healthwatch Norfolk

Veterans’ Healthcare Conferences

An event evaluation by Healthwatch Norfolk

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About this paper

This paper sets out the key findings from an evaluation of four Veterans' Healthcare Conferences for GP trainees in the East of England. The events were organised by **Health Education England** in partnership with **Healthwatch Norfolk** and the **Ministry of Defence**.

The paper will be shared with Health Education England to inform training around this issue in the future.

Acknowledgements

Healthwatch Norfolk gratefully acknowledges the hard work of staff at Health Education England in putting on these events, in particular: **Ross Collett**, **Janet Rutherford**, **Claire Goff**, **Suzanne Watt**, **Marion Mullins**, **Abdul Qadir** and staff from the GP School.

We would also like to thank all the veterans (**Royal Anglian Regiment**) and soldiers (**254 Medical Regiment**) who took the time to tell their stories, as well as representatives from the following veteran agencies:

Outside The Wire
Walking with the Wounded
The Walnut Tree Project
The Royal British Legion
Combat Stress
Help For Heroes
Big White Wall
The Ripple Pond
Veterans First
Blind Veterans UK

Special thanks go to keynote speaker **Lieutenant Colonel** (Lt. Col.) **Julian Woodhouse** (Royal Army Medical Corps, Ministry of Defence) without whose passion and dedication these events could not have been successful.

About Healthwatch Norfolk

Healthwatch Norfolk is the consumer champion for health and social care provision in Norfolk. We are an independent organisation with a statutory remit to use the experiences of local service users to influence improvements in health and social care.

One of our priority areas for 2015-17 is to improve services for local veterans with mental health problems, which has involved supporting the events discussed in this paper. For more details about Healthwatch Norfolk and our work with veterans, please visit www.healthwatchnorfolk.co.uk.

Executive summary

- The 2015-16 Government mandate to Health Education England included the requirement to provide veteran specific training to primary care professionals (amongst others).
- Four Healthcare Conferences were arranged by Health Education England in the East of England, in collaboration with Healthwatch Norfolk and Lt. Col. Julian Woodhouse (Royal Army Medical Corps), to provide this training to GP trainees across the region.
- The events involved veterans, serving soldiers and representatives from veteran agencies. GP trainees were able to talk to these individuals in small groups, as though in the consultation room.
- The events were attended by **272** trainees, which is one in four of all trainees in the East of England.
- This Healthwatch Norfolk evaluation set out to measure **whether** and **why** the events were or were not effective.
- Sixty-four (**64**) trainees gave feedback about the events. Whilst there were some suggestions for future improvements (p.18), the feedback was overwhelmingly positive.
- All but one of the trainees (**98%**) felt that the event had met or exceeded their expectations and **every student** said that they intended to change their practice based on learning from the day.
- Feedback showed that awareness had significantly increased around four key learning outcomes:
    - Veterans' health needs
    - Veterans' entitlements on the NHS
    - The importance of identifying and coding veterans on practice lists
    - Support for veterans in the Third Sector
- This evaluation will be shared with Health Education England, both to shine a light on the success of the conferences and so that any future training is enhanced following the learning from the pilot events.

1. Introduction

A veteran is defined as anybody who has served for at least one day in the Armed Forces, whether Regular or Reserve.[1]

There are an estimated 2.8 million veterans residing in the UK, which is approximately 4% of the total UK population.[2]

It has long been established that the nation has a duty of care towards members of the Forces, past and present. The **Armed Forces Covenant**[3] aims to formalise this duty, and it highlights veterans as a group of people who may have specific needs.

Historically, veterans have not always been well managed by primary care services.[4] This is demonstrated by the fact that very few patients are coded as veterans on GP clinical systems, especially in the East of England.[5]

The 2015/16 mandate to Health Education England (HEE) included the requirement to provide veteran specific training to primary care staff:

The Armed Forces Covenant

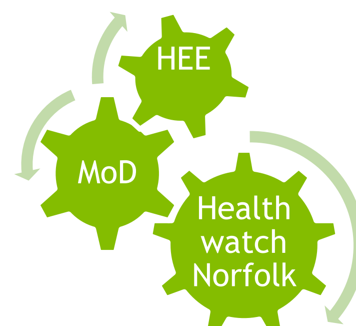
The essence of the Covenant is that members of the Armed Forces community, including **veterans and** their **families**, should face **no disadvantage** when it comes to the provision of commercial and public services like health and social care.

The Covenant also establishes that **special consideration** is sometimes appropriate for those who have given the most, such as the injured and the bereaved.

> HEE will design a training programme/ e-learning module for Veterans' Health Champions, aimed at training health professionals to recognise, and raise awareness of, veterans' health needs across primary, secondary and community care settings.[6]

The conferences discussed in this paper were implemented in order to meet the above requirement for GP trainees across the East of England. They arose from initial conversations between **Healthwatch Norfolk** and **Lt. Col. Julian Woodhouse**, a GP in the Royal Army Medical Corps (Ministry of Defence, MoD) who arranged the speakers and delivered the training.

The events were organised by HEE through the four Workforce Partnerships in the East of England, in collaboration the GP School. Work was led by **Ross Collett**, Head of the Norfolk and Suffolk Workforce Partnership, **Janet Rutherford**, Associate Postgraduate Dean for Suffolk, and **Healthwatch Norfolk**, which provided ongoing support and facilitated the link between the military and the NHS.



2. Information about the conferences

Healthwatch Norfolk and Health Education staff in the East of England wanted to deliver training in such a way that would support GP trainees to change their practice, thereby ensuring that veterans across the region would be able to receive treatment appropriate to their needs.

The Royal College of General Practitioners (RCGP) had produced an e-learning module to provide veteran specific training to GP trainees,[7] but it was felt that peer led, face-to-face training involving stories from real patients would be a more effective method of delivering training that would have a lasting impact (although the e-learning module was recommended as preparatory reading).

To that end, a series of four conferences were arranged, one for GP trainees in each Workforce Partnership area:

Dunston Hall, Norwich
(14th October 2015)

Marriott Hotel, Huntingdon
(4th November 2015)

Weston Homes Community Stadium, Colchester
(27th April 2016)

Knebworth Barns, Stevenage
(28th April 2016)

Whilst this evaluation focuses exclusively on the four events that were organised for GP trainees in the East of England, it is worth noting that similar events have been organised elsewhere around the country. Over the last year, 14 such events have been delivered to around 800 GP trainees (and other professionals) in the following locations:

Learning outcomes

The events had four learning outcomes, which were selected because they had been highlighted by previous research and policy as areas for improvement.[8] More specifically, it was hoped that the GP trainees would be more aware of…

1. **Veterans' health needs**
2. **Veterans' entitlements on the NHS**
3. **The importance of identifying and coding veterans on practice lists**
4. **Support for veterans in the Third Sector**

Format of the day

AGENDA - GP Veterans Health Study Day 14 October 2015

When	What	Who
09:00	Arrival & coffee	Claire Goff & Edward Fraser
09:30	• Introductions • What is Veteran Healthcare?	Dr Janet Rutherford, Associate Dean for Suffolk Lt. Col Julian Woodhouse, RAMC
10:00	Veterans' stories	Maj. Bob Grenfell – Royal Anglian Regiment Maj. Tony Jones – Royal Anglian Regiment Maj. Rhett "Corky" Corcoran – Royal Anglian Regiment Cpl. Colin Branch – Royal Anglian Regiment Luke Woodley – Coldstream Guards
11:00	Tea & coffee	
11:15 – 12:30	Trainees rotate round veterans	
12:30	Trainee feedback	
13:00 – 13:45	Buffet lunch in marquee	
13:45 – 14:45	Agencies' presentations	Royal British Legion – John McCarthy Help For Heroes – Shelly Horsman Combat Stress – Jeff McPherson Outside The Wire – Andy Wicks Walking with the Wounded – Rod Eldridge
15:00	Tea & coffee	
15:15	Trainees rotate around agencies	
16:30	Final debriefing / depart	Lt. Col Julian Woodhouse

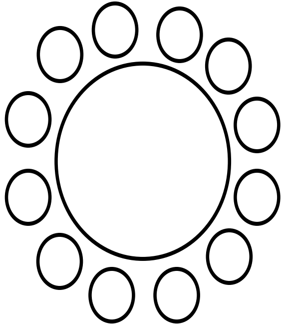
Veteran agency

Veteran agency

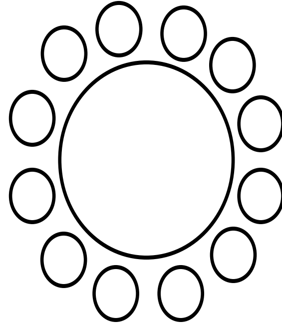
Veteran agency

Veteran agency

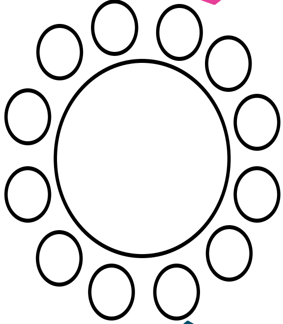
1. Keynote address from Colonel who serves as GP in the Royal Army Medical Corps. Topics covered include: veterans' health needs and entitlements on the NHS and the importance of identifying and coding veterans.



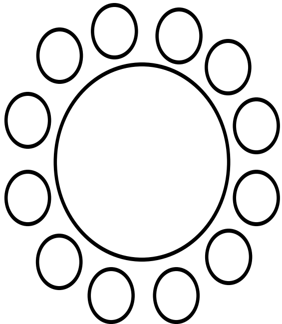
6. Students rotate around the veteran agencies to learn more about Third Sector support for local veteran and families.

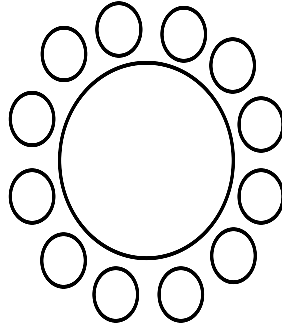


Keynote speaker



254 Medical Regiment





2. Students hear stories from 3-5 veterans from the Royal Anglian Regiment.

3. To learn more about veterans' health needs, the students rotate around the veterans in small groups as though in the consulting room; taking patient histories and writing mock referral letters.

5. Students hear presentations from 3-5 veteran agencies.

4. Lunch and networking.

3. About this evaluation

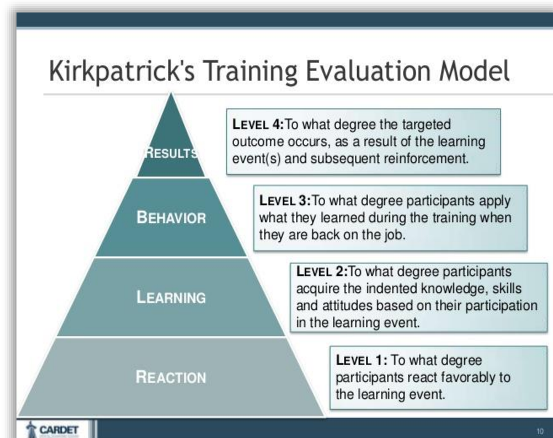
Purpose

Measure whether and why the events were or were not effective.

This was the first time that the HEE mandate had included a veteran specific requirement, and it was not clear how the requirement would be best met. The purpose of this evaluation was therefore to build an evidence base of what worked well and what could be improved, which would enhance training around the issue of veterans' health needs in the future.

Evaluation model

This evaluation made use of Kirkpatrick's four level training evaluation model, which is widely used to judge the effectiveness of training in the NHS.[9-11]



© 2010-2013 Kirkpatrick Partners, LLC (www.kirkpatrickpartners.com).

Levels 1-3 were measured through a participant feedback survey (see below). It is notoriously difficult to quantify the results of any NHS training initiative (level 4). Initiatives rarely operate in isolation and so measuring specific impact can be very laborious. Unfortunately, such work was beyond the scope of this evaluation. Likewise, the evaluation did not include a Cost Benefit Analysis, which is sometimes added as a fifth level to Kirkpatrick's model.

The effectiveness of the conferences was therefore measured exclusively in terms of feedback that was received from the GP trainees. There are some limitations with this approach, which are discussed in more detail in section 6.

Methods

Data collection

Data were captured by Healthwatch Norfolk through an online survey. The survey was entirely optional and anonymous. The survey was advertised during the events and all attendees were sent a link to complete the survey afterwards as part of a follow-up email, which also included supporting information (e.g. speaker slides).

The survey consisted of seven questions, which were largely open-ended to encourage rich responses so that respondents felt able to share their true

experiences of the day as a whole, rather than restricting their answers to a list of pre-determined responses. The survey may be found in **Appendix I**.

Analysis

Analysis was primarily conducted with the aid of the survey host's in built analytics function. Closed questions were translated into numerical terms and interpreted using simple mathematics (total, mean, mode, percentage).

Open questions were analysed using content analysis, whereby feedback was grouped together into categories consisting of similar responses. The numbers of responses relating to each category were counted as a means of identifying which categories seemed to be the most important to the respondents. In addition, individual words were counted to provide a quick indication of the language commonly being used to describe the events.

Individual comments that were particularly useful for the purposes of measuring whether and why the events were (or were not) effective have been picked out and reported in full.

Whilst it was possible to isolate the comments relating to each individual event, the feedback has been presented as a whole because the events were run in similar fashion and the findings were common across all locations.

Survey respondents

The events were attended by **272** trainees. This is **more than 1 in 4** of all trainees in the East of England (982):

64 (24%) trainees completed the feedback survey. The Norwich and Huntingdon events had much higher response rates than the Colchester and Stevenage events:

84% (54) of respondents had attended an event in Norwich or Huntingdon.

4. Findings

98% (63/64) of respondents said that the event had met or exceeded expectations.

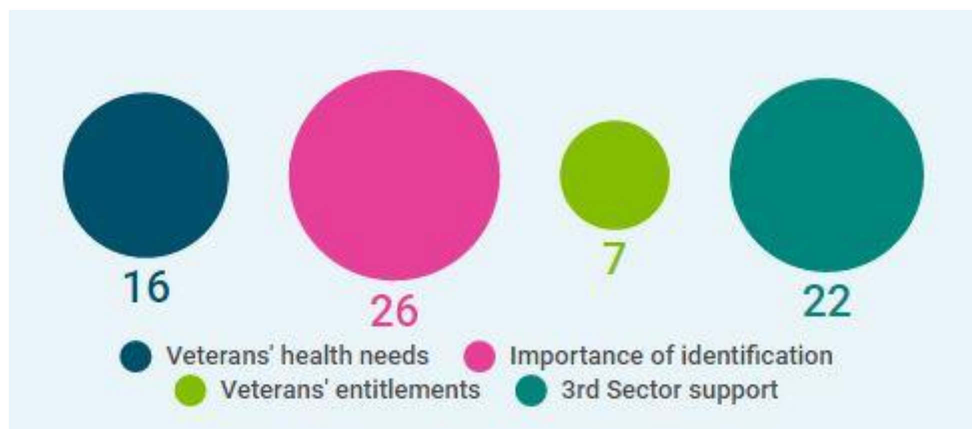
One respondent said that they did not have any prior expectations.

Before the events: on average (mean), respondents rated their awareness of Armed Forces/veteran issues at **3.3**/10. The most commonly selected score (mode) was **1** (selected by 21%) and **8%** gave themselves a score of 7+.

After the events: the average awareness increased to **7.8**/10. The most commonly selected score increased to **8** (selected by 38%) and **91%** rated their awareness at 7+.

100% of respondents said the event would change their practice.

In particular, they felt that they now had increased confidence and awareness when it came to:



Overall, **15** comments related to one of the learning outcomes, **22** related to two and **3** related to three. **7** participants gave feedback that did not relate to the learning outcomes. The other 17 did not leave specific comments or were more sceptical about the events (p.14).

Specific comments are reported in full overleaf.

It will definitely make a difference. I will ask patients if they are a veteran and mark them on the system.

More awareness of issues and will ask if they are a veteran.

I will be able to take a lot of what I learnt today forwards and use it to help patients in the future.

I will now ask if patients are veterans when relevant and know about priority treatment for service related illnesses.

I will be more aware of veteran's needs & their family.

Better awareness of the number of veterans, better understanding of type of possible health problems and knowledge of agencies to refer them to for support.

I will certainly be more aware of the veteran population and think more often about checking veteran status.

Code those identified as veterans. Refer patients to organisations we have learnt about.

More aware of resources available for veterans and the sort of health problems they have.

I am now significantly better informed on what support is available. I also now know to include the military covenant to any referral letters.

I will certainly be more aware of the veteran population and think more often about checking veteran status.

As they mask the severity of the problems, they will need longer consultation time.

I will be likely to ask whether someone is a veteran, and when referring will know about the armed forces covenant.

I will code veterans and have more awareness of referral pathways and how to access assistance.

Lots of helpful pointers for recognising veterans in the future and ways in which we can signpost and help.

I will be more likely to ask about past history and identify veterans, I have a better understanding of support.

Significant difference as I now have a good understanding of the problems veterans can encounter.

I will ask if I think someone may be a veteran as I now know there are lots of resources available.

Outstanding learning experience. My knowledge about this subject was non before.

It will make a difference getting third sector agency support in place early for these Veterans, such as the Walnut Tree Project.

I understand that there is a sizable veteran population in the UK and probably within my practice. Whenever I interact with them or try to identify them I will be using some of the lessons I learnt from the day.

I am now more aware, will actively look out in future. I also feel I have resources to draw on and seek advice re veteran's health. I have already identified one patient who might benefit from being in contact with one of the charities.

Difficulties experienced by veterans in healthcare and mental health after leaving the forces. What we as GPs can do to help and how to refer veterans onto further treatment appropriately, signposting effectively to the relevant agencies.

I will now actively seek out veterans and their families as they are entitled to great benefits which should be used.

I will ask whether patients are veterans and now know where to signpost them to.

It has raised my awareness of servicemen and women and the help available to them. I am more likely to ask if they are/were in service now.

I have a good idea about the services available to veterans.

Much more confident managing and signposting veterans and ensuring I appropriately screen for potential veterans.

A great day that will change my practice.

Increased my awareness of specific issues relating to veterans, awareness of specialised services. Already discussing a case of a soldier seen by a colleague I have advised referral to H4H.

Quite a big difference as much more awareness. Have already come across veterans since.

Made me more aware of issues such as the covenant that I was previously unaware of.

I will try and remember to ask people if they have ever served in the armed forces, consider their specific health needs and prioritise referrals where appropriate.

Being more aware of the needs of veterans and the mental health problems involved and where we can find help.

The Covenant and its wording is a useful way to improve the veteran's experience of the healthcare system.

It will change in every way.

Definitely have greater awareness of veterans and specific issues which may affect them.

A huge difference. To have a personal face-to-face insight into this complex area is key for the improvement of health services to this population.

I may well ask "have you or your partner ever served in the armed forces?" I will also code appropriately.

I have learned that veterans have other needs.

Much more aware of veteran's needs.

A lot, I will now ask people if they served, broach topics and signpost to resources.

A good amount of identifying veterans to adding the question to our new patient questionnaire and knowing what support is available.

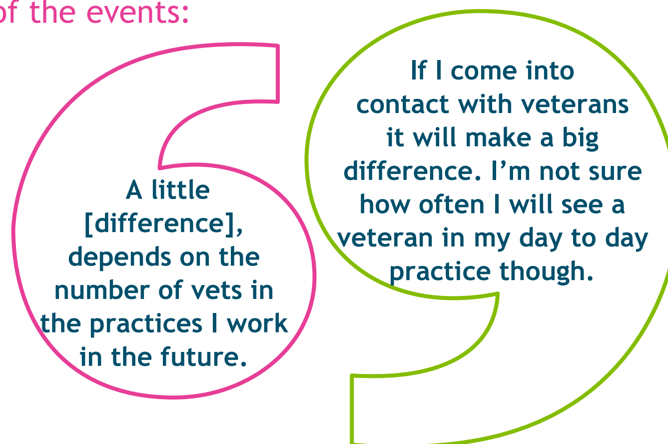
It will be definitely useful, the approach and listening skills will be better.

I plan to encourage partners to look for veterans in our patient list and code them. Also feel more confident about referring veterans.

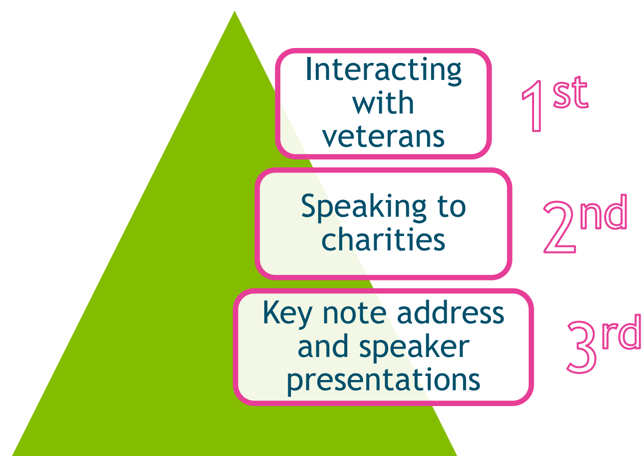
I now appreciate the importance of recognising veterans as it can influence their medical conditions and access to health care.

It will improve the care I provide to veterans, especially due to the knowledge of the organisations available that I can signpost to.

Not all participants were wholly positive. Five trainees (8%) were more sceptical about the benefits of the events:



The respondents identified these aspects of the events as being the most useful:



This 'cloud' shows the words that the respondents most frequently used to describe the event (the larger the word, the more times it occurred in responses):

When asked how the event could be improved in the future…

13 respondents felt that the day was too long.

10 made comments relating to the venue/catering or organisation on the day.

9 wanted to hear from a wider range of speakers.

9 wanted more practical advice about what they could do to help veterans.

6 said it would have been helpful to have received more pre-event information.

And **11** felt that the events worked very well as they were.

Too much repetition. A brief introduction presentation at the beginning would suffice followed by the speed dating.

We did not receive information about what the event was about. It was undersubscribed because of this. It was actually a very useful learning experience and all those that attended have recommended it to our colleagues, who are now booking up for the London course.

Didn't find speaking to the charities useful - they just need to give a presentation. It would be much better to give out a summary sheet with each charity, their main role and their contact details and way of referral.

Representation of other Forces. Also perspective of veteran's families e.g. presentation from a military wife.

More focus on how GPs can make a difference to veterans' health.

Break out groups in PM had a slight sales pitch mentality. More interested in pathology/presentation/experiences.

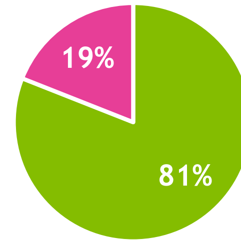
Structured plans how to identify these patients in the community and plan specific prevention plans to address their needs.

And finally…

31 respondents elected to leave further feedback, of which:

25 said thank you for a great event.

6 repeated suggestions for future improvements.



5. Discussion

The purpose of this evaluation was to measure whether and why the events were or were not effective.

Using Levels 1-3 of Kirkpatrick's model of evaluation, it is clear that the conferences were very effective.

Evidence of effectiveness

Level 1: Reaction

The conferences were overwhelmingly well received.

All but one respondent (98%) felt that the events had met or exceeded their expectations (one respondent had no prior expectations).

Level 2: Learning

The conferences were an effective way of raising awareness of key issues relating to veterans' health.

Most respondents felt that they had a low level of awareness of Armed Forces / veteran issues before the conferences (mode = 1/10, mean = 3.3/10) but 91% rated their awareness at 7/10 or higher by the end of the day, which is a remarkable improvement.

More specifically, it is clear that **the conferences successfully met the four learning outcomes.**

Analysis of individual comments revealed that much of the feedback related to the specific purposes of the day, with the majority of respondents pledging their intent to change their practice based upon one or more learning outcomes.

Why were the events so effective?

The conferences were organised (instead of relying on the RCGP e-learning module) because it was felt that peer led, face-to-face training with involving stories from real patients would be an effective way of delivering training that would improve practice.

This feeling was borne out to some extent in the participant feedback, with respondents obviously valuing the interactive nature of the conferences, as demonstrated by the fact that opportunities to speak to veterans and representatives from veteran agencies were identified as being the most useful aspects of the day.

The effectiveness of the training method is further demonstrated by the very high attendance rate of 1 in 4 of all GP trainees across the East of England.

Level 3: Behaviour

The conferences were an effective way of delivering training that leads to changes in practice.

The ultimate purpose of all NHS training initiatives should be to improve patient care, but awareness raising does not necessarily translate to improvements in care if clinicians do not put into practice what they have learned. With that in mind, it is crucially important that every single respondent said that they planned to change their practice based on the learning from the day.

It should be noted that a stated intention to change practice is not the same as an actual change in practice. Measuring actual changes in practice would have involved considerable follow-up work, which was beyond the scope of this evaluation. Seeing that GP trainees are often required to reflect critically upon their training as part of their CPD, it was considered reasonable to take the trainees at their word in this case.

Areas for future improvement

Whilst the respondents were very positive about the events, they did identify some areas for future improvement. There were four key findings.

1. There was too much repetition

The training model involved speakers giving introductory presentations before discussing their stories in further detail with small groups of trainees. Some respondents believed that this format led to some repetition.

Instead of each speaker giving an introductory presentation, it might be more expedient to have one or two presentations to set the scene, with the majority of interaction taking place through conversations around the tables.

2. Further practical information and advice about what GPs can do to help veterans would have been useful

Several respondents felt that they needed more practical information and advice about what they could do to help veterans' on their practice lists. It should be possible to ensure that individual exercises focus more on this crucial issue without having to change to the overall structure of the day.

For example, it was generally felt that the morning session with the veterans was more valuable than the afternoon session with the agencies. Some respondents reported that the time they had spent with the agencies felt like a sales pitch and they would have preferred to use that time to find out practical information about how they could work with local agencies to offer a better care package to their veteran patients.

Instead of having the agencies give presentations about their general wares, it might be more useful for them to provide specific information around pre-identified areas, such as:

- **What** services do the agency offer?
- **Who** provides these services (e.g. professionals or volunteers)?
- **Who** is eligible to receive the services?
- **How** can GPs refer into the services?

It may also be helpful for the agencies to provide supplementary A4 information sheets for the GP trainees to take away with them so that they are better able to remember the lessons from their training when treating veterans in their practice.

On that note, there are doubtless other resources that might be of use. As part of our general work to improve services for local veterans, Healthwatch Norfolk collaborated with a Practice Manager to produce a Veterans Protocol with practical information and advice to support GPs when treating veterans in their practice (**Appendix II**). If the GP trainees were provided with this kind of resource at the end of the day, it might enable them to better translate their learning into practice. With some tangible written guidance they may also feel emboldened to spread what they have learned to colleagues and partners at their practices, meaning that the reach of the conferences would extend beyond the trainees who attended them.

3. It would be good to hear from a wider range of speakers

The Army was heavily represented at all four events. Whilst most veterans in the UK are actually from the Army, some trainees felt that it would be better to have a wider representation from other branches of the Forces. Involvement in the conferences was entirely voluntary and so to some extent representation from the RAF and Navy was dependent upon their interest. Representatives from RAF and Navy agencies were invited but were not able to attend the conferences and so continuing to build these links must be a priority for the future.

Some respondents also reported that they wanted to hear from members of the wider military family, like wives and husbands. **These comments were shared with Lt. Col. Woodhouse following an initial analysis of feedback from the events in Norwich and Huntingdon and this led to representation from The Ripple Pond, a self-help support network for adult family members of physically or emotionally injured service personnel and veterans, at the conferences in Colchester and Stevenage.**

The findings presented in this paper reaffirm the importance of continuing to provide representation from the wider military family alongside veterans. It is worth noting that there may be families represented among the GP trainees, who might like to be involved in future events.

4. The organisation and administration can make a big difference

Some respondents said that there could have been more administrative support before and after the events. It should be stressed that, in the main, the administrative support provided by the Workforce Partnerships was of a high level. However, each conference was arranged by a separate Workforce Partnership team, and whilst the handover between the teams was generally very good some things inevitably slipped through the cracks.

For instance, some GP trainees did not receive information about the day before attending. Others did not receive their follow up email, with supporting documents (e.g. the speaker slides) and the link to the online survey until weeks after attending the event.

Good administrative support can be crucial to the success of an event, enabling attendees to get the most out of the day and encouraging them to make long-lasting changes to their practice and this might be an area for HEE to consider in the future.

Sustainability

A Cost Benefit Analysis was beyond the scope of this evaluation but any NHS initiative should aspire to provide good value for money. In this era of austerity, it is all the more important to consider the sustainability of the conferences as a training method in the future.

There are some simple ways in which HEE could make the events more cost effective. For example, holding the events on military bases – where available – rather than at conference venues may be a way to save money whilst enhancing the atmosphere of the day. The appointment of a dedicated administrative lead at HEE could also help to increase efficiency by providing consistent support, thereby minimizing the duplication of effort described above.

Costs may also be reduced by organising smaller-scale events. These events could be extended to health professionals from all disciplines, alongside Local Authority employees such as housing and police officers who may also encounter veterans in their day-to-day work. Each Local Authority has a Community Covenant Board, which is ultimately responsible for fostering positive relationships between the civilian and military communities (including veterans). Some Boards may already be arranging their own training and by working together more closely with Local Authority colleagues there may be opportunities for HEE to share costs whilst reaching an audience that extends further than primary care professionals.

6. Limitations

This evaluation was designed to be as robust as possible within a very modest set of resources. Some limitations with the approach have already been highlighted. In particular, the evaluation did not attempt to isolate and measure the specific results of the events and so it will not be possible to establish definitively whether or not they had widespread benefits for veterans using primary care services in the East of England (level 4 on the Kirkpatrick model), although one anecdotal story demonstrating how much difference the training made for one veteran in Suffolk will be reported in the conclusion.

The effectiveness of the conferences was measured exclusively in terms of feedback that was received from the GP trainees. Whilst feedback can be a very informative way of measuring effectiveness, there are a number of limitations with its usage as a single measurement, the most important of which are as follows:

The response rate

The survey had a response rate of 1 in 4, which means it did not capture the views of 75% of the trainees. As such, the findings do not tell the whole story.

The especially low response rate from trainees who attended the training in Colchester and Stevenage means that this evaluation cannot support comments about the effectiveness of those individual events. However, seeing as the main aim of the evaluation was to find out more about how effective the events were in general, a decision was made to include feedback from trainees' who attended these events in the analysis.

There is no reason to expect that the lower response rate from Colchester and Stevenage is any kind of reflection upon how well the events were received. Those trainees who did respond were very positive and the low response rate is more likely due to the fact that the link to the online survey was shared with delegates some time after the conferences.

Self-selection

The respondents were self-selecting volunteers (they were not randomly selected). A non-randomised sampling strategy is typical for this kind of evaluation, but the problem is that people who volunteer for surveys tend to have strong opinions, which can lead to exaggerated findings. That being said, we would still expect to see a mixture of positive and negative opinions and so it is fair to interpret the overwhelmingly positive feedback as being indicative of a successful series of events.

7. Conclusion

This evaluation has established that the Veterans' Healthcare Conferences were a huge success, as judged by feedback from 64 of the 272 GP trainees (24%) who attended the events. Thanks to the hard work of Lt. Col. Woodhouse, staff at HEE and other partners, the East of England now has a substantial cohort of GP trainees who feel that they are more aware of key issues when treating veterans, and say that they will change their practice based on what they have learned.

That being said, the trainees did identify some areas for future improvement. These findings will be shared with HEE, both to shine a light on the success of the conferences for Health Education staff arranging veteran specific training across the country and so that any future training is enhanced following the learning from the pilot events.

As has already been explained, this evaluation did not set out to capture whether there were any widespread benefits of the conferences for veterans in the East of England. One of the agencies from the Norwich event did take the time to share with us an anecdotal story, illustrating how much of a difference the training had made to one veteran, presenting to an A&E department in Suffolk:

> **I received a phone call from a family member of a veteran in Suffolk, he had been taken to hospital today after attempting to cut his wrists. Whilst in A&E a doctor who had attended the training last week gave them The Walnut Tree information, this has resulted in us being able to visit the veteran at home this afternoon and put a care plan in place and get him referred for veteran specific treatment. The training has ensured the doctor had the confidence and knowledge to help this veteran by advising family members to contact The Walnut Tree Project.**
>
> **I just wanted to share this with you and say thank you, the way the training day was structured I believe gave all attending a better understanding of veterans health needs, we now see the first positive results of that training. I only wish I knew who the doctor was so I could thank them.**
>
> Luke Woodley, Founder/Director of The Walnut Tree Project

Healthwatch Norfolk will continue to help promote the importance of veteran specific training for health and care staff over the next year. We will be working closely with Norfolk's Community Covenant Board and hope to collaborate again with HEE in the future.

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Appendix I

* 1. In which region did you attend the event?

- ◯ Norfolk/Suffolk
- ◯ Cambridgeshire/Peterborough
- ◯ Essex
- ◯ Hertfordshire/Bedfordshire

* 2. Did you achieve what you hoped by attending today?

* 3. To what extent do you think what you have learned today will make a difference to the way you do your job?

* 4. What do you think were the 3 most useful aspects of the day?

1

2

3

* 5. What do you think would improve this event next time?

[ ]

* 6. On a scale of 1-10, please rate your knowledge of Armed Forces/veteran issues AFTER attending the event

1	2	3	4	5	6	7	8	9	10
○	○	○	○	○	○	○	○	○	○

7. Any other feedback?

[ ]

Note. All GP trainees were also asked to rate their knowledge of Armed Forces/veteran issues on a scale of 1-10 BEFORE attending the event (at registration). These scores were then compared with the sample scores from question 6 to arrive at the results reported on p.10.

Appendix II

Military Veterans' Treatment Priority Protocol

Introduction

In June 1997 the NHS published guidelines relating to the priority treatment of war pensioners, and this was updated in December 2007. From 1st January 2008, all service veterans should receive priority access to NHS care for any condition which is likely to relate to their military service. This is also subject to fair treatment of all other patients based on clinical needs.

The British Government defines a veteran 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." There are an estimated 40,000 veterans in Norfolk (Healthwatch Norfolk, 2014).

The purpose of this protocol is to raise awareness of the requirements in relation to veterans and to summarise the DoH guidance on the subject.

Many conditions do not become obvious until after a veteran has left military service, therefore all GPs should be aware of the government wish to prioritise care of this nature and consider the military aspects of a condition when diagnosing and referring to secondary care.

The July 2015 update to the NHS Constitution ensures that, in line with the Armed Forces Covenant, military veterans are supported, treated equally and receive the same standard of, and access to, healthcare as any other UK citizen in the area they live.

For those with concerns about their mental health who may not present for some time after leaving Service, they should be able to access services with health professionals who have an understanding of Armed Forces culture. Veterans who have lost a limb(s) as a result of their service will be able to access prostheses that reflect their clinical need. Veterans receive their healthcare from the NHS and are encouraged to identify themselves to their GP as member of the Armed Forces Community.

Most Frequent Conditions

- Audiology – noise induced hearing loss. There has been a lack of compensation in the past and little understanding in relating to this problem. It is possible therefore that cases may present now which have been symptomatic for some time.
- Mental Health – may present some years after military discharge. PTSD is not the biggest issue (4%), usually common mental health problems and/or alcohol misuse.
- Orthopaedic – may arise sometime after discharge but be related to in-service activity.

Required Action

- Where a known veteran is referred check with the patient that they are willing for the referral to show that they are a military veteran.

- Where consent is given by the patient the referral can state they are a veteran, and the clinician should give a clinical opinion within the referral as to whether the condition (or request for further investigation) is likely to relate to the period of military service, indicating the issue of priority treatment.
- Where consent is refused by the patient the information should not be included.
- The secondary care provider clinicians are responsible for prioritisation, taking into account the relative priorities of other patient groups based on clinical need.
- When using Choose & Book, GPs should select the correct priority of the referral based on clinical need or clinical guidelines only. Where veterans' details are included within the referral then the secondary care service is responsible for military prioritisation, and they will assess other demands on their limited resources based on clinical priorities.

Sample Text for Referrals

'As this patient is a military veteran and his/her current condition may be related to military service, this referral should be considered for priority treatment under the rules set out in the Commissioning Board mandate and Armed Forces Covenant.'

Identifying Ex Military Personnel

It is important that ex-military personnel are identified, not only so that patients can be referred appropriately within the NHS, but so that they can have access to the wide array of local support in the Third Sector. Further information about this support accompanies this protocol.

To aid with the identification, the Practice will add to its patient registrations leaflet the following two questions:

- Have you previously served in any of the military services?
- Are you content that this is annotated on your medical record?

Other identification tools have been or will be promulgated by the Practice – they are:

- Posters in the waiting room
- Notices in Parish Magazines
- Patient Newsletter

Clinical System

The following Read Code will be used for all known veterans in the Practice:

Military Veteran	13ji (EMIS)
Served in the Armed Forces	Ua0T3 (SYS1)

This will be coded regardless of referral activity where it is known that the patient is an ex-serviceman/servicewoman and entered in the Active Problem list.

Where a veteran considers that the arrangements for priority treatment have not been properly considered or fulfilled they are able to use the NHS Complaints Procedure to have the matter investigated.

Resources

NHS Choices Veterans healthcare

http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/Veterans.ashx

http://www.healthwatchnorfolk.co.uk/sites/default/files/healthwatch_norfolk_veterans_scoping_paper_final_version_15-05-15_ed.pdf