

## Where are all the veterans? A mixed methods assessment of a systematic strategy to increase veteran registration in UK primary healthcare practices

Item Type	Article
Authors	Finnegan, Alan;Randles, Rebecca
Citation	Finnegan, A., & Randles, R. (2023). Where are all the veterans? A mixed methods assessment of a systematic strategy to increase veteran registration in UK primary healthcare practices. <i>BMJ Open</i> , 13(6), e068904. <a href="http://dx.doi.org/10.1136/bmjopen-2022-068904">http://dx.doi.org/10.1136/bmjopen-2022-068904</a>
DOI	<a href="https://doi.org/10.1136/bmjopen-2022-068904">10.1136/bmjopen-2022-068904</a>
Publisher	BMJ Publishing Group
Journal	BMJ Open
Download date	2026-05-10 17:39:39
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Link to Item	<a href="http://hdl.handle.net/10034/627877">http://hdl.handle.net/10034/627877</a>

# BMJ Open Where are all the veterans? A mixed methods assessment of a systematic strategy to increase veteran registration in UK primary healthcare practices

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**To cite:** Finnegan A, Randles R. Where are all the veterans? A mixed methods assessment of a systematic strategy to increase veteran registration in UK primary healthcare practices. *BMJ Open* 2023;**13**:e068904. doi:10.1136/bmjopen-2022-068904

► Prepublication history for this paper is available online. To view these files, please visit the journal online (<http://dx.doi.org/10.1136/bmjopen-2022-068904>).

Received 11 October 2022  
Accepted 10 May 2023



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## ABSTRACT

**Objectives** To identify effective initiatives to increase veteran registration in UK primary healthcare (PHC) practices.

**Design** A structured and systematic strategy was designed to improve the number of military veterans correctly coded within PHC. A mixed methods approach was adopted to evaluate the impact. PHC staff provided anonymised patient medical record data that used Read and Systematised Nomenclature of Medicine - Clinical Terms codes to identify the number of veterans within each PHC practice. This included baseline data, then scheduled further information after two phases of internal advertisement and two phases of external advertisement of different initiatives intended to raise veteran registration. Qualitative data was acquired through post-project interviews with PHC staff to ascertain the effectiveness, benefits, problems and means for improvement. A modified Grounded theory was used for the 12 staff interviews.

**Setting and participants** Twelve PHC practices in Cheshire, England, participated in this research study with a combined total of 138 098 patients. Data was collected between 01 September 2020 until 28 February 2021.

**Results** Overall, veteran registration increased by 218.1% (N=1311). Estimated coverage of veterans increased from a coverage of 9.3% to a coverage of 29.5%. There was an increased population coverage ranging from 5.0% to 54.1%. The staff interviews revealed improved staff commitment and their taking ownership of the responsibility to improve veteran registration. The primary challenge was the COVID-19 pandemic, in particular the significantly reduced footfall and the communication opportunities and interface with patients.

**Conclusions** Managing an advertising campaign and improving veteran registration during a pandemic caused huge problems, but it also presented opportunities. Enabling a significant increase in PHC registration during the harshest and most testing conditions indicates that the accomplished achievements have substantial merit for wider adoption and impact.

## INTRODUCTION

In the UK, primary healthcare (PHC) is the portal to the National Health Service (NHS) with approximately 300 million patient consultations each year<sup>1</sup> and is responsible

## STRENGTHS AND LIMITATIONS OF THIS STUDY

- ⇒ The use of medical records allowed for a highly valid and reliable approach to viewing the veteran profile.
- ⇒ The approaches to raising veteran registration were low cost and easily implemented without further burdening primary healthcare (PHC) practices workload.
- ⇒ The qualitative interviews did not consider the perspective of the veterans themselves but rather only considered the views of the PHC practices.
- ⇒ The identification of veterans was reliant on self-identification, meaning that veterans were likely missed.

for an estimated 2 million veterans.<sup>2</sup> A UK military veteran is classified as anyone who has served at least 1 day in the British Armed Forces. This includes both regular and reservists, and those who were conscripted under National Service.<sup>3</sup> However, there are many staff, veterans and their families who are unaware of these criteria.<sup>4</sup> Veterans are estimated to be predominantly men (89%), aged 65 and over (60%),<sup>2</sup> and they have been identified as having a high prevalence of mental health (MH) disorders.<sup>5</sup> Despite this, only a small number of veterans seek help, citing barriers such as a lack of understanding from healthcare staff,<sup>6</sup> although the UK Royal College of General Practitioners (RCGP) have introduced a veteran friendly accreditation scheme for general practice (GP) where registration criteria include the recording of veteran status and having a dedicated veteran champion who has an awareness of veteran issues and services.<sup>7 8</sup>

On leaving the British Armed Forces, service personnel receive a medical examination and obtain documentation that they are expected to pass onto their civilian PHC practice.<sup>9</sup> PHC practices are required to record diagnostic information, pharmacological treatment and demographic characteristics



such as age and gender onto medical records using Read Codes, or Systematised Nomenclature of Medicine - Clinical Terms (SNOMED CT) codes.<sup>10</sup> These codes extend to military veterans so that any healthcare staff that come into contact with a veteran patient will be aware of their veteran status. The RCGP recommends the use of a single 'Military Veteran' code, however there are several different code options relating to military service that can be applied, and it is at the discretion of the staff member who is recording the information to choose the appropriate code. This is one of the many challenges that prevent the coding of veteran status from working seamlessly, and research indicates that less than 10% of veterans were correctly coded,<sup>4</sup> and that 47% of GPs did not know how many veterans were registered in their practice.<sup>11</sup>

NHS England (NHSE) introduced 'Op COURAGE' to facilitate priority access to veteran specific MH services.<sup>12-13</sup> 'Op COURAGE' encompasses three services; The Veterans Mental Health Transition, Intervention and Liaison Service, the Veterans Mental Health Complex Treatment Service and the Veterans Mental Health High Intensity Service whose services range from supporting families of veterans to providing support for veterans in severe MH crisis.<sup>12-14</sup> To maximise the uptake of these services, it is vital that veterans and their families register with PHC and that staff are aware that these services exist. PHC staff can positively change health behaviour patterns,<sup>4</sup> and there is a requirement to: motivate veterans to register, to identify the reasons why a veteran may choose to not disclose their status and improve PHC staff's awareness and knowledge.

The primary aim of this research project was to identify effective initiatives to increase veteran registration in UK PHC practices. The objectives were:

- Understand the most effective initiative in motivating veterans to notify PHC staff of their armed forces status.
- Identify trends regarding age, gender and marital status from the identified veterans.
- Evaluate PHC staff assessment of the intervention, including the effectiveness, benefits, problems and means for improvement through post-project interviews.
- Distinguish the potential for transferability to a larger national initiative.

This would provide a list of recommendations to help inform NHSE, other UK health organisations and the RCGP to improve the PHC landscape.

## METHODS

### Theory and methodology

This study builds on a pilot project conducted in 2018, which raised veteran registration in four PHC practices in Lancashire, England. This increase was enabled by using zap stands, posters and television (TV) monitors within the PHC practice to display information designed to motivate veterans to inform their PHC practice of

their veteran status. In addition, training materials were provided to the PHC staff, and external advertisements with local professional sports clubs and social media. This pilot project informed the methodology for this initiative.<sup>4</sup>

Quantitative data was gathered from 12 PHC practices via the Read/SNOMED CT codes assigned to patient medical records. The SNOMED CT (Code 753651000000107) or Read Code (Code 13Ji) for 'Military Veteran' was used to establish a reliable and consistent measurement. Practices were also encouraged to recode any veterans that they had categorised under different veteran codes. Anonymised data was dispatched to the authors and input into the SPSS V.27 database for analysis.<sup>15</sup>

Qualitative data was obtained through post-project semi-structured interviews with staff from each PHC. A point of contact in each of the practices was established at the start of the project, and these individuals were used for the interview stage, with an aim to conduct one interview per practice. The interviews were expected to last no longer than 60 min. This provided an understanding of what the practice staff deemed to be effective, what the benefits were to taking part as well as any challenges and ways for potential improvement. Their responses were subjected to a modified grounded theory methodology.<sup>16</sup> This approach included the open coding of transcripts without the influence of preconceived assumptions, as well as constant comparisons across the different transcripts to construct categories and codes. Memo writing was used to operationalise the definitions of each of the categories and consider potential relationships. Grounded theory is commonly used within British Armed Forces Research.<sup>17</sup>

### Procedures

This project commenced with an international systematic review of veterans help seeking behaviour<sup>6</sup> and progressed to a mixed method research study. The initial medical record search was conducted in August 2020, prior to any study initiatives and then periodically repeated by the PHC staff on a 6-week basis. When anomalies in the data were identified, these were queried with the PHC practice to ascertain potential reasons. Being aware of the considerable pressures on PHC, the search strategy was designed to maximise the data that could be collected while being cognisant of other demands and priorities on PHC staff. Therefore, the searches highlighted increases in veteran registration, basic demographical data (age, gender and marital status) and for an aligned morbidity study, the final search identified the common military MH disorders chronicled on the veterans medical records.<sup>18</sup> The PHCs were financially remunerated for their time.

The site for this study were 12 PHC practices based in Cheshire in the Northwest of England with a total patient population of 138 098, equating to an estimated veteran population of 6477, see [table 1](#) for information on number of patients, general practitioners and nurses/healthcare assistants per practice as of August 2020.

**Table 1** Breakdown of practice patient numbers and members of staff in August 2020

PHC	N Patients (August 2020)	N General practitioners (August 2020)	N Nurses and healthcare assistants (August 2020)
Practice 1	9985	7	7
Practice 2	7533	4	8
Practice 3	10500	6	4
Practice 4	15859	13	10
Practice 5	9440	6	9
Practice 6	6956	5	6
Practice 7	13553	7	8
Practice 8	10400	7	4
Practice 9	14056	11	9
Practice 10	16216	9	11
Practice 11	12350	5	9
Practice 12	11,250	10	9
	138098	90	94
PHC, primary healthcare.			

The authors visited each of the 12 practices prior to any initiatives taking place. This was intended to answer any questions the practices had, to deliver the specifically designed advertising zap stands, posters and other materials and to build a rapport with the staff. This also provided an opportunity for the researchers to explain the expectations of the study and data capture to ensure consistency across the practices. All practices were given a USB memory stick which contained virtual copies of the zap stand and posters, information for TV screens, a timeline of the project, details of the code to be used and demographics to be included as well as a handout containing current veteran services that were available. A press release was distributed, and commentaries were subsequently published in local newspapers.

Each of the project's four phases lasted for 6 weeks each with the focus on different forms of engagement within an overarching advertising campaign. All of these stages occurred during the COVID-19 pandemic, and some occurred under a UK national lockdown where restrictions were in place and many establishments were shut (see figure 1).

### Phase one

The first two phases were within the PHC practices, commencing with internal advertisement built on displaying zap stands/posters that contained information on the definition of a veteran as well as showing the benefit of declaring this status to their PHC practice. The PHC staff were directed to place these materials where most patient activity would occur, with the zap stands at the PHC practice entrance and posters were positioned in windows and waiting rooms. In addition to this, practices

4 and 7 chose to use influenza vaccination clinics, where they would ask patients on entry to the PHC if they had ever served in the military. Practice 6 added the question of veteran status to their patient registration form.

### Phase two

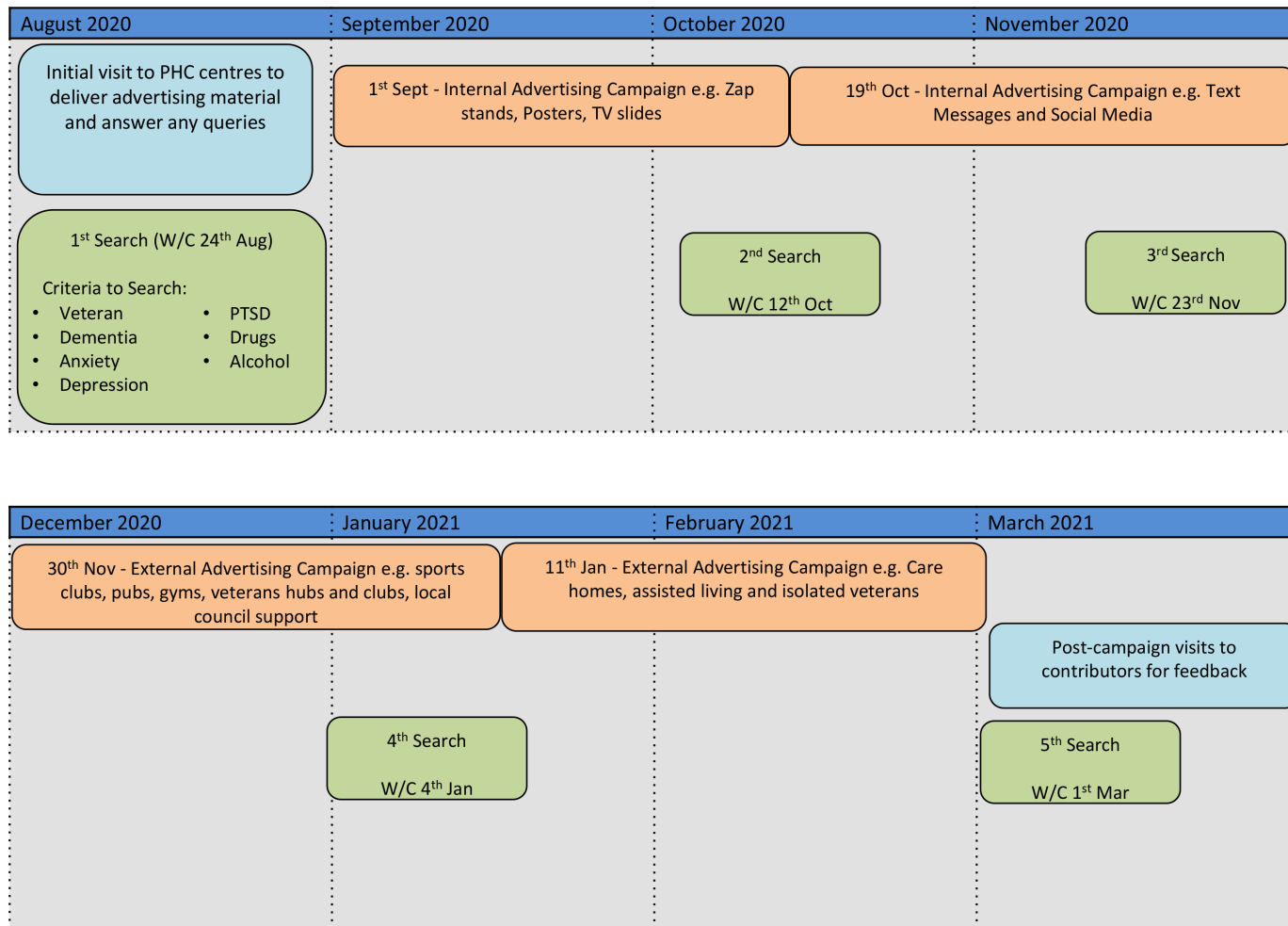
Phase two required the PHC staff to upload a digital version of the project poster onto their website and social media that they had such as Facebook and Twitter. There was also a requirement to send a text message to all patients asking if they were a veteran so that veterans could respond and inform their PHC practice of their veteran status. The PHCs used different text messaging systems and MJOG<sup>19</sup> was the most common, where patients were able to be contacted in batches and were able to respond to text messages. Practices 4 and 9 used iPlato<sup>20</sup> which in addition to the capabilities of MJOG, automatically coded responses. The systems in some PHCs could not receive a response to their messages, they would ask those who were veterans to contact the practice via phone or email.

### Phase three

The external advertisement then commenced with the third phase established in the local community and devised to target areas where younger veterans and their families in particular may assemble such as public houses, gymnasiums and sports grounds. However, due to the COVID-19 pandemic these sites were closed and the focus of attention had, by necessity, to change. Therefore, the authors engaged the support of local shops, supermarkets, churches, pharmacies, schools and community centres and other establishments. A total of 69 of these displayed a poster or flyer, all of which were within the immediate areas of the practices and not beyond the two urban areas. Posters were also disseminated and distributed throughout the vicinity of the PHC practices with local borough councils displaying posters on bus stops and the police in their stations. In addition, there were eight community Facebook postings from four of the practices and one local council that conveyed the project information. Fifty local schools were contacted and asked to disseminate the information although only two responded.

### Phase four

The fourth and final 6-week stage targeted Care Homes for the elderly, with the intent to distribute the advertising information in an attempt to connect with the older cohort of veterans. This phase was chosen due to veterans being a predominantly elderly population, with this group not accurately captured by the pilot study,<sup>4</sup> this phase was an attempt to engage with this older veteran population. The aim was to enter the Care Homes, however, due to the COVID-19 pandemic this was not possible and instead local councils sent the information to all Care Quality Commission registered Care Homes in their area. The authors also personally contacted a total of 62 Care Homes within a 2-mile radius of each of



**Figure 1** Project timeline, including search dates and initiatives. PHC, primary healthcare; PTSD, post-traumatic stress disorder; TV, television; W/C, week commencing.

the PHC practices. Following completion of all stages, descriptive statistics were used to explore the change in veteran registration and the veteran profile. In addition, for inferential statistics Z scores were provided.

### Post-project interviews

Following completion of all stages, staff from each of the 12 PHC practices were interviewed to build a picture of their understanding of what was deemed to be effective, what the benefits were in taking part as well as any challenges and ways for potential improvement. Each PHC centre nominated one primary point of contact for the duration of the project. This individual was then contacted to be interviewed. Sixty seven per cent (N=8) were the Practice Managers themselves; additional points of contacts included an Operations Manager, General Practitioner, Healthcare Assistant and Practice Administrator. The interviewees had been working with the researchers for over 6 months. Regular feedback during that period led to the question set around the three most positive aspects of the intervention and the three challenges. Each theme raised by the respondent was further explored. Following informed consent, all meetings were recorded and transcribed by the researchers before being

analysed using a modified grounded theory approach.<sup>16</sup> In line with grounded theory, the research strove for thematic saturation. However, the research concluded following 12 interviews as this was the entire population for the current study, in addition to being completed under COVID-19 restrictions.

### Patient and public involvement

The paper provides evidence of active engagement with PHC practices, patients and the armed forces community. While the COVID-19 pandemic presented challenges; regular communication with PHC practices included patients within their Patient Participant Forums, together with the projects advisory committee provided valuable guidance in the co-production and modelling of the project's advertising campaign. The project report was enhanced with a free online educational video, and both were widely distributed to armed forces PPI groups.

## RESULTS

### Phased results

The first phase of the project was establishing advertising material within each practice. The baseline for the

practices identified 601 veterans registered, estimated to have identified 9.3% of the total number of veterans based on the population estimate of 5%. Following the implementation of phase one the total number of veterans registered increased to 817, covering an estimated 12.6% of the veteran population. This phase of the project raised veteran registration by 35.9% (N=216).

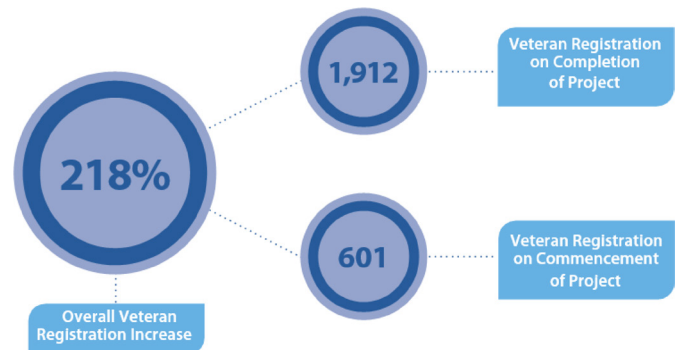
The second phase involved more virtual methods of sharing and disseminating information and using text messaging services. At this stage, five of the practices were unable to send out text messages. However, veteran registration increased from 817 to 1584, estimated to have identified 24.5% of the total number of veterans. This phase of the project raised veteran registration by 93.9% (N=767).

The third phase was based in the community. Following this intervention, veteran registration rose by 12.8% (N=202). This equated to an increase from 1584 veterans to 1786, with an estimation of identified 27.6% of veterans. However, Practice 2 and 10 both sent their text messages during this stage, which may account for the majority of the increase as other practices only had minor increases.

The final phase was that of contacting Care Homes to access the older veterans and potentially more isolated. Veteran registration increased from 1786 to 1912 at this phase, with an estimation of having identified 29.5% of veterans. However, little response was received from the Care Homes, and it is likely that this increase was a result of on-going engagement of the PHC practices.

### Overall veteran registration increase

At the onset of this project, it was estimated that 9.3% (N=601) of veterans were correctly coded. See [table 2](#) for the improvement in veteran registration across the



**Figure 2** Increase in veteran registration with primary healthcare practices.

project. Overall, veteran registration increased by 218.1% (N=1311) (see [figure 2](#)).

Estimated coverage of veterans increased from a coverage of 9.3% to a coverage of 29.5% (see [table 2](#)). In addition, for individual practices, pre-searches ranged from a veteran population coverage of 1.2%–21.2%. After the final search this increased to a population coverage ranging from 5.0% to 54.1%. As well as this, five practices were covering over 30% of their veteran population, and two practices were covering 50% or more of their veteran population. Inferential analysis indicated that the results were statistically significant across all 12 PHC sites (see [table 3](#)).

### Demographics

The sample consisted of 88% (N=1682) men and 12% (N=230) women. The mean and median age was 62 and a mode of 83 years old. Ages ranged from 16 to 99 with a SD of 18. Sixty five per cent (N=1236) of veteran’s marital

**Table 2** Number of veterans registered pre and post initiatives

PHC	Veteran population pre-search	N vets pre-search	N vets post1	N vets post2	N vets post3	N vets post4	Veteran population post-final
			Inside PHC 1. Zap stands/ posters. 2. Text messaging.		Outside PHC 3. Community. 4. Care Homes.		
Practice 1	2.6%	13	18	19	24	25	5.0%
Practice 2	2.4%	9	15	22	65	69	18.3%
Practice 3	4.6%	24	24	147	160	163	31.1%
Practice 4	3%	24	76	375	418	429	54.1%
Practice 5	6.1%	29	39	42	42	47	10%
Practice 6	1.4%	5	36	47	59	137	39.4%
Practice 7	10.2%	69	154	199	205	213	31.4%
Practice 8	21.2%	110	131	131	131	131	25.2%
Practice 9	16.6%	117	120	357	361	351	49.9%
Practice 10	1.2%	10	10	14	44	56	6.9%
Practice 11	12.3%	76	79	81	122	130	21%
Practice 12	20.4%	115	115	150	155	161	28.6%
Total	9.3%	601	817	1584	1786	1912	29.5%

PHC, primary healthcare.

**Table 3** Inferential statistics for veteran registration pre and post initiatives

PHC	N patients	Estimated N of vets (5%)	N vets pre-search	N vets post-final	Z	P value
Practice 1	9985	499	13	25	13.57	>0.0001
Practice 2	7533	377	9	69	22.96	>0.0001
Practice 3	10500	525	24	163	51.20	0.0000
Practice 4	15859	793	24	429	98.61	0.0000
Practice 5	9440	472	29	47	18.14	>0.0001
Practice 6	6956	348	5	137	42.86	0.0000
Practice 7	13553	678	69	213	66.64	0.0000
Practice 8	10400	520	110	131	40.90	>0.0001
Practice 9	14056	703	117	351	94.18	0.0000
Practice 10	16,216	811	10	56	19.77	>0.0001
Practice 11	12350	618	76	130	40.52	0.0000
Practice 12	11,250	563	115	161	50.40	0.0000
Total	138098	6477	601	1912		

PHC, primary healthcare.

status was not known. Of those whose marital status was known (N=676), 70% (N=475) of veterans were married, cohabiting or in a common law partnership while 30% (N=201) were single, widowed, divorced or separated. Demographic details can be seen in [table 4](#).

Sixty per cent (N=1139) of veterans were aged 58 and over, with 79% (N=1518) aged 48 and over. Ten per cent (N=197) were aged 37 and younger, with 2.5% (N=47) aged 27 and under. Fifty per cent (n=6) of practices had a mean age that lay between 60 and 69. Forty two per cent (N=5) of practices lay between 50 and 59 age range. One practice had a higher mean age which is likely due to the practice using influenza clinics as their main method of capturing veterans meaning that they had captured a much older veteran population. Differences in the mean age across PHC practices is shown in [figure 3](#).

In addition, 41% (N=785) of veterans had a code on their medical record for at least one of the following

disorders of post-traumatic stress disorder, depression, anxiety, alcohol misuse, substance misuse and the physical disorder of dementia.<sup>18</sup>

#### Post-project practice interviews

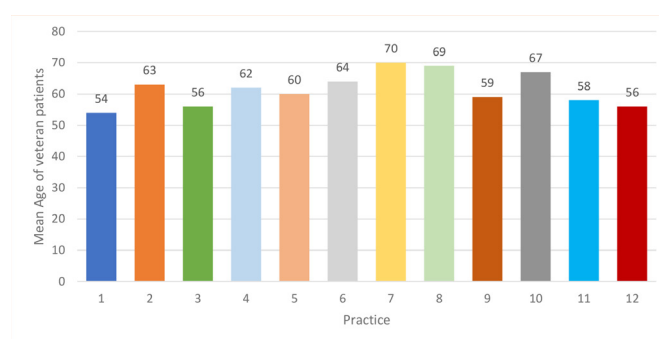
Following completion of all stages, staff from each of the 12 PHC practices were interviewed. Narrative from these interviews is presented anonymously within the following discussion. The noted themes are in [table 5](#).

## DISCUSSION

In the current study, less than 10% of PHC practices were correctly coding military veterans (9.3%) aligning with previous research,<sup>4</sup> and it has become increasingly clear that this is a problem that needs resolving.<sup>11 13</sup> In this project, over a 6-month period across 12 PHC practices, veteran registration increased by 218.1% (N=1311), with an average coverage of 26.7% (range 5.0%–54.1%). Previous research highlighted that there was less than 10% of veterans correctly coded<sup>4</sup> with 47% of GP's being unaware of how many veterans were registered in their

**Table 4** Veteran demographics

Serial	Veteran patient demographics		Percentage	N
1	Gender	Male	88	1682
2		Female	12	230
3	Marital status	Married	68.0	460
4		Single	20.9	141
5		Widowed	4.6	31
6		Co-habiting	1.5	10
7		Divorced	3.7	25
8		Separated	0.6	4
9		Common law partnership	0.7	5
10	Age	Mean	SD	Range
11		62	18.0	16–99

**Figure 3** Mean age of veteran patients within each primary healthcare practice.

**Table 5** Thematic coding of post-project interviews with practice staff

Theme	Axial coding	Open coding	Interview frequency (N)	%	Overall frequency (N)	
Positives  The positive outcomes of the project according to the practices.	Identification (91.7%, N=11)	Coding when not a veteran	1	8.3	2	
		Improved registration	4	33.3	4	
	Internal initiatives (83.3%, N=10)	Identifying veterans	7	58.3	10	
		Pride	2	16.7	2	
		Social media	2	16.7	2	
		Text messaging	6	50	8	
		Using influenza clinics	9	75	10	
		Visual reminders	7	58.3	10	
	Healthcare staff (100%, N=12)	Involvement and education of staff	11	91.7	19	
		Knowing benefits	4	33.3	4	
		Taking ownership	7	58.3	9	
		Understanding veteran definition	7	58.3	9	
	Challenges  The challenges that were faced by the practice during the project.	Accessing veterans (58.3%, N=7)	Care homes	4	33.3	6
Reluctance from veterans			3	25	4	
Communication (100%, N=12)		How to communicate information	2	16.7	4	
		Lack of reach with social media	3	25	3	
		Text messages	8	66.7	9	
		Lack of opportunities to communicate	9	75	12	
COVID-19 pandemic (100%, N=12)		Concentration on vaccines	5	41.7	7	
		Decreased staff capacity	7	58.3	8	
		Increase in phone calls	5	41.7	6	
		Lack of footfall	12	100	15	
		Pandemic in the community	1	8.3	1	
Future Improvements  Means for improvement to further facilitate veteran registration in PHC.		Accessing veterans (33.3%, N=4)	Contacting elderly	2	16.7	2
			Improve text messaging	3	25	3
	Regular reminder		2	16.7	2	
	External improvements (16.7%, N=2)	Improve veteran services	1	8.3	1	
		Transition	1	8.3	2	
	Healthcare staff (50%, N=6)	Involvement of GPs	1	8.3	1	
		Education and opportunities	2	16.7	2	
		Social prescriber	4	33.3	4	
	Recording veteran status (33.3%, N=4)	Improvement of codes	1	8.3	1	
		Include question elsewhere	3	25	3	

GP, general practice; PHC, primary healthcare.



practice.<sup>11</sup> A pilot study related to this research was able to raise veteran registration significantly within a small period of time and with simple and cost-effective methods.<sup>4</sup> To the author's knowledge, this pilot was the first of its kind to explore effective methods of identifying veterans within PHC. This research has built on this to highlight the simple methods that can identify veterans and to therefore, be able to effectively support those that are in need of specialist services which will thus also, release some of the burden on general NHS services. Furthermore, research into the help-seeking behaviour of veterans has found that veterans are facilitated by civilian healthcare systems being educated in their needs, with barriers related to stigma.<sup>6</sup> The results of this study has proven that these simple initiatives have encouraged veterans to self-identify, with staff also highlighting that they felt better educated on the veteran community and therefore, members of staff within PHC will be able to provide better support to this community. Extracts from the study interviews that informed these results are embedded in the following discussion to maintain flow and inform the narrative. Presentation of these findings is intended to protect anonymity of respondents who were referred to as Practice 1, Practice 2 and no further information is disclosed.

### PHC interventions

A successful initiative was the use of text messages to contact all patients who when they responded annotated whether they were a veteran. However, the PHCs text messaging services varied considerably, with some requiring each patient to be sent an individual text, and then each response was individually updated onto the patient's records. This carried enormous human resource implications that tested the most motivated of staff. However, exemplary text messaging systems can deliver batch messages to all patients with the reply automatically coded onto their electronic record, with three practices increasing registration by over 197%. A system that was identified as being effective was iPlato.<sup>19</sup> Of note, several PHC practices reported that veterans had initially mistrusted the text messages and had contacted the PHC practices to enquire why the staff were asking. Once the veterans were aware of the project, then they generally responded positively.

Visual prompts encouraged veterans to inform PHC staff of their status. These notices conveyed key facts and were displayed within PHC practices: in the form of a Zap stand/posters; on the practice information board, or TV information screens. These notices were effectively used in the local community in areas including supermarkets, pharmacies and professional sports clubs.

There is a requirement for consistent and correct application of Read and SNOMED codes onto veterans' electronic medical records as the multiple options cause confusion. The project improved the knowledge and awareness of the PHC staff regarding veterans' characteristics and the specific health and social care options that

were available. This included reception staff who were often the initial point of contact.

Having one of the reception team—one doing it and taking ownership of it. Because they will remind the team—don't forget to ring the military veterans—you need someone on the ground floor to do that. I made sure I shared all the information with the team. All the information whenever our figures went up and had a really big think about it. It keeps it on people's minds.

– Practice 4

The staff were directed to free online educational modules that can be revisited when required, and appeal to all staff irrespective of their background.<sup>21 22</sup> The majority of respondents reported that being able to identify veterans was a positive, with veterans being proud to share their status.

### PHC and the local community

There is a requirement for a concerted UK effort to raise public awareness of the definition of a veteran and to address the issue of poor help-seeking behaviour. To achieve this, PHC need to work together, as different PHC practices have diverse strengths and knowledge. In this project, there were doctors, nurses and other staff who were veterans, married to veterans or had family still serving in the British Armed Forces. Primary care networks provide a strong foundation for motivated PHC practices to work together and including social prescribers can improve their awareness of veterans' services/charities. Some practices were benefiting from the RCGP veteran friendly accreditation programme, and feedback indicated benefits of appointing a veteran to the practice patient participation group.

The community-based engagement required flexibility from the Centre staff but more importantly the support of organisations such as the Borough Councils, health and emergency services, sports clubs and veteran charities and associations. This was offered in abundance, and multiple groups were extremely willing to help and were pivotal in obtaining wider reach.

### COVID-19

The project was delivered under COVID-19 restrictions which resulted in reduced numbers of patients visiting PHC practices and therefore not viewing the specifically designed posters/zap stands and staff not having the opportunity to ask the question of whether they were a veteran. The staff also had to prioritise the administration of vaccines and an increase in the number of phone calls to the practices was probably a deterrent to those who wanted to report their veteran status but often faced a long-pre-recorded message and extended wait times.

We've not had the same contact because a lot of it has been E-consult, they've not even been contacting the receptionist because that comes and goes straight to

**Table 6** Recommendations to improve veteran care in PHC

Serial	Requirement	Action
1	Increasing national awareness	Reducing stigma and improving knowledge
2	Staff education	Online E-learning
3	Dedicated veteran's champion	RCGP Veteran Friendly Accreditation Programme
4	Consistent coding	SNOMED (753651000000107) or Read code (Code 13Ji) for 'Military Veteran'
5	Text messaging	Exemplary systems - iPLATO
6	Visual notices	Zap stands and posters
7	Primary care practice events	Influenza clinics
8	Primary healthcare practices working together	Include veteran participation in PHC patient committees
9	Mobilising the local community	Shops and borough councils
10	Third sector collaboration	Veteran specific charities

PHC, primary healthcare; RCGP, UK Royal College of General Practitioners; SNOMED, Systematised Nomenclature of Medicine.

the doctor. They've not been able to have that opportunity to ask.

– Practice 12

However, the PHC responded with creative initiatives to increase veteran registration and took ownership for maximising engagement with veterans by using practice events such as COVID-19 and influenza vaccination clinics as a way to get veterans to engage.

The intention on commencement of the project was to connect with the isolated hard-to-reach elderly veterans including those residing in Care Homes. This was not achieved and only 45% of respondents were aged 65 and over, significantly lower than the Ministry of Defence estimate of 60% for this age group.<sup>2</sup> Age analysis revealed that elderly veterans were not correctly registered with their GP practice. There were multiple reasons for this, such as veterans being unaware of the 1-day inclusion criteria and therefore being unaware of their veteran status and never declaring as such. This could extend to those more vulnerable members of the population in Care and Residential Homes, or with dementia, who may be reliant on others for much of their engagement with PHC. These recommendations are summarised in [table 6](#).

### Study limitations

The intent of this project was to take a systematic approach to addressing the study objectives and use the PHC medical records searches to attribute any increase in registration to particular initiatives. However, due to COVID-19 pandemic, some practices were unable to

implement certain phases such as sending text messages at the intended time. In addition, the reduced number of patients accessing PHC practices meant that the external community-based initiatives were likely to have been less effective. Due to the PHC practices sending messages to all phone numbers that they had on file, children sometimes had their parents phone number registered as a contact. This meant that there would be isolated instances of children being recorded as a veteran, as the parent had responded believing the message to be for themselves. The practices were informed of this error and made the necessary corrections.

### CONCLUSION

Enabling a significant increase in PHC veteran registration during the challenges presented by the COVID-19 pandemic indicate that the accomplished achievements have significant merit. In particular, text messaging services were beneficial for prompting engagement, reducing human resource demands and improving the available data. The advertising campaign managed to connect with large parts of the veteran's community. If it was not for the sense that during the COVID-19 pandemic that this was not a priority, or if the veteran could have entered the PHC practice or had easy access via a phone call then there is face validity that the numbers registered would have been considerably higher. There was a positive shift in the PHC staff's attitudes to one of ownership of the challenges and taking responsibility and commitment to resolve. They need further educational support, and the project has played a part in addressing that. There remains the issue of engaging with elderly veterans and their families, which would help to get an accurate review on the issue with dementia in the veteran population. The lessons learnt from this study would be cost-effective to introduce and are applicable to transfer to a larger nationwide or UK initiative.

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**Acknowledgements** The research team are grateful to the Forces in Mind Trust for funding this research and for Kirsteen Waller for supporting the centre during this project and it's publications. A thank you also goes out to all the primary healthcare centres and individuals who participated in this research. As well as to those who supported the team in this research such as Cheshire Police, Warrington Council, Cheshire West and Chester Council, Warrington Wolves, LiveWire and any other body/establishment that has reinforced this research. They all played a vital role in this project.

**Contributors** AF: The principal investigator for the research involved in data collection and management. Contributed considerably to editing and redrafts of the paper. Is the guarantor of the published data and decision to publish. RR: Lead researcher on the project, involved in data collection, analysis and writing of the first draft of the paper.

**Funding** This work was supported by Forces in Mind Trust (FIMT), grant number (FIMT19/0122UC - UoC HSC19-08).

**Competing interests** None declared.

**Patient and public involvement** Patients and/or the public were involved in the design, or conduct, or reporting, or dissemination plans of this research. Refer to the Methods section for further details.

**Patient consent for publication** Not applicable.

**Ethics approval** Ethical approval was granted for this research project by the University of Chester Faculty Research Ethics Committee in the Faculty of Health and Social Care (RESC0320-1033). All ethical guidelines were followed and considered for the project. Participants gave informed consent to participate in the study before taking part.

**Provenance and peer review** Not commissioned; externally peer reviewed.

**Data availability statement** All data relevant to the study are included in the article or uploaded as supplementary information. There is no additional unpublished data available.

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