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Chair

Mr. Greg Kerr

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● (0845)

[*English*]

The Chair (Mr. Greg Kerr (West Nova, CPC)): I call the committee to order.

As everybody knows, we're doing the comparison study on services and benefits offered to veterans by Canada and its allies. We're very pleased this morning to have Dave Rutter, head of armed forces and veterans' health with the Department of Health in Britain. I'm sure things are fine in London and the weather is perfect. We're glad to have you with us today.

Our process is that we'll ask you to give an opening statement, around 10 minutes or so, but it's your time call. Then the committee members will ask you some questions, and we'll all go home happy.

Are you ready for this?

Mr. Dave Rutter (Head, Armed Forces and Veterans' Health, Mental Health, Disability, Equality and Offender Health, Department of Health, Government of the United Kingdom): Absolutely fine.

The Chair: The committee is prepared, so then we'll ask Mr. Rutter to begin his presentation.

Please go ahead.

Mr. Dave Rutter: I'll just say I'm Dave Rutter, sir. I head the armed forces and veterans' health team here in the Department of Health. I lead a very small team here, but we work very closely with NHS England with regard to delivering the programs and services that we provide.

It's important to note that this is England and not the U.K. Health is devolved within the U.K., so the Scots, Irish, and Welsh would have their own NHS health provision. I apologize if you're already aware of that, but I thought I'd better make it clear that when I speak of the programs that we run, they're predominantly for veterans' families and armed forces in England. Bearing that in mind, of course, with veterans of the military we work obviously with MOD —the Ministry of Defence—which has a U.K.-wide footprint and beyond. Veterans, when they leave the armed forces, will go back to their homes anywhere within the U.K. So we have to work very closely with our colleagues in the devolved administrations and we do so.

Just by way of context, and again apologies in advance if you are familiar with this, the Ministry of Defence here in the U.K. have health responsibility for the primary health care of those servicing, including dentistry, across the U.K. They do in some instances have primary health care responsibility for some families that are registered with their GPs. This tends to be in the very large bases or where they're in outlying areas. For veterans within NHS England, within U.K. as well more generally, the health care is the responsibility of the NHS administration. So within NHS England, we have responsibility for around about 4.5 million veterans, and our program is also designed to help their families as well where appropriate.

My responsibility here within the Department of Health is to take forward the government policies determined by our ministers, working very closely with NHS England, which was just set up quite recently, the first of April this year, with a responsibility for delivering armed forces health. But we also work very closely with service charities as well. You may be familiar with Help for Heroes, Royal British Legion, and others. We have a program designed to just go beyond the statutory services, if I can put it that way.

There are three key areas of work for us, which I'm very happy to answer questions around. One is around the continuity of health care for those who have been seriously injured or wounded during their time in the armed forces. The second key area is the mental health care of veterans, and the third area is the physical care of veterans, particularly those who have lost a limb as a result of their service.

I should say at the outset, although l know a lot about those programs and the wider areas of veterans and family health care, I'm not an expert in relation to the detailed compensation payments, etc., but certainly familiar with the way in which they are applied across the board within the NHS. I mentioned that we work closely with service charities. This is key in delivery. We have a small budget to deliver against these programs. I'm happy to go into that as well on request.

Actually, I think that probably concludes my opening remarks. I'm very happy to start taking questions from you.

● (0850)

The Chair: Thank you very much, Mr. Rutter. You may be setting a bad precedent by being so brief. We're not used to people being brief like that. We appreciate that.

Mr. Dave Rutter: I was briefed to be brief.

Some hon. members: Oh, oh!

The Chair: We appreciate that very much.

In our system, as you know, we have multiple parties. We're going to go to the official opposition with Ms. Mathyssen first for five minutes.

Ms. Irene Mathyssen (London—Fanshawe, NDP): Thank you very much, Mr. Chair, and thank you very much, Mr. Rutter. We appreciate you taking time to tell us about how you look after your service personnel in Great Britain, particularly in England. Of course veterans are our primary concern.

You talked about there being a continuity of care for service personnel and their families. Does this extend to veterans? For example, once someone who's been injured leaves the service, can they expect that they will continue to receive care?

Mr. Dave Rutter: Absolutely. You'll be familiar with the way in which health care is provided here in the UK, which is obviously free at points of need. One of the things we identified some years ago —four or five years ago when I came into this work—was the difficulty of those who had been seriously injured being discharged from the armed forces and then facing what's been described as a cliff edge in relation to care. That level of care would dip until such time as the NHS and other services of course help with the needs of that individual.

We approach this challenge through welcoming the Ministry of Defence to create a seriously injured leaders protocol. So this puts an onus on the Ministry of Defence working within their own system—their own clinicians, welfare staff, social care staff, etc.—to engage at a much earlier time with the NHS. Rather than leaving it to almost the very end of that person's time within the armed forces, we would expect them to be in contact up to six months in advance of departure, making contact with the statutory services in the area where this person will live, ensuring that the clinical handover is fully understood and any challenges that go with that particular individual—health care challenges with that individual—are seen in advance so that they can be addressed before departure, along with the welfare and living requirements of that individual. They may need adaptations to their home, for example, depending on their injuries.

So we aim for that to be as seamless as possible. The measure of success of that is hard to gauge. With some of these things, you gauge it on the basis of not receiving complaints, difficulties, or issues being raised by individuals. We receive some—and we're talking single figures where there have been difficulties—but the protocol has been designed in such a way that where these do arise, there are contact mechanisms in place to ensure that those are dealt with as soon as possible.

● (0855)

Ms. Irene Mathyssen: Thank you.

If a veteran leaves the forces and there are situations in regard to that individual's health that crop up 10 or 15 years later, does that veteran have a standard of proof that he or she does indeed have injuries or health problems related to their time in the forces? Do you have a protocol whereby the veterans have to demonstrate that they need specialized help from your department?

Mr. Dave Rutter: There's no protocol in answer to that part of the question. The requirement for those who will be in receipt of armed forces compensation or war pension...then they can certainly make reference to that in accessing the health services. That will particularly help them access some of the services we put in place specifically for veterans. But we're very trusting over here, and if somebody presents to—particularly one of our veteran's mental health teams—and says that they're a veteran, then they will be dealt with as a veteran.

Clearly if there is a problem and that continues, the professionals who are dealing with that individual will learn whether indeed that person is a veteran. But for those with very specialized needs, it's safe to say that more than likely, they'll be receiving armed forces compensation or a war pension scheme. That's the reference point, if you like.

The Chair: Thank you very much, Mr. Rutter.

We now go to the government for five minutes, to Mr. Lobb, who has been up all night practising for his questions. He's just ready to go.

Mr. Ben Lobb (Huron—Bruce, CPC): Thank you, Mr. Chair, and thank you for that endorsement.

The first question I have this morning for Mr. Rutter is on the topic of mental health services.

I know that's under your mandate, and I wondered if you could give us an idea of how that has evolved in the last number of years and what the situation is today. Is it deemed to be a success or a work-in-progress at this point?

Mr. Dave Rutter: We have taken the work in relation to veterans' mental health quite some way over the last two years, or over the last four years, actually. But it's only over the last two that there has been real progress made. Any veteran will of course have access to the National Health Service mental health services in any event. They will have immediate access to that.

As for what we've done, Dr. Murrison, MP, produced a report in October 2010 called “Fighting Fit”. It's publicly available. It can just be googled.

The report made a number of recommendations around veterans' mental health, including such things as an online mental health provision, which we do in partnership with Big White Wall, and the creation of veterans' mental health teams around England. We've put in place 10 veterans' mental health teams around England. We've also put in an e-learning package for GPs, so that when somebody presents in front of them, they have that to refer to. We have a 24-hour helpline that we've put in place in partnership with Combat Stress, one of the leading veterans' mental health charities here.

We're in the process of producing something called the veterans information service. This will be a process whereby folk who have discharged from the armed forces will be contacted a year or so after discharge by e-mail, and by letter if needs be. Basically, they will just be asked how they are and whether they need help with certain mental health problems, but also with other issues, such as housing, welfare, benefits, etc.

We're working in collaboration with the Royal British Legion here to provide a one-stop shop to help with those problems. Obviously, depending on their problem, they may go on to statutory services or charity services.

We've also created the National Veterans' Mental Health Network, which brings together the devolved administrations of Wales, Scotland, and Northern Ireland, and also brings in the service charities and the statutory services. The idea there is to bring together the learning as we're presenting these programs, and to bring the best of those programs together. We're now at the stage where we're looking beyond 2014 and 2015, if you like, to see how we actually embed these services into the NHS.

So have they been successful or a work in progress? Both. I think it's an 80:20 situation. We still have more to go.

● (0900)

Mr. Ben Lobb: Could you elaborate on the 10 mental health teams you have? I guess that was throughout England, or was it throughout the entire U.K.?

Mr. Dave Rutter: This is throughout England. I have a small amount of funding, which works out to £1.5 million per year to fund these 10 teams. It doesn't go too far once you split it down to 10 teams, but we gain the critical mass, if you like, within those teams by working very closely with Combat Stress, the charity. You have NHS clinicians and professionals working in partnership with Combat Stress, who are also routing veterans directly to them.

There are 10 teams around the country. They've applied their programming in slightly different ways in each area to reflect their own populations. The northwest, for example, and the northeast have very high veteran populations, so they design their service in a slightly different way to some of the teams down in the southeast, in the Kent and Surrey areas.

So they're different, but the teams together create local links with veterans' organizations and make themselves known. People can refer themselves to each of those services, or they can be referred through GPs or other sources.

Mr. Ben Lobb: Okay.

From the time a veteran comes forward to discuss an issue to the time he or she would see a specialist or see a doctor and start to receive care, what kind of timeframe is that? I know it's pretty vague because there can be a multitude of different issues, but is that something you measure? Where are you with that right now?

Mr. Dave Rutter: We're in very early stages. The last of the teams came into being at the back end of last year and early this year, so it's a bit of a rolling program getting those up to speed. Early indications are that veterans are able to access care faster than they would through other National Health Service avenues. They will see a clinician within the first week or two of being referred, depending on the need, and certainly within six weeks.

The Chair: Thank you very much.

Mr. Dave Rutter: It is very vague because it's still quite early days for that part of the program.

The Chair: Thank you, Mr. Rutter.

We'll now go to the Liberal Party and Mr. Casey, for five minutes please.

Mr. Sean Casey (Charlottetown, Lib.): Mr. Rutter, I want to start with a bit of a broader question. I noticed that your department's Service Personnel & Veterans Agency is actually part of the Ministry of Defence, which is unique among the countries we're studying because Australia, United States, and Canada each have a stand-alone department. I am also aware there was a bit of a merger done back in 2007 that gave rise to the structure that you have.

Can you offer any comment on the benefits or the challenges to being a part of the Ministry of Defence as opposed to being a stand-alone department?

Mr. Dave Rutter: I would suggest that's probably more for the Ministry of Defence than the Service Personnel & Veterans Agency to answer, as the Service Personnel & Veterans Agency, or SPVA, is part of the MOD rather than the department I work for, the Department of Health. Certainly, as a government department that has to have a close working relationship with the Ministry of Defence, I also have a close working relationship with the SPVA.

It does provide challenges because you're like an essential government arm of the organization, which is the Ministry of Defence, then you have a service delivery arm, the SPVA, who are providing advice to individual veterans on welfare and other issues. I know that others have commented on this within the U.K. and have suggested, for example, there might be a veterans' champion elsewhere within government, perhaps a cabinet office or elsewhere. It's not for me to comment on that, but I would say that the SPVA are well regarded and I know work very well with the service charities and others in delivering their services.

I suppose in some ways you might argue, perhaps, there's some similarity in the way in which we have the Department of Health, here in Whitehall, working through ministers, then you have a separate organization, which is NHS England, actually providing the health services for the population.

● (0905)

Mr. Sean Casey: In this country one of the biggest issues we hear about from veterans' groups is this whole idea of a lump-sum payment versus an ongoing pension allowance. I notice that in your country the lump-sum payment was doubled from £285,000 to £570,000—about $900,000 Canadian—back in 2008. Can you tell us the reason for the original lump sum? What was the rationale for it, and what was the discussion and debate around the increase?

Why was it at the level it was and why was it increased?

Mr. Dave Rutter: I'm afraid I'm unable to answer that question. I don't wish to be unhelpful, but the detail around armed forces compensation payment is very much a Ministry of Defence issue and they would have consulted at that time, so I'm not in a position to comment on the reasons behind the increase. I would suggest one of the reasons why they looked at it again would have been the increased operations internationally through the Gulf War, Iraq, Afghanistan, etc.

Mr. Sean Casey: Still on the subject of compensation, I know that you had a 2010 review of your compensation scheme. There has been a suggestion that promotions in service be factored into the amount of compensation that a veteran receives, such that, if they start from a certain level and you assume that over the course of their military career they would have been promoted but for their injury, that assumption is factored into their compensation. I know that was one of the recommendations.

Can you tell me whether it has been implemented?

Mr. Dave Rutter: I'm unable to answer that question. I would need to refer to the Ministry of Defence; my apologies.

Mr. Sean Casey: Not at all; you explained up front that you have a particular specialty. There are just some areas that I need to learn about in order to better do the comparison.

Let me try one final one, if I may.

Your ministry, your department, serves about 900,000 veterans, if my research is correct. Your total budget is just under $20 billion. That would be about six times the budget in Canada and for four times the number of clients. Can you break down the most expensive elements of that $19 billion of spending on the program?

Mr. Dave Rutter: I'm not sure what you base those figures on. Within the Department of Health, as I explained, National Health Service England have a responsibility for about 4.5 million veterans in total. Obviously there are fewer, fortunately, who are seriously injured or have mental health problems, so the number of those is that much smaller.

Mr. Sean Casey: My numbers came from the SPVA corporate plans for 2009 to 2012. The figures I have are 900,000 clients, 190,000 of whom are war pensioners.

Mr. Dave Rutter: Those figures would be for the Service Personnel & Veterans Agency as part of the MOD, as an agency providing those services. They also provide pension services and advice to veterans. I can only guess that this is where that expenditure comes from.

Veterans and veterans' health are provided for within the NHS services more generally. I have a specific budget for the programs that I have been running here, of approximately £8 million for mental health and approximately £15 million for physical health, prosthetics, and other care.

The SPVA is a separate agency within the MOD, so the numbers that you quote are absolutely right. But this would include the pensions arm of the agency, as well as all the requirements around compensation, etc.

● (0910)

The Chair: Thank you very much, Mr. Rutter.

Now we have Mr. Lizon for five minutes, please.

Mr. Wladyslaw Lizon (Mississauga East—Cooksville, CPC): Thank you very much, Mr. Chair.

Good day, Mr. Rutter.

I have a few questions, first with regard to funeral and burial services. Here, we provide funding for veterans under the funeral and burial program, and for some eligible veterans there is full coverage. The recent budget, the economic action plan 2013, doubled the amount of financial support for veterans and their families from previous amounts.

What does the U.K. provide for veterans with respect to funerals and burials? The follow-up question would be, if you do provide support, what is covered under the program?

Mr. Dave Rutter: As far as I'm aware, we do not provide any financial assistance for those other expenditures. Your minister met with ours, I think about 18 months back, and this was one of the issues raised. That wider expenditure for provision for veterans, which I know you provide in Canada, is not replicated here. When a veteran or a veteran's family are in particular need, they would normally, if it's not a statutory provision for all, often look to the services provided by the service charities—the Royal British Legion, Help for Heroes, SSAFA, and others.

Mr. Wladyslaw Lizon: Thank you very much. That was quick.

We have here a program for veterans, the veterans independence program, which is designed and focused on providing home and health support to allow veterans to stay at home if they wish. We have improved this program by moving to a grant format, where upfront payments are provided.

Does the U.K. system focus on keeping veterans in their homes as they seek to maintain their independence?

Mr. Dave Rutter: That's certainly the aim across the population, where we look to ensure, wherever possible, people are able to stay at home and receive care at home. With veterans, there's an element where veterans will perhaps use some of their compensation as part of that care at home. The vast majority will be through the statutory authorities. I mentioned earlier on about that protocol to ensure that when people move out of the armed forces and back home that their care needs are properly met. That would be part of that process.

There will be other benefits, etc., available to veterans, but there would be benefits that are available to the wider population as well—disability payments, etc. That is about as much detail as I know on the actual payments.

Yes, there is encouragement that some older veterans will make use of some of the shelter homes. These are again made available by the service charities that we work with—so, again, the Royal British Legion and others—to provide a certain amount of housing stock for older veterans or veterans who are in particular need.

Mr. Wladyslaw Lizon: If I understand correctly, there's no specific program that would be focused on providing services for those veterans who want to stay home, like providing cleaning services, lawn cutting, or snow removal, if necessary.

Mr. Dave Rutter: No, there's no specific service in that respect, just the wider services that would normally be made available to the public.

Mr. Wladyslaw Lizon: How much time do I have?

● (0915)

The Chair: You have about 30 seconds.

Mr. Wladyslaw Lizon: That's okay. Thank you, Mr. Chair.

The Chair: Thank you very much, Mr. Rutter.

We now go back to the opposition. We have Mr. Stoffer for five minutes, please.

Mr. Peter Stoffer (Sackville—Eastern Shore, NDP): Thank you, Mr. Rutter.

I should start off, sir, that I'm a Tottenham Hotspur fan. Which is your football team?

Mr. Dave Rutter: Nobody's perfect, sir.

Voices: Oh, oh!

Mr. Peter Stoffer: Ouch, ouch.

Mr. Dave Rutter: Shall I leave now?

Mr. Peter Stoffer: Sir, I'm not sure if you're able to comment on this fact. When veterans here have a dispute with the government over a pensionable benefit, whether it's a certain percentage of the benefit they receive, or they don't receive anything at all, and they're appealing these decisions, are you able to discuss the appeal process of a veteran with the department in England in that regard. How does it work?

Mr. Dave Rutter: My understanding of this, again, is slightly without my immediate range of experience. My understanding is that where there is a dispute, as you describe, they can take that up with the Service Personnel & Veterans Agency.

Also there are pension boards—I may not have the correct terminology there. I know that within areas they have local boards that will help and discuss pension issues. The individual would be able to take up help and advice from one of the service charities to present their case to those boards. I think it's the Ministry of Defence SPVA process that allows people to access appeals in that way.

Mr. Peter Stoffer: Thank you.

Sir, one of the debates going on in Canada is the issue of mental health concerns, not just within the military and veteran community but also in the general population. One thing we have in Canada is a shortage—it's unfortunate but it's the reality—of mental health providers, psychologists, psychiatrists. Do you suffer the same concern in England? If you do, how do veterans achieve the help they require in order to obtain the counselling they deserve?

Mr. Dave Rutter: Yes, we have similar challenges over the numbers, with regard to mental health. There are a number of programs that are being run in the wider sphere of mental health care, including the IAPT, or improving access to psychological therapies program. A number of initiatives have been taken forward for the wider population.

With regard to veterans, partly because of the military ethos, the culture, and the type of individual likely to be within the armed forces, we realized we had a smaller, hard-to-reach group, which might be reluctant to admit to a mental health problem, and even harder still, to take steps to deal with it.

The report by Dr. Murrison that I mentioned earlier picked up on that theme and looking to recommend initiatives that would help encourage those individuals to come forward to access the mental health services that already exist. The 10 teams that I referred to earlier are very much geared toward providing that encouragement, and also to raising public awareness of veterans' mental health issues. They are able to signpost people to the services that we have more promptly than has previously been the case.

Mr. Peter Stoffer: Are those services also provided for the spouse and children of the veteran?

Mr. Dave Rutter: There is a mixed community there. The teams that I mentioned earlier have set themselves up in a slightly different ways. There are some teams that have recognized the impact of mental health problems on veterans' families, and they give their services not just to the veteran but also to the wider family unit.

We are in the process of undertaking another project, with an organization called Mental Health First Aid. This is to train people who will train others in mental health first aid within the armed forces community. So they can help identify those who may be displaying signs of mental health problems. They can give initial advice, and they will be able to signpost them in and refer them to the right level of care. That's a new program that we hope to launch later this year.

Mr. Peter Stoffer: That's very kind of you. Thank you so much.

● (0920)

The Chair: Thank you, Mr. Stoffer.

We'll now turn to Mr. Zimmer, and I hope we won't get into a British football conversation.

Mr. Bob Zimmer (Prince George—Peace River, CPC): I just watched Canada play Fiji last night, and we won, so it was a good night for Canada. We won last night 22 to 18.

Thanks, Dave, for coming.

I have a question for you about OSI clinics. You referred to teams, but we have what are called Operational Stress Injury Clinics here in Canada, and we operate 17 of those. They basically deal with what you'd imagine—with psychologists, social workers, and mental health issues.

Does the U.K. operate similar clinics, and what is your opinion of the model?

Mr. Dave Rutter: Is the model you describe for veterans or for serving personnel?

Mr. Bob Zimmer: Actually, it's for veterans.

Mr. Dave Rutter: The nearest we would have to it would be the teams I've described to you. From your description it sounds as if there may be some similarities to what we're trying to do here in the UK—bringing together the clinicians and the wider carers within that community who may be able to help.

It's often the case that the cause of the mental health problem may not be combat-related. It may be related to housing, employment, or life-changing problems. So although that person is a veteran, their mental health may be the result of another problem. Having people within the teams who can recognize that and then plug into the appropriate support and advice agencies is very important.

I'm not sure whether that's what your teams do. Ours are still fairly new. I think at the moment they're still getting the clinical expertise up to speed. They're getting the veterans in and through the system. The challenge for us is how we embed that and grow the service toward 2015 and beyond, particularly with the drawdown from Afghanistan.

Mr. Bob Zimmer: My next question is on case management. We have a system that assists former veterans and members of the RCMP and their families; they find it difficult to transition into normal life afterwards. I wondered if you had a case management system that helps a veteran along, through those steps.

It's very similar, I guess, to what you had mentioned with the teams. For me, it's just hard to understand where the mental health part is. Maybe it's just different language but the same thing.

Mr. Dave Rutter: Yes. There are several stages to this.

There is the work that the Ministry of Defence will do with the individual as they are coming to discharge from the armed forces. There will be a lead-up to that discharge, which will help them with re-skilling, if appropriate. Certainly if they have been injured there are the recovery centres, and lots of other training goes on that will help with that transition back into civilian life. It's not necessarily with a mental health focus but with a life skills focus, if I could put it that way.

With the mental health piece, that's a component of it, if you like. The evidence suggests that most are leaving the services fit and well, with not too high an instance of mental health problems. Mental health problems would appear to come forward a year, two years, three years or longer after the discharge from the services.

Mr. Bob Zimmer: Maybe you could just expand on that a little bit. We too have an employment initiative, called Helmets to Hardhats, that helps transition a veteran to a job. It sounds like that's part of your program as well, or that's what I heard there.

Do you have a similar system to ours? Or how would you define it? What would you call it?

Mr. Dave Rutter: We do have a similar system to that. As part of that transition process from the services back to civilian life, the Ministry of Defence does work with an organization called Remploy. They work with other agencies as well so that veterans can be placed into employment upon departure.

Now, that's obviously not appropriate for all who are leaving, but clearly for those who are in need, or perhaps who need some additional help, they will be identified and taken through that system.

That's very much a Ministry of Defence process that they get taken through.

● (0925)

Mr. Bob Zimmer: Dave, does that help with the skills component too? Let's say I was a veteran leaving the service and I needed to be trained as a carpenter or as a computer technician or something like that. Would the U.K. provide for that as well?

Mr. Dave Rutter: Yes, the Ministry of Defence is part of that discharge process. It depends on the individual length of service, and on which part of the armed forces they are in, etc., but as a general rule, they will look to help re-skill, retrain, and inform that individual of that process. I know anecdotally from somebody who has recently left the services that they took some time to really re-skill in relation to IT, etc.

So yes, those are available.

Mr. Bob Zimmer: Thanks for your time, Dave.

The Chair: Thank you very much.

Mr. O'Toole, you have five minutes, please.

Mr. Erin O'Toole (Durham, CPC): Thank you, Mr. Chair.

Thank you very much, Mr. Rutter, for meeting with us and sharing the perspective from England and the U.K.

I have a couple of questions, one related specifically to a statement you made in relation to the service charities. I loved your phrase "beyond the statutory services". I was involved in creating here in Canada sort of the equivalent to Help for Heroes, called the True Patriot Love Foundation.

My question for you is this. In that service charity space, we have noticed that it's very difficult sometimes for these well-intentioned and disparate groups across the country—some large, some small—to coordinate and prioritize needs so there is not overlap and it's not more complicated to work with NHS or government equivalents.

How has the experience been in the U.K.? You're saying that it's critical to provide that added level of service excellence to our veterans, but how do you coordinate the groups and government?

Mr. Dave Rutter: With great difficulty. I met with colleagues from True Patriot Love a year or so back and they asked a very similar question at that stage. It is difficult. Within the U.K. I think there are over 2,000 service charities. Some are very small, local; others very large—Help for Heroes, Royal British Legion, Combat Stress, etc.

One of the programs that we have run over the last three years is a strategic partnership program, where we have funded a group of service charities, the larger ones—so that's Royal British Legion, Combat Stress—but also with SSAFA, Help for Heroes, and one or two others. The idea of part of that program is creating an opportunity for central government, from the department and the Ministry of Defence, to have open, honest discussions with the service charities. We're all trying to achieve the same thing, we just may attack it a slightly different way. So we all know our starting point in that respect, but we also use that relationship for them to, if you like, cascade and take the views of the other agencies and the other charities out there.

Now I've stood on many a platform at conferences, etc., with service charities and have made the point that this whole system works best when you have the statutory and the service charities working like that. I don't think you can see my hands, but working very closely together, and not overlapping because that's a waste of resource. I've certainly said publicly that one of the challenges for the service charities is, wherever possible, to avoid that overlap.

That overlap does happen. It is inevitable. There are—and this isn't a criticism—a number of very small service charities that have been set up to provide a service, to provide, again, a particular need that they see locally, and that's to be supported. I think the more that they can start to work with some of the bigger charities, or recognize what the other charities are doing and complement them, the better. I think the important thing—I think this is an early stage and the service charities recognize that as well.

We have something over here called COBSEO, the Confederation of Service Charities. That's an umbrella body that has been created to help bring together the service charities as one. I think we have some way to go before we can really start to get them to move in a far more coordinated way. That will always be a challenge. But as I say, what we have achieved, I would suggest, over the last four or five years is a transparency and honesty with the service charities so that we can have a very good conversation about what we can do, and more importantly, what we can't do. Then we work with those services charities to say, “We can take it to this level; what is it that you can bring to the game to add to that?” So it's not replicating statutory services, because that's wrong, that's what the statutory services are there for and we must provide it. It's what is it in relation to veterans and their families we can do that will provide that added value? I think this where the programs, where we worked with Big White Wall, Combat Stress, Royal British Legion, have brought that added value—for a very small budget, I would suggest.

● (0930)

Mr. Erin O'Toole: That's very helpful.

Very quickly, then, you explained the NHS structure of rehab under the heading of injured veterans, loss of limb...you broke down the categories. Is the rehabilitation for veterans who have lost a limb done through NHS in the regular system alongside everyone else, or does NHS break out specific rehab for veterans?

Mr. Dave Rutter: We are just in the process. I mentioned Dr. Murrison. He produced another report, this time on those who lost a limb in service. Dr. Murrison, I should point out, is now a minister in the Ministry of Defence. He wasn't at the time he produced the reports.

He identified the need for a service within the NHS that would be able to address the particular needs of veterans. You may be aware that for those who are injured in service, the Ministry of Defence provides an excellent service through Headley Court rehabilitation services. They provide high-tech, high-spec limbs as appropriate to these individuals. So the question was raised as to what happens when they go into the NHS, because the NHS was not providing to that level for the wider population.

We've identified what I think is a relatively small budget but certainly one that will more than meet the needs of veterans who have been injured. The numbers are relatively low. It's £15 million over a period of three and a half or four years. With that money, apart from the cost of the kit, the hardware that's needed, we're upscaling nine centres across England. Roughly speaking, there are three in the north, three across the midlands, and three across the south. There will be some extra financing going in from there so they can provide not only, as I said, the high-spec limbs the veterans need but also the other rehab requirements that go with those.

I should add very quickly of course that the NHS here does not want to run a two-tier service. We're very conscious of that and that does create challenges when we're creating something different for veterans.

So although we've put this extra money in for veterans who have lost a limb, the wider objective of this of course is to bring the skills and the knowledge of the clinicians and so on, within the NHS up so that the wider limbless community within England will also benefit from what we're trying to do. But certainly the needs of those individual veterans are being met and will be met in the future as they discharge from the services.

The Chair: Thank you very much, Mr. Rutter.

That's the end of round one. As we go to round two, the four-minute round, we'll start with Ms. Perreault from the opposition, please.

[*Translation*]

Ms. Manon Perreault (Montcalm, NDP): Thank you, Mr. Chair.

Hello, Mr. Rutter. It is nice to speak to you this morning.

With your permission, I would like to come back quickly to the transition from military life to civilian life.

I know that, in order to help veterans to move away from homelessness, you have taken several initiatives, through your Single Persons Accommodation Centre for the Ex Services, which help veterans to find a home. Am I mistaken? It boils down to finding them a home during their transition back to civilian life.

Does this program really reduce homelessness among veterans?

● (0935)

[*English*]

Mr. Dave Rutter: I'm not familiar with that specific program you refer to. Certainly in my discussions with the Ministry of Defence in relation to that transition piece, that's not been raised as a specific issue or problem for them. The vast majority of those leaving will have homes to go back to.

The issue, where it is raised or where I have come across it, is in relation to those who have already left the armed forces, who would have had a home, but then subsequently lost it, possibly because of mental health problems, possibly because of drinking or other behaviour problems, and who would have become homeless a short while or sometime after leaving the services.

I'm not familiar with any programs to provide specific housing for those who are leaving the services per se.

[*Translation*]

Ms. Manon Perreault: The Galleries Project is another project designed to help people who are most likely to become homeless, isn't that so?

[*English*]

Mr. Dave Rutter: That's not a project I'm familiar with. I think that must be a Ministry of Defence project not immediately linked to the health provision we provide here to veterans. I'm unsighted on that, I'm afraid.

[*Translation*]

Ms. Manon Perreault: That's fine.

Since I have some time left, I would like to speak about a new project designed to secure expertise within the veterans health system. Here in Canada, veterans are covered by the public system, but the federal government has decided to transfer the responsibility for the last veterans hospital to the province where it is located, of course. We are concerned that this expertise will be lost.

Can you tell us how you ensure that veterans caregivers, in your system, really have an expertise focused exclusively on veterans needs?

[*English*]

Mr. Dave Rutter: That's certainly an issue that has been ongoing since I came into this post five years or so back. I think there's a mixture in response to that, because clearly, a veteran's problem can be a problem that's experienced by anybody. It's not necessarily a veteran's problem, if I can put it that way.

There will be some issues around culture and maybe some specific issues around a veteran as a result of their service, whether that actually may be a physical or a mental injury. Within the NHS what we have done is we created, as part of our program, a series of armed forces networks within each of the 10 regions, again. These armed forces networks were led by local health authorities, and the networks brought together veterans. They brought together, more importantly, people within the health service who were also veterans themselves—many move on to new careers, etc—as well as reservists who work within the health services.

It was an opportunity to identify people who were within the system, who were veterans themselves or had a familiarity with the armed forces, and who were very willing and very keen to bring their skills and their knowledge to those networks.

Of course, by bringing that group of people together, it was a great way of informing other professionals and clinicians, particularly at that stage when we were creating the mental health teams. But also, with the other work that we've been doing more widely, it was a great way to actually inform and signpost and do those other things you would expect a network to do. That's on one level.

If you're also asking around the clinical skills and the social care skills in relation to veterans, again, it moves across to that. The number of reservists, NHS reservists, at one stage who were in Afghanistan, in Bastion, I think it was somewhere around 48% to 50% of the U.K. force out there. Again, it's the learning and the knowledge they take from their reservists' work within combat, within serving in Afghanistan, and their wide reservist experiences, that they are taking back into their own NHS hospitals, their trusts, their own medical environments, and obviously, that moves across to their colleagues as well.

● (0940)

The Chair: Thank you very much.

We are over quite a bit.

Mr. Stoffer had a quick comment, and then I'm going to add the time to you, Mr. Hayes, at the end.

Mr. Peter Stoffer: Sir, I wanted to say, because we'll be concluding soon, perhaps you could give Pippa Middleton my very best, if you don't mind.

Thank you.

Mr. Dave Rutter: I'm sorry, I didn't quite catch that.

Mr. Peter Stoffer: Perhaps you could say hello to Pippa Middleton for me, if you don't mind. Thanks.

Mr. Dave Rutter: Okay. I'll bump into her down the road.

The Chair: If only you could pronounce her name correctly, you might do a little better on the international stage.

Voices: Oh, oh!

The Chair: Anyway, thank you very much.

Mr. Hayes will have the last slot. As I said, we'll extend the time a bit to allow for this.

If you would, Mr. Hayes, please.

Mr. Bryan Hayes (Sault Ste. Marie, CPC): Thank you, Mr. Chair.

Hi, Dave. Good afternoon.

Mr. Dave Rutter: Hello.

Mr. Bryan Hayes: I want to speak a little bit about the appeal process that's available to veterans. In Canada we have an arm's-length, independent tribunal to appeal decisions made by Veterans Affairs Canada. Does the U.K. have a similar tribunal for appeal?

Mr. Dave Rutter: Not that I'm aware of.... I'm loath to go into detail in that area because that's really the Ministry of Defence and SPVA's role. I wouldn't like to misinform you on that. I do apologize.

Mr. Bryan Hayes: No, that's fair enough, but I'm going to keep on the same line of questions because maybe the next one you might have an answer to.

Mr. Dave Rutter: That's absolutely fine.

Mr. Bryan Hayes: In Canada, free legal representation is provided by our government through the Bureau of Pensions Advocates. Are you aware of what type of legal assistance is provided to U.K. veterans, and whether or not it's free of charge?

Mr. Dave Rutter: U.K. citizens, generally, are able to access legal aid here, which is free. Also, veterans, certainly if they have a pension appeal process to go through, will have been informed by the SPVA that they are able to receive assistance, legal and other, from the Royal British Legion, which I know provides that sort of assistance to individuals. That part is not statutory. It's part of the service charity function and the Royal British Legion continues to do that. They would help represent that individual in appeal cases.

Mr. Bryan Hayes: Thank you.

You mentioned that one year after a veteran retires, they're contacted either by email or by phone simply to see how they're doing. I want to speak a little bit in terms of what services you might have available online for veterans, online programs and websites. What we have in Canada is fairly extensive, but I don't know where the U.K. is in terms of online services and whether veterans can go online and see everything that's available to them—all the associated costs and all the associated processes.

Mr. Dave Rutter: Certainly, that's where we're heading with the Royal British Legion, as part of the service that I described. At the moment, we're in a bit of a hybrid situation in which they're being informed, and in effect, emailed a letter that will signpost them to some of those key agencies: SPVA, Royal British Legion, statutory services, and others. The objective going forward...the Royal British Legion are redesigning their services so they will have an online one-stop shop for veteran services, where they can advise or refer to other services as appropriate. That would go down to the level of a Royal British Legion welfare officer visiting that individual in their home, if that's what's needed.

We also have the online mental health service, which is the big Whitehall service I referred to earlier on. We have commissioned that. We fund that. It allows veterans, their families, and those who are serving, to access that site where they can talk with others from that community, receive online one-to-one mental health counselling, etc. That's the other arm of that service we've been developing.

Mr. Bryan Hayes: Thank you.

I'll stop there, Mr. Chair. I do have another question.

The Chair: Okay. Go ahead.

Mr. Bryan Hayes: Here is my final question. You've been doing this for five years now, so I anticipate you're making a lot of changes. It seems like there's a lot of transitional things happening. Have you assessed what other countries are doing in terms of providing things to veterans? Specifically, have you had a good look at what Canada is doing? If you have, what one thing would you want to incorporate in the U.K. that Canada does very well?

● (0945)

Mr. Dave Rutter: I'm unable to answer that. I have spoken to some Canadian colleagues over the past year, but I've not had the opportunity to really look at and understand what Canada or the U.S. A and other colleagues are delivering. It's not a matter of not wanting to, because with the team we've had here and the changes we've been putting through, we've had our hard hats on to think.

I think one of the challenges that we.... It doesn't stop us from looking, because I think there is always something to learn from colleagues, but the way in which health is delivered here is, perhaps, different to.... You know, the starting point in the way in which health services are delivered within the U.K. is quite different from how they're delivered elsewhere.

Mr. Bryan Hayes: Thank you kindly. I appreciate your time.

The Chair: Thank you very much.

Mr. Rutter, that concludes our questions. We very much appreciate the time you took today to enlighten us and share the information. We wish you all the best with your future endeavours and I know the good cooperation will continue in the future, so thank you from all on the committee.

Mr. Dave Rutter: Thank you very much. My apologies to those who had questions that I wasn't able to answer at this point in time.

The Chair: That's okay. Thank you.

We'll suspend for a couple of minutes. We're going to come back in camera to do some business, so those not associated with the committee, I'd ask if they wouldn't mind departing.

We'll resume in about two minutes. Thank you.

[*Proceedings continue in camera*]