Transcript of talk given to HQ DMS on the evening to celebrate the foundation of Defence Primary Healthcare, 2nd October 2023.

Thank you very much, and it is always good to see my own responsible officer appearing here, unfortunately in video rather than in the audience.

Thank you very much for asking me to come along this evening and talk about DPHC. When we talk about Defence Primary Healthcare and how it was set up, I think we should not talk about an event but rather a process. And that process, I believe actually begins with Sir Henry Yellowlees. Now, I'm sure there are some people in the audience here who will remember Sir Henry Yellowlees. He had an interesting medical career. He joined medicine late, but before he went into medicine, between 1941 and 1945 he was a pilot in the RAF and a pilot instructor. He qualified in medicine in 1950, he went into public health and he rose rapidly and became Chief Medical Officer, United Kingdom, in the days before devolution. So he was a direct predecessor of Sir Chris Whitty. And I mentioned him because when he retired from the Department of Health in 1982, he was taken on by MOD for one year. Paid employment to write a report on future top structures of the medical services in defence. And over that year, he looked at it, produced his report. And out of that report came the nascent Surgeon General and an enhanced Defence Medical Services. He recommended the removal of the three, three star posts within the single services. But he set in train tri-service working which has continued onwards to this day.

The next major step, and again I am biassed as with DPHC, but I am also biassed on this one, was the Falklands War. And I mentioned that because the Falklands War, I believe, and most people believe, was a huge success militarily, but it was a huge success medically as well. But it was an operation run by the Royal Navy, very much with the Army and Air Force assisting and helping the Royal Navy. And when that was reviewed afterwards, it was determined that, although it had worked in a very limited construct in the Falklands, it was not the best way forward.

And as a result of the post war review, PJHQ was set up with Tri Service Operational Healthcare falling out of that. PJHQ has had a number of different iterations and changes and improvements, but it did well in the Gulf War, the subsequent wars in the Gulf and has remained ever since.

The first bit of tri-service primary healthcare, perhaps surprisingly, was the dentists. And they set up the Defence Dental Agency. That then morphed into the Defence Dental Services. Now I will not go into the details about the legal situation and the financial situation of an agency versus a service. But the dentists were set up in Halton and when the service was set up as the agency it had a two star headquarters in Halton. That went down to one star and finally became a 1 star DDS headquarters, based in Coltman House. And from then it got absorbed into Defence Primary Healthcare. So thank you very much for the dentists. They led. But as part of the tri service process I mentioned the use of the agency. And that was the first time an agency was used in MOD healthcare.

The next major one was hugely important and great in scope. And huge, both in terms of size of population, in terms of cost and huge in terms of complexity. And I'm talking about Germany. And when the new arrangements for Germany were started in 1995 the

population had slimmed down considerably from when I was first there. So the first time I was in Germany, out in Hohne in 1976, there were 400,000 people in Germany, but it had slimmed down considerably from that number. But in 1995 when we started on the Germany project we had to do primary healthcare, community care and of course the hospital side. And I remember going down to the offices of PA Consulting in London, who were our advisors in setting up The Health Alliance, later BFGHS.

On the secondary healthcare side, which I'll start off initially, we used to have five army hospitals in Germany. Berlin had closed and the others were closing, leaving Rinteln. West of the Rhine was Wegberg, an RAF hospital, and both Wegberg and Rinteln are commemorated in Coltman House to this day. So we, or the Army and RAF Germany, delivered Secondary Healthcare through our own hospitals. But it was determined in the mid-90s that that was not the best arrangement and The Health Alliance should assume responsibility. And at that time it was coming towards the end of the government phase of market testing. It was determined that it would not be set up as an agency of MOD, but rather be contracted out. And when I say contracted out, I'm talking in terms of secondary healthcare being contracted out and primary and community care being contracted out as well, but on a separate contract. The secondary healthcare side was to run by GST, the then Guys and St Thomas's Trust. But they didn't deliver actual health care. They commissioned healthcare through 5 designated German provider hospitals, which were German hospitals in the main areas of northern Germany where we were based. And that was a very complicated contract and set of subcontracts to those German hospitals. They also provided hospital care elsewhere in Germany and in the corridor between Antwerp, the ports and towards Germany and the Rhine.

One of the things that was discussed a lot was medico-legal indemnity and some people here may remember the seminal case of baby A. Born in Rinteln, with parents stationed in Hameln. And there are huge differences in the quantum of legal damages between the UK system and the German system. The family sued MOD, wishing to sue in UK rather than Germany. But the family of baby A lost their case. They appealed it. It went to the UK High Court and the Court of Appeal where it was heard by the Master of the Rolls. MOD won its case. And MOD won on the strength of the contract, and the SOR that was written for Germany. It just drives the importance of accuracy in prior documentation.

On the primary and community side the contractor who won was SSAFA, a charity with a very large and expanding commercial arm. And they wanted to deliver primary healthcare services and community services mostly with their own staff apart from the general practitioner side. The GPs were to be provided mostly by uniformed army and civil servants already working for the army. But SSAFA produced nursing staff and community staff and together we formed an alliance, so the “A” in THA was alliance, not agency.

And the alliance was run not by either of the contractors, but it was headed up and run by a one star UK civil servant recruited specifically for the job. THA was set up in Wegberg in the old hospital, while in the Big House in Rheindahlen was the Healthcare Commission, again headed up at that stage by a one star civil servant, and set up to monitor THA. The Big House housed BFG headquarters, HQ RAF Germany, and Headquarters NORTHAG.

The Health Commission and HQ BFG monitored THA, but THA was unstable. It was always an unstable construct on the command side, while it successfully delivered healthcare on the ground. Secondary healthcare worked very well. Primary healthcare, and again, I am

biassed, but I believe also worked well. But as regards to the command side, it floundered. Because working in an alliance, how do you actually do it? The first director of THA was sacked for financial impropriety and I was in Bielefeld when he fell. The second director wasn't sacked but left just before the 52 week point and I was actively involved in his demise.

And at the time it was then realised that The Health Alliance was unstable, was actually ungovernable, and change was required. So BFGHS was established as a service. Again to be run by a MOD civilian one star. The Health Commission was disbanded, was broken down, with a small team led by a uniformed OF5. With these changes, BFGHS continued to deliver until final subjugation into DPHC fairly recently, albeit with a number of different contracts, basically with the same providers but a progressively smaller population.

The next change was a big one and the formation of the Army Primary Health Care Service. I had left Germany at that stage and was posted to Wilton, the Army Headquarters, or UKLF to be precise, and I was working for ACOS Pers. I was the lead person on the UKLF HQ side running with the setup of Army Primary Healthcare Service. A separate team under the then Adjutant General was set up to develop and implement the service. It was led by a one star uniformed non-medical officer. And one of the key things that we did, myself from Wilton and the implementation team, was to try and get the documentation correct. And I remember spending ages, effectively locked in by ACOS Pers at night, until the two sides had agreed the wording of all agreements.

There were agreements on funding, but also for line management and command structures, plus the reporting structures; hugely difficult issues that remain to this day. But having said that, much of the documentation was carried forward into DPHC. So APHS was set up with a decision very early on that there was not going to be an agency, that it was not going to be by contract. Rather that it would be Army delivered, with an Army one star uniformed lead, staffed with army uniformed personnel together with MOD civilians.

Also with APHCS we set up the regional construct. Now the regional construct for APHS was modelled on BFGHS. And when we set up BFGHS, we set up regions with regional clinical directors at OF4 and operations managers. We carried that forward into DPHC, but because of the populations, areas and size, with OF5 uniformed RCDs, civilian operations managers and area managers. To the command and clinical side we added plans and civilian secretariat and finance.

At the same time, there was the setting up of another agency and some people will remember DMETA and DMTO. They looked after or delivered secondary healthcare through the MDHUs, but also many aspects of medical training and postgraduate training. And they set up with a two star headquarters in Gosport. It delivered training in Gosport, then in Keogh Barracks in Mytchett, some temporary accommodation in Birmingham, and finally up here in Lichfield. And this development? £138 million, cutting the turf in September 2011, finally bringing training up here onto the one site.

The other developments were lead service for mental health, less the inpatient contract, and lead service for rehabilitation, less the then Headley Court. These services would be pushed together and delivered on a lead service basis, with mental health delivery going to the Army to be run by Army Primary Healthcare Service. Community rehabilitation was to be run by the Royal Air Force. The Navy lost out when these responsibilities were allocated.

Now spanning all this, and a hugely important part of primary healthcare development, was computerisation. And without computerisation the whole concept of setting up DPHC would have been almost impossible. And you cannot overstate the importance of it. Now if you go back to the mid-90s, the NHS were leading on computerisation and MOD was falling behind. The RAF then started having a bit of a lead. And certain people in the Army thought, yeah, we want to be computerised. And Army Medical Directorate, who were not running primary healthcare at that time of course, because that was run by the Army and Army Medical Directorate was really an advisory body. AMD was sort of talking about computers but was going nowhere. I was posted in as SMO in Tidworth and I wanted Tidworth to be computerised and I wanted Tidworth to be at least on par with the RAF.

But I also got involved in a research project and a research organisation that had quite a large pot of money. And an organisation that was outwith the DMS, but within MOD, and they wanted medical information. And so, in conjunction with this research project and the Garrison Commander, I computerised Tidworth with EMIS. This was paid for by the research project. Army Medical Directorate then asked how it had happened and how we had also got Catterick computerised on EMIS at the same time on the back of the same project.

I then got posted from Tidworth to Sandhurst. And of course, that practise was not computerised. But I just could not cope without computerisation. Additionally, the Academy, as with many of the training organisations at that time, was having huge problems with injuries and prevention of injuries in training. And so with the Commandant, we agreed that we would buy another computer system. But interestingly, the IT staff of the Academy refused to have EMIS on site because of the perceived security implications and software, things which perhaps sort of continue to this day, and it was agreed that the Academy would buy a Meditel system. Now at that time the two main primary healthcare delivery systems were Meditel and EMIS, so I had put EMIS into one, Meditel into another, and Army Medical Directorate got even more upset. But it worked, and we got data and another paper published. But AMD and the other single service medical branches realised that having anarchic lieutenant colonels putting computer systems randomly into medical centres on different budgets and different systems was probably not the best way forward, and they have a point. And so they decided that they would work with the DMS, and there would be a pan DMS computer system. And EMIS was bought centrally by the DMS and put into the medical centres. Success.

Headquarters DMS in London then almost had a sort of fit of the vapours and decided that, based upon their fantastic success, they would do something even better. And so they brought in SGIS, Surgeon General's Information Strategy. It wasn't just a computerisation of medical records, it was also HR and other functions for the DMS, including staff and planning. But the span was far too big, going way beyond a clinical system, and with areas replicating other MOD systems. I remember going down to the Metropole Building in London, on stage, presenting to industry on what we wanted industry to do for us to deliver SGIS. However, shortly after doing that presentation, it was canned.

And the thing coming out of that canning was something that most people have probably heard of: DMICP. Now I could talk all night about DMICP, but I will not.

One of the worst jobs I ever had in uniform was being invited to go down to Corsham to mark and grade the two shortlisted bidders. Logica as was, before they were taken over by the

Canadians, and IBM. And I and a few others had a large list of questions and we had to answer the questions and mark IBM and Logica's bids. And their bids at that stage were produced in paper format, each in five lever arch files and I had somehow to produce answers to these questions, by thumbing through five lever arch files of computer speak. It was not an easy task, but please don't blame me if you don't like what was chosen. However, DMICP did come. It was delivered.

DMICP came in and it drove primary healthcare delivery, medical and dental. And whether it was policy from single service medical directorates and headquarters DMS, or whether it was the fact that people had to use a single NHS compatible system designed for the NHS and therefore had to work to that system is an academic question. But I suspect it was probably more of the latter than the former. But what happened was that the three single services had to work together in the same manner. And you cannot overestimate the importance of DMICP coming in before Defence Primary Healthcare.

So I will put it to you that, perhaps inadvertently, the DMS found itself in a remarkably good position. We had the dentists tri-service based in Coltman House. We had lead service mental health. We had lead service rehabilitation. We had a unified computerisation that everybody was using. We had experience of agency working. We had experience of BFGHS. And also we had Army Primary Healthcare Service. And Army Primary Healthcare Service brought in a headquarters that had functioned well for 10 years, from 2003 to 2013. It had the regional headquarters and their proven construct, but it also had the regional headquarters' infrastructure owned by the tri-service DIO. And then of course the medical centres and the dental centres the dentists used. And of course it had the training element being built here in DMS Whittington.

When we actually come to Defence Primary Healthcare, I believe we need to think of it not as an event, but more as a process. And that process started with the Levene report that many here will remember. Levene looked at the structures of Defence and as part of the report recommended setting up JFC, Joint Forces Command, now StratCom, a new 4 Star command. And into JFC would go PJHQ as we discussed before, the Defence Academy and intelligence. And medical. So medical would be moved out of MOD Head Office under the tutelage of the Vice Chief to being under the command of a new JFC 4 star headquarters. Once that was agreed, the COS(I), Chief of Staffs Informal, gave orders that Defence Primary Healthcare would be set up. They laid down certain parameters including that it would be led by a 2 star uniformed commander, that it was to deliver improved healthcare for patients, and also that it was to be cost saving. And they laid down the cost savings of £8,000,000 in year zero to four, to £31,000,000 in years zero to 10.

The three single service medical branches produced individual teams. I had already come up here to Coltman House from APHCS. As Deputy IG, and with my background of helping to set up Germany and full involvement in setting up APHCS, I was involved on the Surgeon General side. The decision was made early that it would be MOD delivered, with MOD uniformed and civilian staff, backed up by temporary health care workers. So not an agency, and not by contract. Much of the paperwork from before, especially Army Primary Healthcare Service, was brought in. And all the work we did down in Wilton proved invaluable. There was quite a lot of bad practise, I have to say. Not on the single service command headquarters, but from the some of the single service medical headquarters. There was one single service medical headquarters I well remember that was insisting on

over 200 key performance indicators. That's an oxymoron if ever there was one, and they also admitted that they could see no possible manner in which the demands for their performance indicators could even be measured. Eventually, they realised that and accepted that and backed down and we had something more sensible. So, after much discussion it was agreed DPHC would be set up with a pilot region which would start on the 1 Apr 13. To achieve that, the first people to be posted into Defence Primary Healthcare were posted in on 2 Jan 13 and four people arrived. Myself, with a squadron leader, a naval warrant officer and a civilian. And from these four people setting up in Tamar Block, we incorporated a huge amount of documentation. We worked tirelessly on the financial side trying to get the UINs in order, trying to get the reporting chain in order. Writing all this documentation so we could go live in in a region on the 1st of April. We chose the south region of APHCS, a geographically small compact area with a good mix of operational units and training units. It had easy access for all the single service medical headquarters and on the 1st of April 13, a small team arrived in Aldershot, setting up in the Army Primary Healthcare Headquarters regional headquarters.

It had a naval OF5 to lead and that worked from day one. A report was meant to have been written and published, but it was never properly published because there are so many ongoing developments. We had a conference down at Shrivenham which was very well attended. We delivered road shows up and down the country and then we were intended to take over the various other regions in UK during the next couple of years. But it proved impossible, not surprisingly, for the single services to maintain primary healthcare in their own single service headquarters, plus provide the staff for DPHC Headquarters and the regional headquarters. And there was a danger that the single service headquarters, in particular the Army and the Navy, would collapse. And so the decision was made that in autumn 2013 DPHC would take over all UK regions. That happened, and it succeeded. In the following year, we took over the reserves, the dentists and the overseas team.

The overseas team was initially set up in Coltman House, a small team and because of the financial constraints and headcount cap, we couldn't have everybody we wanted. The overseas team expanded later into their lovely building in DMS Whittington but physically separated from Coltman House. We delivered, and we delivered on quality. I fully accept it is exceptionally difficult to measure primary healthcare outputs and quality, especially when you're looking at GP and primary healthcare services as well as the occupational outputs. But Def Stats were monitoring healthcare criteria and of the 10 QOF criteria that they were measuring DPHC delivered and indeed improved.

DPHC was also agile enough that during covid it absorbed a huge amount of change, a large amount of extra computerisation and IT, but it delivered flexibly and it has continued to deliver ever since.

Today we welcomed our current Chief Medical Officer. Unfortunately, he could not be here physically, but it was great to see and hear his presentation. Forty years ago we invited his direct predecessor into the Services to make recommendations on how we should deliver healthcare. If Sir Henry had been able to come here today, and if he had he would have been 103, I personally believe he would be quietly satisfied with what he saw.

DPHC delivered, and on time and it delivered an improved quality of service.

To finish, I would like to thank our staff. Not the people here, although you deserve thanks. But you have had thanks already. But the people who very rarely, or never, come to DMS Whittington. And by those people, I'm talking about our contract cleaners, our receptionists, our managers, our regional staff and of course our clinicians, civilian and military. Without them, we could not have delivered to our patients and it is patients to whom DPHC delivered care.

Thank you.