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National Health Service interventions in England to improve care to Armed Forces veterans

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BMJ – Military – “*National Health Service interventions in England to improve care to Armed forces Veterans (AFVs)*”

Abstract

Armed Forces Veterans (AFVs) are first and foremost citizens of the UK and are therefore (like all UK residents) entitled to universal healthcare, free at the point of need. This means that AFVs have nearly all their healthcare needs met by the National Health Service (NHS) and this provides access to a full range of generic services. However, since 2013 there has been an armed forces team that can also support veterans. This review is an assessment of the work of this group over the last 8 years.

The health needs of AFVs have been investigated and are not significantly different from those of their demographically matched peers. However, due to their demographics, selection at recruitment and their roles, AFVs compared to the general population are more: male, white and old and have fewer pre-existing, or hereditary conditions. However, they do suffer from higher rates of musculoskeletal injury, different patterns of mental health illness and have historically been higher users (and abusers) of alcohol and tobacco. In addition to supporting mainstream services used by AFVs, the NHS in England commissions a bespoke range of specific “Priority” NHS services such as those for mental health, or for the rehabilitation of veterans using prostheses. New interventions are continuing to be developed to improve AFVs’ healthcare and are aligned to the NHS Long-Term Plan and the Restoration and Recovery Plans after the Covid-19 pandemic.

Background and Policy

Within the United Kingdom (UK) health is a devolved matter and so services and the health system is different in its four constituent jurisdictions. The NHS in England is an organisation that has had multiple reorganisations. The most recent of these reforms resulted from the Health and Social Care Act 2012¹. This act identified serving armed forces as a separate population that would not fall under the (variable) local payer arrangements and created a single payer/commissioner for this population. This was to ensure equal and equitable access to services across England for serving personnel and meant for the first time there was a specific body with Armed Forces (AF) expertise. This team also has the knowledge to act as a subject matter expert for all AF (serving, reservist, veteran and families) matters (the 3 other devolved administrations have taken different approaches to address similar issues).

The government has also produced the AF Covenant² and to ensure “no disadvantage” accrued from service to those that are serving (regular and reserve), have served, or their families. This Covenant is contained within the NHS Constitution³ and has several health clauses. These include the requirement that “priority treatment” be made available (subject to the clinical needs of others) for service attributable illnesses and injuries and specific funds were transferred to the NHS to meet these needs. This separate funding is important, as the NHS has clinical need as its defining principle and has sought to avoid a potential ethical clash. This is because some might interpret the Covenant as providing preferential services, especially for not service-related needs.

Principles and Themes

Since its inception, the NHS has sought to optimise its budget and develop services in line within its allocated resources. To achieve this, it has sought to follow a set of principles, which are:

Patient Involvement. Traditionally, the views and opinions of the AF community have been represented by a variety of stakeholder groups. These representatives have been the chain of

command, the medical establishment, quasi-government bodies, charities, and associations such as the families’ federations. The NHS has brought a new approach and has used independent consultations, needs assessments and engagement exercises to directly assess patients’ needs and opinions. There is an active Patient and Public Voice Working Group, where all opinions are represented and heard. This has worked well and has had at least two positive effects: a greater voice for minorities (e.g., females, members of ethnic groups, gay veterans, etc.) and greater independence (e.g., from those charities that are also service providers).

Clinically Led. The NHS prides itself on its clinically led decisions and the NHS has established a joint Defence Medical Services (DMS)/NHS Clinical Reference Group. This has been able to ensure clinical leadership of service specifications and commissioning policies. This has been particularly effective in designing mental health specifications.

Evidence Based. The NHS is fortunate in having its National Institute for (health and social) Care Excellence (NICE) which guides treatment decisions and has done so via (for example) recent guidance on the treatment of Complex PTSD⁴.

Forward Looking. The NHS and defence medical services always seeks to innovate and there are many examples of where the armed forces led, responded to, or supported research into new ways of working (the widespread expansion of the use of video and telephone consultations in the military is a well-known⁵ example).

Armed Forces Veterans (AFVs) in the NHS

Nearly all the population in England register with an NHS general medical practitioner (GP) and routine commissioning decisions are made locally via a GP led organisations called Clinical Commissioning Groups (CCGs); these organisations plan and pay for services for their local populations. AFVs therefore fall under the statutory health responsibility of their local CCGs. There is also a requirement on CCGs to abide by the AF Covenant and ensure “no disadvantage” and “Priority Treatment” where appropriate. The duties of service planning and funding of care for AFVs are split between local CCGs (for the generic services) and the AFV national team (for bespoke services (and looks after the hospital needs of the serving)). Very few CCGs have provided local veteran specific services, but this has not been consistent and so National AFV services have also been provided to enable a “veteran friendly environment” to be created that recognises the context of military service. A summary of these differences between local and national is at Table 1 below.

Table 1:

NHS General Services (locally Commissioned/provided)	National Health Services (NHS) Nationally Commissioned Veterans’ Services
<ul style="list-style-type: none"> • Primary Care (Medical, Dental, etc.) • Mental Health (c 23k veterans per annum seen in Talking therapy services) • Hospital Care • Specialised Services • Emergency, Out of hours & Urgent Care • A few areas (e.g., Greater Manchester) commission bespoke services. 	<ul style="list-style-type: none"> • Prosthetic Services (ensuring continuity with in-service provision): <ul style="list-style-type: none"> • NHS Provided • Additional DMS access • Tiered Mental Health Services: <ul style="list-style-type: none"> • Transition, Intervention and Liaison (“TILS”) – Brief Interventions • Complex Treatment Services (“CTS”) – Sustained treatment • High Intensity Services (“HIS”) - Chronic, resistant to treatment, Highly complex

The two national key priority services provided for AFVs are:

Prosthetics

A Veterans' Prosthetics Panel (VPP) was established in 2012 by the Department of Health (DH) as the Government's response to *A better deal for military amputees*⁶ due to concern for recent military amputees, who had been treated in military facilities after injuries in the conflicts of Iraq and Afghanistan (and the responsibility transferred from DH to the NHS in 2013). This was because the NHS was unable to support military supplied modern prosthesis in the short term, and in the longer term would not be able to replace them once the warranties had expired. The VPP aimed to ensure funding could be made available to enable NHS provision to match that of the military. It also aimed to ensure access to continuity of provision to all veterans with a service attributable amputation, regardless of their age, providing there is evidence of clinical benefit and to reduce any disparity of care⁷. The VPP continues to operate and adapt to new technology as a nationally commissioned specialised service with a common specification and policies. The limbs that veterans receive may be of a higher functional standard than those of the mainstream NHS, which reflects the difference in provision between the military and civilian patients and recognises the Covenant commitments to reflect the sacrifices made by the armed forces. These services have also provided a wider (modest) dividend to the wider amputee community and NHS prosthetists (because of the increased standardisation and availability of similar services to non-veteran patients and a new national specification which enabled a greater number to benefit from a change in mainstream NHS policy giving access to micro-processor knees). The VPP has ensured that veterans' needs are met to the satisfaction of users and charities. It has also adjusted its budgets to meet changing needs, as warranties expire.

Mental Health Services for Veterans

Mental healthcare provision for the general population is fully available to veterans and they use these general services to meet most of their needs. These include primary care, community mental health teams, improved access to psychological therapies (IAPT) and mental health crisis response teams. Military veterans IAPT services offered notable improvements such as a better understanding of service culture⁸. However, it was felt that there was a need for more bespoke multi-layered services to complement this mainstream provision and offer improved speed of access. These extra services focus on the AFVs but also recognise the support provided by the veteran's family, peers, home environment and look at the psycho-social determinants of good mental health and wellbeing. They were also established to enable different levels of intensity of treatment depending on the individuals' changing needs. They can also provide services for those who are about to transition out of service but have not yet been discharged. There are 3 service levels which are described at Table 2 below:

Table 2:

Level	Name	Description
1	Transition, Intervention and Liaison Service (TILS)	<p>Transition: for serving personnel due to leave the armed forces, working with the DMS to offer them mental health support through their transition period.</p> <p>Intervention: for those with complex presentations, the service provides a range of treatments in an outpatient setting.</p> <p>Liaison: for those veterans who may not have complex mental health difficulties, yet would benefit from NHS care, TILS helps them access local mainstream mental health services and psycho-social support.</p>

2	Complex Treatment Service (CTS)	<p>CTS provides:</p> <ul style="list-style-type: none"> Enhanced outpatient services for ex-serving personnel who have service-related, complex mental health difficulties that have not improved with previous treatment. Access through TILS and provides more intensive care and treatment for a range of physical, social and mental health issues, including occupational and trauma-focused therapies. Supported from an armed forces-aware team who work with them to develop a personalised care plan including arrangements for crisis care.
3	High Intensity Service (HIS)	<ul style="list-style-type: none"> HIS is for a cohort of highly vulnerable veterans who are: <ul style="list-style-type: none"> struggling to maintain their mental health, in a crisis and/or need urgent, or emergency mental healthcare. HIS provides crisis care, therapeutic inpatient support, help with coordinating care across organisations and support and care for family members and carers where appropriate

These statutory services are complemented by the work of armed forces' charities as sub-contractors, or from separate services that they fund, or provide themselves. The NHS is also working with charities in the Contact Group⁹ to develop and implement a common accreditation, assessment frameworks and case management for Veterans' Mental health (VMH) to provide veterans with improved comparability, standardisation, quality, and improve the sharing of information. This closer integration between service charities and the NHS has benefited patients, as shown by increased numbers of referrals.

Issues Affecting NHS Interventions.

Data use is a key part of modern healthcare delivery, as it supports clinicians, researchers and planners, so that patient's needs are met, and systems support the patient through complex pathways between multiple providers. Over the last few years, the access to data has improved particularly for the veteran community. However, there is still significant room for improvement.

At time of writing, DMS use an old legacy primary care system which has very limited integration with more modern NHS systems and so automated transfers of digital patient records from in service for use with ss has not been possible. Thankfully, an upgrade is expected in 2021.

Information on AFVs has been transformed over the last 10 years. Reasonable quality data is now available on the location of resettling veterans, working age veterans and some of their health needs from a combination of registration services, analysis of the census and from the Annual Population Survey¹⁰. This has enabled much better local planning of services. When this data is merged with the newly emerging treatment data that can show AFV status (e.g., IAPT), utilisation rates can be analysed, comparisons made, and trends looked at. However, the routine registration and coding of veterans on primary care and other NHS information systems is still in need of improvement¹¹. These data deficiencies hamper planning and research and the ability to look at sub-sets and minorities within the veteran community and limit the ability to plan to reduce inequalities.

Transition

For serving personnel, their in-service health requirements, including primary care, occupational and mental health, have been organised by DMS, with oversight from 'command' to ensure operational capability. Once discharged, the health responsibility falls to the individual. Health-related

transition includes detailed discharge medical assessments at which a summary of current medical issues is provided to the leaver. They also receive instructions on how to register with an NHS GP and are provided with a letter of introduction. Once they seek to register with their civilian practice, they pass the letter to the GP advising on how to get access to full in-service health records if required. As noted above, current DMS Information systems are unable to link directly to the NHS IT systems and so an opportunity to directly inform the GP of prior service and code them as AFVs is lost.

Accreditation

Not all those that offer service to veterans are of the same or even adequate quality. AFVs need good information of where quality services can be found. There have been a wide range of initiatives to ensure quality of provision for veterans, which include the accreditation of service providers, such as those of the Royal College of GPs “Veteran Friendly” Practice Scheme¹², the Veterans Covenant Health Alliance¹³ and one planned by the Royal College of Psychiatry (to accredit VMH providers). Access to accredited providers is also facilitated by the Veterans’ Gateway¹⁴ and “Map of Need” is being developed for social prescribing. Both accreditation processes need to expand but the Covid-19 pandemic has delayed this.

The response to the COVID-19 Pandemic of 2020/21

The complementary expertise of the Armed Forces and the NHS were well demonstrated during the Covid-19 pandemic and the NHS armed forces team was able to play its part in this collaboration. Activities varied from the delivery of contingency hospitals, the provision of protective equipment the delivery of testing for the virus and arranging vaccinations. There was also a great deal of joint logistics, and integrated command and control. The AF charities also supported the NHS with offers of help and these were reciprocated by emergency funding to mitigate the effects of the pandemic on several services charities.

Early (unpublished) indications appear to suggest that veterans appeared to have coped relatively well with the pandemic. Services continued to be provided for veterans but with an increase in digital services, increased stabilisation and less face-to-face therapy. Though there was a mixed picture in terms of those whose health improved or worsened, referral numbers have remained relatively constant. However extensive plans have been made for mental health waiting list recovery, once services are up to full operating capacity.

Where Next for AFVs in the NHS

It is hoped that the successful joint campaigning between government departments and service charities to get the “veteran question” into the UK 2021 census will unlock further data on veterans and their health needs (as well as reservists, and both of their sets of families). It is also hoped that it can help us better understand the health needs of minorities within these communities, whether due to disability, caring duties, or because they are part of a minority population, based for example on gender, ethnicity or sexual orientation.

Developments are also planned on the three-tiered approach for VMH, which has evolved over many years with multiple contracts and a lack of contiguity of regional boundaries. After 2022, it is planned to develop fully integrated service of region-based contracts and with multiple partners to enable multidisciplinary working at different levels of service need.

There have been a few recent changes to the governance arrangements and to partnerships with service charities. The Office for Veterans Affairs¹⁵ works with all UK Government departments and has a large range of other collaborators from the private, charity and public sectors. It aims to coordinate the functions of the UK Government to ensure the best support for veterans and their families as they transition back into civilian life. It is hoped that this will align with the development

of Integrated Care Systems (ICS) in NHS organisations and bring social and health care closer together at all levels and enable earlier intervention and collaboration (as proposed in a recently tabled set of new NHS reforms for England).

The military charity sector is wide and diverse¹⁶, with health and welfare representing nearly 68% of sector expenditure. Many of the approximately 2,200 charities sit under the umbrella of the Confederation of British Ex-Services Organisations (COBSEO)¹⁷, which acts as a link for the sector to statutory governmental services and as cross-sector point of contact and collaboration. However, the charities' fund-raising capacity has been reduced by the Covid-19 pandemic. A rebalancing of the partnerships between the NHS and the charities is likely. It is hoped that both should be able to benefit from closer relations. The NHS can offer recurrent funding and a system-wide approach, whilst the charities have an ability to focus on specific needs, detailed understanding of the community and ability to innovate.

In this review, it would have been helpful to compare different approaches to healthcare for AFVs. However, the recent changes that have been made together with national differences in healthcare systems makes direct international and UK-wide comparisons difficult. This has also been exacerbated by poor data and this exacerbates a lack of comparative research in veteran service interventions at a system level.

Conclusion

The NHS provides a comprehensive national health system that meets most AFV needs. However, for it to deliver the services that veterans expect (and to ensure “no disadvantage”), it requires a good understanding of this population's needs and to ensure that the health workforce is adequately informed about the culture and needs of the armed forces and has providers that are accredited to deliver high quality services. The NHS will also need to provide some bespoke services for those that have had service attributable illness and injury and require priority provision. It can only do this through collaboration and partnerships with the Ministry of Defence (especially around transition) and charities (with their insight and flexibility). The NHS will also need to reach out to more minorities to ensure that no groups are left behind, and health inequalities are further reduced. There will also be a need for more research to better compare and understand why systems and interventions are most effective. To date there is relatively little published research that independently evaluates the changes in services in recent times and the differences within UK, or with overseas veteran provision.

Key Messages:

1. Armed Forces veterans are in general have no more health needs than the general population and in the UK their needs are met by the (different and separate) National Health Services in the four administrations.
2. NHS England has a specific and dedicated area of subject matter expertise and has introduced several new policies and services over the last 8 years.
3. NHS England continues to refine its policies and services towards veterans and most recently in response to the Covid 19 pandemic.

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Key (MeSH) words: military health services; state medicine; national health programs Note:

Military personnel appears to be specific to US military and veterans' affairs

Scholar One key words: mental Health, Health services administration and Management, Health Policy, Organisation of health services , Occupational and industrial medicine (Note: no military options)

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