Veterans’ Health Needs Assessment
Southampton, 2012
Version 1.0

ACKNOWLEDGMENTS
With particular thanks to Public Health Department, NHS Hampshire for use of their Veterans’ Health Needs Assessment as key reference. Thanks also to colleagues at NHS Portsmouth for their help in adapting the needs assessment. More information about sources referred to in this document can be found in their Needs Assessment. Actions which can be taken by NHS Southampton, NHS Hampshire, NHS Isle of Wight and NHS Portsmouth working together are identified as SHIP actions.

1 EXECUTIVE SUMMARY

1.1 Introduction

In recent years, there has been a national focus on the health and well-being of serving members of the Armed Forces, their families and of veterans. The UK Government has promoted the need to recognise the sacrifice made by the country’s Armed Forces personnel and has emphasised the importance of considering this population and their specific health and health-related needs when commissioning services.

During their time in Service, serving personnel are provided with healthcare from the Defence Medical Services. On discharge, however, this responsibility returns to the NHS, with veterans eligible for the same full range of local NHS services as the general population.

A veteran is defined as:

“anyone who has served for at least one day in the Armed Forces (Regular or Reserve), as well as Merchant Navy seafarers and fishermen who have served in a vessel that was operated to facilitate military operations by the Armed Forces.” (p3).1

Understanding the characteristics of the veteran population and their specific needs is crucial for ensuring local services are commissioned to adequately meet these needs.

1.2 Aims and objectives

1 Identify and quantify the size of the veteran population within Southampton

2 Describe the characteristics of Southampton’s veteran population

3 Assess the health needs of the local veteran population and identify important differences with those identified at a national level

4 Identify local services currently available for the veteran community

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5 Make recommendations for future service development within NHS Southampton and partner organisations to meet the needs highlighted by the report

1.3 Methods

National data was supplemented with local sources of data where available to estimate the size of the veteran population. Research conducted at the national level and any local evidence was collated to identify the main health and health-related needs of veterans and are documented in this report.

1.4 Results and conclusions

Most veterans are reported to view their time in the Services as a positive experience and do not suffer adverse health effects as a result of the time they have Served. However, for a minority, adverse physical and mental health outcomes can be substantial and can be compounded by other factors – such as financial and welfare problems.

Key health issues facing the veteran population relate to common mental health problems and excess alcohol consumption. In addition, time in the Services was noted to be associated with musculoskeletal disorders for some veterans.

Stigma plays an important adverse role in veterans’ access of healthcare services, together with perceptions of levels of understanding of Forces' cultures amongst civilian healthcare staff.

The main limitation of this needs assessment was the lack of quantitative data available about the veteran population, both nationally and most notably locally. As a result, it is extremely challenging to establish a robust estimate of the size of Southampton’s veteran population which is crucial for commissioners in planning services.

1.5 Recommendations

Most recommendations made in this report (and NHS Hampshire’s) relate to improvements in the collection of data about the veteran population, as well as the provision of information for healthcare professionals and veterans themselves.

1 Promote the development of an NHS Southampton Military and Veterans plan

In NHS Hampshire a working group has been established (including representatives from Public Health, Primary Care Commissioning, Mental Health and the Information Team) to ensure the recommendations in their needs assessment are implemented. The veteran population in Southampton is smaller than in Hampshire or Portsmouth so a working group may not be appropriate but a plan should still be developed.

2 Data collection

NHS Hampshire’s finding of a lack of robust sources of quantitative data about this vulnerable population is also highlighted here. There are opportunities to improve data collection which would enable commissioners to more accurately estimate the size of the local population, and assist with identifying their health needs.
2.1 **Encourage all GP practices to use Read codes relating to veteran status when registering new patients**

There is no national agreement on which Read code to use but Xa8Da is advocated by the Department of Health and cited in RCGP guidance. However, Practices use different primary care clinical record systems and this particular code will not be appropriate for all Southampton practices. NHS Hampshire sought guidance from the Department of Health about which codes are most appropriate and definitive advice is awaited. SHIP should continue to stress the importance of this clarification.

2.2 **Encourage recording of veteran status for all referrals to secondary care for conditions relating to military service**

Although veteran status may be recorded in the individual’s referral, there is currently no system of identifying veteran status in the Secondary Users System (the commissioners’ anonymised view of the hospital and community patient systems). NHS Hampshire has raised this issue nationally and SHIP should continue to stress the importance of this data field. This information plays a key part in determining population-level health and social care needs.

2.3 **Encourage recording of veteran status on registers of partner organisations, such as local authority registers of homelessness acceptances**

Identifying veteran status on homeless acceptance registers would enable better estimation of the number of homeless veterans in Southampton (and SHIP) thereby enabling an appreciation of the burden of need on housing services and related health services.

2.4 **Stress the need for local-level data on the veteran community from nationally held sources, such as DASA (Defence Analytical Services Agency)**

The recent provision of data by resettlement town for Service leavers (outflow data) provides a more detailed estimate of the size of the local veteran community than we have had previously. However, there are data gaps and we need more data about the Service leavers to allow a more accurate estimate of the number of injured or wounded veterans resident in Southampton. NHS Hampshire has raised this issue nationally and SHIP should continue to stress the importance of this data.

3 **Include veterans in other NHS Southampton (and SHIP) needs assessments and audits**

We need to ensure that veterans are considered in other health needs assessments (such as mental health) and audits (such as the suicide audit – although numbers are small).

4 **Education and training of GPs and other healthcare providers**

4.1 **Provide education and training for healthcare staff**

Veterans’ perception that civilian healthcare staff lack knowledge and understanding about military cultures and the specific needs of veterans was frequently cited as a potential barrier to accessing services in the qualitative research presented in NHS Hampshire’s report, as well as at a national level. NHS Southampton (and SHIP) should promote the importance of
publications (such as that produced the RCGP, RBL and Combat Stress\(^2\)) amongst all primary healthcare staff. In addition, consideration should be given to providing training on veterans’ health for all staff likely to come into contact with veterans, such as GPs, community and secondary care mental health staff. Such training would require liaison with the area’s DMS teams to ensure key areas are addressed.

4.2 **Encourage GPs to request veterans’ complete medical records at Registration**

GPs should be encouraged to request a veteran’s full medical record at registration in order to develop a full picture of their medical history. NHS Hampshire found that work is in progress at a national level to enable the transfer of medical records from the Defence Medical Systems to NHS systems which, it is anticipated, will greatly improve the continuity of care received by veterans across the UK. The current status of this work was not known at the time of completion of the report.

5 **Adopt partnership working**

NHS Hampshire has established relationships with key stakeholders in Veterans’ services, such as members of 145 (South) Brigade, Combat Stress, the RBL, Mike Jackson House, VOS-P and the VICS Champion at HMP Winchester. These stakeholders have provided vital insight into the local veteran population and NHS Southampton should adopt a similar model of partnership working with relevant local stakeholders.

6 **Promote information about NHS services, including GP registration, as well as other sources of support amongst the veteran community**

6.1 **Encourage veterans to register with an NHS GP and identify their veteran status**

NHS Southampton (and SHIP) should promote veterans’ self-registration with local GP services, as well as encouraging veterans to tell their GP if they are a veteran. This should act as a flag for GPs to consider the potential for specific health and wellbeing needs in such individuals and target assessments and treatments most appropriately. NHS Southampton (and SHIP) should ensure such information is routinely provided to all personnel being discharged into the local area.

6.2 **Promote other sources of support available in Southampton**

NHS Southampton should seek to ensure information on local support services is widely available to the veteran population.

2 INTRODUCTION AND METHODS

2.1 **Introduction**

**Health needs assessment**

A health needs assessment is “a systematic review of the health issues facing a population leading to agreed priorities and resource allocation that will improve health and reduce

\(^2\) Royal College of General Practitioners, The Royal British Legion and Combat Stress. 2010. *Ibid*
inequalities.” (p3) This assessment informs decisions about commissioning services to meet needs.

**Why focus on the Armed Forces community and Veterans?**

Support to the Armed Forces community has received political impetus over recent years - for example in the Command Paper ‘The Nation's Commitment: Cross-Government Support to our Armed Forces, their Families and Veterans, 2008’ and in the Armed Forces Covenant. These highlight that serving and Veteran personnel, and their families, experience unique factors as a result of their time in service, including not only the risks of injury or death, but also those related to armed services’ lifestyle, such as frequent moves and the disruption this may bring. The Command Paper seeks to ensure that these circumstances are taken into account in commissioning and delivering services:

“the essential starting point is that those who serve must not be disadvantaged by virtue of what they do - and this will sometimes call for degrees of special treatment”. (p9)

Commissioners need to consider the implications of this in the provision of all services that may be required by members and ex-members of the military community. Healthcare organisations must:

1. Ensure that commissioning plans provide for a smooth transition into NHS care for the increasing numbers of returning personnel who have been injured in the course of duty
2. Ensure that their dependants are not disadvantaged by their circumstances (eg if they move location)
3. Provide priority treatment, including appropriate mental health treatment, for veterans with conditions related to their service, subject to the clinical needs of others (p23)

and this requirement is reflected in subsequent revisions.

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This health needs assessment is intended to inform local decision making about services needed by the Veteran population. The local NHS service has direct commissioning responsibility for Veterans.

2.2 Local Ministry of Defence locations

Although there are no Ministry of Defence locations within the Southampton itself, a substantial number exist in the surrounding districts of SHIP (Figure 1)

Fig 1 Schematic representation of Ministry of Defence (MOD) locations in Hampshire, Southampton and Portsmouth

Source: Hampshire County Council

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2.3 Who is a Veteran?

In general terms, the UK is considered to have adopted an “inclusive” (p161)\textsuperscript{10} or broad definition of the term. The Ministry of Defence defines a veteran as:

“Anyone who has served in HM Armed Forces at any time, irrespective of length of service (including National Servicemen and Reservists)” \textsuperscript{11}

Guidance for GPs on the treatment of veterans gives a more extensive definition:

“Anyone who has served for at least one day in the Armed Forces (Regular or Reserve), as well as Merchant Navy seafarers and fishermen who have served in a vessel that was operated to facilitate military operations by the Armed Forces.” (p3)\textsuperscript{12}

The term “veteran” does not apply exclusively to those who served in the Second World War. No distinction is made between those who may have served in more recent conflict operations (such as the Gulf War, Iraq or Afghanistan), and those who have spent time in basic training with one of the Services, nor between the length of time personnel may have served. As a result, the veteran population is large and encompasses a wide age range.

Commissioning services for Southampton veterans requires assessment of the needs of younger and older veterans, as well as Regular and Reserve personnel who are likely to present different challenges.

For this health needs assessment, the term “veteran” relates to the definitions highlighted above, not including adult or child dependents. NB The distinction between veterans and ‘the ex-service community’ should be noted, the latter being defined as veterans and their dependents.

2.4 Data sources

2.4.1 Quantitative information

One aim of this needs assessment was to identify and quantify the number of veterans living within Southampton in order to establish the size of the population and estimate the potential impact of health needs on local service provision. In common with other geographical areas (eg Hampshire, Bedfordshire,\textsuperscript{13} Hull,\textsuperscript{14} North East Joint Health Overview and Scrutiny Committee\textsuperscript{15}) routinely collected local data for veterans in Southampton was extremely limited. Consequently,\textsuperscript{10,11,12,13,14,15}

\textsuperscript{11} Ministry Of Defence. 2011 Available at: \url{http://www.mod.uk/DefenceInternet/DefenceFor/Veterans/}, accessed 13 October 2011
\textsuperscript{12} Royal College of General Practitioners, The Royal British Legion and Combat Stress, 2010. Ibid
national data (eg from RBL and the Defence Analytical Services and Advice (DASA)) was used as a primary source.

3 DEMOGRAPHY

3.1 Current demographic profile

The UK Census questionnaire collects information on those currently serving in the Armed Forces (in questions relating to current occupation) but does not collect data on veterans.

The most robust estimates of the national veteran population are obtained from survey data from the Royal British Legion (RBL) and the Office for National Statistics (ONS). The RBL estimates a UK veteran population of 4.8 million (8% of the UK population) – 84% of whom are male. ONS estimates approximately 3.8 million veterans in England (9% of the English adult population) - 87.5% of whom are male.

Both estimates are limited in that they sampled adults living in residential dwellings. Consequently, this excluded veterans in prisons, hospitals, residential or nursing homes, and veterans who are homeless. These exclusions may have had a disproportionate impact on estimations of the veteran population as veterans may be more likely than the general population to be found in these settings. Both estimates are therefore likely to under-estimate the size of the total veteran population but this cannot be quantified given the difficulties in identifying the excluded populations in question.

Applying these prevalence estimates to Southampton gives an estimated 18,433 to 21,227 veterans living in the city. Most veterans are estimated to be in the older age groups, with 26% to 30% aged 65-74 years, and 30% to 35% aged 75+ years. This age profile reflects veterans of National Service which operated from 1939 to 1960. (Table 1)

Table 1

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Royal British Legion</th>
<th>ONS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Estimated prevalence (%)</td>
<td>Estimated number</td>
</tr>
<tr>
<td>16-24</td>
<td>1</td>
<td>472</td>
</tr>
<tr>
<td>25-34</td>
<td>5</td>
<td>2195</td>
</tr>
<tr>
<td>35-44</td>
<td>8</td>
<td>2432</td>
</tr>
<tr>
<td>45-54</td>
<td>9</td>
<td>2358</td>
</tr>
<tr>
<td>55-64</td>
<td>16</td>
<td>3440</td>
</tr>
<tr>
<td>65-74</td>
<td>30</td>
<td>4590</td>
</tr>
</tbody>
</table>


Estimated Veterans Population, Southampton, 2010

<table>
<thead>
<tr>
<th>Age group (years)</th>
<th>Royal British Legion</th>
<th>ONS</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Estimated prevalence (%)</td>
<td>Estimated number</td>
</tr>
<tr>
<td>75-84</td>
<td>26</td>
<td>2730</td>
</tr>
<tr>
<td>85+</td>
<td>4</td>
<td>216</td>
</tr>
<tr>
<td>Total</td>
<td>18433</td>
<td></td>
</tr>
</tbody>
</table>


Ethnicity data is not available for the veteran population specifically. The RBL reports that the vast majority of the whole ex-Service community (ie veterans and their dependents) is white (99.3%), compared to a figure of 92.1% for the UK population in general according to 2001 Census data (p19).

3.2 Population projections

Both the RBL and ONS surveys project a decline in the total veteran population.

RBL suggest that between 2005 and 2020, the UK veteran population will reduce by 35% to 3.1 million. Although the overall number of veterans is projected to decline, the proportion of veterans aged 85 years and over is projected to increase. This is likely to be a reflection of the last veterans of the National Service cohort moving through the age profile, as well as increasing longer life expectancy within the UK population as a whole. However, there are increased proportions in age groups 16-24 years and 25-34 years due to the majority of personnel leaving the Armed Forces each year being in the younger age groups. There is also an unquantified impact of reductions in overall Service numbers (put in place after the RBL and ONS surveys) which may lead to personnel leaving sooner than expected. The health needs of younger veterans are likely to differ significantly from those in older age groups.

Figure 2.1 shows the predicted change in the age structure of the UK veteran population.

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Between 2007 and 2027, ONS predicts a 50.4% reduction in the size of the veteran population in England. Much of this reduction results from declines in the oldest age groups with a disproportionate number of deaths in these age groups compared to the in-flow of new veterans each year. Once again, this has implications for the age profile of veterans in future, although the average age of the national veteran population is likely to remain older than that of the general population.20

Both studies predict a higher proportion of younger veterans over the next 16 years.

3.3 Sources of local data

3.3.1 Primary care
The primary care database used by the Practitioner and Patient Services Agency includes a flag indicating veteran status. While serving, primary medical care services are delivered by the Defence Medical Services (DMS). On leaving the Armed Forces, veterans register with a local NHS GP (Appendix 1 – NHS Family Doctor registration form). Veterans are given a summary of their medical notes from their time in service but at present there is no automatic transfer of medical records from DMS to the NHS. The flag is populated when the patient first registers with a GP and declares that they are “returning from armed forces” on the registration form. It is therefore incumbent on veterans to notify their GP of their status. The flag disappears if the veteran moves to another practice as this is then counted as an internal patient transfer between practices.

GP Practices themselves can identify veterans registered with their practice using Read codes:

**Read V2 systems**
- 13q3 - Served in the Armed Forces
- 13JR – Left military service
- 13JI – Military Veteran
- 13JY – History relating to military service
- 091 – Occupation domain – Armed Forces
- 06E – Occupation domain – Officer Armed Forces

Systems using V2 coding are used by 22 Southampton practices

**CTV3 systems**
- 13q3 – Served in Armed Forces
- XE0pb – Left military service
- 13JR - Left military service
- XaX3N – Military Veteran
- Xa8Da - History relating to military service

Systems using CTV3 coding are used by 15 Southampton practices

There is no national agreement on which Read code to use but Xa8Da is advocated by the Department of Health and cited in RCGP guidance (p5). The equivalent code matching the description of Xa8Da in the V2 coding system is 13JY.

Use of Primary Care data is therefore limited by:
- The willingness of Veterans to identify themselves as such when first registering with a GP
- Awareness of the existence of relevant Read codes by GPs and other primary care staff

Given these caveats, data from Primary Care is likely to under-estimate the size of the local veteran population.

The Hampshire Health Record (HHR) is a potential source of data linking primary care (subject to caveats above), prescribing and hospital activity. Twenty-one of the 37 practices in Southampton are linked to the HHR (although individual patients within each of these practices may have opted out). The 16 practices not linked to HHR cover 35% of all registered patients aged 16+ years and serve some of the most deprived populations:

A query run on the HHR identified 1,013 ex-service personnel in the 21 Southampton practices that link to the HHR – a prevalence of just 0.65% amongst the 16+ population. Clearly there are limitations in using this data for the reasons stated above.

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3.3.2 Pensions data and additional sources

In July 2011 there were 890 people in receipt of an occupational pension under the Armed Forces Pension Scheme (AFPS). The distribution of these across the postcode districts covering Southampton is shown Table 2.

<table>
<thead>
<tr>
<th>Postcode district</th>
<th>Number of AFPS recipients</th>
</tr>
</thead>
<tbody>
<tr>
<td>SO1</td>
<td>60</td>
</tr>
<tr>
<td>SO14</td>
<td>40</td>
</tr>
<tr>
<td>SO15</td>
<td>120</td>
</tr>
<tr>
<td>SO16</td>
<td>200</td>
</tr>
<tr>
<td>SO17</td>
<td>45</td>
</tr>
<tr>
<td>SO18</td>
<td>170</td>
</tr>
<tr>
<td>SO19</td>
<td>240</td>
</tr>
<tr>
<td>UK total</td>
<td>339,745</td>
</tr>
</tbody>
</table>

Note: SO1 postcode district included as this is an obsolete district that did cover Southampton area.  
Source: DASA

The largest proportions of veterans live in SO16 and SO19 which are the postcode districts covering the West and East/South localities of Southampton. These localities include some of the city’s most deprived areas.

We need more information at below the level of postcode districts better to understand health and social care needs of veterans in these areas.

3.3.3 War Pensions Data

The UK’s War Pensions Scheme applies to ex-Service personnel whose injuries, wounds and illnesses arose before 6 April 2005. The scheme includes War Disablement Pensioners and War Widowers.

At 30 September 2010, there were 320 people (6% female) in receipt of a War Disablement Pension in Southampton. Sixty-one percent of recipients were aged over 65 years (see Table 3)
Table 3

Number of recipients of War Pension Scheme in Southampton, September 2010

<table>
<thead>
<tr>
<th>Age Group yrs</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt;30</td>
<td>~</td>
<td>~</td>
</tr>
<tr>
<td>30-34</td>
<td>~</td>
<td>~</td>
</tr>
<tr>
<td>35-39</td>
<td>20</td>
<td>6.3</td>
</tr>
<tr>
<td>40-44</td>
<td>20</td>
<td>6.3</td>
</tr>
<tr>
<td>45-49</td>
<td>20</td>
<td>6.3</td>
</tr>
<tr>
<td>50-54</td>
<td>25</td>
<td>7.8</td>
</tr>
<tr>
<td>55-59</td>
<td>15</td>
<td>4.7</td>
</tr>
<tr>
<td>60-64</td>
<td>15</td>
<td>4.7</td>
</tr>
<tr>
<td>65-69</td>
<td>35</td>
<td>10.9</td>
</tr>
<tr>
<td>70-74</td>
<td>25</td>
<td>7.8</td>
</tr>
<tr>
<td>75-79</td>
<td>25</td>
<td>7.8</td>
</tr>
<tr>
<td>80-84</td>
<td>35</td>
<td>10.9</td>
</tr>
<tr>
<td>85-89</td>
<td>50</td>
<td>15.6</td>
</tr>
<tr>
<td>90-94</td>
<td>25</td>
<td>7.8</td>
</tr>
<tr>
<td>95+</td>
<td>~</td>
<td>~</td>
</tr>
<tr>
<td>Total</td>
<td>320</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Source: DASA personal communication from Veterans Welfare Support. Figures have been rounded to the nearest 5. Note data may not sum due to rounding and suppression. Data has been suppressed in any cell with a total figure of <5.

The age profile of War Disablement Pensioners is older given the eligibility criteria.

In March 2011 the number of people claiming war pension in Southampton had risen to 390. The distribution of these by postcode district is shown in Table 4.

Table 4

Recipients of on-going War Pensions under the War Pension Scheme (WPS) for Postcode districts SO14 to SO19, as at 31st March 2011

<table>
<thead>
<tr>
<th>Postcode district</th>
<th>Number of AFPS recipients</th>
</tr>
</thead>
<tbody>
<tr>
<td>SO1</td>
<td>~</td>
</tr>
<tr>
<td>SO14</td>
<td>15</td>
</tr>
<tr>
<td>SO15</td>
<td>65</td>
</tr>
<tr>
<td>SO16</td>
<td>115</td>
</tr>
<tr>
<td>SO17</td>
<td>30</td>
</tr>
<tr>
<td>SO18</td>
<td>75</td>
</tr>
<tr>
<td>SO19</td>
<td>110</td>
</tr>
</tbody>
</table>

Note: SO1 postcode district included as this is an obsolete district that did cover Southampton area.

Source: DASA23

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23 DASA website

Veterans whose injuries resulted from Service after 6 April 2005 are covered by the Armed Forces Compensation Scheme (AFCS). There are fewer than five Veterans receiving such compensation in Southampton.

Applying this data to estimated prevalence shows that about 1.5% of local Veterans are claiming either War Pension or AFCS. However, these data sources only identify Veterans whose claim was successful under each scheme and the estimated prevalence may greatly over-count the true prevalence.

3.3.4 Service Leavers Data

Nationally, about 22,000 Armed Forces personnel leave Service and return to civilian life every year. During 2009/10, 18,570 personnel left UK Regular Armed Forces.

The Ministry of Defence is now making available data on service leavers at a local level. During 2010/11, 78 personnel leaving Service indicated they had a permanent home contact address in Southampton postcode areas (see Table 5). Eleven service leavers indicated they were settling in Southampton.

<table>
<thead>
<tr>
<th>Postcode of permanent home contact address</th>
<th>No of leavers</th>
</tr>
</thead>
<tbody>
<tr>
<td>SO1</td>
<td>2</td>
</tr>
<tr>
<td>SO14</td>
<td>8</td>
</tr>
<tr>
<td>SO15</td>
<td>10</td>
</tr>
<tr>
<td>SO16</td>
<td>20</td>
</tr>
<tr>
<td>SO17</td>
<td>12</td>
</tr>
<tr>
<td>SO18</td>
<td>1</td>
</tr>
<tr>
<td>SO18</td>
<td>16</td>
</tr>
<tr>
<td>SO19</td>
<td>9</td>
</tr>
</tbody>
</table>

Source: MOD Joint Personnel Administration system

There are a number of caveats about this data. The information relates mainly to Permanent Home Contact Addresses which may have been completed at various points before leaving the Services and in some cases therefore may not be up-to-date. Also, approximately 25% of Service Leavers do not provide any contact address when they leave.

3.4 Summary of local data

- The ability to establish a quantitative picture of Southampton’s veteran population is severely limited by the lack of available sources of local data.

- The most robust estimate of the local population, by extrapolation of national survey data to local populations, estimates 18,433 to 21,227 veterans living in Southampton.

- A key recommendation of this health needs assessment is the development of robust sources of data relating to the local population. Without this, it is difficult to formulate an accurate assessment of the size of the veteran population and the nature and extent of their needs.

4 THE WIDER DETERMINANTS OF HEALTH AND THE VETERAN POPULATION

Most veterans leave the services without physical or mental health problems and view their time in the Services as a positive experience. However, a minority experience complex mental and physical issues and these can be compounded by a number of wider adverse issues relating to crime, housing and income.

4.1 Veterans and the criminal justice system

Overall, male veterans are less likely than the general male population to be in prison or be supervised by Probation. A range of factors may lead some veterans to be involved with the criminal justice system – for example, pre-existing characteristics not associated with time in the Armed Forces; mental health problems, substance misuse and addictions or difficulties adjusting to civilian life, possibly related to experiences during their time in the Services.

In 2010, DASA estimated that 3.5% of prisoners (99.6% male) in England and Wales were veterans. However, for males aged 18-54 years, the proportion of the general population in prison was significantly greater (43%, 95% confidence interval 37% to 49%) than the proportion of Regular veterans in prison. The age groups 45-54 years and 26-34 years represented the highest proportions (22% and 20% respectively) of veterans in prison. Their most common offences were violence against the person (33%), sexual offences (24.7%) and drug offences (10.7%).

DASA estimates that about 3.4% of all offenders (99% male) supervised by Probation Trusts in England and Wales are veterans. However, for males aged 18-54 years, the proportion of the general population supervised by Probation was significantly greater (12%, 9% to 15%) than the proportion of Regular veterans. Sixty-nine percent of veterans being supervised were aged 18-44 years. Nationally, the most common offences were ‘Summary offences – other’ (eg criminal damage, trespass) (30.8%), violence against the person (18.8%) and ‘Other indictable’ (eg drugs, common assault) (13.9%). In the Hampshire Probation Trust area (which includes...

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Southampton City), 189 veterans were under supervision orders as at March 2011 (this may be an underestimate given the incompleteness of DASA’s Service leavers’ database).27

In both surveys, the majority of offences are violent in nature and are often associated with alcohol and/or drug use (see Section 4 of this Report). NAPO highlights the need to tackle the culture of alcohol use associated with the Armed Forces, as well as promoting help-seeking by veterans for mental health conditions in an aim to reduce rates of offending.28

In order to support veterans who find themselves in prison, the Prison-In-Reach (PIR) initiative aims to ensure veterans have knowledge and access to resettlement and support services. As part of this, the Veterans in Custody Support (VICS) scheme has been introduced, in which a VICS Champion is appointed within the prison system to identify and link with veterans, providing information and support in accessing specialist services if required.29

4.2 Welfare needs of veterans

Veterans may experience a variety of welfare needs after their time in the Services. For some, this may be related to the transition to civilian life and the requirements this brings. For example, veterans may have difficulties finding suitable housing, obtaining adaptations to accommodate injuries or other physical health needs, or obtaining financial aid to which they are entitled. All these areas play a vital role in the overall physical and mental health of the veteran population.

The Royal British Legion (RBL) is a vital source of welfare support for many veterans, although the Legion also provides support for serving personnel and dependents. The charity provides a wide range of services across the UK, with county offices and numerous local branches providing support for local populations.

For many veterans, their first contact with support services such as the RBL may not be for many years after having left the Armed Forces. This may be due to a lack of awareness about entitlements and eligibility to apply for help or, as may be the case for veterans experiencing mental health disorders, a delay in recognising that problems exist. For others, however, support may be sought much earlier after discharge. Although the overall number of veterans is projected to decline over future years, it is clear that welfare and health needs are prevalent across the age range and commissioners should ensure they continue to consider the population in future service provision.

4.3 Housing

The importance of ensuring veterans have access to quality housing and housing support is recognised in the Armed Forces Covenant.\(^{30}\)

Homelessness is closely linked to adverse physical and mental health, both for veterans and the general population. Capturing data on the population who are homeless is difficult due to their mobile nature. Data from studies conducted over 10 years ago suggested that 20% - 25% of the homeless population in the UK may be veterans (p32).\(^{31}\) A 2008 study of the ex-Service homeless population in London estimated that 6% of London’s current non-statutory (single) homeless population has served in the Armed Forces (p ix). Of these veterans, the majority were male and were found to be older than the wider homeless population. The authors identified that there were a range of factors contributing to homelessness in the veteran group, including the following:

- One-quarter had risk characteristics that pre-dated their time in the Armed Forces and which were carried through their military careers and their return to civilian life
- One-quarter experienced difficulties during their time in the Services, such as mental health disorders and substance misuse, which continued after their discharge
- A small proportion (one in six) did not experience difficulties during their career in the Services but had problems with the transition to civilian life, such as difficulties finding employment
- One-third had successful careers in the Services and did not find the transition difficult initially but faced issues later on as a result of a bereavement, or relationship or financial difficulty which served as a trigger for problems ultimately leading to homelessness. (p x).\(^{32}\)

Ensuring veterans are made aware of sources of local and national support at an early stage in their transition to civilian life is therefore vital in helping to prevent homelessness in this population.

In the context of this needs assessment, it was identified that local authorities do not currently include any record of veteran status on housing registers or homelessness acceptances. Encouraging them to do so would be one way to estimate the size of the problem of homelessness amongst the Southampton veterans’ community.

5 THE HEALTH AND HEALTHCARE NEEDS OF VETERANS

Much national and international attention has focussed on the health of serving and veteran personnel – for example, the mental health of personnel returning from the 1991 Gulf War or how best to meet the needs of severely physically disabled Veterans who have served more recently in Iraq and Afghanistan.

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Again, there is no robust source of data relating specifically to the health of Veterans within Southampton. Instead, national data is relied upon to highlight the key health issues facing Veterans, with information obtained from local stakeholders highlighted where available.

5.1 Physical health needs of Veterans

A recent review of health and social factors affecting the UK’s Veterans suggests that overall the health of the Veteran population is comparable to that of the UK’s general population.\(^{33}\)

The RBL survey (2005) includes self-reported health information from veterans and the wider ex-service community (including dependents). With this caveat, when compared to the UK general population, significantly higher prevalence was reported for the ex-Service community for the following conditions:

- Musculo-skeletal
- Cardiovascular
- Respiratory
- Mental health
- Sight
- Hearing

Table 6 highlights the key differences by age group.

<table>
<thead>
<tr>
<th>Age group</th>
<th>Conditions with HIGHER prevalence vs UK population</th>
<th>Conditions with LOWER prevalence vs UK population</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-44 years</td>
<td>Musculoskeletal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Mental health – (particularly affecting male veterans)</td>
<td></td>
</tr>
<tr>
<td>45-64 years</td>
<td>Musculoskeletal</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cardiovascular</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Respiratory</td>
<td></td>
</tr>
<tr>
<td>65-74 years</td>
<td>Mental health</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sensory disorders (sight, hearing, speech)</td>
<td>Musculoskeletal</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Circulatory</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Respiratory</td>
</tr>
<tr>
<td>75 years and over</td>
<td>Mental health</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hearing</td>
<td></td>
</tr>
</tbody>
</table>

Source: adapted from narrative p15-16, The RBL, Profile and needs: comparisons between the ex-Service community and the UK population, 2006

5.1.1 Mental health of veterans

Research suggests that most people “do not suffer with mental health difficulties even after serving in highly challenging environments”. (p2) However, some veterans face serious mental health issues. The most common problems experienced by veterans (and by the general population) are:

♦ Depression
♦ Anxiety
♦ Alcohol-abuse (13%)

Probable Post-Traumatic Stress Disorder (PTSD) affects about 4% of veterans. Each year about 0.1% of all Regular service leavers have been discharged for mental health reasons.

Certain groups of veterans have been identified as being at higher risk of mental health illness. Risks may be linked to:

♦ Characteristics of people joining the Armed Forces – traditionally from areas of economic and social deprivation, and particularly during periods of economic decline. The Army’s educational threshold is low with numeracy and literacy standards being those expected for seven year olds. It is important Forces’ personnel develop life and social skills as part of their training – including responsible alcohol consumption

♦ Experiences during an individual’s period of service with the Armed Forces – there is a link for all service personnel between exposure to combat and the risk of developing mental health problems. This may explain why young, male members of Infantry appear to be particularly at risk

♦ Transition period from military to civilian life which, for some, can be extremely challenging. People who have been medically discharged receive a comprehensive range of special services to assist with the transition back to civilian life. People discharged for psychiatric reasons are followed-up by the defence mental health social work service for up to year to ensure smooth handover to NHS care.

♦ Personnel who have served more than 16 years receive the most wide-ranging level of employment, training and housing support and graduated resettlement time. Far less support is offered to early service leavers. Leaving the services within four years is associated with a higher incidence of mental health problems

♦ Risk of suicide in ex-army males aged under 24 years is approximately two to three times higher than the risk for the same age groups in the general and serving populations. Pre-existing mental health problems and social experiences may be causal factors for this group. Suicide rates amongst the veteran population are comparable with those in the general population

♦ Of Service personnel who leave the Forces after serving a sentence in the Military Correctional Training Centre, 50% were in debt with no settled housing six months


after discharge. Just over half had a mental health problem, the most common being alcohol dependency.\(^{37}\)

- Members of the Reserve forces who had been deployed to Iraq and Afghanistan had higher rates of PTSD compared to those who did not experience conflict, and compared to members of Regular forces. Reserve forces may experience differences in comradeship and support, with Regular personnel more likely to remain with fellow service personnel for longer periods following deployment which may offer a stronger degree of support.\(^{38}\)

- Use of alcohol – alcohol is frequently used and is readily accessible to serving personnel, with evidence that rates of ‘hazardous drinking’ (p30) are higher than amongst the general population.\(^{39}\) Younger males from the lower service ranks are associated with the heaviest use.

**Issues for commissioners**

Mental health services for veterans need to ensure services cover the range of common and more specific mental health problems.

Young male veterans are associated with other risk factors such as leaving Services early and excess alcohol use. Identifying young male veterans is key to ensuring potential alcohol-related disorders are highlighted and addressed early. This may mitigate adverse associations between alcohol and crime or homelessness. Targeted early interventions in primary care should be considered and is one of the recommendations made for Hampshire in a recently completed Alcohol Needs Assessment for the area.

Young males aged under 24 years are at increased risk of suicide. They may be particularly reluctant to seek help (and some may not even identify themselves as veterans). Ensuring data systems identify veterans locally, as well as promoting registration with GPs and help-seeking behaviours is key to mitigating any increased risk within the local cohort of veterans.

In addition to appreciating the specific mental health conditions experienced by veterans, recognition of the stigma associated with such disorders in this population group also needs to be highlighted. Although stigma surrounding mental health disorders is by no means unique to this population, the culture associated with the Armed Forces may be associated with a greater degree of shame in seeking help for such conditions. In particular, some individuals may view it as ‘weak’ to seek help and others may be concerned about the impact on any future career options, military or otherwise. Mental health services should ensure they recognise the detrimental effect such stigma may have on veterans’ willingness and ability to seek help for mental health conditions.\(^{40}\)

Primary care and mental health care staff should recognise and understand the challenges posed by the Forces’ culture as it is thought to be key to removing some of the barriers veterans perceive in accessing health care, particularly for mental health services. The joint RCGP, RBL and Combat Stress publication aims to promote better understanding of the specific needs of

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veterans amongst primary care staff and should be promoted amongst all local health providers.41

5.2 Current mental health services for veterans

5.2.1 National services

1. Medical Assessment Programme (MAP)42

Local GPs may refer veterans to the MAP, based at St Thomas Hospital, London. The MAP was initially established by the MOD in 1993 in order to provide general medical examinations for Gulf War veterans who felt their health had been affected by their time in service in the conflict. Although it now offers this same service for veterans of Iraq and Afghanistan conflicts, as well as those involved in Porton Down studies, a key focus is on provision of mental health examinations for any veteran who has been involved in operational service since 1982. Staff with extensive experience and knowledge of military service and cultures assess, diagnose and make treatment recommendations for the individual veteran’s GP. The MOD reports high levels of patient satisfaction with the service and this is likely to reflect the desire by many veterans to be able to access care provided by staff with experience of time in the Armed Forces.

2. Reserves’ Mental Health Programme (RMHP)43

The RMHP, based in Nottingham, was established in partnership between the DMS and NHS to provide assessment and outpatient based treatment, where necessary, for current and former Reserve personnel who have had experience of operational service, returned to civilian life, and who have a mental health problem associated with their time in Service. Referrals are via GPs and assessments and treatment plans are provided by the DMS in close liaison and communication with the GP. All treatment provided through the programme is on an outpatient basis, offered at an individual’s nearest DMS treatment centre. If a hospital admission is considered necessary, this is arranged via the NHS route.

Once again, the provision of a service offering joined-up care between the NHS and those with military background has been welcomed by veterans. In addition, this service offers care targeted towards a group identified as being at higher risk of mental health problems, as highlighted earlier.

3. Veterans’ Community Mental Health Pilots

Since 2007, the MOD in collaboration with the Departments of Health for the UK has rolled out six regional community mental health pilot services for veterans, with individuals or GPs as well as partner services able to refer into the service. Each pilot service had a dedicated veterans’ mental health therapist, although the specific model varied at each site. The evaluation of the pilot programmes made several recommendations, including:

41 Royal College of General Practitioners, The Royal British Legion and Combat Stress. 2010. Ibid.
♦ Staff providing mental health services for veterans should have knowledge and understanding of the culture of the Armed Forces and, if possible, veterans should have the option of being seen by a veteran
♦ There should be good data and record-linkage systems so that mental health services are able to access the individual’s service record to obtain a full history
♦ The services should have good links with other organisations, including those providing housing and welfare support to enable a well-rounded service is provided
♦ A minimum data set should be maintained to allow monitoring of use and effectiveness.44

The Government has stated that the recommendations from this evaluation will be implemented as part of the UK’s 2011 Mental Health Strategy45, as well as its commitment to the Armed Forces Covenant.46

4. HM Government commitments to the mental health of veterans

In addition to the implementation of the recommendations made by the evaluation report of the community mental health pilots scheme, ‘The Armed Forces Covenant: Today and Tomorrow’47 makes several commitments to improving veterans’ mental health, including:

♦ Arrangements to enable veterans to continue to access mental health services from the DMS services for up to six months after discharge from the Services, should their mental health condition have been detected prior to discharge. It is hoped this will help remove barriers to accessing care and enable treatment by those with experience of the Armed Forces culture.
♦ A pilot project of a Department of Health Veterans’ Information Service is due to start in 2012 which will offer a link to support services, including mental health services, as well as evaluating service use to inform future decision-making for commissioners.
♦ An e-Learning programme for GPs to further promote the specific mental health needs of veterans and increase understanding of the nature and culture of military service.

5. Online help for services personnel and their families

Members of the armed forces, veterans and their families now have access to specialised help from a 24/7 online support network - Big White Wall. The Government is funding £250,000 and Help for Heroes £100,000 for a one-year pilot of a 24/7 online wellbeing service. Among other services, Big White Wall users can chat anonymously to others who may have gone through similar experiences, with a team of trained counsellors always online to offer support. See: www.bigwhitewall.com.

46 Ministry of Defence UK. The Armed Forces Covenant: today and tomorrow.. 2011. Ibid.
5.2.2 Local services

1. Local NHS services including Improving Access to Psychological Therapies (IAPT) services

In Southampton, local NHS mental health services are commissioned by NHS Southampton from Solent NHS Trust, with a range of services covering the age ranges. Referrals into the services are accepted from a number of health professionals including GPs, A&E, other departments at University Hospital Southampton Foundation NHS Trust and the Police.

The IAPT programme is a national programme rolling out the provision of psychological therapies for all adults with common mental health problems (depression and anxiety). In 2009, the scheme highlighted the need to consider the veteran population in the provision of such services in their guide ‘Veterans- Positive Practice Guide’. They stress the importance of identifying the local veteran population and recognising their specific mental health needs when commissioning local services.

The IAPT service was awarded a grant from the Strategic Health Authority in October 2011 to look at increasing access to psychological therapies for Veterans. To date, they have conducted a scoping exercise looking at existing services available locally, regionally and nationally and in March 2012 held a focus group to look at how different services join up in the city and differences in how Veteran status is captured. The IAPT service are currently looking at developing strategies to increase awareness of mental health issues in this population and raise awareness that there is support available from appropriately trained people.

Data on the use of these services by veterans was not available during this needs assessment. Establishing data systems to record such use would be valuable in assessing the mental health of the local veteran population, as well as offering an additional source of identifying the veteran population.

2. Combat Stress

Combat Stress is ‘the UK’s leading military charity specialising in the care of veteran’s mental health’. The charity provides community-based outreach care, as well as residential treatment for UK veterans suffering with service-related mental health conditions, including PTSD as well as depression, anxiety and other common mental health disorders. Services targeting detoxification for addictions to alcohol or other substances are not currently available via the charity’s services, so alternative sources for such needs are sought. The charity reports a substantial increase in the number of veterans making contact over the past five years but that a key aim is still to promote earlier help-seeking, with the current average remaining at ‘thirteen years from Service discharge’.

Discussions with the South East England Regional Welfare Office as part of Hampshire’s needs assessment, identified that it is common for veterans to seek help and to suffer PTSD, for their condition to be complex and be related to exposure to multiple traumas during their time in the Armed Forces. In addition, an individual’s mental health needs are frequently compounded with additional needs (eg relationship, welfare and financial issues). It is important, therefore, to

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49 Personal communication from Colin Hicks, Steps2Wellbeing (The Southampton IAPT provider)
ensure that veterans are able to access the full range of support services for their needs in order to adequately address their mental health problems.

5.3 Musculo-skeletal disorders

Along with mental health conditions, musculo-skeletal disorders are a key issue for the health of veterans – which is perhaps not surprising given the physical nature of their work in the Armed Forces, along with the potential risk of injury. As highlighted earlier in Table 3.1, veterans aged between 16 and 44 years report higher rates of musculo-skeletal conditions than their counterparts in the general population. A study of United States’ Veterans found they are more likely to report ‘doctor-diagnosed arthritis’ than members of the general population (p20).\(^{51}\)

Musculo-skeletal disorders affect an individual’s health but also impacts on other areas (eg employment). At an individual level, any detrimental effect on the ability to work is also likely to impact on mental health, potentially compounding any existing problems.

Perhaps more commonly focussed on is the risk of serious injury, particularly limb injuries, associated with time spent in the Services. For wounded or injured serving personnel, the DMS and MOD provide an extensive range of services covering treatment and rehabilitation. In Hampshire, the 145 (South) Brigade Personnel Recovery Unit (PRU), which opened in September 2010, provides individually-tailored recovery plans for Army personnel, covering welfare and physical needs. Work is also underway to develop an effective local Army Welfare Pathway for personnel returning to civilian life, which will promote close liaison between the PRU and partner organisations, including the NHS, to ensure smooth transitions and ease of access to local services.

As previously discussed, the provision of healthcare passes on discharge from the DMS to NHS providers. For those veterans who have received prosthetic limbs from the DMS for injuries related to their time in service, the Government has confirmed that the NHS will provide replacement prostheses that are at least an equivalent standard to those issued by the DMS. This is likely to have a substantial impact on local NHS providers, particularly as the number of veterans returning from active conflicts continues to increase. As a result, Dr Andrew Murrison is currently undertaking a review of the NHS prosthetics service on behalf of the Government, with a report expected in the Summer of 2011.\(^{52}\)

At present, no data systems to enable an assessment to be made of the current number of veterans receiving NHS prosthetic services in Southampton were identified by this needs assessment.

5.4 Healthcare needs of veterans

5.4.1 Key issues relating to the provision of health services for veterans

Although a minority of veterans may experience specific needs related to mental or physical health, a key feature for all is ensuring all veterans are able to access NHS services adequately. For commissioners, a key part of this is in recognising that the local veteran population does present some specific challenges, particularly in terms of help-seeking behaviours. Additionally,

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the responsibilities of all NHS services to meet the commitments set out by the Government, including priority access to NHS treatment for conditions related to a veteran’s time in the Services, must be realised at a local level.

Central to this is ensuring all local healthcare providers are aware of these commitments and responsibilities. A publication by the RCGP, RBL and Combat Stress offers a guide for General Practitioners. Ensuring such documents are promoted throughout primary care services is vital to enable GPs to offer appropriate advice and treatment to veterans.

An additional issue related to the provision of primary care services is the recording of veteran status in an individual veteran’s medical records. The current NHS Family doctor services registration form (GMS1), included in Appendix I, requests those returning from the Armed Forces to complete their previous contact details. This offers an opportunity to identify new registrants as veterans. Recording the appropriate Read code relating to veteran status to the medical notes at this stage would enable all clinicians involved in the delivery of primary care for that individual to be aware of their military history so that military history can and should be considered and taken into account when assessing any future medical conditions, promoting effective referrals to appropriate services. Encouraging accurate coding of veteran status throughout primary care would also allow a more reliable assessment of the registered veteran population to be made – crucial for future commissioning of services.

However, it should be highlighted that veterans themselves may face real or perceived barriers to registering with an NHS GP on discharge from the Armed Forces. It is recognised that some veterans suffer ‘social exclusion’ (p6), making them less likely to make contact and register with NHS services. It is often these veterans who are in greatest need of support, particularly in relation to mental health needs. Additionally, the perception on the part of veterans that civilian clinicians lack understanding of the needs and culture of the veteran community can serve as a barrier to registration for some. Anecdotal information from stakeholders in NHS Hampshire’s needs assessment suggested that the process of self-registration itself may pose a significant problem for some. This relates to Service personnel being ‘used to’ following orders and processes whilst on discharge, the responsibility for organising medical care, housing etc falls to the individual and this may be particularly challenging for those who have served for a considerable period of time.

To overcome these issues, it is vital that local service providers are provided with opportunities to increase their understanding of veterans’ issues. It is equally crucial to promote access to healthcare services to veterans themselves, providing up-to-date information and encouragement.

As part of the needs assessment carried out by NHS Hampshire, to assess the number of veterans currently referred to NHS services via the priority access route, the possibility of ‘tracing’ veterans via the Secondary Uses Service (SUS) was explored. Although veteran status may be recorded in the individual’s referral, there is currently no system of identifying veteran status via the SUS system. The RBL have also highlighted this fact at a national level, stressing that without the means to audit the number of priority referrals, the demands on the NHS cannot

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54 Improving Access to Psychological Therapies. 2009. Ibid.
be assessed.\textsuperscript{55} An audit tool to allow such an assessment to be made will require introduction at a national level, although local NHS providers will be key in stressing its importance and need.

Finally, current information systems do not allow the automatic transfer of veterans’ medical records from the DMS to NHS on discharge. GPs are able to request a veteran’s complete record from the DMS but this, again, relies on awareness that an individual patient is a veteran. Where this is possible, GPs should be encouraged to request the complete records to enable a complete picture of a veteran’s medical history can be developed. In his 2010 ‘mental health plan for servicemen and veterans’,\textsuperscript{56} Dr Andrew Murrison reported that methods to allow the transfer of medical records from the DMS to NHS are currently being piloted. The outcomes of these pilots were not available at the time of completion of this needs assessment; however, this likely to have a key positive impact on future service provision.

6 CONCLUSIONS AND RECOMMENDATIONS

6.1 Conclusions

The veteran population is an important sub-group of the wider community. The wider community recognises the importance of the sacrifices they make during their time in the Services. Although overall numbers may be projected to decrease, they remain a group with specific health and health-related needs which should be considered by local commissioners during service development. In addition, increasing awareness of the mental health problems experienced by veterans may lead to increases in the number of veterans seeking help, impacting on the demand for NHS mental health services.

The majority of available information does relate to the mental health issues of veterans, although physical health is also noted to be important. National commitments to ensuring adequate provision of services within the healthcare setting exist and offer some guidance for local provision.

However, although local needs assessments carried out across SHIP are able to highlight some of the key issues facing the veteran population, they are severely limited in their ability to identify specifics relating to the veteran community due to a lack of reliable data. This situation is not unique to the SHIP area and must be addressed in a co-ordinated way to better understand the needs of this group and enable commissioning decisions to adequately reflect them.

6.2 Recommendations

The following recommendations are based on the evidence obtained by this needs assessment, including national and local data where available.

1 Work with SHIP colleagues to promote the development of a SHIP Military and Veterans plan?

A working group across SHIP should be developed to ensure the recommendations in the SHIP needs assessments are implemented.


\textsuperscript{56} Murrison, A. 2010. Ibid.
2  Data collection

NHS Hampshire's finding of a lack of robust sources of quantitative data about this vulnerable population is also highlighted here. There are opportunities to improve data collection which would enable commissioners to more accurately estimate the size of the local population, and assist with identifying their health needs.

2.1  Encourage all GP surgeries to add Read codes relating to veteran status when registering new patients

There is no national agreement on which Read code to use but Xa8Da is advocated by the Department of Health and cited in RCGP guidance. However, Practices use different primary care clinical record systems. NHS Hampshire sought guidance from the Department of Health about which codes are most appropriate and definitive advice is awaited. SHIP should continue to stress the importance of this clarification.

2.2  Encourage recording of veteran status for all referrals for conditions relating to military service

Although veteran status may be recorded in the individual's referral, there is currently no system of identifying veteran status in the Secondary Users System (the commissioners' anonymised view of the hospital and community patient systems). NHS Hampshire has raised this issue nationally and SHIP should continue to stress the importance of this data field. This information plays a key part in determining population-level health and social care needs.

2.3  Encourage recording of veteran status on registers of partner organisations, such as local authority registers of homelessness acceptances

Identifying veteran status on homeless acceptance registers would enable better estimation of the number of homeless veterans in SHIP, thereby enabling better appreciation of the burden of need on housing services and related health services.

2.4  Stress the need for local-level data on the veteran community from nationally held sources, such as DASA

The recent provision of data by resettlement town for Service leavers (outflow data) provides a more robust estimate of the size of the local veteran community than we have had previously. However, there are data gaps and we need data about the Service leavers at the same geographical level as that for Armed Forces Pension Scheme, War Pension or Armed Forces Compensation Scheme to allow a more accurate estimate of the number of injured or wounded veterans resident in Southampton. NHS Hampshire has raised this issue nationally and SHIP should continue to stress the importance of this data.

3  Include veterans in other NHS Southampton (and SHIP) needs assessments and audits

We need to ensure that veterans are considered in other health needs assessments (such as mental health, prison health) and audits (such as the suicide audit – although numbers are very small).
4 Education and training of GPs and other healthcare providers

4.1 Provide education and training for healthcare staff
Veterans' perception that civilian healthcare staff lack knowledge and understanding about military cultures and the specific needs of veterans was frequently cited as a potential barrier to accessing services in the qualitative research presented in NHS Hampshire's report, as well as at a national level. NHS Southampton (and SHIP) should promote the importance of publications (such as that produced the RCGP, RBL and Combat Stress) amongst all primary healthcare staff. In addition, consideration should be given to providing training on veterans' health for all staff likely to come into contact with veterans, such as GPs, community and secondary care mental health staff. Such training would require liaison with the area’s DMS teams to ensure key areas are addressed.

4.2 Encourage GPs to request veterans’ complete medical records at registration
GPs should be encouraged to request a veteran’s full medical record at registration in order to develop a full picture of their medical history. NHS Hampshire found that work is in progress at a national level to enable the transfer of medical records from the Defence Medical Systems to NHS systems which, it is anticipated, will greatly improve the continuity of care received by veterans across the UK. The current status of this work was not known at the time of completion of the report.

5. Develop partnership working within Southampton and SHIP
NHS Hampshire have established relationships with key stakeholders in veterans services, such as members of 145 (South) Brigade, Combat Stress, the RBL, Mike Jackson House, VOS-P and the VICS Champion at HMP Winchester. These stakeholders have provided vital insight into the local veteran population and the relationships should be extended across SHIP to ensure service provision is effective across the area.

6 Promote information about NHS services, including GP registration, as well as other sources of support amongst the veteran community

6.1 Encourage veterans to register with an NHS GP and identify their veteran status
NHS Southampton (and SHIP) should promote veterans' self-registration with local GP services, as well as encouraging veterans to tell their GP if they are a veteran. This should act as a flag for GPs to consider the potential for specific health and wellbeing needs in such individuals and target assessments and treatments most appropriately. NHS Southampton (and SHIP) should ensure such information is routinely provided to all personnel being discharged into the local area.

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APPENDIX I - NHS Family doctor services registration form (GMS1)

<table>
<thead>
<tr>
<th>Patient's details</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Mr</td>
<td>Mrs</td>
</tr>
<tr>
<td>Date of birth</td>
<td></td>
</tr>
<tr>
<td>NHS No.</td>
<td>Previous surname</td>
</tr>
<tr>
<td>Male</td>
<td>Female</td>
</tr>
<tr>
<td>Home address</td>
<td></td>
</tr>
</tbody>
</table>

Postcode | Telephone number |  |

Please help us trace your previous medical records by providing the following information

Your previous address in UK | Name of previous doctor while at that address |  |
|  | Address of previous doctor |  |

If you are from abroad

Your first UK address where registered with a GP |  |

If previously resident in UK, date of leaving | Date you first came to live in UK |  |

If you are returning from the Armed Forces

Address before enlisting |  |

Service or Personnel number | Enlistment date |  |

If you are registering a child under 5

I wish the child above to be registered with the doctor named overleaf for Child Health Surveillance |  |

If you need your doctor to dispense medicines and appliances

I live more than 1 mile in a straight line from the nearest chemist |  |

I would have serious difficulty in getting them from a chemist |  |

Signature of Patient | Signature on behalf of patient | Date |  |

*Not all doctors are authorised to dispense medicines

Please see overleaf re: Organ donation