatives (Committee Chair)

Eraill yn bresennol
Others in attendance

Lisa Bainbridge	Pennaeth Polisi Cyhoeddus, y Lleng Frenhinol Brydeinig Head of Public Policy, the Royal British Legion
Yr Athro/Professor Jonathan Bisson	Cyfarwyddwr Ymchwil a Datblygu, Ysgol Meddygaeth Prifysgol Caerdydd, a Bwrdd Iechyd Lleol Prifysgol Caerdydd a'r Fro Director of Research and Development, Cardiff University School of Medicine, and Cardiff and Vale University Local Health Board
Dr David Howells	Orthodeintydd Orthodontist
Dr Dafydd Alun Jones	Seiciatrydd Ymgynghorol Consultant Psychiatrist
Janet Robins	Prif Weithredwr, Grŵp Cenedlaethol Orthodontig Chief Executive, Orthodontic National Group

Swyddogion Cynulliad Cenedlaethol Cymru yn bresennol
National Assembly for Wales officials in attendance

Stephen Boyce	Gwasanaeth Ymchwil yr Aelodau Members' Research Service
Marc Wyn Jones	Clerc Clerk
Sarita Marshall	Dirprwy Glerc Deputy Clerk

Dechreuodd y cyfarfod am 9.04 a.m.
The meeting began at 9.04 a.m.

Cyflwyniad, Ymddiheuriadau a Dirprwyon
Introduction, Apologies and Substitutions

[1] **Darren Millar:** Good morning, everyone, and welcome to this morning's meeting. I remind everyone that headsets for simultaneous translation and sound amplification are available in the public gallery. If anyone has any problems using them, the ushers will be able to help. Committee members and members of the public may wish to note that the simultaneous translation feed is available on channel 1, while channel 0 is for the language being spoken. I would be grateful if everyone could ensure that mobile phones, BlackBerrys and pagers are switched off, so that they do not interfere with the broadcasting or other equipment.

[2] If it is necessary to evacuate the room or the public gallery in the event of an emergency, everyone should follow the instructions of the ushers, who will be able to guide people to an appropriate exit. I remind everyone that the microphones are operated remotely, so you do not have to press any buttons. They should work independently.

[3] We have received apologies from Veronica German, and Peter Black is substituting for her. I have also received a note from Helen Mary Jones to say that she will be joining us shortly. I now invite Members to make any declarations of interest under Standing Order No. 31.6. I see that there are none.

9.05 a.m.

Ymchwiliad i Driniaeth ar gyfer Anhwylder Straen wedi Trawma i Gyn-filwyr y Lluoedd Arfog: Casglu Tystiolaeth
Inquiry into Post-traumatic Stress Disorder Treatment for Veterans: Evidence Gathering

[4] **Darren Millar:** I am delighted to welcome Professor Jonathan Bisson to our evidence session today. We have had a paper from Professor Bisson, which has been circulated to Members. So, if the witness its content, we will go straight into questions on that paper.

[5] General practitioners are often the first point of contact for veterans who are seeking help when presenting with some of the symptoms of post-traumatic stress disorder. How effective are primary health services at picking up PTSD and treating people appropriately?

[6] **Professor Bisson:** It varies, to a degree. There are some excellent primary care practitioners, who are very competent and will make a good assessment and accurately diagnose post-traumatic stress disorder. They will certainly be able to identify individuals who are at high risk of suffering from the condition and make appropriate referrals for more thorough, comprehensive assessments. In some areas of primary care, for various reasons, individuals do have difficulty picking up and diagnosing the disorder. That is partly because people do not necessarily ask the right questions and partly because of the limited time that individuals have with people, which means that the disorder may not come to light unless the right questions are asked. The knowledge base in primary care is also quite variable, and there is a job to be done to try to enhance that knowledge and raise awareness of post-traumatic stress disorder, as well as the other psychiatric disorders and social difficulties that veterans experience.

[7] **Darren Millar:** Is this a training issue in NHS primary care, do you think?

[8] **Professor Bisson:** Yes, it is a training issue, or an educational issue, certainly.

Current general medical training touches on post-traumatic stress disorder within its curriculum, but it has been a recognised disorder only since 1980 in America and since the early 1990s in the United Kingdom. During my training, PTSD was not an entity. I was exposed to it only when serving in the army in the late 1980s, and it would have been very new to most people at that time. So, taking into account the age of the people currently working in primary care, it follows that many people will not have covered PTSD in their basic training; it would not have existed as an entity, although the symptoms would have present long before. Most GPs will have had veterans from the second world war on their books, and would therefore have come across a similar constellation of symptoms, but they may have been labelled as depression or anxiety, rather than post-traumatic stress disorder.

[9] **Darren Millar:** Should there be some sort of compensatory training to ensure GP awareness across the board in the Welsh NHS?

[10] **Professor Bisson:** I am always nervous about compulsory training. There are many different areas in which you would have to train people up. I certainly think that it should be a requirement for GPs to have knowledge across the broad range of common mental disorders, of which post-traumatic stress disorder is one. So, that knowledge should be a given in continuing professional development. There are different ways of gaining that knowledge. For some people, appropriate reading and access to appropriate articles on the matter will be enough to provide them with the knowledge that they require, rather than requiring them to go on a half-day training scheme. Training should be available as part of overall training packages for primary care practitioners.

9.10 a.m.

[11] **Peter Black:** Good morning. The committee has heard that the range of treatments offered by the NHS is constrained by guidance from the National Institute for Health and Clinical Excellence. Do you agree? What is the best way to ensure that the most effective treatments are available to veterans suffering from PTSD?

[12] **Professor Bisson:** I think that it is very important that veterans are treated using evidence-based and effective treatments. The NICE guidelines clearly laid down the evidence that was available in 2005 when they were developed. If I am honest, there have not been big changes in the evidence available subsequently. Most of the research trials, and therefore the evidence, are based on what we would classify as simpler forms of post-traumatic stress disorder, where it is not in co-existence with several other disorders and social issues. It is recognised within the NICE guidelines that, for such individuals, a longer course of treatment and a more complex approach to treatment are often needed.

[13] The NICE guidelines focus on trauma-focused psychological therapies, such as trauma-focused cognitive behavioural therapy and eye movement desensitisation and reprocessing therapy as the treatments with the best evidence for post-traumatic stress disorder. However, they also include other treatments that can help individuals with more complex difficulties. For example, within the trials that have been summated to provide the evidence in the NICE guidelines, there is a trial of something called skills training in affective and interpersonal relationship regulation. That is well recognised as being a big issue among veterans and other individuals with more complex presentations. Rather than just having the constellation of post-traumatic stress disorder symptoms—the re-experiencing, the avoidance, the numbing of responsiveness, and the hyper-arousal symptoms—they also have difficulties with interpersonal relationships and with controlling their emotions. Often, that results in significant difficulties for the individual and those around them. With STAIR therapy, you try to deal with those issues initially to prepare the individual with post-traumatic stress disorder for the trauma-focused therapy, which then follows as a second step.

[14] Most veterans with post-traumatic stress disorder, as I am sure we will go on to discuss, also have another psychiatric disorder. So, to say that we are constrained by the NICE guidance on post-traumatic stress disorder of the treatment of veterans is wrong, because we should also be following the NICE guidance for other conditions, such as depression, anxiety disorders, substance misuse and dependence, and personality issues, which are all key issues. From my practice, I think that, if we follow what is available to us under the NICE guidance, we have a very good range of treatments that we can help veterans with. The bigger issue is the availability and accessibility of such treatments within the national health service. Again, I think that is a two-way process. We have just touched on the fact that, within the NHS, perhaps some practitioners do not detect post-traumatic stress disorder and associated issues, so the diagnosis is not made, which prevents individuals from being directed to the available treatments. There are also issues of veterans not being able to trust the NHS and practitioners within it at the moment. That is an issue for several of them.

[15] **Peter Black:** Why would they not be able to trust the NHS?

[16] **Professor Bisson:** Many veterans felt that they were very supported while they were in the military, and they find it quite difficult to adjust to civilian life and have confidence in civilians in the same way as they do in military personnel. That is something that we come across a lot within the veterans' service and the traumatic stress service in the Cardiff and Vale University Local Health Board. Veterans say that they prefer to relate to ex-military personnel rather than civilians. Interestingly, my experience is that, if the civilians are well versed in military culture and know and understand the needs of veterans, once veterans engage with them it can work very well. Then, it does not make a difference whether the therapist is a veteran or a non-veteran. That is what I would aspire to achieve within the service.

[17] **Peter Black:** You said that some treatments are not available. Are we talking about oversubscribed treatments, such as those for substance misuse problems, or other treatments?

[18] **Professor Bisson:** Most treatments are available, but there can be quite long waiting lists to access them. For example, in the Cardiff and Vale University Local Health Board traumatic stress service, the waiting list for psychological treatment for individuals with complex difficulties is over a year, for veterans and non-veterans. That is what we can provide at the moment with the resources that we have for our service.

[19] **Peter Black:** So, it is a resource issue.

[20] **Professor Bisson:** Yes.

[21] **Peter Black:** Are you aware of any examples of good practice in treating and supporting veterans with PTSD in other countries?

[22] **Professor Bisson:** It is interesting to think about other countries, because they have a very different system to ours. If we think of the United States, for example, the veterans administration has responsibility for the treatment of veterans once they leave the service, whereas in the United Kingdom, the responsibility lies with the national health service. So, it is difficult to make direct comparisons between different systems, but we need to make our system work. In the United States, there are some good examples of programmes to helptreat veterans. The programmes that I like best are the ones that use the evidence base; there are very good examples of using things like STAIR, which I just mentioned. It is an American-developed system; most of the trauma-focused psychological treatments and the first-line treatments recommended by NICE were developed in America and are widely used there. The United States veterans administration has rolled out a programme to train all practitioners in the service in some of the key trauma-focused techniques, namely prolonged exposure-type

therapy and cognitive processing therapy, which is a slightly more complicated trauma-focused therapy. The word on the street is that it is effective and that it is bringing all practitioners to use evidence in their practice. That is the sort of approach that I would advocate locally. One of the good things in the States that has impressed me is the fact that it is trying to adopt a recovery model and to help individuals to get back into functioning at the maximum possible level and to achieve their maximum possible health and wellbeing. So, things like vocational rehabilitation programmes are positive things. That is the United States system; there are also models in Australia and Canada that we could look at, but they have a slightly different way of dealing with their veterans than we do.

[23] **Peter Black:** I will just go back to the Chair's question about GPs' awareness of PTSD and its symptoms. Given that the symptoms of PTSD can take some time to appear, a doctor can often miss the cause, because they are not aware that the patient is a veteran or they may not associate the two because such a long period of time has elapsed. Is there a case for including a note in veterans' health records to highlight the fact that they have served in the armed forces? Are there any other ways in which we could tackle that issue?

[24] **Professor Bisson:** I totally agree. That would help a lot. One of the big problems is that it has not been recorded routinely on people's records, and there have been difficulties in passing information from the military to the NHS. It often relies on the veteran taking a letter to the GP. With modern technology, there are better ways of doing that. You make an important point about the fact that unless you are aware that an individual has been traumatised, you will not necessarily go down the right questioning route. So, we advocate the NICE guidelines, which state that when you have individuals who present with a particular type of symptom—perhaps irritability, anxiety or depression—one of your standard questions should be about whether the individual has ever been involved in a traumatic event, such as being a veteran, a road traffic accident or sexual assault. You should go through a few common events that individuals with PTSD might have suffered from.

[25] **Lorraine Barrett:** I have to confess that my colleague Ann Jones and I were talking about this earlier today, so I will ask a question that Ann raised with me. Has any work been done to look at incidents in the lives of armed forces personnel before they go into the armed forces? Do you know how they are screened as to their suitability to enter the forces and whether it involves consideration of mental health problems or traumatic experiences? We were just wondering how many might be affected more adversely, in a way.

9.20 a.m.

[26] **Professor Bisson:** It is a very good point. It is well-recognised from research now that if you have had traumatic experiences during your childhood, for example, then you are more vulnerable to being adversely affected by traumatic events in the military. It will come as no surprise to any of us that, when you look at individuals recruited to the military, you will see in their backgrounds that they are more likely to have experienced adversity during childhood than some others. Of course, the military has often been a helpful way of providing a structure and support for those individuals. One of the biggest problems that we see in veterans is that, when they leave the army and do not have that supportive framework, the adjustment to civilian life and the transition to an unstructured, less supportive environment can be difficult. That is not necessarily about post-traumatic stress disorder. It is an important point that you raise.

[27] The other important follow-on from that is that, if you have had childhood adversity, you are more likely to have a complicated course for the post-traumatic stress disorder later on. In fact, the STAIR model that I was talking about earlier was designed for individuals who had been abused during their childhood and then had had problems with post-traumatic stress disorder as adults.

[28] **Andrew R.T. Davies:** If I may seek a point of clarification, you talked about the structure in America being so different, and we understand that it has a veterans department that organises the programmes that you touched on. Is there any reason why we should not try to consider some of those programmes as best practice for Wales? We may be limited because we are a far smaller country, with a far smaller resource base, but I take it that there is nothing to say that those types of programmes of excellence that you have highlighted could not transfer over the pond, as it were, into practice in Wales.

[29] **Professor Bisson:** I totally agree with that and, as you intimate, we have an opportunity in Wales to develop a specific service that must be based on evidence. It gives us the opportunity to properly evaluate new systems within our country and to provide the best for veterans. With the all-Wales veterans service that has just been funded in the last year, we are starting to try to do that, and to have a common pathway that includes different types of intervention that will meet the needs of veterans, and are informed by the evidence that is available and emerging, and will continue to emerge in the future.

[30] **Irene James:** Good morning, Professor. What contribution to treatment and support is made by the third sector, and how do you think that that can be best used?

[31] **Professor Bisson:** There are an awful lot of positive things going on in the third sector for veterans at the moment. The big challenge that we have is to join together and work cohesively and coherently. It is the classic case where, if you bring everything together, we will have a much more effective service than if we all tried to work in glorious isolation from one another. The key things that the third sector offers are the welfare support that a lot of veterans need—[*Interruption*.]

[32] **Darren Millar:** Sorry for the interruption.

[33] **Irene James:** That was someone who should have gone to a different committee.

[34] **Professor Bisson:** The third sector excels at the welfare side of things. Organisations like the Royal British Legion have a significant resource, with highly skilled people working to provide a lot of positive support to veterans. They tend to focus on the social welfare side of things, and that very much complements the health side, which we should be majoring on. Often, we are not the right people to grapple with the things that the RBL is best at, and, likewise, we should have clear lines as to what we should be doing.

[35] There are other providers as well. It is not part of the third sector, but the Service Personnel and Veterans Agency is important in terms of the overall package of care for veterans. Combat Stress is a charity that specifically focuses on the mental health of veterans and provides a lot of input for veterans from Wales. We have a great opportunity to work much more closely with Combat Stress to work out a common care pathway between the NHS and Combat Stress that uses both our sets of resources in the most joined-up way that we can. At the moment, Combat Stress has a model that is primarily focused on veterans going into residential units for a fortnight at a time a few times a year. Several veterans find this very helpful as a means of getting away from a stressful environment. Certainly, for individuals whom I treat and support, the respite function and being in a different mileu is what they value most.

[36] There are big questions to be asked about the role of residential units in an overall plan, particularly when we are looking at a community-based recovery model within the NHS as our primary focus of treatment. I am very keen that we explore that further. I do not think that the model is totally right at the moment, because we should be looking at doing comprehensive psycho-social assessments on individuals that involve the different agencies,

and having bespoke individual management plans that look at the individual's needs. We should try our very best to help individuals to get the support and the treatment packages that they need in the community, and those, from a very early stage, should involve not just treatment but rehabilitation, and try to help individuals function and to get back to a structured life that gives them a sense of purpose.

[37] For some—and, hopefully, for more than some—that will mean trying to help them to get back to work in the future and achieve a vocational outcome. I do not think that some will achieve full employment, but several individuals whom I treat are doing voluntary work, for example, which is less pressured. Well, on one level it is, but it is not always so. However, there are additional demands when you have a contract of work and you are in paid employment, so it is often a good stepping stone. That is where some people will reach. For some individuals, that is going to be too much, and so you are then looking at meaningful activities for them within the community. There is a variety of things in which veterans are engaged locally, such as a gardening project, from which people have gained immense satisfaction, and which has helped their mental health no end—more than the tablets that I have prescribed for some. Going to do some gardening a few times a week in a supportive environment has been excellent for people.

[38] So, there is a wide variety of things that we should be looking at, but what we want to do is to help veterans live and function at a more positive level in their own communities, rather than them being away from their communities and that being the only place in which they feel they can function.

[39] **Helen Mary Jones:** You have touched already on the fact that there is a lack of co-ordination of services for veterans, and that we need an all-Wales body to fulfil that role. Can you tell us more about how this needs to happen and how the need for an all-Wales body to co-ordinate at some level should be addressed?

[40] **Professor Bisson:** There are various levels, so you need to have very high level political support to make anything work. If we are talking about an operational body that will make things work, you need to get key players from the various statutory and non-statutory organisations that are involved in the management of veterans to discuss and come up with a common pathway that everyone is agreed on. In the veterans pilot project in the Cardiff and Vale University Local Health Board, which I know you are aware of, we developed a steering group; I think that Neil Kitchiner has already given evidence to the committee about that. On an all-Wales basis, a similar type of format would be helpful. In fact, we have set up a steering group in the new all-Wales veterans' service that involves members and representatives from the key organisations, so we have representation from the Royal British Legion, the Ministry of Defence, the armed services, Combat Stress, the Service Personnel and Veterans Agency, and NHS representation from the different health boards that provide services to veterans.

9.30 a.m.

[41] We work together to try to develop a service, and we have a common care pathway. That is the way to go. That sort of group needs to have a mandate to deliver that, and we have been fortunate in working closely with the Welsh Assembly Government and we feel that we do have that mandate at the moment. I think that that is working well and is moving forward. Resource is an issue, and getting £0.5 million a year of recurrent funding is a positive thing to have happened over time, but when you spread that out across Wales, it does not get rid of waiting lists or anything like that. However, we are moving in the right direction, and the next challenge will be to work closely with the third sector and, hopefully, for it to invest its resources to help with the common pathway. By doing that, we will increase the capacity of the service far beyond what we get from a £0.5 million investment in the NHS.

[42] **Helen Mary Jones:** I want to pursue that point on resources, if I may. Clearly, this places considerable demand on the NHS in Wales, and we would all want to see that demand being met in full. In your view, does the Ministry of Defence have some responsibility in this regard? It has been put to us by other witnesses that the Ministry of Defence takes an awful lot of time to take someone and turn them into a soldier, but it does not put much resource, effort and time into de-programming that person, as it were, to help them to deal with civilian life. Would it be your view that the Ministry of Defence ought to be prepared to put resources into dealing with the aftermath and helping soldiers, some of whom, although not the majority, find it difficult to adjust to civilian life?

[43] **Professor Bisson:** It clearly needs to be funded, and more resource needs to be put into that. As to who is responsible for it, that is a matter for Governments to determine. My understanding of the agreements in our country is that, once an individual leaves the military, the responsibility lies with the national health service. If that is the case, I would argue that more resource should be made available in the NHS for us in the NHS to deal with that. Another model would be for the MOD to take responsibility for doing some work with veterans as well. You could argue for either model, but more resource and effort needs to be put in. The Ministry of Defence is aware of the issue, and it has been making increasing efforts to prepare military personnel better for the transition into civilian life. There are several initiatives that are being piloted to look at that, and courses are being run for people who are just about to become veterans. I am sure that you are aware of the 'Fighting Fit' paper that has just been written by the MP, Mr Murrison, which recommended that there should be an ongoing commitment to veterans, including a one-year screening system. Those ideas need to be evaluated and worked up, but they are good ideas in terms of joining people up more tightly.

[44] Many veterans—I am sure that this is a recurring theme for the committee—almost get lost once they leave the military, and then they present to services 10 or 15 years later. So, the gap between someone leaving the military and our seeing them is massive. If we can reduce that, which I think these initiatives would do, we have a much better chance of helping people to achieve a better end function than if we see them 20 years after their problems have started.

[45] **Andrew R.T. Davies:** I want to get a better understanding of this, although to be fair, Professor, you might not be able to help me with it. Helen Mary makes the point that the military trains someone up to be in a fighting unit, and that is its remit as the Ministry of Defence. Is it the case that, structurally, it has no remit beyond training those individuals to be fighting machines? Twenty or 25 years ago, the Ministry of Defence and the armed services had their own internal health service, but the function was then transferred over to the national health service. Perhaps in that transfer no structure was put in place for the civil servants and the military top brass to give meaningful consideration to a template for people after the military. Perhaps we as a committee should look at the formal structures that are in place, because at the moment the way in which things are done seems to be informal and ad hoc, and no-one is really taking ownership.

[46] **Professor Bisson:** I totally agree. That is a very good point. There are always going to be joins, are there not? It is about trying to make it as seamless as you can. We know that it is virtually impossible to do it 100 per cent, but I think that we have been dealing with a system where you are suddenly transformed, almost overnight, from being one thing to being another. It is not surprising that it is very difficult for people. We have mentioned before how vulnerable some of the veterans are, and it will be even more difficult for them. Interestingly, the research tends to show that it is the veterans who have not been in the services for very long who are most vulnerable to developing problems. If you have been in for less than four years, you are more at risk of having problems than you are if you have been in for more than

four years. I agree totally that that is a key issue.

[47] **David Lloyd:** Yn nhermau gwasanaethau i'r dyfodol, yr ydych wedi sôn gryn dipyn eisoes ynghylch y gwasanaeth iechyd meddwl Cymru gyfan i gyn-filwyr. A allech chi egluro eto rhai o gryfderau y gwasaneth hwn ac a allech chi gadarnhau mai'r bwriad yw ehangu'r gwasanaeth hwnnw i bobl sydd mewn carchardai? Hefyd, a fydd y gwasanaeth ar gael drwy gyfrwng y Gymraeg?

David Lloyd: In terms of future services, you have already talked quite a bit about the all-Wales mental health service for veterans. Could you explain again some of the strengths of this service and could you confirm whether the intention is to expand that service to people in prison? Also, will the service be available through the medium of Welsh?

[48] **Professor Bisson:** The service brings together practitioners across the whole of Wales, and we are developing it on a hub-and-spoke model. Within Cardiff at the moment, we probably have more experience and, in some instances, more expertise than other areas of Wales. The idea is to try to disseminate that across Wales so that, wherever you live in Wales, you have access to the same level of service. I agree that that should be available in both English and Welsh. There are, as I am sure we all appreciate, some issues around that, but that should certainly be our goal, and that is what we should try to do for all services.

[49] We would see ourselves as having a remit in trying to help veterans who find themselves in prison. When you only have a limited amount of resource, you have to be very careful about how you do that. Locally, we feel that the best way of doing that is by forming close links and liaisons with prisons' in-house mental health services and enabling them to recognise the issues of veterans, to give them training in how to do that, and to rely on them to develop systems to provide treatment to individuals in prison. There are mental health professionals to whom people have access, and so it is a case of giving them the skills to deliver. Then, with the current level of resources, once individuals are released from jail, that is another transition, like leaving the military, really, that we need to be very careful about. We know that many people get lost in that transformation, so I would advocate having strong liaisons with the in-house services. For example, there could be joined-up case conferences before an individual is released so that we hand over individuals properly and make sure that they are then linked in to the all-Wales veterans' service. That service is funded and led by the NHS, but it is a multi-disciplinary, multi-agency service. That is the big message that we need to get out, that this is not just about a single NHS service, it is about everybody having a joined-up service for veterans' mental health and wellbeing.

[50] **Val Lloyd:** That fits in nicely into my question. In your response to my colleague, you talked about the all-Wales service that is being developed. What about the capacity issues for that, particularly the need for specialist staff training?

[51] **Professor Bisson:** Capacity is a difficult thing to estimate, because of the point raised earlier about not knowing who is, and who is not, a veteran. It is difficult to know what the needs of veterans as a whole are or to simply do research to look at a random sample of veterans in Wales. We are just finishing some research that was funded by the Welsh Assembly Government, looking at the needs of veterans. We have interviewed just over 200 individuals. That will help us to clarify the needs of the veterans we are speaking to, which will allow us to guess better what the capacity issues will be.

9.40 a.m.

[52] We have the data from the Cardiff and Vale University Local Health Board pilot service. We had about 150 referrals over a two-year period; their needs were quite complex—I cannot think of a single individual who presented to us with very simple needs. So, the NHS

needs to be able to perform complex psychosocial assessments of individuals, including full risk assessments, which should be multidisciplinary in nature. NHS staff also need to have an awareness of military matters, and some basic skills in military language are quite useful for people within the NHS. There are sometimes differences in how you relate to veterans compared to civilians, and there are things that we can help to develop with regard to the communication of NHS staff with veterans.

[53] Another issue is the clinical treatment required by veterans, because there is a big overlap with the clinical treatment required by non-veterans. So, it is a case of ensuring that we have a well-trained NHS workforce. As I said, if we had individuals within our mental health services who could deliver all the interventions listed in the various guidelines from the National Institute for Health and Clinical Excellence, we would be more than capable of providing an excellent service for veterans.

[54] **Val Lloyd:** So, you have envisaged the scope of it, but is there capacity to meet that?

[55] **Professor Bisson:** There are major capacity issues within the national health service, not just with regard to mental health, but physical health as well. Unless you have an infinite source of money, you will never meet the full capacity, particularly with the advances in technology and treatments. We should therefore try to ensure that there is no waste within the system, and that we are not providing individuals with treatments that do not work or treatments that are suboptimal. We should be trying to deliver our treatments in the most cost-effective manner. So, returning to my earlier point again, delivering community-based treatments that are as effective as residential treatments would be a more cost-effective way of delivering them.

[56] **Lorraine Barrett:** Can you say anything about your experience with regard to the co-ordination between mental health services and the substance misuse services, because the two often go together? How are those services working together?

[57] **Professor Bisson:** That is an important point. There is a significant area of co-morbidity with regard to post-traumatic stress disorder. There is a need for strong positive relationships between the local addiction teams and the veterans' therapists, if we are talking more generally about the relationship between veterans and local mental health services. In Cardiff, we have made close links with the local addiction service through meetings and discussions. We have presented information about the veterans' service, about the issues that veterans have and we are trying to move towards developing joint working practices. Our addiction service now recognises priority treatment for veterans, so it is now using that when treating veterans, which is a positive thing.

[58] **Darren Millar:** Is that just a local priority, or is it a national priority within the NHS?

[59] **Professor Bisson:** It is a mandated national priority within the NHS, but there is variation with regard to the way in which it is delivered.

[60] **Darren Millar:** So, it is not necessarily monitored.

[61] **Professor Bisson:** One of the key roles of the veterans' service is to raise awareness among people of the priority and to ensure that it is always considered appropriately. By having a proactive relationship with our addiction service, we have ensured that it considers that priority when a veteran presents to it.

[62] **Lorraine Barrett:** Is that only with regard to the NHS addiction service, because there are other services within the third sector that we touched on earlier? There are many voluntary groups, for example. So, is there a problem with sharing information, or is it down

to the person receiving the service to go to the third sector?

[63] **Professor Bisson:** No. We have set up our service in such a way that the veterans' therapist takes on a case management sort of role. Therefore, he or she will act as the advocate and try to link people up with services. With addiction, our main links are probably with the NHS service; therefore, we would liaise with them, and then, hopefully, they would engage and they would have a much better knowledge and relationship with the other local and third-sector non-statutory services and be able to link them up appropriately. We have had some good experiences in that respect. We also set up training sessions for staff to deal with these issues. For example, in December, we have someone coming over from America, who is a specialist and has developed a programme for individuals with co-morbid substance misuse and post-traumatic stress disorder, who will run a series of workshops for us, in which we will also include the local addiction service. Those are the sort of things that we should be doing, and again, are what we should be trying to advocate on an all-Wales basis.

[64] **Darren Millar:** Okay. That brings us to the end of the first part of our meeting. Thank you very much for the written and oral evidence that you have provided to us. It will be very helpful as we come to our conclusions in the inquiry. Thank you.

[65] We will now take a short break before we invite our next witness to the table to make a presentation.

Gohiriwyd y cyfarfod rhwng 9.46 a.m. a 9.50 a.m.
The meeting adjourned between 9.46 a.m. and 9.50 a.m.

[66] **Darren Millar:** We will move on to the next part of our meeting, which continues our inquiry into post-traumatic stress disorder treatment for veterans. I am delighted to welcome Dr Dafydd Alun Jones, who is a consultant psychiatrist and an expert, it is fair to say, on the subject of PTSD. Dr Jones has asked if he can make a short presentation to the committee prior to our questioning, so it is over to you. Thank you for your attendance today.

[67] **Dr Jones**: Diolch am yr anrhydedd a'r fraint o gael annerch pwyllgor ein Cynulliad am y tro cyntaf.

Dr Jones: Thank you for the honour and privilege of addressing a committee of our Assembly for the first time.

[68] I will concentrate on one area of this work. Am I perfectly audible? I lost my voice last week, but I see that you can hear me.

[69] Os ydych am fy holi yn Gymraeg, holwch fi yn Gymraeg.

If you want to ask me questions in Welsh, please feel free to do so.

[70] I want to concentrate on the part of the work that has become prominent in recent years, partly through the work of the probation service and partly through the work of Elfyn Llwyd, who has recently been to a court in America where they are looking at the particular problems of ex-servicemen who offend. Over the years, I have become increasingly involved with this area, namely ex-servicemen at the black end of the spectrum—those who get into trouble and offend, whose crimes range from fighting to murder. I have seen a frightening number of ex-servicemen in prison on murder charges. Sometimes, we are able to reduce those charges to manslaughter, but sometimes no-one takes any notice.

[71] Some of what I will say may be rather sensitive, but only last week a general practitioner rang me from London and she spoke of a man whom she knew I had seen. She said, 'I had to phone you. I'm afraid'. She named him and she said, 'He said he's going to strangle his wife, and I'm afraid'. She really was afraid. This man had abortively been involved with all sorts of local services. He had come to Tŷ Gwyn, where we had tamed him

quite considerably, and he still comes up quite regularly. This is real. Only a year ago, there was a similar situation with a friend of that man who was sentenced to a 20-year tariff and is now in Cardiff prison. So, I am talking of real things. I am talking the hard end of the spectrum and things that are really happening. I have seen a large number of these men in prison. There are ways of dealing with lesser degrees of trauma, but with these very difficult cases, there is nothing. I still get calls from solicitors, the men themselves and their mothers—it is often their mothers.

[72] I began this work in 1981 in a clinic in Dolgellau, where I saw a man who had been referred by a general practitioner. I knew nothing of ex-service work and I do not think that the criteria for PTSD had been noted in the *Diagnostic and Statistical Manual of Mental Disorders* by then. I realised that something had happened to him: he had had a terrible war, in which he had been caught by the Gestapo. I will come back to these data, but I wrote to the former War Pensions Agency asking whether it could do anything for him. That is where my interest began.

[73] My health authority then allowed me sessions to do this work as part of my NHS contract. People would be referred from all over, and I found myself seeing ex-service cases, particularly combat stress cases, from all over England and Scotland. They were travelling great distances and, on Saturdays and the like, I would hold sessions in all sorts of odd places. I remember an ex-service welfare officer asking me to do something the other side of the Pennines, because they had nothing there. I remember a lad from Scotland saying at a meeting in Manchester that they had nothing in Scotland and asking me to do something there, so I went there.

[74] That work increased. I began in 1981 and it was part of my NHS contract work, but the National Health Service and Community Care Act 1990 allowed the provision of independent contractors in the health service. I persuaded a small unit in Llandudno to set up a facility. I wanted an in-patient facility. I had done a lot of in-patient provision before, but I wanted to combine them for the ex-servicemen. That is where Tŷ Gwyn came from. It began in 1993 and ended in 2005 when the funding just failed.

[75] Over the years, I have reported to and spoken to many bodies, and I have tried to cultivate an awareness of, and an interest in, this issue. It is rather nice that you had Professor Jonathan Bisson here this morning. He may have mentioned to you that we first met in 1988. I refer you to the screen behind me—can you read it?

[76] **Darren Millar:** It is all right, as we have paper copies.

[77] **Dr Jones:** I began in 1981, and I was invited to speak to the Royal Army Medical College at Millbank on the subject of the hidden aftermath. It was rather nice, you know, as I was introduced by the head of army psychiatry. The meeting was of psychiatrists from the three services, NATO, and other friendly powers—and I said, 'I presume that I come under the last, if you still regard the Welsh as friendly'. I said to the head of army psychiatry, 'Brigadier, I am not a military person in any way; I am a white-robed druid, bearing no arms. I salve the fallen warrior'. I used the slide being shown now to explain to English audiences that I remain completely neutral, which has been important in my work.

[78] Ex-soldiers all over England were isolated and in trouble, and there was nothing for them. Then they found Tŷ Gwyn. One or two of you have been there and have seen it for yourselves. They found a place of solace, and it is curious that it was in Wales. In a way, we were outsiders, and we did not represent the brass, the military or anything to do with them. We represented a certain understanding. The place became a great symbolism to many ex-servicemen all over the UK.

[79] Over the years, I saw about 2,500 ex-servicemen. When Tŷ Gwyn closed and the ability to run my clinics failed, I still had about 1,800 patients on my list. I tried to make the work known. When I began in 1981, a Brigadier Murphy was working at Combat Stress. He was very good. He was Irish, and he travelled all over with his wife for many years on an Irish passport. So, we were both slight outsiders, and because of that, we were different; we had a place to stand, you could press our levers and we would move things. We did a lot together.

[80] At that time, there was very little awareness of ex-servicemen's needs. Mostly, I saw a great many men from world war two, from every campaign you could mention. They had been very badly dealt with—I am referring to war pensions and other things—and so I undertook a great deal of work for them, going to tribunals and fighting their case. I also spoke on many occasions to try to raise public awareness of the issue. After I spoke at the Royal Army Medical College, I was invited, as a druid, to speak to the association of army chaplains, which was quite an experience, and then, as you will see, I was invited to a series of places where I tried to cultivate an awareness of this special need, particularly the need of this group, which nobody could tackle. The penultimate talk was at the River Centre, where, during the first world war, they started treating battle shock and the like. As you can see from the next slide, all over Britain, in Wales, and even in Berlin and Holland, I have tried to convey the needs of this particular group. All this began in 1981.

[81] You can now see a copy of an interesting letter, which is the response that I got from the War Pensions Agency to a letter that I wrote about this little man from Dolgellau—an Englishman, mark you—who had been retired by his family to the Cardigan coast. They had despaired of him. I had seen him clinically, and the response of the War Pensions Agency was surprisingly positive and generous. Afterwards, the people at the agency came to hate my guts, as I improved so many people's pensions.

10.00 a.m.

[82] I reckon that, if you take 2,000 ex-servicemen, and improve their pension by about £10 a week, that is a total of between £1 million and £2 million a year, so, by the end, I think that I became something of a bête noire to the War Pensions Agency. I think that Combat Stress was given a Gypsy's warning and it distanced itself from me. I saw this man in my clinic in Dolgellau. I also sent him to his Member of Parliament. It is rather nice that I can refer to a letter that Dafydd Êl sent back to me when we got a pension for this man in 1982. Here we are, 30 years on, and I have the privilege of telling you about the same work.

[83] This next slide shows where I ended up seeing these ex-servicemen. I had clinics in all these places. They were entirely voluntary clinics; they were not funded from any source. I was able to do it as part of my NHS work. I had a secretariat in the NHS, and Clwyd health authority allowed me a session of my consultant contract time to work with ex-servicemen. I do not think that anyone in the UK was doing this at that time. However, as you can see, there were patients everywhere. Perth was the furthest north that I went, I think, but they were scattered all over. I was holding these clinics on a cycle of about two months.

[84] Then I set up Tŷ Gwyn in 1993. I arranged with the people who owned it to set up this unit. I said that it must not cost more than an NHS bed in Denbigh, it must not cost the men anything, and it must do only NHS work. We did it on a contractual basis, and it was an horrific struggle. If I could not get someone funded and they desperately needed to come, they felt that I had let them down, which was terrible. People would turn up on the doorstep, and the staff could not turn them away. Half the time, a large part of the work was unfunded. In the end, the place simply could not continue. It was an absolute tragedy. It was unique. It combined a particular skill in running group therapy—something that derives really from William Williams Pantycelyn's 'Drws y Society Profiad', which I will expand on—with

expertise in drugs and alcohol, as well as a great deal of court and criminal work, so it really was unique.

[85] This slide shows the number of active cases that I was dealing with when Tŷ Gwyn closed. They were at the hard end of the ex-service spectrum. These were not people who went to GP or out-patient clinics. Look at the locations, the number of active cases at that time at those locations, and then look at how many belonged in Wales. In total, I had an active list of 1,898 at these various clinics and, of those, 337 were in Wales. On my waiting list, beseeching me for admission at that time, I had 90 in the UK as a whole, with 25 of those in Wales. When Tŷ Gwyn closed, CAIS made an offer to the Assembly Government. There was a great deal of discussion, but it came to nothing. Four years ago, had the Assembly Government agreed a contract for even six beds, we could have provided the whole of this service at a pretty reasonable cost. CAIS is a charity that has a great deal to do with the Assembly Government. This is still on and is still possible. This offer is being submitted to you by us as evidence now.

[86] **Ann Jones:** Can I just ask—

[87] **Darren Millar:** We will take questions in a second. Can I ask you to bring your presentation to a close, please?

[88] **Dr Jones:** I will wind it up. This slide shows ex-servicemen who served in campaigns after the second world war. There are a whole lot of things that people forget about. I saw people from all these campaigns. One thing that you need to know is that an ex-serviceman on a war pension has priority in the health service over all but emergency patients. There is a letter confirming that. This slide shows how a man of 75 from Nottingham saw things. I hope that you will forgive me, but I have one last thing to say. My name came from the name of my father's brother, who was killed in Jerusalem in the first world war. The name that I signed on all these thousands of letters for ex-servicemen is David Jones from Penmachno, who is also someone who died at the age of 25 in 1918 in Jerusalem. That was a very strange turn of fate, among all this. So, his name now goes on a great many letters as one of many ex-servicemen.

[89] There you are: I have been dealing with the hard end of the spectrum. Tŷ Gwyn closed, and there is nothing. There are men in prison. It is a funny thing that it is a Welsh MP who is really taking most notice of this. It is as though these are forgotten men. There is nothing for them, and yet something is possible.

[90] **Darren Millar:** I will open the meeting to questions now. Rather than sticking to the prescribed questions, I think that it would be good to explore the various issues that have been raised.

[91] **Dr Jones:** Ask me about any part of it.

[92] **Darren Millar:** Before I bring Ann in, I want to ask about the Tŷ Gwyn residential facility. You obviously think that residential treatment is an important part of the package of care that veterans who are suffering from PTSD require. How many beds were available at Tŷ Gwyn?

[93] **Dr Jones:** About 12 to 14 were available, but we rarely had more than six or eight funded. A unit of about 12 beds would be an optimum number and could deal with most of the hard stuff that emerges in Wales.

[94] **Darren Millar:** You were treating patients there from throughout the United Kingdom, not just Welsh patients. What proportion of those beds would be required for the

needs of Welsh veterans? If you are saying 12 for the whole of the UK, how many beds do you think would be required just for Welsh veterans?

[95] **Dr Jones:** If we had had a contract for six beds, we could have dealt pretty well with anything of that severity that cropped up in Wales. We could have transferred people out of prison and worked with the courts. If you can tell a court that a man offended because he was volatile owing to PTSD and that you can treat him and prevent future harm, almost invariably, the court will refer him to us. However, if I cannot fund, I cannot do anything.

[96] **Ann Jones:** I have a question on the funding. How were the other clinic locations outside Wales funded for your work? How did you get the funding to deal with 1,898 veterans at that time?

[97] **Dr Jones:** How were the out-patients funded?

[98] **Ann Jones:** You had clinics at various locations in England and Wales.

[99] **Dr Jones:** In many of the locations, the men in places like the Royal British Legion clubs and ex-servicemen's clubs would find a venue and I would hold a clinic. The main problem was the cost of travelling there and the cost of letters, typing and other secretarial costs. Until my retirement from the health service in 1995, all my personal secretariat costs were met as part of my work. After that, it did not come from any source. When there were patients in Tŷ Gwyn, it paid a part of the fee towards the cost of running the clinics. So, where the NHS paid, it paid for in-patient care in Tŷ Gwyn and, of that, a proportion went to cover the costs of running the clinics.

[100] **Ann Jones:** What part of the NHS paid for that in-patient care? If you had 12 to 14 beds, and, of those, you had only two Welsh patients, how were the other 10 funded?

[101] **Dr Jones:** Each patient would have to be funded individually on what is called an extra-contractual referral. We would have to write to the health authority and ask it to fund a person for so many weeks. Initially, they would almost invariably decline. They might be persuaded to pay, but the effort required was enormous. If you managed with great difficulty to get it to pay, it would pay roughly what an NHS bed cost in my area. I did not want the place to be expensive; I wanted it to cost what an NHS bed would cost. When Tŷ Gwyn closed, it was then impossible. I had no source of funding for anything. I still see a lot of these men, but I see them in my own place. There was nothing to meet the cost of running a clinic, the secretariat to write the letters and so on.

[102] **Ann Jones:** So, in the case of the people you treated from Birmingham and Newcastle, their national health service authority did not find that you could have had a six-bed unit just treating people from England, so they were not prepared to fund it any more.

[103] **Dr Jones:** If I had a patient, for instance, from Birmingham, the health authority in Birmingham would pay Tŷ Gwyn.

[104] **Ann Jones:** However, it was not prepared to fund you when you were finding financial difficulties?

[105] **Dr Jones:** The financial difficulties arose because so few people were funded.

[106] **Darren Millar:** It was not that the service was not needed.

10.10 a.m.

[107] **Dr Jones:** The need for the service was tremendous. People would phone me, and I would get calls from custody officers late at night, who would say, 'This is the custody sergeant at so-and-so police station; we have a man here who says that you know him', and I usually would. If I had the capacity, I would say, 'I will send a note to the court the next morning', or 'Tell the police surgeon to phone me', and I would give him the background. We could intervene and, provided I had any sort of funding, I could get that man into Tŷ Gwyn. The courts were very good—the judges in the crown courts generally understood, and were very good.

[108] **Val Lloyd:** Following on from what you said about Tŷ Gwyn, would you say that residential care is the optimum way forward for the treatment of veterans with post-traumatic stress disorder?

[109] **Dr Jones:** I am sorry, but could you repeat that? My hearing is rather poor.

[110] **Val Lloyd:** Do you think that residential care is the best way forward for treating veterans with post-traumatic stress disorder?

[111] **Dr Jones:** There are a lot of men for whom it is pointless to have a sporadic contact. Many of the men who I saw in my clinics would come every month or two, and their wives would come, and they would phone, sometimes, when they were stressed—sometimes in the middle of the night. They would phone Tŷ Gwyn in the middle of the night, and that contact was important. However, treatment in a peer group, as an in-patient in residential care, was totally essential for some of them—particularly when you look at those men who were in prison or in court. The courts will not let them loose; they want to know that there is a place of care. The courts and the Home Office allowed me to transfer many of the people who I transferred from prison because there was a safe residential place for them. The residential element would still be provided by CAIS if the Assembly Government wanted it. It is essential for a certain proportion of people. They do not respond well in ordinary psychiatric units. If you put one of these men in an ordinary mixed unit of depressed little old ladies and people with all sorts of other problems, they know that they are not the same and the other patients are afraid of them.

[112] **Darren Millar:** So, a veteran-specific residential unit is crucial in your opinion.

[113] **Dr Jones:** It is absolutely crucial. Anyone who has visited Tŷ Gwyn or seen some of the archived video material would know that it was totally unique. It was a peer group—it was like a 'seiat' in Welsh; I do not know how you would convey that in English. There was great emotion and people would say to me, 'I could never tell anyone, and then I came here, and I do not need to; everyone knows'. One of them said to me, 'Dr D.A., you must be the only psychiatrist with his own private army'. [*Laughter*.]

[114] **Andrew R.T. Davies:** Thank you, Dr Jones, for your evidence this morning. I have read the paper to the best of my ability, but I would like to clarify one point: Tŷ Gwyn was outside the NHS, was it not? It was commissioned by the NHS to offer the provision, but it was not an integral part of the NHS, was it?

[115] **Dr Jones:** No. I took advantage of the National Health Service and Community Care Act 1990. I spoke to the people who owned Tŷ Gwyn, whom I knew, and told them that the Act allowed for an independent provider. I wanted to create a unit combining what I did with my group therapy unit in Denbigh with on-call services and my work with offenders. I wanted a unit where I could bring these men together as a group. They treated each other.

[116] 'Gŵr a hoga wyneb ei gyfaill,' 'A man sharpeneth the countenance of his friend,'

[117] ‘as iron sharpeneth iron’. You know these texts.

[118] **Andrew R.T. Davies:** You said that the work at Tŷ Gwyn was essential for the individuals referred to you. Is that work continued at all within the Welsh NHS as you understand it?

[119] **Dr Jones:** It is not continuing anywhere, to my knowledge, in the UK. There are men in prison now who would not be there, if treatment were available. There are men who went to prison because I could not get funding for their treatment. There are men who are in prison now because we were unable to treat them with periods of stabilisation in Tŷ Gwyn. There is a man from south Wales—and this grieves me—who is on a 20-year tariff for murder. Had we been allowed to continue his management as we might have done, that might have been avoided. He started from Birmingham, and then moved back to south Wales. The funding stopped. I failed. I now correspond with him. We were providing an extremely powerful intervention, but the men were also treating each other—they were a group, and if one of them was playing up rough, the others contained him. We were able to do things that, in an ordinary NHS unit, you could not do. At this time, there is nothing.

[120] **Andrew R.T. Davies:** Would you say that the NHS itself would not be inclined or in a position to develop such a service, so it would have to look to the independent sector, or could the NHS, if the will was there, create a model like the one that you had in Wales?

[121] **Dr Jones:** I have created a lot of specialist units within the NHS. I created an in-patient group therapy unit in Denbigh way back in 1965, where I was able to use NHS resources. I have set up alcohol units and drugs units. I was helped by the Presbyterian Church of Wales to set up CAIS. These things were possible, but working with ex-servicemen was a different proposition. They came from all over the place and one health authority could not really be expected to treat them all. If I had set up a unit in Denbigh, I would have been seeing patients from all over. I was holding clinics in Manchester, Leeds, Hull and all sorts of places. It was a remarkable experience. My relationship with these men was very profound and very special. They still phone and they are still in touch. I have pictures of hundreds of them on my hard disk. However, I feel that I failed them—it was terrible when the place closed. You may have received an e-mail from a lady called Sue Riggs who has written to say something of her experience. Her husband had been in Northern Ireland in the 1970s, and they found nothing, but by chance she found this treatment. I always tried to collaborate with the health service as closely as I could. Occasionally, I found consultants who took an interest and who would refer patients, but generally the administration did not want to see money leaking out to other units, and it was extremely difficult. It failed for that reason.

[122] **Darren Millar:** I do apologise, Dr Jones, but the clock is against us and a couple of Members want to come in. If we keep questions and answers brief, we will be able to get through everyone’s questions.

[123] **Helen Mary Jones:** Mae gennyf ddau gwestiwn. A allwch ddisgrifio’r dulliau arbennig yr oeddech yn eu defnyddio i drin dynion yn Nhŷ Gwyn? Yr ydych wedi sôn am therapi grŵp a chydweithio felly. O ran trin dynion o bob rhan o Brydain, yr oeddent yn aros gyda chi am gyfnod yn Nhŷ Gwyn, ond wedyn yr oedd yn rhaid iddynt fynd adref i Birmingham neu le bynnag, felly pa fath o ddilyniant oedd yn bosibl er mwyn parhau â’r driniaeth yn eu cymunedau ac i ba

Helen Mary Jones: I have two questions. Could you describe the specific methods that you used to treat these men in Tŷ Gwyn? You mentioned group therapy and such collaboration. With regard to treating men from all over Britain, they stayed with you for a period in Tŷ Gwyn, but then they had to go home to Birmingham or wherever, so what kind of continuity was possible in order to continue the treatment in their own communities and to what extent could the

raddau oedd y gwasanaethau gofal cynradd a meddygon teulu yn medru ymateb i'w hanghenion ar ôl iddynt fynd adref?

primary care service and GPs respond to their needs after they had gone home?

[124] **Dr Jones:** I gyfeirio at y dilyniant yn gyntaf, yr oedd y cyswllt â Thŷ Gwyn yn bwysig iddynt. Yr oeddent yn ffonio Tŷ Gwyn yn gyson ac yr oeddent hwy a'u gwragedd yn ymweld. Yr oedd gennyf glinig hefyd o fewn cyrraedd iddynt, felly yr oeddwn yn cadw cyswllt personol â hwy, ac yr oedd hynny yn bwysig iawn. Yr oeddent wedi bod ar ben eu hunain heb neb, ac yr oeddent yn awr wedi dod o hyd i rywbeth. Yr oeddwn bob amser yn ysgrifennu at eu meddygon teulu ac yr oeddwn yn chwilio i weld a oedd unrhyw ymgynghorydd neu seiciatrydd a allai gymryd diddordeb yn eu hachos. Yr oeddwn bob amser yn gofyn i'r meddyg teulu am enw ymgynghorydd lleol. Os oedd un yn bodoli, yr oeddwn wedyn yn anfon llythyrau atynt. Yr oeddwn weithiau yn anfon llythyrau at gyfarwyddwyr iechyd cyhoeddus er mwyn gweld a oeddent yn adnabod rhywun a fyddai â diddordeb. Yr oeddwn weithiau yn cael gafael ar nyrs seiciatrig cymunedol a oedd yn gallu gweithredu fel cyswllt. Yr oeddwn yn chwilio lle y gallwn am gysylltiadau, ond y gwir amdani oedd nad oedd y rhan fwyaf o'r dynion hyn yn medru ymwneud â staff eraill. Nid oedd staff eraill, at ei gilydd, yn ddigon cyfarwydd â'r math hwn o beth. Ni fedrwch weld claf unwaith yn y pedwar amser—mae'n rhaid ichi ddod i'w nabod. Os nad yw'r dynion yn teimlo eich bod yn eu hadnabod a'u deall, nid ydynt yn aros. Yn achos y wraig a wnaeth fy ffonio yr wythnos diwethaf, yr oedd y meddyg teulu wedi ceisio bob sut i gael rhywun lleol i helpu'r dyn, ond nid oedd unrhyw un wedi gallu ymateb.

Dr Jones: Referring first to the continuity of treatment, the link with Tŷ Gwyn was important to them. They would phone Tŷ Gwyn regularly and they and their wives would visit. I also had a clinic that was within easy reach of them, therefore I maintained personal contact with them, which was very important. They had been left alone without anyone, but they now had something. I would always write to their GPs and I would search to see whether there was any consultant or psychiatrist who could take an interest in their cases. I would always ask the GP for the name of a local consultant. If one existed, I would then write to them. I would sometimes write letters to the directors of public health to ask whether they knew of anyone who would be interested in assisting. I sometimes got hold of a community psychiatrist nurse who could act as a contact. I was always looking where I could for contacts, but the truth is that the majority of these men could not get along with other staff. For the most part, other staff were not familiar enough with this sort of thing. You cannot see a patient once in a while—you have to get to know them. If the men do not feel that you know and understand them, they will not stay. In the case of the woman who phoned me last week, the GP had tried every way of getting someone local to assist the man involved, but no-one had been able to respond.

[125] O ran y driniaeth, yr elfen fawr oedd bod y dynion yn cael bod gyda'u tebyg. Yr oeddem yn defnyddio pob mathau o driniaethau seicolegol, ond y peth mawr oedd eu bod mewn seiat gyda'i gilydd. Yr oeddent yn deffro yn y nos ac yr oedd rhywun yno i siarad â hwy. Dyna oedd y cefndir.

On the treatment, a major element was that the men could be with others who had had similar experiences. We used all sorts of psychological treatments, but the main thing was that the men could share their experiences. When they woke at night, there was someone there to speak to them. That was the background.

[126] **David Lloyd:** Diolch, Dafydd, ac mae wedi bod yn hyfryd i glywed eich tystiolaeth y bore yma. Credaf y gallaf siarad ar ran y pwyllgor i gyd drwy ddweud hynny,

David Lloyd: Thank you, Dafydd, and it has been wonderful to hear your evidence this morning. I believe that I can speak for the whole committee in saying that, so thank you

felly diolch yn fawr iawn ichi am eich cyflwyniad.

very much for your presentation.

10.20 a.m.

[127] Yr ydych wedi canolbwyntio ar yr agwedd fwyaf difrifol o anhwylder straen wedi trawma, sef y rheini sy'n cyflawni troseddau difrifol ac yn mynd i garchar o ganlyniad. Yr ydych yn dweud nad oes gwasanaeth i'r bobl hynny ac nad oes cydnabyddiaeth o'u bodolaeth fel mae pethau ar hyn o bryd. Wrth gynnal yr arolwg hwn o wasanaethau ar gyfer y sawl sydd ag anhwylder straen wedi trawma, yn naturiol yr ydym yn chwilio am argymhellion. A fyddech yn cytuno y dylai o leiaf un argymhelliad ddatgan bod y bobl yr ydych yn sôn amdanynt, sef y sawl sydd wedi cyflawni troseddau difrifol ac sy'n gyn-filwyr, yn haeddu cydnabyddiaeth yn y lle cyntaf, yn ogystal â gwasanaeth arbennig ar gyfer eu hanghenion hwy?

You have focused on the most serious aspect of post-traumatic stress disorder, namely those who commit serious crimes and consequently go to jail. You say that there are no services for those people and that, as things stand, there is no acknowledgement of their existence. In conducting this review of services for those who have post-traumatic stress disorder, we are of course looking for recommendations. Would you agree that at least one recommendation should state that the people who you are talking about, namely those who have committed serious crimes and who are former soldiers, deserve to be acknowledged in the first place, and deserve specific services for their needs?

[128] **Dr Jones:** Yn sicr. Os oes rhywun peryglus mewn cymdeithas, rhaid diogelu'r gymdeithas. Gallwch dosturio a gofidio ynglŷn â'r dyn, ond ni allwch ei ollwng yn rhydd i droseddu; rhaid ichi ddiogelu cymdeithas. Rhaid i'r llysoedd wybod y gellir gwneud rhywbeth real, a rhaid imi allu dangos a phrofi bod cyflwr yn cael ei drin. Ymysg y sawl a oedd wedi bod yn Nhŷ Gwyn, nid oedd bron neb yn mynd i helynt o bwys wedyn. Yr wyf yn adnabod llawer ohonynt, ac maent yn gyfeillion. Maent yn mynd â fi yn y car pan wyf eisiau mynd i rywle, ac maent yn ffonio neu'n anfon negeseuon testun yn gyson. Felly, mae cyswllt. Ar hyn o bryd, nid oes dim byd o gwbl ar eu cyfer, ac i garchar yr ânt. Mae llawer, pe byddem wedi gallu eu trin a'u tawelu cyn iddynt droseddu, na fyddent wedi cyflawni troseddau mor ddifrifol. Felly, byddem wedi atal rhai pethau.

Dr Jones: Certainly. If there is someone dangerous in society, society must be protected. You can pity that man and show concern, but you cannot set him free to commit crimes; you have to protect society. The courts need to know that something real can be done, and I have to show and prove that a condition is being treated. Of those who had been to Tŷ Gwyn, almost no-one got into serious trouble afterwards. I know many of them, and they are friends. When I need to get somewhere they will take me by car, they phone me and send text messages regularly. Therefore, there is a link. At the moment, there is nothing at all for them, and they will go to jail. Many of them, if we had been able to treat and calm them before they offended, would not have committed such serious crimes. So, we would have prevented some things from happening.

[129] Pe byddech yn argymell y dylid cael contract sy'n datgan y dylid cael chwe gwely, dyweder, ar gyfer y math hwn o waith yng Nghymru, ac y byddai hynny yn gynsail inni fynd at yr awdurdodau cyfatebol yn Lloegr ac yn yr Alban, fel y gwnaethom o'r blaen, gallem greu'r uned mewn misoedd. Bydd tystiolaeth yn dod ichi gan Tony White o CAIS, sy'n cynnwys copi o'r cynllun busnes

If you recommended that there should be a contract stating that there should be six beds, say, for this kind of work in Wales, and that would be a precedent with which we could go to the corresponding authorities in England and Scotland, as we did before, we could create the unit in a matter of months. Evidence is on its way to you from Tony White from CAIS, which includes a copy of

a osodwyd gerbron Llywodraeth y Cynulliad bedair blynedd yn ôl, ond ni aeth i unlle. Yr oedd popeth wedi cael ei drefnu, yr oedd yr adeilad yn barod, yr oedd Cymdeithas Tai Clwyd Alyn wedi neilltuo adeilad, ac, felly, yr oedd y cwbl ar gael. Gallech argymell yn awr y dylid derbyn y cynnig ar gyfer chwe gwely. Ni fyddai'r contract yn afresymol, gan na fyddai'n golygu llawer mwy na'r hyn a neilltuwyd yn ddiweddar ar gyfer y gwaith cymunedol yr oedd Jonathan yn ymwneud ag ef. Os gwnewch hynny, o fewn chwe mis, bydd CAIS wedi rhoi'r uned yn ei lle, a byddwn wedyn yn ceisio ehangu'r gwaith i rannau eraill o Brydain. I mi, pleser arbennig fyddai gweld ein bod ni yng Nghymru wedi canfod angen, wedi darparu ar gyfer yr angen hwnnw, a bod gennym rywbeth i'w gyfrannu, sy'n unigryw i Gymru. Dywedodd Dafydd Elis-Thomas hynny yn 1981, ac fe gewch chithau wneud yn awr.

the business plan that was laid before the Assembly Government four years ago, but it did not go anywhere. Everything had been worked out, the building was ready, Clwyd Alyn Housing Association had set aside a building, and so everything was available. You could recommend now that the proposal for six beds should be approved. The contract would not be unreasonable, because it would not entail much more than what was allocated recently for the community work that Jonathan was involved with. If you did that, within six months, CAIS will have put the unit in place, and we will then try to expand the work to other parts of Britain. For me, it would be a great pleasure to see that we in Wales had identified a need, made provision for that need, and had something to contribute that is unique to Wales. Dafydd Elis-Thomas said that in 1981, and you can do so now.

[130] **Darren Millar:** Thank you for the written and oral evidence that you have provided. It would be useful if you could provide a copy of the business plan to the committee.

[131] **Dr Jones:** If you, as the select committee, in effect, can put the pressure on and get the Government to say that it can happen.

[132] **Darren Millar:** As we gather the evidence from various sources, there are differences of opinion among the witnesses. However, it is clear from your evidence that an in-patient facility in Wales is an important part of the overall service. We have listened carefully to your evidence, and you made the case very powerfully.

[133] **Dr Jones:** It has existed, it has been proven, and it has been seen.

[134] **Darren Millar:** Diolch yn fawr iawn ichi.

Darren Millar: Thank you very much.

[135] We will continue with our inquiry into post-traumatic stress disorder. I am pleased to welcome Lisa Bainbridge, head of public policy at the Royal British Legion, which has already been referred to today by other witnesses. We are grateful that you have provided a paper to the committee, which has been circulated to Members. We will therefore go straight into questions because time is against us. You state in your written evidence that some published evidence suggests that PTSD in veterans is less common than is sometimes suggested. However, we have heard from the witnesses that have been before us that PTSD is probably under-reported. How can these different perceptions be explained?

[136] **Ms Bainbridge:** We have looked at different types of evidence, and we sometimes need to look at the sources of the evidence. I agree that there are differences between some of the wider population studies and the views of the clinicians who are dealing with mental health issues. A lot of the evidence has come from the King's Centre for Military Health Research, which is the biggest population study that we have of currently serving individuals. It is a longitudinal study, but it is also the first study of this type, and it is only associated with operations TELIC and Herrick, so the data are still quite young. A lot of the other data from clinicians, which show higher instances of PTSD, relate to former conflicts. The issues

around that are about late presentation, or even late onset, of PTSD, on which there has been some minor work, which is looking to be expanded. The information from Combat Stress and some of the pilot schemes, although those data have not been published yet, shows that higher levels of diagnoses of PTSD among people who are presenting with a mental health disorder tend to be from conflicts such as those in Northern Ireland, Kosovo or Bosnia. There seems to be a long delay in people presenting with a mental health condition, and PTSD in particular.

[137] One of the interesting commentaries emerging from the King's centre's work is that people tend to come back from deployments and have difficulty adjusting back to life in the UK, which tends to lead to many stress-related disorders, such as anxiety, alcohol misuse and related issues. However, in the main, those tend to die down. When we start to look at PTSD, it is about the more entrenched conditions that perhaps take longer for people to seek treatment for.

[138] **Ann Jones:** You emphasise in your written evidence the importance of early detection and treatment for those who may need clinical interventions. What actions are needed by the armed forces and mainstream health and support services to improve the record on early detection and treatment?

[139] **Ms Bainbridge:** As an organisation, we have been quite supportive of Dr Murrison's latest report, which has looked specifically at this issue, particularly at how we can identify people prior to discharge and follow up individuals post-discharge. Dr Murrison has come up with some sound ideas, particularly on pre-discharge screening. The committee will be aware that King's College has been given some funding from the United States of America to look at successful models of screening. Dr Murrison has also made an interesting proposal for the veterans' information service, which is looking to proactively ask people to opt into a data protection release, which will allow a follow-up 12 months post-discharge. We think that that allows enough time for someone to make adjustments to civilian life, such as settling back into work and home life. If problems are still occurring, they should perhaps seek treatment at that point and be signposted to the appropriate veterans' service.

[140] So, we are quite supportive of those kinds of ideas, but data protection is an issue for us as an organisation in the voluntary sector with regard to mental health services and identifying veterans who may be at risk.

[141] **Ann Jones:** Is there a need to include a note identifying veterans as such on their health records?

[142] **Ms Bainbridge:** The evidence that we have seen is that a lot of people within the forces tend to mask or hide a mental health condition, because of the stigma, because they think that it may affect their promotion, and for a variety of reasons. So, it is unlikely that a veteran would present at discharge as having a mental health condition. Screening might uncover some risks, but, even with the transfer of medical records, it is unlikely that there would be any evidence of a mental health condition that would be picked up by a GP without screening.

[143] **Ann Jones:** You mentioned looking at veterans 12 months after discharge. What happens to those veterans who present with post-traumatic stress disorder years later? We are talking about a considerable number of years later. You have talked about people coming forward with PTSD who served in Northern Ireland; the Troubles were some years back. How do we help them?

10.30 a.m.

[144] **Ms Bainbridge:** You have hit on the considerable problem there. Veterans are widely

dispersed throughout the UK, and after a significant period many of them tend not to identify themselves as veterans. It is hard to come into contact with them, unless they proactively tell their GP or a health professional that they have served in the armed forces. We are looking at a variety of things. Dr Murrison has suggested looking at online services such as Big White Wall, where people can proactively find information online. The King's Centre for Military Health Research is currently carrying out an evaluation of a US programme called Battle Back, where information is presented not only to veterans, but to their families. Perhaps that is one route that we can start to explore further: getting in contact with spouses and children of veterans, as they see the signs and symptoms of a PTSD condition at home and can seek treatment on behalf of the veteran, who may not proactively do that themselves because of the stigma associated with the condition.

[145] **Andrew R.T. Davies:** Thank you for your evidence this morning. In your written evidence, you highlight that many veterans do not make any contact with services that are provided to support them, particularly in the field of mental health. Ann Jones touched on the issue of noting on the medical records of servicemen and women that they have been in active service. What other, perhaps less intrusive, things could be done? Some people might resent military service being noted on their medical records. What other things could we be doing on a more voluntary basis? Are there examples of best practice in other countries that we could use?

[146] **Ms Bainbridge:** I served in the Australian armed forces, as did my father, and in Australia there is very much a link between service, healthcare and the department of defence. So, where a veteran has a recognised medical condition that is related to service, an identity card is used to access health and welfare services, and it has other benefits associated with it. Veterans in Australia quite like that, because it is not just related to their healthcare and compensation, but to other benefits of being a veteran and being part of that community. It is seen as a positive thing, rather than a card to show that you have a mental health condition. It is about veterans being part of a community. Those are the kind of things that we are trying to foster as an organisation, looking more to our membership and our grass roots to do more work in the community and more outreach work. One main issue with seeking treatment, particularly for mental health conditions, is not that there is a need for veteran-specific services, but that there is a need for them to be labelled as being for veterans and a need for there to be pathways to them through veteran-specific organisations. That would have a real impact on the issues around access and awareness.

[147] **Darren Millar:** Given the priority status that veterans have for NHS services—as we have heard today, they are the highest priority, following those who are in need of immediate, emergency treatment—do you think that raising awareness of that among veterans might encourage them to share the fact that they are a veteran when they present themselves before a GP?

[148] **Ms Bainbridge:** There are two aspects to that. Veterans are grateful for the priority access to or service from the NHS. However, when many veterans try to use that priority, people say that they do not know about priority treatment or that they will be seen according to clinical need. We tend to see more complaints than positive reports about priority treatment. I think that there is a lack of awareness within the health service about priority treatment for veterans and how it should operate. Clinical need will always come first, and when you have a system, particularly in mental health, that is under strain, and where services are not available, in practice, that starts to fall down slightly.

[149] **Andrew R.T. Davies:** I am led to believe that the priority only kicks in with regard to the medical condition that you were discharged from the armed services with; you do not get priority as a result of having served in the armed services. The evidence that we have heard is that some of the people who present with symptoms of PTSD left the armed services with no

medical problems. Those people are therefore not given priority, because you have to have been discharged on a military pension for a specified condition to be given priority.

[150] **Ms Bainbridge:** The priority treatment system as announced in the 1950s was related to war pensions, so it was related to the condition for which you were receiving compensation, which, by definition, is service related. In 2007, priority treatment criteria were changed to be for a condition that was related to service; you did not have to be in receipt of compensation for that condition. It is, therefore, for the primary clinician who is making the referral to the secondary service to make that judgment. If you present to your general practitioner with a mental health condition that you believe is related to your service, and your GP notes that on your referral, you should receive priority treatment for the condition. That provision was extended in Wales, England and Scotland in 2007.

[151] **Andrew R.T. Davies:** What type of support do the armed services as an organisation provide to families and veterans on civvy street? I raised this issue with a previous witness. There is a formal structure to train people to be an integral part of the armed services, but once people are discharged, there does not seem to be a formal structure that people can buy into. There may be individuals who have a passion for trying to develop that service, which is all well and good, but there is no formal structure for that. Is that right?

[152] **Ms Bainbridge:** The only formal structure that exists is through the Service Personnel and Veterans Agency. There are also in-service welfare services, such as the Army Welfare Service, which will continue to act as a support mechanism for a maximum of three to six months post service. It is very good at helping the family to deal with issues related to a mental health condition. Andrew Murrison's report, 'Fighting Fit', recommends that if someone is picked up as having a mental health condition prior to discharge, that person should have access to the department's community mental health service for a maximum of six months post service. The Service Personnel and Veterans Agency has a welfare service. It will tend to make a home visit and an assessment, and make a referral to other services, but there is no real service mechanism available other than the compensation scheme. There is an element of welfare, but that is probably at risk under the strategic defence review announced yesterday. With 25,000 civilian redundancies, I would expect that announcement to have an impact on the SPVA.

[153] **Darren Millar:** Recently, the UK Government announced a helpline service and said that more mental health nurses would be available for veterans with PTSD. What is your assessment of that announcement, and the impact that it will have on capacity in services?

[154] **Ms Bainbridge:** It certainly goes down the avenue that we, as an organisation, have been supporting. As an organisation, Combat Stress has, in the past, come in for a bit of criticism, because it has been delivering in-patient services only, through a two-week respite stay in one of its two centres. Over recent years, with the assistance of the Ministry of Defence, it has started to develop outreach services, many of which are connected to the six current mental health pilot schemes, and we have been supporting that model of outreach and the community psychiatric nurses financially. The announcement of a doubling of the number of psychiatric nurses is very welcome. As I was saying, labelling that type of outreach service as a veteran-specific pathway helps to deal with some of the issues of stigma that affect people coming forward for treatment, because it is then seen as a veteran's service and that this is an issue that affects veterans, so it is okay to have the condition. We see that labelling of veteran's services and pathways as a very positive thing.

[155] A trial of the helpline would be good, as I am not sure that the numbers of individuals who would be calling would mean that a 24-hour service would be sustainable.

[156] **Darren Millar:** Would it be better if it were open to families? As I understand it, it is

for ex-service personnel only at the moment.

[157] **Ms Bainbridge:** The inclusion of families is a trick that is being missed quite often. Families—particularly spouses—are normally the ones who will first approach a welfare organisation and to encourage husbands and wives to seek treatment if it is impacting on family life, particularly if they see someone acting differently. Many service spouses talk about a change in personality when their spouses come back from deployment. They behave differently, drink more and are more isolated, so they pick up those early signs, which are very important for early detection and treatment, as you mentioned earlier.

10.40 a.m.

[158] **Peter Black:** You say that the Increasing Access to Psychological Therapies programme should be fully developed in Wales. How has the programme helped veterans in England, and what do you believe that it could contribute in Wales?

[159] **Ms Bainbridge:** It is still in its infancy, but it has identified veterans as a specific group with specific needs. We have always tried to encourage embedding veterans' services within wider NHS programmes. That allows access to funding, commissioning and highlighting cases with clinicians. While many service organisations are able to deal with a number of clinicians and health services—both in England and Wales—it is difficult for small organisations to do so. So, embedding these services within the NHS and its programmes is a positive move. Even with the six mental health pilot schemes, we have seen that the treatment programmes do not differ largely, but veterans are much more comfortable with those services, and the funding streams give sustainability, allowing those services to continue.

[160] **Darren Millar:** I think that we have covered the next two issues. If Members have no further questions on those, we move on to Lorraine.

[161] **Lorraine Barrett:** You say in your evidence that mental health services need to be better integrated with other services, such as alcohol misuse and employment support, so that you can address the whole needs of veterans, and we have discussed that with other witnesses. How do services need to change to improve integration?

[162] **Ms Bainbridge:** There needs to be much more integration with the voluntary sector. Some of the mental health pilot schemes are using that model to adopt a multidisciplinary approach, particularly Veterans First Point in Scotland, which it has found quite successful. Scotland is having difficulty as it has grown very much too quickly, and it is now widening the service. Our colleagues at Combat Stress and my colleague here in Cardiff suggest asking voluntary organisations to step in to help the family with some of the welfare issues, such as housing, general welfare, and not having enough money for daily living. They can deal with those other stresses of daily life, allowing the veteran to concentrate on getting well and to seek treatment without the added stresses. Once those stresses pile up, the veterans tend to close down. So, we have found that that multidisciplinary approach has worked well.

[163] **Lorraine Barrett:** Is it the veterans themselves who approach the Royal British Legion? Some of us get various casework, but we do not automatically think of the legion—although I do, because I have one nearby. Do the statutory services think of you, or is it up to the veterans to come to you?

[164] **Ms Bainbridge:** Both, really. We take direct contacts. Our basic welfare services work on the premise that we send out a volunteer case worker who will meet the family in their home, discuss their issues and take down some information, and it is then referred back to one of our case managers, who refers it to our services or makes referrals to other services outside the organisation, particularly health services. We are working on trying to build

capacity among our volunteer case workers and raising awareness about the different types of mental health services available, including the reserves' mental health programme and the medical assessment programme in London. Veterans are aware of the services available to them.

[165] We have just been researching the extent to which other organisations realise what the legion does, and we have found that there is low awareness of the fact that the legion delivers welfare services. We know that we need to work on that. We are seen very much as an old veterans' club, with clubhouses where lots of drinking goes on. That is not an image of the organisation that we would like to portray, as it is not what we are about. We spend approximately £70 million per year on welfare services, and we probably deliver welfare services to 100,000 people a year. So, it is not a small operation, but we need to do more to link with clinicians and other welfare providers to look at how we can augment their services.

[166] **Val Lloyd:** You state in your written evidence that if you are to create effective mental health services for veterans, it is important that you have partnerships and networks of supporting expertise from a range of organisations. Could you help us by telling us how partnerships and networks should be developed in Wales, and what is the contribution of the armed forces network?

[167] **Ms Bainbridge:** On those things that we are trying to develop with the outreach programme, Combat Stress has a lot of expertise in mental health and it links in with clinicians in the NHS and is able to refer to those services. We believe that we can add things like general welfare support, as we can do home visits, but we also recognise our limitations. Many families need information about financial matters. In the past couple of years, we have taken up a partnership with Citizens Advice to deliver benefits and money advice services to our clients. It is those specialist services that cause a lot of stress for a family, such as access to social housing benefits, income and those kinds of issues. There is also alcohol abuse, and we know that there are limited services within the NHS for that. Combat Stress will generally not take a referral to its in-patient service if someone is still drinking heavily and does not have that under control. That is one of the main issues that we believe needs to be addressed through the pilot models. Many individuals use alcohol as a coping mechanism to deal with PTSD, for example, but a lot of treatment is not as successful if people are still drinking, and so that is the one gap in the service provision currently available. We believe that we can link to most things, but accessing alcohol-misuse treatment is an issue.

[168] **Val Lloyd:** In Wales, we have a hub-and-spoke model, which is in its infancy but it is developing. The hub is in Cardiff and the spokes are going out from there. As well as that, we are having a veterans' champion in each of our seven local health board areas. Do you think that that will address some of the issues that you have raised today?

[169] **Ms Bainbridge:** Yes. I have been to only a couple of the networks in England and not to any of the meetings here, but I think that my colleague in the Cardiff office has. I think that they are successful at sharing information across different agencies in the voluntary sector, the NHS and other welfare services, including social services. It is very much in its infancy, but the meetings that I have seen and the people whom I have spoken to that have been involved have all reported that they have learned a lot. They did not know that things were available, and they are now able to share best practice. It is a good model and we are slightly concerned that it may be lost with the loss of strategic health authorities. We are trying to promote it to become self-sustaining under the new models of the NHS.

[170] The spoke model that is being operated here looks like a good model. We are being a little cautious about the number of services that should be provided in particular areas, but that is simply because we have not seen the pilot evaluations as yet. The six different mental health pilots that have been operating have yet to report on which work best with these client

groups, and which numbers are being referred to each of these services. We would not like to have a large number of services set up to fail because the referral routes are not ready. If services are set up with these networks, with multiple routes of referral, they can be successful. However, awareness is still such an issue that if services are growing too fast, I fear that they may just fail, and we will be back to where we are now, sitting here trying to encourage Governments to provide services where we think that they are needed.

[171] **Val Lloyd:** What about the champions that are proposed? We have seven LHBs throughout Wales, geographically positioned.

[172] **Ms Bainbridge:** I have only really had experience with champions working in some of the new welfare pathway pilots set up by the Ministry of Defence. The first one was in Kent. The champion there was a member of Kent County Council. He had past military experience, and he has been successful. However, it has yet to evaluate, bringing different agencies to the table, ensuring that local unitary authorities, the NHS and primary care trusts are involved in those discussions. Without that kind of gravitas, it is sometimes difficult to make these things work. So, champions can be very useful to bring agencies to the table, and, as a voluntary sector organisation, we can sometimes have difficulty expressing the importance of these things. So, having that leadership will be important.

10.50 a.m.

[173] **David Lloyd:** Fel y gwyddoch, yr ydym yn ymchwilio i driniaeth ar gyfer anhwylder straen wedi trawma i gyn-filwyr y lluoedd arfog. Ar ddiwedd yr ymchwiliad, byddwn yn cyflwyno rhestr o argymhellion i'r Gweinidog. Pa brif argymhelliad yr hoffech ei weld yn rhan o'r rhestr?

David Lloyd: As you know, this inquiry is into the treatment of post-traumatic stress disorder among veterans of the armed forces. At the end of this inquiry, we will be presenting a list of recommendations to the Minister. What main recommendation would you like to see as part of that list?

[174] **Ms Bainbridge:** My recommendation would be that services that are dealing not only with PTSD but also with the other types of mental health conditions that veterans suffer from are important. We are in danger of PTSD becoming a generic term for veteran mental health issues, and we would be doing ourselves a disservice if that were to happen. All the services would then become targeted at PTSD, which is actually a minority problem. So, I would like to see a veterans' mental health service that is perhaps augmented with alcohol-related services, which would be really beneficial to this group of people.

[175] **Darren Millar:** On that note, with that recommendation, I thank you, Lisa, for your attendance at committee today. We have really appreciated it. You have been an excellent witness with the responses that you have given.

10.52 a.m.

Ymchwiliad i Wasanaethau Orthodontig: Casglu Tystiolaeth
Inquiry into Orthodontic Services: Evidence Gathering

[176] **Darren Millar:** We move swiftly on to the next item, and I am delighted to welcome Janet Robins, chief executive of the orthodontic national group, and Dr David Howells, who is an orthodontist from west Wales. We are grateful for the written evidence provided, which has already been circulated to committee members. So, we will go straight into questions on that written evidence.

[177] Janet, in the evidence provided by your organisation, you state that 14 trainee therapists recently completed a course in Wales, at Morriston Hospital, which achieved a 100

per cent pass rate. However, of those 14, you state that only four are known to be currently working in Wales. Why are we so poor at keeping people who trained in Wales in Wales?

[178] **Ms Robins:** There is quite a backlog of nurses waiting to train to be therapists. They have been waiting for this process to get through Parliament for it to be expanded and for funding to be found. So, there are many nurses waiting to get onto any places available. So, as Swansea was one of those centres, I guess that the places were filled by people from all around the country.

[179] **Darren Millar:** This is a problem because of the national shortage of courses, then, is it? The courses attract so many people that we are training people who do not necessarily stay in the country.

[180] **Ms Robins:** These are quite new courses. The first was only in 2007 and the course at Swansea began in 2009. So, as different courses get accredited by the General Dental Council, the spaces on them are being filled up by the great pile of nurses who are out there waiting to become therapists.

[181] **Darren Millar:** How important is the role of an orthodontic therapist? How has it developed throughout the profession?

[182] **Ms Robins:** It is an important new job that was created in the early 2000s. It releases clinicians for decision-making processes and treatment planning. So, in a funny sort of way, the therapists, once qualified, can do the routine jobs, thereby releasing the professional clinicians to do more of what they are trained to do.

[183] **Darren Millar:** So, it is a much more effective use of NHS resources.

[184] **Ms Robins:** Yes, but they must be supervised, so there must be a clinician on the premises. Just as an aside, therapists are not allowed to work anywhere in America without being supervised on the premises.

[185] **Darren Millar:** That is the case in Wales; they have to be supervised, do they not?

[186] **Ms Robins:** According to the General Dental Council, there should be a dentist on the premises and the British Orthodontic Society has said that it should be an orthodontist on the specialist register.

[187] **David Lloyd:** Mae gennyf gwestiwn am ddeintyddion â diddordeb arbennig mewn orthodonteg. Yn eich tystiolaeth chi, Dr Howells, yr ydych yn nodi nad yw gwasanaethau orthodontig mewn gofal sylfaenol yn gallu tyfu i ateb y galw. O gofio hynny, beth ydych yn credu y gellir ei wneud i sicrhau darpariaeth ddigonol o ran gofal yn y dyfodol?

David Lloyd: I have a question about dentists with a special interest in orthodontics. In your written evidence, Dr Howells, you say that orthodontic services in primary care are not able to grow to meet demand. Bearing that in mind, what do you think can be done to ensure that there is sufficient provision of care in the future?

[188] **Dr Howells:** The main problem with growth is funding. The infrastructure and the professional personnel are there. If we can expand our therapist workforce, there is no shortage of manpower. The new system that came in in 2006 effectively fossilised spending and budgets in orthodontics and, because of the cash flow under the old system, it took the budgets back by a couple of years. They were inadequate and that has not yet been recognised, certainly not in west Wales. Additional funding is undoubtedly required.

[189] **Andrew R.T. Davies:** Thank you very much for your written evidence and for giving oral evidence this morning. Can you give us an idea of the role that you believe general practitioners and dentists with a special interest in orthodontics should have in shaping the service going forward? Who would ultimately be best placed to monitor the skills mix within our local health boards so that you get a true reflection of what is going on?

[190] **Dr Howells:** I have no doubt of the value of specialist qualifications, and that is British Orthodontics Society policy. In an ideal world, orthodontics would be the remit of specialist teams led by people on the specialist register working to a ratio of four therapists to one orthodontist. The role of general practitioners in treatment is declining. Perhaps in some rural areas there would be a place for generalists working to the prescription of a specialist or a dentist with special interest, but, on average, that service would be provided in specialist centres.

[191] **Irene James:** As a committee, we have heard evidence that waiting lists for specialist practices can be up to three years in some parts of Wales. In your evidence, you suggest that waiting times in Carmarthen are even longer. What action is needed to address underprovision in the west?

[192] **Dr Howells:** The hold-up or logjam is the number of patients whom we have funding to treat. At the practice that I run in Carmarthen, we have seven years' worth of potential work on our books if you assume that the people on the list will follow the average ratio of those in need and eligible for treatment. It is something that has been allowed to build up, but we have been pointing it out since 2006. We need the funding to be able to get through the work.

[193] **Irene James:** Following on from that, do you agree with Abertawe Bro Morgannwg University Local Health Board that more effective referral management would help to improve patient access to orthodontic treatment and make better use of resources?

[194] **Dr Howells:** Hywel Dda Local Health Board has already introduced a referral management system, and we have not found it helpful at all. We have found no benefit to it. Referrals can be monitored, but duplicate referrals are still occurring. They are being passed on and there are administrators, but it would not be appropriate for them to redirect or filter those referrals. I cannot see any merit at all in the referral management centre. We need accurate reporting from the practices. When the referral management centre was introduced, we were told that it would not need statistics from our practice anymore, because it would be replaced by it. We were then criticised some 18 months later for not supplying statistics, but obviously we now provide them.

11.00 a.m.

[195] **Lorraine Barrett:** What is the best way to deal with inappropriate or duplicate referrals? We had quite a bit of evidence in the last committee about how many people may be on the waiting list who need not be. Is there a triage system? Would that work? The duplicates caused us some concern—how would they be managed?

[196] **Dr Howells:** A couple of waiting list initiatives have been funded over the past four years, and we have gone through patients on the waiting list. We found quite a low proportion ineligible for orthodontic care, and quite a few referred a little too early. As waiting lists lengthen, there is more incentive to refer early, and more likelihood of dentists referring to more than one centre. Indeed, patients change their dentists—they move where they will get referred. I do not think that a huge number of people on the several-thousand-long waiting list are duplicates. There is a really big need, and the waiting lists reflect that.

[197] **Lorraine Barrett:** Could I just pursue that? You say that you do not think that there are a huge number of duplicates; how can you be sure? Who would or should be overseeing all of that? Even if there is only a small number, at least they could be taken out, so that you would get a more accurate picture of what is needed.

[198] **Dr Howells:** When we send for patients, only a tiny proportion of those called do not arrive. I am assuming that there are not large numbers of duplicates, or they would perhaps have been taken off the list elsewhere. Unless we are funded to go through the list and audit it, we will not know who is out there—at least, not with the list of people waiting to be seen. We have large waiting lists for treatment, and those people have been seen, and assessed as being in need and eligible for NHS treatment. They are just waiting for treatment—for the funding to be available.

[199] **Darren Millar:** Irene, do you want to continue with the next question?

[200] **Irene James:** Are there grounds for the Welsh Assembly Government to fund a one-off initiative to address the backlog of patients waiting for orthodontic treatment?

[201] **Dr Howells:** Funding is desperately needed, and there is a big backlog that needs to be addressed. Of course, capacity cannot be increased very rapidly; we have three very good candidates who will be applying this year for the therapist course, and we have just one therapist who was successful in finding training in Wales, so far. We will be looking further afield, but that has expense implications—the course fees are about £10,000 for each individual, and if they undertake courses in England, then we will have to subsidise the residential element because it is something that they cannot afford to fund themselves. We will have to fund their subsistence and travel costs.

[202] **Darren Millar:** We have two issues here, do we not? There is dealing with the backlog, and then ensuring that the capacity is there to maintain the number of referrals that you are getting.

[203] **Dr Howells:** Dealing with the backlog needs quite an increase in capacity—which we can do. We can certainly do that.

[204] **Ann Jones:** Could I follow on from that? You said earlier that there had been waiting list initiatives and, although we thought that they cleared the backlog, you are saying that it was not cleared. So, if we were to give you another one-off initiative, how certain can we be that you would clear that? Might you clear that one, but allow another to build up during that process?

[205] **Dr Howells:** The backlog initiative did not fund treatment. It was a one-off and was paid at rather less than the rate for one unit of orthodontic activity—the standard examination fee for us to examine the patients, check their appropriateness, and check their treatment need. A few of them we referred on to the hospital service, and some we told, regretfully, that they were not eligible, so the NHS would not fund their treatment. However, the great majority have been added to treatment waiting lists that we have been working through. We have mainly been taking the older patients, as they are coming up to ineligibility for NHS orthodontics.

[206] **Lorraine Barrett:** We have already talked about orthodontic therapists, but we have had some evidence that, through good employment of orthodontic therapists, services should be able to treat more patients. However, one of the issues to have come through is that of clinical space, for them to have their own dental chairs. That is more easily done in hospitals or multi-chair practices. Taking all that into account, do you think that the work capacity of therapists is too limited in Wales?

[207] **Dr Howells:** Practices vary. In the two that I established in west Wales, we have four chairs. Again, we look to work with one clinician and three therapists at each of those premises. Other practices are not so well-off for infrastructure, but they will make a big difference. The number of patients that each specialist can treat will be increased greatly when we have an optimum complement of therapists working with us.

[208] **Lorraine Barrett:** Janet, do you have any thoughts or some other evidence on that point?

[209] **Ms Robins:** The Chair was concerned about the number of therapists and the fact that Welsh places had been taken up by English people. We have several more training centres coming online, and nationally, we are up to eight training centres. The number of therapists who could be trained if every place is filled is 90 annually. The pressure on Swansea will therefore be slightly less because of other centres opening.

[210] Of all the therapists who have qualified and gone into jobs, none has changed jobs; they have stayed with the person who has trained them.

[211] **Darren Millar:** That is because of training contracts, is it?

[212] **Ms Robins:** Not necessarily, it is just that they have enjoyed going through and working with the team. To be a therapist, you have to have a trainer, and the trainer and those trained form quite a strong team, and they are quite happy to carry on in that team.

[213] **Lorraine Barrett:** The nature of rural areas probably means having a smaller practice compared to those in cities or Valleys areas. How can the issue of smaller practices be resolved where you might not have the capacity to take on or to provide space for therapists to work properly?

[214] **Ms Robins:** If the therapists were to work in the multi-surgeries and larger practices, it might release some orthodontists to go to the smaller, single-chair or unsupervised practices. That might release them.

[215] **Dr Howells:** Perhaps I can answer that. Certainly in mid and west Wales, there is very little orthodontic availability outside the three specialist practices based in Carmarthenshire. We are seeing patients from as far afield as Corris, Borth, Machynlleth, Fishguard, St David's, and Milford Haven—they are travelling a long way to such specialist centres.

[216] **Darren Millar:** It is a long way. How do you see that being resolved, then? Do practices need to be established in some other areas?

[217] **Dr Howells:** There is a factor of scale, in that you need expensive radiographic equipment, infrastructure, training, nurses, specialist orthodontic nurses, as well as therapists. It is difficult to do that with a small and scattered population. I would be interested in exploring the possibility of satellite practices, perhaps part-time ones, but that would be an expensive way of doing it. Those premises would not be greatly used, so perhaps it could be done in underutilised community or hospital clinics. However, I cannot see anyone setting up a commercially viable specialist practice in a smaller centre.

[218] **Darren Millar:** This really is where having general practitioners skilled up to a certain skill level with orthodontics is important, is it not? Where you have dentists in those rural parts of mid and west Wales where significant distances have to be travelled to reach services, we need to be encouraging general practitioners to take an interest in orthodontics. It

is a cheaper way forward, is it not?

[219] **Dr Howells:** Well, in terms of cost effectiveness, a specialist team should have the advantage in terms of throughput and efficiency. Looking at outcome measures, perhaps it has advantages there, too. Over the past 20 years, there have been a lot of centrally funded schemes in Wales for practitioners to come into hospital departments. I have worked with quite a few in my hospital as part of my practice. That model seems to have gone out of favour, in that we are looking at specialist-led centres now. I do not think that there are any plans to fund clinical assistant posts for training any more.

11.10 a.m.

[220] **Andrew R.T. Davies:** May I quickly pick up on the point about rurality and the distances travelled? You talked about travelling some considerable distances to the centres that you have at the moment. That would not be uncommon around the rest of the United Kingdom, would it? Or is that specific to Wales? Obviously, rural areas are not specific to Wales: there is Cumbria, Cornwall, the highlands of Scotland, and so on. Is there a model that we should be looking at of this satellite-type operation that we are talking about? In reality, with the constraints on funding at the moment, it is not the best time in the world to start up such projects. However, is there a template that we could look at, instead of reinventing the wheel?

[221] **Dr Howells:** If we look back five years, the situation in Wales then was not as bad as it is now. There was a hospital department, with a visiting consultant in Aberystwyth. There was one in Haverfordwest, which closed finally just two weeks ago, although it had been winding down for a while. So, there were centres. Whether they come under the auspices of the hospital service, or whether they are perhaps under contract with specialist practice providers, there is scope to re-establish those treatment centres in Aberystwyth and Haverfordwest.

[222] **Helen Mary Jones:** This question is for you, Ms Robins. In your written evidence, you raise concerns about how therapists should be used, and you are very clear that they should not be working unsupervised. Do you have any evidence to suggest that orthodontic therapists are being asked to undertake work that is inappropriate and where they are not supervised properly? For example, are you aware of therapists being asked to treat patients when there is not a qualified practitioner present? Is there a concern that it might happen or is it already happening?

[223] **Ms Robins:** It is a concern, but the British Orthodontic Society has had cases of therapists coming to it to say that their clinician is going on holiday and wants them to see all of his patients while he is away. That involves a decision-making process, and they are not trained to make decisions on orthodontics. They literally work to written prescriptions that need to be reassessed at each visit because, in orthodontics, you can put a wire in and, within a month, something can change. So, quite often, at each visit, you need a clinical decision.

[224] **Helen Mary Jones:** Absolutely, but, without wishing to encourage you to breach confidentiality in any way, do you have a take on how widespread that situation is in Wales? Is it worse in some places than in others?

[225] **Ms Robins:** We have had nothing from Wales at all.

[226] **Helen Mary Jones:** It is only just starting.

[227] **Ms Robins:** You have only two working therapists in Wales. I hope that it will expand, but it is a new career pathway.

[228] **Helen Mary Jones:** So is that something that you would want us to make recommendations about to ensure that that does not happen as the therapist service grows?

[229] **Ms Robins:** Yes. The British Orthodontic Society's document on the supervision of therapists is quite comprehensive. The society has also been writing to insurance companies to ask what would happen if a patient made a complaint, because we are obviously all about patient care here. The insurance societies were saying that they would have to take gold standard advice from the British Orthodontic Society. So, no case has been brought as yet, but it would take the line that someone needs to be supervised or that there should be a dentist on the premises.

[230] **Ann Jones:** Currently, the unit of orthodontic activity value within the contract remains independent of the quality of the outcome. Do you agree that we should change that?

[231] **Dr Howells:** If there are robust measures of quality, that would be appropriate. There is a variation in the value of the UOA in Wales that is quite inexplicable. In some cases, different practitioners working in the same practice are working to different UOA values.

[232] **Darren Millar:** In the same premises?

[233] **Dr Howells:** Yes.

[234] **Darren Millar:** That is extraordinary.

[235] **Ann Jones:** Is anyone offering an explanation for that?

[236] **Dr Howells:** The whole system was a bit of a pig's ear, and how it was set up is a mystery to many of us.

[237] **Darren Millar:** I find that extraordinary. We were advised that one reason for the difference in the unit cost was premises costs. So, it might be more expensive in different premises. However, you are indicating that two people working in the same practice could have individual contracts with a different UOA.

[238] **Dr Howells:** That does not apply to the two practices that I run, because we elected to have an average between the two. However, the other practice in Carmarthen, for instance, did not elect to do that, and the different clinicians working there within the same premises have different unit of activity values.

[239] **Darren Millar:** That is astonishing.

[240] **Helen Mary Jones:** Without seeking to ask you to explain the clearly inexplicable, Dr Howells, is this to do with the new contract being based on what people were being paid before?

[241] **Dr Howells:** Yes.

[242] **Helen Mary Jones:** It is bonkers.

[243] **Darren Millar:** Yes, it is bonkers.

[244] **Ann Jones:** Do you have any view, Ms Robins, on whether the way that the units of activity value are calculated should be changed?

[245] **Ms Robins:** The UOA value should be the same whoever is doing the treatment, because whether it is done by a clinician or an orthodontic therapist, the same amount of work is being done. It is a swings-and-roundabouts situation. Sometimes one visit is more expensive than another, because x-rays are involved, for example, but, on the whole, it should be the same.

[246] **Darren Millar:** So, should there be a standard price across Wales? Is that what you are suggesting?

[247] **Ms Robins:** Yes.

[248] **Darren Millar:** If that recommendation is made, then some sort of transition arrangements will need to be put in place. Some people will be getting a much higher unit price and will therefore be used to that unit price, and will also have staffing levels that are perhaps different to other, more frugal practices, as it were. So, how would you make that transition, if that were to be suggested?

[249] **Dr Howells:** Most of the current contracts will expire either next year or the year after. Health boards are now trying to negotiate on price, which has implications for quality. However, I think that there will be moves to change pricing when the next round of contracts are negotiated, and I hope that it will be done in enough time to allow everyone to make appropriate provisions.

[250] **Val Lloyd:** I will stay on funding, but I will take a slightly different tack. You suggest, Dr Howells, that public money is wasted, as it is sometimes given to practices where little or no treatment is provided. In light of that, will a change in the way that orthodontics receives funding ensure that resources are distributed appropriately?

[251] **Dr Howells:** The practices that I was talking about were largely general practices, which, under the old contract, would quite frequently make an orthodontic assessment and be funded for that before referring the case onwards. There are several practices that are still making orthodontic assessments and then referring cases to a specialist, and therefore undertaking no treatment. It is hard to see value for the taxpayer in that arrangement.

[252] Perhaps contracts should be linked to treatment starts, which could be done by looking at the ratio of treatment starts to UOAs paid. When the pilot was originally done in Bedfordshire, it was estimated that it would be about three or four assessments to one treatment started. I looked up the figures and, in my practice, it is about 2.4:1, which is more efficient. However, in a practice that is not treating anyone and being paid UOAs, then the ratio is infinity. So, it is a completely different ratio.

[253] **Darren Millar:** Should there be a different unit price for an assessment and for a treatment?

[254] **Dr Howells:** Treatments are funded at a rate of 21, 24 or 4; it is a multiple of UOAs. So, that is the way that it works, which seemed sensible to those who were involved in setting it up. It is workable, but one would need to look at the ratio of assessments to treatment starts.

[255] **Peter Black:** When the Aneurin Bevan Local Health Board gave evidence to us, it suggested that paying orthodontics at the start of a patient's treatment is not a good use of resources, because if the patient does not complete the treatment, the money will already have been transferred and no saving could be made. I think that it suggested that payment should be made on completion of a treatment, rather than upfront.

11.20 a.m.

[256] **Dr Howells:** It is not quite true to say that payment is made at the start of treatment. Twenty-one or 24 units of orthodontic activity are accrued when you start a course of treatment, but that is part of the funding for that month's activity. The rest of the treatment is not funded. There is the assumption that you will go on and do your best. People will drop out of treatment: they move away, some patients do not stick to the course, and some treatments have to be completed in the interests of dental or periodontal health. I think that we need to be looking at the completion ratio and the quality of outcome, as Ms Jones suggested. However, that would need to be introduced gradually; it could not be done with some magic bullet. However, yes, it is a factor.

[257] **Darren Millar:** This will be our final question, I think, unless anyone else has a question. If you think that there is one particular problem in the service as it stands, what would you identify that particular problem to be, and what would be your solution to it?

[258] **Dr Howells:** As I suggested in the written evidence, the problem is the lack of funding. It is a fact that services in Wales were rather small. They were growing rapidly under the old system, but that growth was reversed. Therefore, I think that we just need to put the money in the system to provide the treatment that is needed.

[259] **Darren Millar:** Given the problem that you have articulated, in terms of a solution to that—obviously, finances are tight and the NHS will no doubt feel the pinch and is already beginning to feel the pinch—from where would you secure that funding if it was from within existing dental services in the NHS?

[260] **Dr Howells:** That is a very difficult question. One question that I asked at the Minister's working party on orthodontics was: why are we funding treatment for families who could afford to fund that treatment themselves? That was not something that it was felt appropriate to put on the table. However, if we want to look at providing treatment for all of those families who need orthodontic treatment, but cannot fund it themselves, perhaps we should look at a means-tested service for the whole of dentistry.

[261] **Darren Millar:** Now that you have lobbed that grenade, I think that we will call the meeting to a close. [*Laughter*.] Thank you both for your attendance today, and for the written and oral evidence that you have provided. You have been excellent witnesses and we have appreciated your attendance at our meeting. Thank you very much indeed.

[262] We have a few papers to vote, which have been circulated by the committee clerks. I will assume that those have been noted. I will now draw the meeting to a close. Our next meeting will be held on 3 November. Thank you.

Daeth y cyfarfod i ben am 11.23 a.m.
The meeting ended at 11.23 a.m.