South West Peninsula

(Devon, Plymouth, Torbay, Cornwall and Isles of Scilly)

Veterans' Health Needs Assessment

September 2014

Acknowledgements

This Health Needs Assessment is being produced by consultants, analysts and specialists from across the Public Health teams in Cornwall and the Isles of Scilly, Devon, Plymouth and Torbay.

It draws on a range of health needs assessment work that has and is taking place across NHS and Public Health teams across the country. The work of colleagues in Hampshire, Portsmouth, Southampton, Kent and Medway and the North East region is particularly appreciated.

Contents

Foreword

The Armed Services are an integral part of the history and heritage of Devon. Alongside the military bases situated in the County, there are many veterans who have chosen to retire here to the extent that it is estimated that over 100,000 people in Devon have served in the Armed Forces at some time.

The conflicts of the last 30 years have produced a stark picture of the impact of warfare. The nature and extent of injury and ill health arising from the various combat engagements has raised the national interest and awareness of the human cost that serving your country can bring. The needs of a number of veterans will be ongoing and will require commitment from public, private, voluntary and community sector organisations to enable them to continue to live active lifestyles.

Most veterans have a smooth transition into civilian life, but about 15% have a complex mix of physical and mental health needs which can affect family life and, in some cases, can lead to offending behaviour. A tenth of Devon's prison population are veterans.

This Health Needs Assessment scopes the issues and makes a series of observations as to what needs to happen to achieve the early identification of and intervention with our most vulnerable veterans. The Devon Armed Forces (Community) Wellbeing Partnership will monitor and report on the extent of progress achieved in responding to these findings.

I should like to thank all those who have contributed to the production of this document. I commend it to you and ask for your support in improving the health and wellbeing of all our veterans.

Dr Virginia Pearson
Director of Public Health
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South West Peninsula (Devon, Plymouth, Torbay, Cornwall and Isles of Scilly) Veterans' Health Needs Assessment

1. Executive Summary

Introduction

1.1 This Health Needs Assessment seeks to understand the health and wellbeing needs of the veteran population in the South West Peninsula to guide decisions about the commissioning of appropriate services.

1.2 As a direct result of the combat engagement since the early 2000's in Kuwait, Iraq and Afghanistan, there has been an increasing national and political focus on the health and wellbeing of serving members of the Armed Forces, their families, and of veterans.

1.3 For this Health Needs Assessment, a veteran is defined as:
"anyone who has served for at least one day in the Armed Forces (Regular or Reserve), as well as Merchant Navy seafarers and fishermen who have served in a vessel that was operated to facilitate military operations by the Armed Forces." (Royal College of General Practitioners, The Royal British Legion and Combat Stress 2010 page 3).

1.4 Whilst serving personnel, their healthcare is provided by the Defence Medical Services. On discharge, however, this responsibility returns to the NHS with veterans eligible for the same full range of local NHS services as the general population.

Aims and Objectives

1.5 The aim of this Health Needs Assessment is to understand the characteristics of the veteran population and their specific needs is crucial for ensuring local services are commissioned to adequately meet these needs by:

- identifying and quantifying the size of the veteran population within the South West Peninsula. This includes the sub areas of Cornwall and the Isles of Scilly, Plymouth, Devon and Torbay
- describing the characteristics of the South West Peninsula and specifically each of the sub areas regarding their veteran population
- assessing the health needs of the local veteran population and identify important differences with those identified at a national level
- identifying local services currently available for the veteran community
- making recommendations for future service development within the South West Peninsula for partner organisations to meet the needs highlighted by this Health Needs Assessment which meet the obligations of the Armed Forces Covenant (Department of Health 2011).

Methods

1.6 Drawing on national data supplemented with local data (where available) the size of the veteran population is estimated. National and local research evidence has been searched to identify the main health and health-related needs of veterans and is documented in this Health Needs Assessment.

Conclusions

1.7 As the Veterans' Transition Review (Lord Ashcroft 2014) confirmed, for most veterans serving in the Armed Forces is as a positive experience but, for a minority, adverse physical and mental health outcomes can be substantial and can be compounded by other factors such as financial and welfare problems.

1.8 There is a major issue of stigma which may prevent many veterans accessing healthcare services and is compounded by perceptions of a lack of understanding of the Armed Forces culture amongst civilian healthcare staff. Other main health issues facing the veteran population relates to common mental health problems and excess alcohol consumption. There is also an association with musculo-skeletal disorders for some veterans.

1.9 A lack of quantitative data available about the veteran population both nationally, and most notably, locally, means it is extremely challenging to establish a robust estimate on the size of the South West Peninsula's veteran population which is crucial for commissioners in planning services.

Observations

1.10 The observations reflect the need to improve the collection of data relating to the health, wellbeing and welfare of the veteran population alongside improving the provision of and access to relevant information for healthcare professionals and veterans themselves. The following observations (overleaf) are based on the evidence obtained by this Needs Assessment, including national and local data (where available) which are framed against three overarching strategic objectives:

1. To ensure that information about, and access to, services for veterans, reservists and their families is readily available.
Observation 1.1 - Improve data collection by: **a) Encouraging all GP practices to use the same Read codes relating to veteran status when registering new patients.** *There is no national agreement on which Read code to use but Xa8Da is advocated by the Department of Health and cited in RCGP guidance. However, practices use different primary care clinical record systems and this particular code will not be appropriate for all Peninsula practices.*
b) Encouraging the recording of veteran status for all referrals to secondary care for conditions relating to military service. *Although veteran status may be recorded in the individual's referral, there is currently no system of identifying veteran status in the Secondary Users System (the commissioners' anonymised view of the hospital and community patient systems).*
c) Encouraging the recording of veteran status on registers of partner organisations, such as local authority registers of homelessness acceptances. *Identifying veteran status on homeless acceptance registers would enable better estimation of the number of homeless veterans in the Peninsula thereby enabling an appreciation of the burden of need on housing services and related health services.*
d) Dis-aggregating local-level data on the veteran community from nationally held sources, such as DASA (Defence Analytical Services Agency). *The recent provision of data by resettlement town for service leavers (outflow data) provides a more detailed estimate of the size of the local veteran community than has been available previously. However, there are data gaps and more data about the service leavers is needed to allow a more accurate estimate of the number of injured or wounded veterans resident in the South West Peninsula.*
Observation 1.2 - Communication of need and numbers well in advance of transition from Defence Medical Service to NHS will be important to inform commissioning intentions, particularly for the following conditions: • **complex case (mainly neurological) management 24/7/365** • **mental health issues, with alcohol a compounding factor** • **primary care support whilst in service for certain cases** • **prosthetics** • **continuing support for cognitive injuries (learning disabilities)**
Observation 1.3 - Promote information about NHS services, including GP registration, as well as other sources of support amongst the veteran community by: a) When registering for NHS services, veterans and reservists should be encouraged to identify their status.
b) Encouraging veterans and reservists to register with an NHS GP and identify their veteran's status.
c) Promoting other sources of support available in the Peninsula.
Observation 1.4 - Provide support to reservists and their families by: **a) Encouraging veterans and reservists to identify their status when registering children at school.**
b) Delivering education inputs, as appropriate, in key settings, eg schools and workplaces on the potential impact on reservists and their families.
c) Providing access to operational stress management records and programmes, where appropriate, and peer networks for reservists and veterans.
Observation 1.5 - Enhance local support networks to address the needs of pupils, parents and staff in schools in relation to Armed Forces pupils and produce a Devon Passport for armed forces, veterans and reservist children.

Observation 1.6 - Improve data collection processes for veterans to ensure early identification and direction to appropriate support in line with the Jobcentre Plus covenant objectives.
Observation 1.7 - Identify personnel leaving the service who indicate they had a permanent home contact address in the South West Peninsula and the service leavers who indicated they were settling in the local authority areas of the South West Peninsula.
Observation 1.8 - Ensure local directories have up-to-date information on local mental health, substance misuse and domestic violence and sexual abuse support services.
2. To ensure that the needs of veterans, reservists and their families are specified in contracts so identification and support is mainstreamed.
Observation 2.1 - Promote the education and training of GPs and other healthcare providers.
Observation 2.2 - Promote the uptake of the Royal College of General Practitioners 'on line' training package by GPs.
Observation 2.3 - Specifically include 'Have you ever served in the Armed Forces?' as a question on the registration of new patients with GP practices and subsequently request veterans' complete medical records.
Observation 2.4 - In order to comprehensively address the issues of veterans in the Criminal Justice System and utilise the NHS mental health and police diversionary schemes, develop a veterans' support programme as an alternative to custodial sentencing so as to meet the challenges of the Transforming Rehabilitation agenda and to further promote enhanced partnership working. *(The Veterans Change Partnership is seen as a suitable model for such provision. This proposal aims to provide an intensive and comprehensive joined up programme of rehabilitation, linking to all associated agencies and funding streams).*
Observation 2.5 - Promote the Veterans in Custody Support (VICS) scheme in prisons in the Peninsula.
Observation 2.6 - Raise awareness of veterans' mental health needs with health and social care staff in primary and community care settings and ensure local directories have up-to-date information on local mental health support services.
Observation 2.7 - Implement the agreed procedures with local authority housing teams to ensure veterans are made aware of sources of local and national support at an early stage in their transition to civilian life.
Observation 2.8 - Promote veterans' employment and housing advice peer support networks, eg the Exeter and Plymouth hubs and Veterans 2 Veterans groups, and establish links to local services, ie benefits
Observation 2.9 - Identify the prosthetic requirement for the Clinical Commissioning Groups in the South West Peninsula.
Observation 2.10 - Explore with partner or sister charities, NHS and local authorities, amongst others, how to utilise the Help for Heroes resources to provide non-clinical rehabilitation support for wounded, injured and sick veterans in Plymouth.
Observation 2.11 - Promote access to the armed forces, veterans and reservists hubs in Exeter and Plymouth.
Observation 2.12 - Commissioning organisations to ensure the collection and recording of armed forces status is a specific requirement of contractual arrangements with providers.
3. To ensure the case is made for service commissioners to recognise needs early and provide support before problems become embedded.
Observation 3.1 - Develop a Peninsula-wide Veterans Action Plan.
Observation 3.2 - Establish appropriate governance arrangements to measure the impact of an action plan.
Observation 3.3 - Include veterans in other NHS Peninsula needs assessments and audits, eg mental health and suicide.
Observation 3.4 - Promoting the registration of veterans and reservists with primary care and community services.
Observation 3.5 - Promote partnership working across all agencies to produce a co-ordinated response to the health, housing, employment, education, welfare and criminal justice (H2E2WCJ) challenge.

2. Introduction and Methods

Introduction

Health Needs Assessment

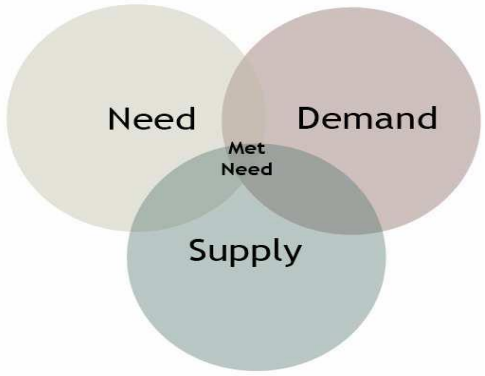
2.1 The objective of the South West Peninsula Veteran's Health Needs Assessment is to understand the health and wellbeing needs of this particular population, including high risk groups. This will involve undertaking a systematic review of the health and wellbeing issues faced by many veterans leading to agreed priorities and resource allocation that will improve health and reduce inequalities.

2.2 **Figure 1** below sets out the principles behind a needs assessment and the stages to be taken as part of a rapid and a comprehensive needs assessment:

Figure 1: Core Elements to a Needs Assessment
(Department of Health 2007)

The core elements are:

- map need
- examine demand
- map service provision
- assess gaps



Why Focus on the Armed Forces Community and Veterans?

2.3 The death and injury that has occurred from the range of combat scenarios involving British Armed Forces over the last decade and the current decade to date has brought a very powerful political focus on the health, wellbeing and welfare needs of the Armed Forces and veterans. Consequently, a number of policy directives have been produced to inform the nature and extent of services to be commissioned and delivered. These include:

- Command Paper The Nation's Commitment: Cross-Government Support to our Armed Forces, their Families and Veterans (Ministry of Defence 2008)

- Fighting Fit: A mental health plan for servicemen and veterans (Murrison 2010)

- The Armed Forces Covenant (Ministry of Defence 2011)

- A better deal for military amputees (Murrison Prosthetics Review 2011)

- Briefing paper for Clinical Commissioning Groups regarding Armed Forces and Veteran Health (NHS England 2013)

- The Veterans' Transition Review (Lord Ashcroft Report February 2014)

- Mental Health Crisis Care Concordat Improving outcomes for people experiencing mental health crisis (Department of Health 2014).

2.4 In contrast to the majority of the general population, serving and veteran personnel and their families experience unique factors as a result of their time in service, including not only the risks of injury or death, but also those related to armed services' lifestyle, such as frequent moves and the disruption this may bring.

2.5 The **Command Paper** (Ministry of Defence 2008) seeks to ensure that these circumstances are taken into account in commissioning and delivering services:

"The essential starting point is that those who serve must not be disadvantaged by virtue of what they do - and this will sometimes call for degrees of special treatment." (Page 9)

2.6 It then specifies that healthcare organisations must:

- ensure that commissioning plans provide for a smooth transition into NHS care for the increasing numbers of returning personnel who have been injured in the course of duty

- ensure that their dependants are not disadvantaged by their circumstances (eg if they move location)

- provide priority treatments, including appropriate mental health treatment, for veterans with conditions related to their service, subject to the clinical needs of others (Page 23).

2.7 The **Armed Forces Covenant** (Ministry of Defence 2011) sets out the relationship between the nation, the government and the Armed Forces. It recognises that the whole nation has a moral obligation to members of the Armed Forces and their families, and it establishes how they should expect to be treated.

2.8 To inform the commissioning infrastructure, in March 2013 the NHS Commissioning Board produced ***'The Securing Excellence in Commissioning for the Armed Forces and their Families'*** document which sets out where commissioning responsibility lies for all members of the Armed Forces community ie serving Armed Forces, their families, reservists and veterans.

2.9 Furthermore, an Armed Forces Clinical Reference Group (CRG) has been established to provide NHS England with advice on clinical service delivery and other issues relevant to the Armed Forces community. The CRG will be responsible for developing key 'products', such as commissioning policies, eg for Individual Funding Requests (IFRs), service specifications and working with clinical leaders, patients and providers of services to identify and promote best practice whilst always taking positive action to improve patient experience and outcomes in the NHS.

2.10 Lord Ashcroft's report **'The Veterans' Transition Review'** published on 11th February 2014) recognises that for many service leavers their transition into civilian life is a smooth one but *"… there can be no doubt that some Service Leavers suffer real hardship; for others transition is more of a struggle than it should be."* (Ashcroft 2014, Page 9). The report draws a number of conclusions:

- transition is important for the Armed Forces and society as a whole not just the individual
- there is no shortage of provision for service leavers – and most do well
- preparation by the individual is essential and good information is key
- the service leavers most likely to struggle get the least help
- public perception of service Leavers needs to change.

Whilst the main recommendations cover:

- the Ministry of Defence (MoD) and the Armed Forces should be more proactive in changing perceptions of service leavers
- all personnel should complete an online personal development plan
- all service leavers who have completed basic training should be eligible for the full transition support package
- a new work placement scheme should be created in partnership with industry
- a single 24/7 contact centre should be established by the Veterans' Welfare Service and Forces charities
- a Directory of Armed Forces charities should be created

2.11 The **Mental Health Crisis Care Concordat Improving outcomes for people experiencing mental health crisis** is about how a wide range of public service bodies can work together to deliver a high quality response when people of all ages with mental health problems urgently need help.

2.12 Mental illness is a challenge for all of us. When an individual's mental state leads to a crisis episode this can be very difficult to manage for the person in crisis, for family and friends, and for the services that respond. All may have to deal with suicidal behaviour or intention, panic attacks or extreme anxiety, psychotic episodes or behaviour that seems out of control, or irrational and likely to endanger the person or others. Some veterans will come into this category and therefore benefit from a more co-ordinated and comprehensive response.

The South West Region and South West Peninsula Armed Forces Community

2.13 Historically, both the South West Region and South West Peninsula have strong military ties and heritage arising from both serving personnel being stationed here and veterans living locally. Whilst the Armed Forces reviews have resulted in a reduction of serving personnel and military infrastructure, there is still a significant military presence with an accompanying economic benefit across the two regions.

2.14 Research commissioned by Wiltshire County Council and the then South West Regional Development Agency (Hunter 2009) started to quantify the impact of the Armed Forces community (including veterans) on the region. The main headlines were:

a) Around 25% of the national expenditure is estimated to be allocated to the South West region, suggesting MoD expenditure in the region of around £9bn for 2009, with the following estimated breakdown by function:

- personnel - £3.5bn
- operations and maintenance - £3bn
- research and development - £0.7bn
- procurement – £1.8bn
- construction – £0.1bn.

b) It is further estimated that, of this total £9bn regional expenditure, around £5bn is associated with the military bases and other MoD sites in the region and around £4bn is associated with the defence industry.

c) In 2009, there were around **38,800** Armed Forces personnel stationed in the South West region, being mostly Naval Service and Army personnel. The highest numbers are stationed in Wiltshire followed by Plymouth, Devon, Cornwall and Somerset.

d) The largest numbers of Naval Service personnel are located in Plymouth, which is home to the largest naval base in Western Europe, with significant numbers also at training establishments, naval air stations and Royal Marines locations in Devon, Cornwall, Somerset and Poole.

e) There are estimated to be 37,000 direct full-time jobs in industry and commerce supported by MoD expenditure in the South West. Combining this with the total number of military personnel and defence civil servants in the region gives a total direct employment supported by defence of around 93,000 (around 4% of overall employment in the region).

f) This study estimates that the total number of service leavers per year in the South West region is around 4,000. By far the largest numbers are focused in Wiltshire (around 1,600) followed by Plymouth (**around 700**) with around **200 to 400** in Devon, Cornwall, Dorset and Somerset. The majority of these leavers are from junior ranks with relatively few officers. For officers, most leavers are between the ages of 25 and 54, while for the more junior ranks there is an approximately even split between those aged 16 to 24 and 25 to 54.

g) A survey of military personnel intending to leave the services has been carried out for this study at the two Career Transition Partnership Regional Resettlement Centres in the South West. This indicates that around 60% of leavers currently serving in the region would consider settling somewhere in the South West. Around 20% would consider settling in Wiltshire and just over **10%** in Plymouth and Devon, with 5% or less considering settling in the other local authority areas of the region.

2.15 In October 2013 there were 156,690 full time trained Armed Services personnel supported by 63,810 civilians nationally. In the South West there were **39,040** Armed Services personnel - a reduction of **6%** on the previous year. They were supported by **18,100** civilians - a reduction of **16.5%** on the previous year.

The Location of Military Bases in the South West Peninsula

2.16 There are currently 13 military bases under the following command in the South West Peninsula:

The Naval Service: 10 Royal Air Force: 1 Army: 2

Figure 2 overleaf shows the geographical location of each base or centre in the South West Peninsula and **Table 1** lists the military bases in the South West Peninsula.

Figure 2: The Location of Ministry of Defence Bases in the South West Peninsula

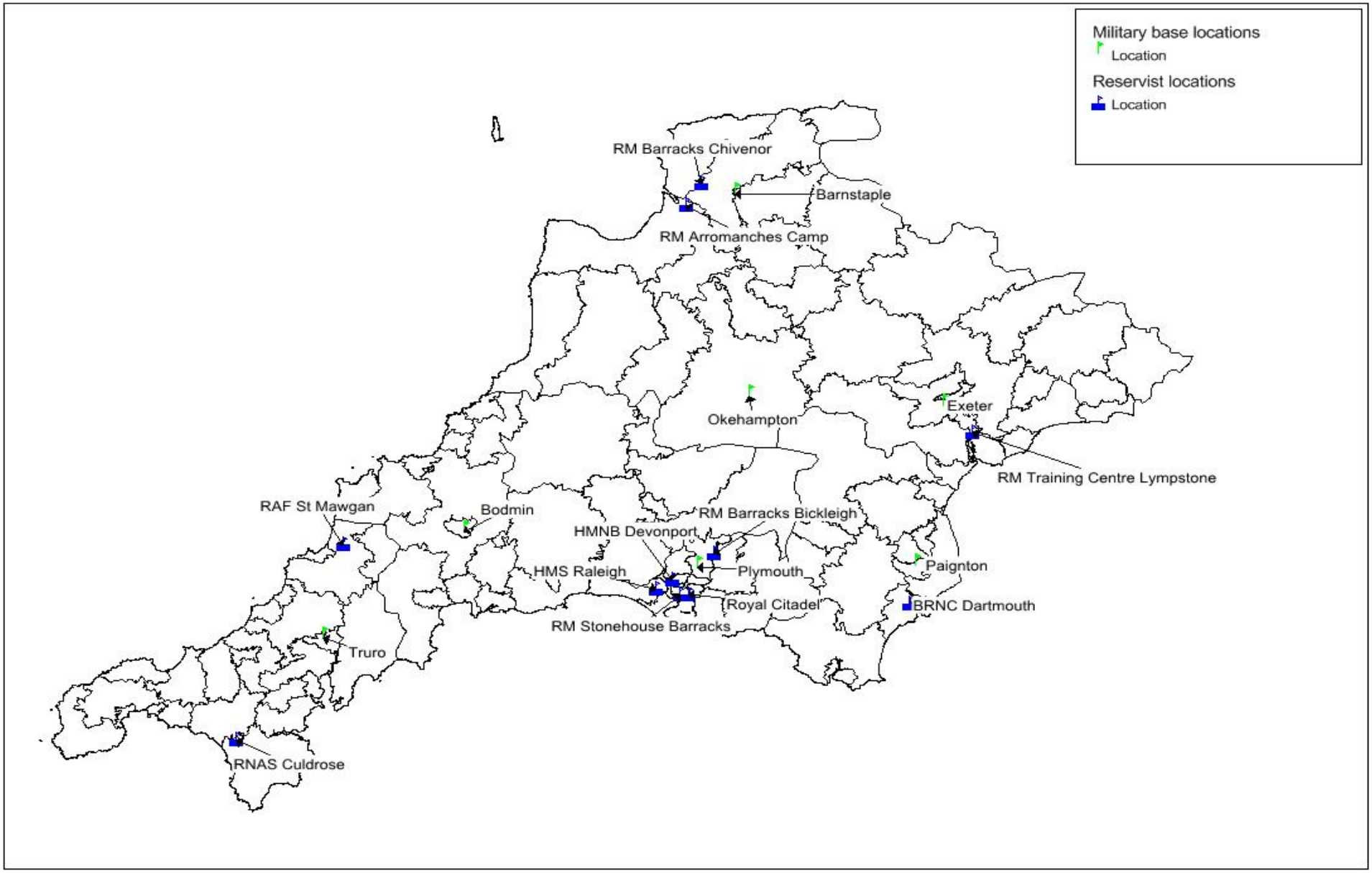


Table 1: Military Bases in the South West Peninsula

Base/Command	Designation
Chivenor Barracks, Braunton The Naval Service	Commando Logistics Unit 24 Commando Unit Royal Engineers 22 Squadron RAF Search and Rescue Force 624 Volunteer Gliding Squadron
Arromanches Camp, Instow The Naval Service	11 Amphibious Trials and Training Unit Royal Marines and 1 Assault Group Royal Marines – equipment testing and training
Bickleigh Barracks, Plymouth The Naval Service	42 Commando Royal Marines within 3 Commando Brigade
Commando Training Centre Royal Marines, Lympstone The Naval Service	Principal Military Training Centre for the Royal Marines
Royal Citadel, Plymouth The Naval Service	29 Commando Regiment of the Royal Artillery
Royal Marines Tamar Royal Navy, Plymouth The Naval Service	539 Assault Squadron, Royal Marines
Her Majesty's Naval Base, Devonport Plymouth The Naval Service	**Devonport flotilla**: Amphibious Assault Ships, Type 23 Frigates, Trafalgar Class Submarines, Surveying Squadron, Antartic Patrol Ships (from 2015). **Other Units:** • Flag Officer Sea Training • Hydrographic, Meteorological & Oceanographic Training Group • HQ Amphibious Task Group • HMS Vivid RNR • Royal Marines Tamar/1 Assault Group Royal Marines • 10 Landing Craft Training Squadron • 4 Assault Squadron • 6 Assault Squadron • 9 Assault Squadron • 539 Assault Squadron • Supacat manufacturing unit • South West Armed Forces Rehabilitation Unit • Hasler Company Royal Marines • Southern Diving Group Royal Navy • Defence Estates South West • HQ Western Division Ministry of Defence Police • CID Devonport MoD Police and DSG Devonport MoD Police

Royal Navy Air Station, Culdrose The Naval Service	**Three** major roles: serving the Fleet Air Arm's front line Sea King and Merlin helicopter squadrons; providing search and rescue for the South West region; and training divers for the Royal Navy. Squadrons based at Culdrose: • 750 Naval Air Squadron • 771 Naval Air Squadron • 814 Naval Air Squadron • 820 Naval Air Squadron • 824 Naval Air Squadron • 829 Naval Air Squadron • 849 Naval Air Squadron • 854 Naval Air Squadron • 857 Naval Air Squadron Other units: • Maritime Aviation Support Force (MASF) • RN School of Flight Deck Operations • Merlin Training Facility • Fleet Requirements Air Direction Unit (FRADU) • Engineering Training Section • Naval Flying Standards Flight (Rotary Wing) • Merlin Depth Maintenance F
Britannia Royal Naval College, Dartmouth The Naval Service	Britannia Royal Naval College (BRNC), commonly known simply as Dartmouth, is the initial officer training establishment of the British Royal Navy, located on a hill overlooking Dartmouth, Devon, England. While Royal Naval officer training has taken place in Dartmouth since 1863, the buildings which are seen today were only finished in 1905, and previous students lived in two wooden hulks moored in the River Dart. Since 1998, BRNC has been the sole centre for Royal Naval officer training. BRNC is widely considered one of the most prestigious officer training establishments in the world.
HMS Raleigh, Plymouth The Naval Service	HMS Raleigh is the modern-day basic training facility of the Royal Navy at Torpoint, Cornwall, United Kingdom. It is spread over several square miles, and has damage control simulators and fire-fighting training facilities, as well as a permanently moored training ship, the former HMS Brecon. Its principal function is the delivery of both New Entry Training & Basic Training. In 2007, phase one training for all new Royal Navy recruits was increased to nine weeks (from eight) of their career at the base, which also provides courses in military training, seamanship, logistics and submarine operations. It also delivers training for crews preparing for operational deployments. HMS Raleigh is also the home of Defence Maritime Logistics School (DMLS) providing training for the Royal Navy's logistics officers, chefs, stewards, pay clerks (referred to as writers) and supply chain ratings, the Seaman Specialist School, the Submarine School and HM Royal Marines Band Plymouth.
RAF St Mawgan Royal Air Force	RAF St Mawgan is currently home to Defence Survival Training Organisation (DSTO), which is a tri-service unit that teaches 'Survive, Evade, Resist, Extraction' (SERE) methods for the Armed Forces in support of operations and training. They also conduct trials and equipment development. The Royal Air Force maintains a small workshop on the station enabling construction of components for the upgrading of aircraft across all three services. Accommodation on the airfield is often used by students of AgustaWestland's training facility at Newquay Airport.

RAF St Mawgan Royal Air Force (cont'd)	Other lodger units located at St Mawgan are Plymouth & Cornwall Wing of the Air Training Corps. The gate guard, which is an Avro Shackleton aircraft, will remain at RAF St Mawgan as long as there is a military presence.
Okehampton Camp Army	There is a tradition of military usage of Dartmoor dating back to the Napoleonic wars. There is still a large British Army training camp at Okehampton - also the site of an airbase during the Second World War. The MoD uses three areas of the northern moor for manoeuvres and live-firing exercises, totalling 108.71 square kilometres (41.97 square miles) or just over 11% of the National Park. Red and white posts mark the boundaries of these military areas (shown on Ordnance Survey 1:25,000 scale maps). Flagpoles on many tors in and around the ranges fly red flags when firing is taking place. At other times, members of the public are allowed access. Blank rounds may also be used but the MoD does not notify the public of this in advance. Some "challenge" and charitable events take place with assistance of the military on Dartmoor including the long established Ten Tors event and the more recent Dartmoor Beast.
Wyvern Barracks Army	Battalion HQ for 6th Battalion The Rifles (6 RIFLES), one of the Regiment's two Army Reserve battalions, comprising 520 part-time soldiers from a wide variety of backgrounds throughout the South West of England. The principal mission of this Light Roled Infantry Army Reserve Battalion is to train and prepare soldiers for front-line operations in southern Afghanistan; having deployed in Helmand almost non-stop since formation in 2007. Up to 85 soldiers are deployed at a time, supporting five regular Rifles battalions in the form of individual reinforcements when they deploy. 243 (Wessex) Field Hospital have detachments in Wyvern Barracks Exeter and in Plymouth (where they are co-housed with 155 RLC Wessex Transport Regiment, Army Reserve Centre, Brest Road) 155 Transport also has detachments in Truro and Bodmin. Exeter University Officer Training Corps (EUOTC), also based at Wyvern Barracks, serves the Universities of Exeter and Plymouth but also other higher education establishments in the South West

Who Is a Veteran?

2.17 There are differing views on the use of the term 'veteran'. Whilst it does not apply exclusively to those who served in the Second World War many young 'veterans' feel it refers to older personnel who served in conflicts pre-Iraq and Afghanistan and think of themselves more as 'ex-military' or 'ex-armed forces'. No distinction is made between those who may have served in more recent conflict operations (such as the Gulf War, Iraq or Afghanistan) and those who have spent time in basic training with one of the Services, or between the length of time personnel may have served. As a result, the veteran population is large and encompasses a wide-age range.

2.18 The Ministry of Defence defines a veteran as:

"*Anyone who has served in HM Armed Forces at any time, irrespective of length of service (including National Servicemen and Reservists)"* (Ministry of Defence 2011).

2.19 Earlier guidance for GPs on the treatment of veterans gives a more extensive definition:

"Anyone who has served for at least one day in the Armed Forces (Regular or Reserve), as well as Merchant Navy seafarers and fishermen who have served in a vessel that was operated to facilitate military operations by the Armed Forces." (Royal College of General Practitioners, the Royal British Legion and Combat Stress 2010)

2.20 Consequently, commissioning services for South West Peninsula veterans requires assessment of the needs of younger and older veterans, as well as regular and reserve personnel who are likely to present different challenges. For this Health Needs Assessment, the term "veteran" relates to the definitions highlighted above, not including adult or child dependants. (The distinction between veterans and 'the ex-service community' should be noted, the latter being defined as veterans and their dependants).

2.21 With the increased emphasis on the contribution of reservists in support of full-time serving personnel, moving in and out of domestic, work and military roles, may give rise to the need for more support services to the reservists and their relations/family. This Needs Assessment will give some consideration to what those needs may be.

Data Sources

Quantitative Information

2.22 This Needs Assessment seeks to identify and quantify the number of veterans living within the Peninsula in order to establish the size of the population and estimate the potential impact of health needs on local service provision. Routinely collected local data for veterans in the Peninsula is extremely limited. Consequently, national data, eg from the Royal British Legion, Office for National Statistics and the Defence Analytical Services and Advice (DASA), was used as a primary source.

3. Demography

Current Demographic Profile

3.1 Data on veterans is not collected in the UK Census questionnaire but it does collect information on those currently serving in the Armed Forces (in questions relating to current occupation).

3.2 Consequently, the most robust estimates of the national veteran population are obtained from the Royal British Legion (RBL) survey data and the Office for National Statistics (ONS). The RBL estimates a UK veteran population of 4.8 million (8% of the UK population); 84% of whom are male (Royal British Legion 2005); whilst the ONS estimates approximately 3.8 million veterans in England (9% of the English adult population); 87.5% of whom are male. (Woodhead et al 2007).

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

Veterans in the South West Peninsula

3.4 The methodology used to calculate prevalence of veterans is as follows: identify some national estimates (RBL and ONS survey) by age groups then using the relevant ONS mid-year population estimates to calculate a national prevalence. Using the national prevalence extrapolated to the latest population (ONS 2011 census) for local authorities.

3.5 Applying these prevalence estimates to the Peninsula gives an estimated **174,041** to **191,839** veterans living in the area. Most veterans are estimated to be in the older age groups with 26% to 30% aged 65 - 74 years and 30% to 35% aged 75+ years. This age profile reflects veterans of National Service which operated from 1939 to 1960.

3.6 The following **Tables 2 – 6** show the estimated number of veterans by each local authority area and the Peninsula and, in both cases, reflect a significant population group for each local authority area.

Table 2: Estimated Veterans Population, Cornwall, 2011

	Royal British Legion		Office for National Statistics	
Age Group	**Estimated**	**Estimated**	**Estimated**	**Estimated**
Years	**Prevalence %**	**Number**	**Prevalence %**	**Number**
16-24	0.84	453	1.58	847
25-34	3.28	1,740	3.14	1,664
35-44	4.44	2,967	5.11	3,416
45-54	5.45	4,106	5.81	4,374
55-64	10.54	8,235	6.87	5,372
65-74	28.54	17,626	23.05	14,235
75-84	36.55	13,795	0.00	0
85+	17.88	2,813	0.00	0
(ONS 75+)			32.79	17,535
Total		51,735		47,444

Table 3: Estimated Veterans Population, Devon 2011

	Royal British Legion		Office for National Statistics	
Age Group	**Estimated**	**Estimated**	**Estimated**	**Estimated**
Years	**Prevalence %**	**Number**	**Prevalence %**	**Number**
16-24	0.84	671	1.58	1,256
25-34	3.28	2,367	3.14	2,263
35-44	4.44	4,027	5.11	4,637
45-54	5.45	5,753	5.81	6,129
55-64	10.54	11,248	6.87	7,338
65-74	28.54	24,662	23.05	19,916
75-84	36.55	20,557	0.00	0
85+	17.88	4,607	0.00	0
(ONS 75+)	0.00	-	32.79	26,892
Total		73,891		68,432

Table 4: Estimated Veterans Population, Plymouth 2011

	Royal British Legion		Office for National Statistics	
Age Group	**Estimated**	**Estimated**	**Estimated**	**Estimated**
Years	**Prevalence %**	**Number**	**Prevalence %**	**Number**
16-24	0.84	331	1.58	619
25-34	3.28	1,124	3.14	1,075
35-44	4.44	1,475	5.11	1,699
45-54	5.45	1,850	5.81	1,971
55-64	10.54	3,066	6.87	2,000
65-74	28.54	6,278	23.05	5,070
75-84	36.55	5,152	0.00	0
85+	17.88	1,005	0.00	0
(ONS 75+)	0.00	-	32.79	6,465
Total		20,281		18,899

Table 5: Estimated Veterans Population, Torbay 2011

	Royal British Legion		Office for National Statistics	
Age Group	**Estimated**	**Estimated**	**Estimated**	**Estimated**
Years	**Prevalence %**	**Number**	**Prevalence %**	**Number**
16-24	0.84	108	1.58	201
25-34	3.28	421	3.14	403
35-44	4.44	706	5.11	813
45-54	5.45	1,000	5.81	1,066
55-64	10.54	1,959	6.87	1,278
65-74	28.54	4,441	23.05	3,587
75-84	36.55	3,735	0.00	0
85+	17.88	907	0.00	0
(ONS 75+)	0.00	-	32.79	5,014
Total		13,276		12,361

Table 6: Estimated Veterans Population, South West Peninsula 2011

	Royal British Legion		Office for National Statistics	
Age Group	**Estimated**	**Estimated**	**Estimated**	**Estimated**
Years	**Prevalence %**	**Number**	**Prevalence %**	**Number**
16-24	0.84	1,564	1.58	2,926
25-34	3.28	5,660	3.14	5,413
35-44	4.44	9,188	5.11	10,580
45-54	5.45	12,727	5.81	13,559
55-64	10.54	24,541	6.87	16,009
65-74	28.54	53,085	23.05	42,870
75-84	36.55	43,299	0.00	0
85+	17.88	9,343	0.00	0
(ONS 75+)	0.00	-	32.79	55,983
Total		159,408		147,342

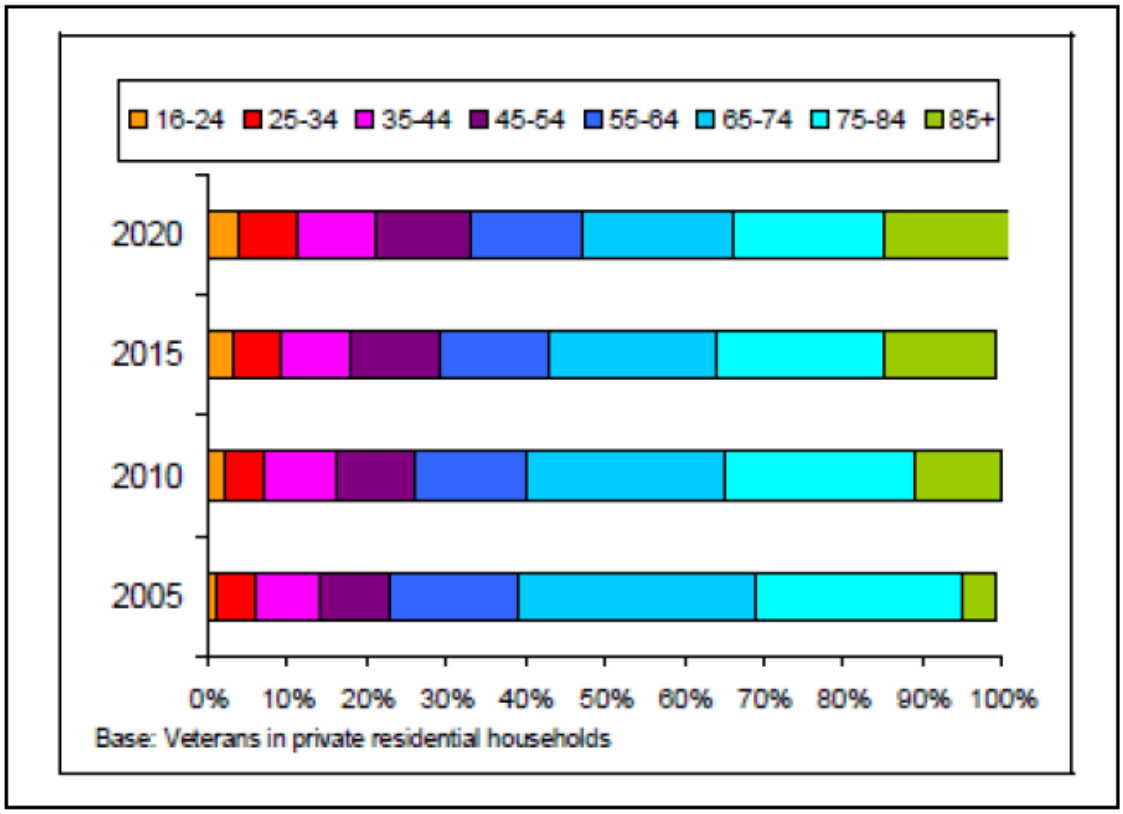
Source for Tables 2 – 6: Royal British Legion, 2005. Profile of the Ex-Service Community in the UK. Woodhead C. et al for the Office for National Statistics. An estimate of the veteran population in England: based on data from the 2007 Adult Psychiatric Morbidity Survey, 2009. Extrapolated to ONS Census Population Estimates for 2011.

Population Projections

3.7 The largest proportion of the veteran population is aged 65 and over in each of the local areas shown in Tables 2 – 5 above. Due to the majority of personnel leaving the service being in younger age groups, there are increasing proportions of veterans in the16 – 24 years and 25 – 34 years age groups. This occurrence is likely to increase as a result of enforced personnel reductions, arising from various services and spending reviews, with the health needs of younger veterans likely to differ significantly from those in older age groups. (Royal British Legion 2006)

3.8 Across the United Kingdom the projections show a reduction in the number of veteran's (see Figure 3 below). Between 2007 and 2027, ONS predicts a **50.4%** reduction in the size of the veteran population in England. Much of this reduction results from a decline in the oldest age groups with a disproportionate number of deaths in these age groups compared to the inflow of new veterans each year. Once again, this has implications for the age profile of veterans in future, although the average age of the national veteran population is likely to remain older than that of the general population. Both the ONS and RBL studies predict a higher proportion of younger veterans over the next 16 years.

Figure 3: Predicted Age Structure of UK Veterans from 2005 to 2020



Source: The Royal British Legion, 2006, Future profile and welfare needs of the ex-Service community (Figure 4.10, Page 20).

Sources of Local Data

Primary Care

3.9 While serving, primary medical care services are delivered by the Defence Medical Services (DMS). On leaving the Armed Forces, veterans should register with a local NHS General Practitioner (GP). Veterans are given a summary of their medical notes from their time in service and it is proposed to have an automatic transfer of medical records from DMS to the NHS in place by April 2014. There is a data recording flag which is populated when the patient first registers with a GP and declares that they are "returning from Armed Forces" on the registration form. It is therefore incumbent on veterans to notify their GP of their status. The flag disappears if the veteran moves to another practice as this is then counted as an internal patient transfer between practices.

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

Read V2 systems:

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

Systems using V2 coding are used by 22 Cornwall practices

CTV3 systems:

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

3.11 There is no national agreement on which Read code to use but Xa8Da is advocated by the Department of Health and cited in Royal College of General Practitioners' (RCGP) guidance (Page 5). The equivalent code matching the description of Xa8Da in the V2 coding system is 13JY.

3.12 Whilst offering an opportunity, the use of primary care data is therefore limited by:

- the willingness of veterans to identify themselves as such when first registering with a GP

- awareness of the existence of relevant Read codes by GPs and other primary care staff

3.13 Given these caveats, data from primary care is likely to under estimate the size of the local veteran population.

Pensions Data and Other Data Sources

3.14 Pension data provides another means of identifying the veteran population. Table 7 below provides a breakdown by the former Primary Care Trust localities, which mainly overlap with the top tier local authority geographies, whilst Table 8 provides further analysis by district, borough, city and unitary authority.

Table 7: Numbers on All Armed Forces Pension Scheme (AAFPS); All War Pensions Scheme (AWPS) and All Armed Forces Compensation Scheme (AAFCS) by Former Primary Care Trust (PCT) Area

Former PCT Areas	All AFPS	All WPS	Disablement Pension	War Widow(er)s	All AFCS
Cornwall & Isles of Scilly	7,885	2,715	2,260	430	105
Devon	8,895	3,865	3,205	645	285
Plymouth Teaching	7,325	2,525	2,215	300	195
Torbay	1,145	630	495	135	10
Total	25,250	9,735	8,175	1,510	595

(Disablement pensions and war widowers are a sub-section of all WPS).

Table 8: Numbers on All Armed Forces Pension Scheme (AAFPS); All War Pensions Scheme (AWPS) and All Armed Forces Compensation Scheme (AAFCS) by Local Authority

Local Authority	All AFPS	All WPS	War Disablement Pension	War Widows	All AFCS
Cornwall	7,870	2,705	2,255	430	105
East Devon	2,030	1,070	910	155	125
Exeter	740	450	370	75	10
Mid Devon	690	275	225	45	~
North Devon	1,060	375	295	75	70
Plymouth	7,325	2,525	2,215	300	195
South Hams	1,560	485	405	75	65
Teignbridge	1,320	660	535	125	~
Torbay	1,145	630	495	135	10
Torridge	545	255	210	45	5
West Devon	955	305	255	50	~

Location of Armed Forces Pension and Compensation Recipients released on 15 November 2011.

3.15 The age profile of War Disablement Pensioners is older given the eligibility criteria: the distribution of these by postcode district is shown in **Appendix A** and a map displaying the number of people receiving AFPS, WPS and AFCS is shown in **Appendix B**. **Appendix C** shows a crude rate of the number of people receiving AFPS, WPS and AFCS.

3.16 Veterans whose injuries resulted from Service after 6th April 2005 are covered by the Armed Forces Compensation Scheme (AFCS). There are **595** veterans receiving such compensation in the Peninsula.

3.17 Applying this data to estimated prevalence shows that about **0.4% (696 – 768)** of local veterans either claim War Pension or AFCS, however, these data sources only identify veterans whose claim was successful under each scheme, and the estimated prevalence may greatly over count the true prevalence.

Service Leavers Data

3.18 Nationally, about 22,000 Armed Forces personnel leave service and return to civilian life every year. During 20012/13, 23,520 personnel left UK Regular Armed Forces, out of these 430 (1.8% of service leavers) were discharged for medical reasons. Out of the medical discharges, there were 256 (1.1% of service leavers) for musculo-skeletal disorders and 45 (0.2% of service leavers) for mental and behavioural disorders (Defence Analytical Services and Advice 2010a). The MoD is now making available data on service leavers at a local level.

Summary of Local Data

3.19 Key points arising from an assessment of the data are:

- the ability to establish a quantitative picture of the Peninsula's veteran population is severely limited by the lack of available sources of local data

- The most robust estimate of the local population, by extrapolation of national survey data to local populations, estimates **147,300 to 159,400** veterans living in the Peninsula

- A key recommendation of this Health Needs Assessment is the development of robust sources of data relating to the local population; in its absence, it is difficult to formulate an accurate assessment of the size of the veteran population and the nature and extent of their needs.

4. The Wider Determinants of Health and the Veteran

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

4.2 Figure 4 below presents a model pathway to support the health, wellbeing and welfare needs of veterans premised on early identification, early intervention and therapeutic responses to need. To put this pathway in place requires the commitment of a range of partners.

4.3 This section considers a range of social and economic factors that can affect some veterans.

Veterans and the Criminal Justice System

4.4 Overall, male veterans are less likely than the general male population to be in prison or be supervised by Probation, however, research has also identified that in the male prisoner population, former service personnel may now comprise the largest occupational subset (The Howard League 2011).

4.5 A variety of factors may lead some veterans to be involved with the criminal justice system, eg pre-existing characteristics not associated with time in the Armed Forces; mental health problems, substance misuse and addictions or difficulties adjusting to civilian life, possibly related to experiences during their time in the services.

4.6 Recent research (University of Chester unpublished 2014) has identified that of the 16% annual leavers who have known health and wellbeing issues, 60% of these are classified as early service leavers having served for less than 48 days and share similar characteristics (see below) and, subsequently, a number of these leavers may be more vulnerable to entering the criminal justice system:

- low educational attainment
- single
- family breakdown
- poor self esteem
- inability to have positive relationships
- housing issues

Veterans in Prison

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

4.8 An HM Inspectorate of Prisons Survey (HM Inspectorate of Prisons 2014) of 4,731 adult male prisoners in 2011–12 showed that the average proportion of prisoners identifying themselves as ex-service personnel was **7%** (n=318; circa 6,000). The survey responses echo the DASA data showing a larger proportion of prisoners aged over 50 in the ex-service personnel population, compared with the general prisoner population (**46% compared with 14%**). The HM Inspectorate survey findings, with regards to sentence length, may well support the DASA evidence that suggests ex-service personnel are convicted of more serious crimes.

4.9 The Inspectorate reports showed that during the period of September 2012 and July 203, 228 veterans were detained within the three Devon prisons. (The figures are based upon the following: December 2013 - HMP Dartmoor 15%; September 2012 - HMP Channings Wood 11%; July 2013 – HMP Exeter 10%).

4.10 Using the local prevalence estimates in Section 4, 94 - 110 veterans are estimated to be in prison for the Peninsula. The method used in this calculation is the number of veterans in prison (nationwide) divided by the estimated veteran population (nationwide) then multiplied by the estimated local veteran population.

The Transforming Rehabilitation Programme

4.11 The main driver for this new overarching criminal justice approach is partnership working which is key to delivering a reduction in re-offending and protecting the public from future harm.

4.12 As part of these changes, the Devon & Cornwall Probation Trust ceased to exist from 31st May 2014. From this point, offenders will either be supervised by the National Probation Service (NPS) - if they pose a high risk of harm or there are significant public protection issues or by the recently established Community Rehabilitation Companies (CRCs) - if they pose a low or medium risk. The NPS will also be responsible for court work and for the preparation of court reports.

4.13 From 1st June 2014, medium and low risk offenders in Devon will be supervised by the new Dorset, Devon and Cornwall CRC. Both the NPS and the CRCs will continue to have local delivery offices, some of which will be shared between the respective organisations. Offenders have been advised of the new arrangements and everything done to minimise the disruption to their supervision.

4.14 The other significant proposed change is the management of the short-term Automatic Unconditional Release (AUR) prisoners who, on receipt of at least two days' imprisonment, will qualify for 12 months' defined supervision. At present, the AUR prisoner group do not receive supervision. This is a significant opportunity to now deal with this group who, previously, have had a very high reconviction rate and become part of the 'revolving door' problem, and account for approx 25% of the current offender group at area level (Devon and Cornwall) - something in the region of 1,200 offenders. Clearly, veterans will be found within this group and are likely to be disproportionate in numbers.

Veterans Subject to Probation Supervision

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

4.16 In the Devon & Cornwall Probation area, **150 veterans** (2.8% of all veterans subject to probation supervision) were under supervision orders as at September 2009. (This may be an under estimate given the incompleteness of DASA's service leavers' database). This compares to **189** (3.5%) in Hampshire Probation area; **129** (2.4%) in Avon & Somerset Probation area and **52** (1%) in Wiltshire Probation area.

4.17 Analysis shows that the majority of offences are violent in nature and are often associated with alcohol and/or drug use. NAPO (the Trade Union and Professional Association for Family Court and Probation Staff) highlights the need to tackle the culture of alcohol use associated with the Armed Forces, as well as promoting help-seeking by veterans for mental health conditions in an aim to reduce rates of offending (NAPO 2011).

4.18 Veteran offenders are increasingly recognised as a complex service user group with the offending behaviour also having a profound and often damaging impact upon families. A recent award winning research by Andrea Macdonald, Durham and Tees Probation Trust, has shown that a variety of factors can lead to some veterans becoming involved with the criminal justice

system. Click on Link to access: http://probation-institute.org/wp-content/uploads/2014/06/Probation-Quarterly-No1-web-abridged.pdf

4.19 Adjustment disorders are particularly evident and more common than post-traumatic stress disorder. These can include profound feelings of separation, detachment and dislocation from military life; low self-esteem outside of the military environment; social isolation; social and life skills deficits; poor intimate relationships; empathy problems; poor coping or self-management skills and adverse developmental experiences. In some examples, poor socio-economic backgrounds, lower educational ability and a lack of housing and employment also contribute to these factors.

4.20 Other recent research (University of Chester unpublished 2014) also identified that of the 16% annual leavers who have known health and wellbeing issues, 60% of these are classified as early service leavers, having served for less than 48 days, and share similar characteristics. Subsequently, a number of these leavers may be more vulnerable to entering the criminal justice system.

4.21 Suicide rates are more prevalent among veterans than mainstream society with rates four times the national average for civilians among some service groups. Pre-existing characteristics, not necessarily associated with time in the Armed Forces; mental health problems, former substance misuse and addictions, are also evident.

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

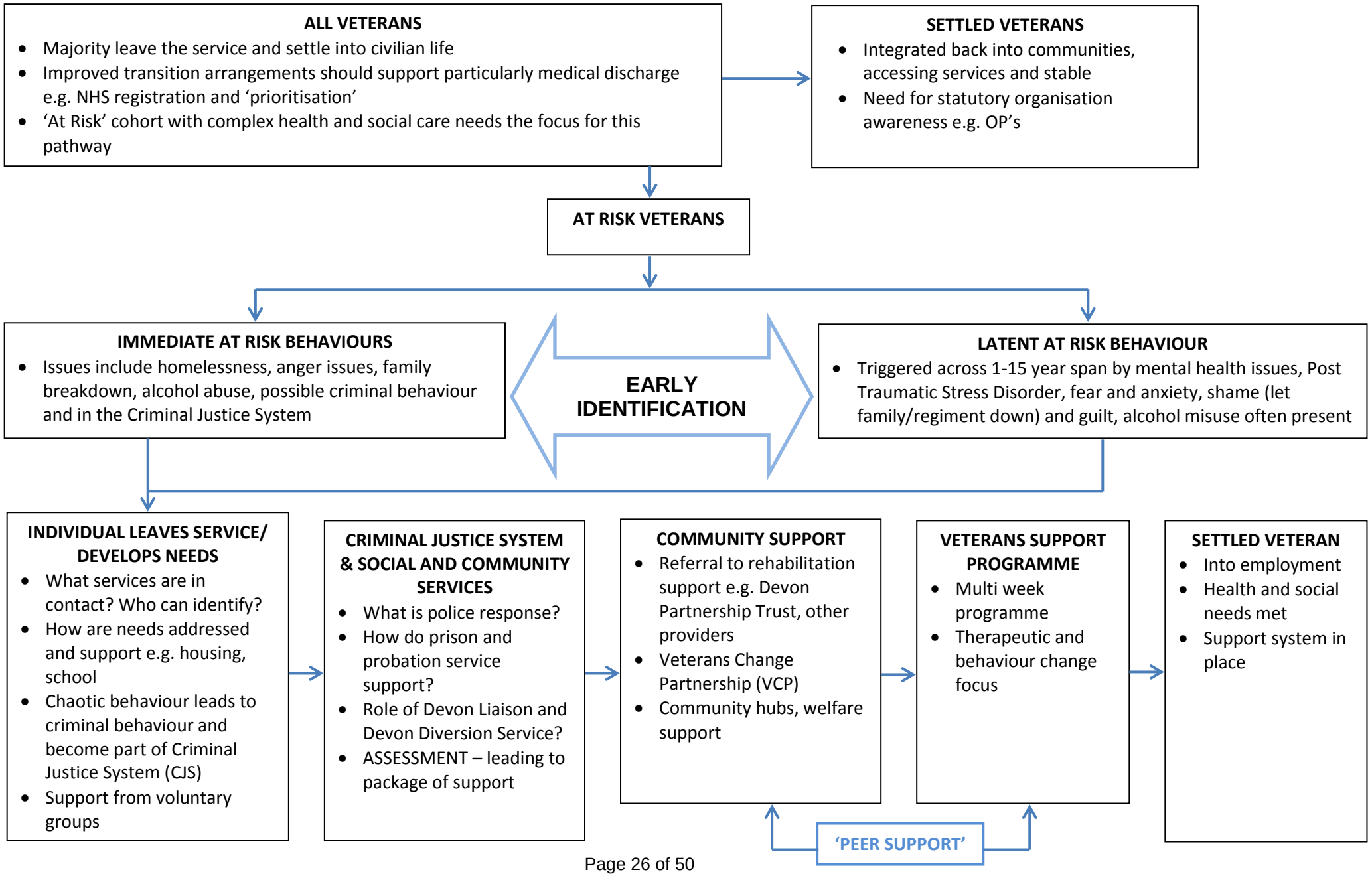
Welfare Needs of Veterans

4.23 The transition to civilian life is likely to bring a number of welfare requirements which prove problematic. For example, veterans may have difficulties finding suitable housing, obtaining adaptations to accommodate injuries or other physical health needs, or obtaining financial aid to which they are entitled. All these areas play a vital role in the overall physical and mental health of the veteran population.

4.24 A range of voluntary and community organisations, including The Royal British Legion (RBL), Combat Stress and SSAFA, are a vital source of welfare support for many veterans as well as, in some cases, providing support for serving personnel and dependants.

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

Figure 4: Veterans' Health and Social Care Pathway



Housing

4.26 The Armed Forces Covenant recognises the importance of ensuring veterans have access to quality housing and housing support. Homelessness is closely linked to adverse physical and mental health, both for veterans and the general population. Capturing data on the population who are homeless is difficult due to their mobile nature. Data from studies conducted over 10 years ago suggested that 20% - 25% of the homeless population in the UK may be veterans (Fear et al 2009). A 2008 study of the ex-service homeless population in London estimated that 6% of London's current non-statutory (single) homeless population has served in the Armed Forces (Johnsen et al 2008, Page ix). Of these veterans, the majority were male and found to be older than the wider homeless population. The authors identified that there were a range of factors contributing to homelessness in the veteran group, including the following:

- one quarter had risk characteristics that pre-dated their time in the Armed Forces and which were carried through their military careers and their return to civilian life

- one quarter experienced difficulties during their time in the Services, such as mental health disorders and substance misuse, which continued after their discharge

- a small proportion (one in six) did not experience difficulties during their career in the Services but had problems with the transition to civilian life, such as difficulties finding employment

- one third had successful careers in the Services and did not find the transition difficult initially but faced issues later on as a result of a bereavement or relationship or financial difficulty which served as a trigger for problems, ultimately leading to homelessness.

Housing Need

4.27 In Devon, which includes Plymouth and Torbay for this purpose, the Housing Register is held by Devon Home Choice and does include details of the number of veterans registered. This is broken down further by local authority area and category of housing need: Band A being the highest (emergency) housing need, through to Band E being no housing need.

4.28 Table 9 below contains this detail for all applicants on the housing register and Table 10 contains the same detail for applicants who have advised that they are or have served in the Armed Services.

Table 9: Housing Register - All Applicants by Local Authority and Band (April 2014)

Local Authority	Band A (Emergency)	Band B (High)	Band C (Medium)	Band D (Low)	Band E (No Housing Need)	Grand Total
East Devon	0	284	493	733	945	2455
Exeter	2	477	499	982	2122	4082
Mid Devon	0	158	271	403	1203	2035
North Devon	1	203	287	603	869	1963
Plymouth	8	1182	1482	2889	4726	10287
South Hams	1	164	201	452	1145	1963
Teignbridge	5	399	561	592	1622	3179
Torbay	5	298	422	657	1727	3109
Torridge	3	191	175	199	758	1326
West Devon	1	105	199	333	934	1572
Grand Total	26	3461	4590	7843	16051	31971

Table 10: Housing Register - Veterans by Local Authority and Band (April 2014)

Local Authority	Band A (Emergency)	Band B (High)	Band C (Medium)	Band D (Low)	Band E (No Housing Need)	Grand Total
East Devon	0	4	19	23	45	91
Exeter	0	11	10	25	48	94
Mid Devon	0	5	8	5	17	35
North Devon	0	10	11	12	29	62
Plymouth	0	39	61	112	186	398
South Hams	0	3	8	12	39	62
Teignbridge	0	7	15	19	16	57
Torbay	0	14	19	18	35	86
Torridge	0	7	3	4	20	34
West Devon	0	3	5	6	22	36
Grand Total	0	103	159	236	457	955

4.29 The Devon Home Choice policy in relation to veterans was amended in October 2013 so that the requirement for an applicant to have a local connection to Devon no longer applies to members of the Armed Forces and their families, unless a home is subject to specific planning conditions (eg in very rural areas). This, in line with the guidance from Government, recognises the special position of members of the Armed Forces (and their families) whose employment requires them to be mobile and who are likely therefore to be particularly disadvantaged by local connection requirements; as well as those injured reservists who may need to move to another local authority district to access treatment, care or support.

4.30 In addition, the Devon local authorities have considered the Housing Act 1996 (Additional Preference for Armed Forces) (England) Regulations 2012, which came into force in November 2012, requiring local authorities to provide additional preference to the following categories of person who fall within one or more of the reasonable preference categories (see above) and who have urgent housing needs:

- is serving in the Regular Forces and is suffering from a serious injury, illness or disability which is attributable (wholly or partly) to the person's service
- formerly served in the Regular Forces
- has recently ceased, or will cease to be entitled, to reside in accommodation provided by the MoD following the death of that person's spouse or civil partner who has served in the Regular Forces and whose death was attributable (wholly or partly) to that service, or
- is serving or has served in the Reserve Forces and is suffering from a serious injury, illness or disability which is attributable (wholly or partly) to the person's service.

4.31 The Devon local authorities have agreed to apply this new legislation by placing the application of the types of person set out above, in Band C, where they would otherwise have been placed in Band D. Applicants who have served in the UK Armed Forces will continue to have their application placed in Band A or Band B where a Devon local authority assess that their housing need meets one of the categories of either band. The local authorities have also decided not to take into account any lump sum received by a member of the Armed Forces, as compensation for an injury or disability sustained on active service, when assessing whether they have sufficient resources to meet their own housing need.

Homelessness

4.32 Currently, most local authorities do not record whether a homeless application is made by veterans or current serving personnel who will be leaving the Armed Forces imminently but with no future place to live, however, the following data has been provided by Teignbridge District Council:

Table 11: Availability of Disabled Facilities Grants (DFGs) for Veterans

LA name: Teignbridge District Council	2012/13		2013/14	
	Serving personnel	Veterans	Serving personnel	Veterans
Nos. Housing advice and assistance approaches	1	Not recorded	5	Not recorded
Homeless application made	0	Not recorded	0	Not recorded
Homeless application decision	N/A	Not recorded	N/A	Not recorded

4.33 Local authorities have a statutory duty to provide DFGs, on receipt of an application form, for works which are recommended by an Occupational Therapist employed by the Social Care Authority. There are financial assessments for this grant. Data collected by the local authorities covering the years 2012/13 and 2013/14 indicates that, in most areas, no grant applications were received, however, the data shown in **Table 12** below has been provided by Plymouth City Council.

Table 12: Disabled Facilities Grants Applications Received Including Value (Plymouth City Council)

Local Authority: Plymouth City Council	2012/13		2013/14	
	Serving personnel	Veterans	Serving personnel	Veterans
Number of DFG applications approved	0	2	0	4
Value of work undertaken £	0	£6,928.40	0	£19,859.29

No detail of the adaptations which were carried out is available.

4.34 North Devon District Council reports that, historically, those who have links to the Armed Services have elected to seek funding via the British Legion and other organisations, rather than choosing to remain on the DFG waiting list. North Devon District Council also has the facility to record if military funding has been received as part of a DFG which is approved by the Council, as this is reclaimable from central Government. However, this has not been used to date because if an Armed Forces support service approves funds to contribute to a DFG, it has normally taken on the whole cost of the work carried out.

Employment

Jobcentre Plus Armed Forces Champions

4.35 The Department for Work and Pensions has now established an Armed Forces Champion in every Jobcentre Plus District (Department of Work and Pensions 2014). The Champion is there to ensure that Jobcentre Plus support, advice and guidance reflect the needs of the service community. The Champion focuses specifically on the Jobcentre Plus support available to:

- service leavers
- serving personnel currently within their resettlement period, and
- spouses/civil partners of currently serving and ex-service personnel

4.36 The role of the Armed Forces Champions is to:

- develop and maintain joint working arrangements between Jobcentre Plus and the Armed Forces community in their district

- provide information to Jobcentre Plus staff about specific Armed Forces initiatives

- provide an understanding of the issues the Forces community face that can be a barrier to employment

- be the first point of contact for Jobcentre Plus staff and Services welfare/families staff to advise on queries regarding individual Armed Forces cases, and

- focus specifically on the Jobcentre Plus support available to service leavers, those within their resettlement period, and spouses/civil partners of currently serving and ex-service personnel. Where necessary, and appropriate, the Champions will work to put support in place.

4.37 Jobcentre Plus has a designated Champion covering the Cornwall, Devon, Plymouth, Somerset and Torbay areas. In each of the local authority areas there are partnership managers. In relation to Armed Forces and veterans, Jobcentre Plus has a number of client categories/markers (listed below) and, nationally, ensuring the appropriate marker is logged for each client is a priority:

- service leaver
- early service leaver
- spouse/partner of people in the service
- reservists
- prefer not to say
- not applicable

Health and Wellbeing Needs of Veterans' Families Including School-Aged Children

4.38 Identifying the children of veterans is problematic as there is no mechanism for collecting the data. The Forces Pupil Premium provides a more accurate record of the children of serving personnel in schools. As would be expected, schools in the vicinity of military bases have a higher percentage of serving children, often giving rise to a mix of nationalities and an increase in younger parents with less stability.

4.39 Feedback from schools (Davies 2013) identifies a number of issues:

Information and Support for Parents

4.40 Many service families move on a relatively frequent basis, sometimes at short notice. Each time they move they must get to know the new area quickly and place children in suitable child care, where necessary, and enrol children into school. Schools can support and ease this process by providing useful and accessible information and securing effective communication channels.

Supporting Pupils

4.41 In 2012 there were 842 service children in schools in Devon which rose to 1,233 in 2013. This is set to rise with the re-organisation of troops from German bases back to the UK in the near future. Ensuring effective transition documents that are useful to all, such a using 'pupil passports' to ensure pupils do not have to keep repeating information and can maintain some link with previous schools and friends by use of postcards etc is a priority.

Support for Schools

4.42 Schools in Devon range from having only one service child in school to 91 in another. Percentages range from 0.2% to 36.4% - Spring 2012 (Devon census data). Each school, regardless of size, will have the challenge of supporting those children in the best way possible and helping them to achieve their potential. Research shows that if a child moves every two years they lose a total of one year of schooling. Areas for consideration include:

- relevant and informative transition documentation in place
- effective signposting to information and other support offers
- supervision opportunities for staff
- developing and supporting effective pre-school links and collaboration
- opportunities for bereavement counselling training and support
- supporting effective links to Service Welfare Officers
- identification and sharing of good and best practice between Devon schools and beyond
- ensuring multi agency links clear

4.43 It will be important to understand the extent to which Armed Forces, veterans and/or reservists families are coming within the scope of the Early Help and Targeted/Troubled Families initiatives.

5. The Health and Healthcare Needs of Veterans

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

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

Physical Health Needs of Veterans

5.3 A recent review of health and social factors affecting the UK's veterans suggests that overall the health of the veteran population is comparable to that of the UK's general population (Fear et al 2009).

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

- musculo-skeletal
- cardiovascular
- respiratory
- mental health
- sight
- hearing

5.5 **Table 13** below highlights the key differences between veterans and the general public by age group.

Table 13: Key Differences in Self-reported Prevalence of Long-term Conditions between Ex-Service Community and the UK Population by Age Group

Veterans	**16-44**	**45-64**	**65-74**	**75+**
Musculo-skeletal	higher	similar	lower	lower
Cardio-vascular	similar	higher	lower	similar
Respiratory	similar	higher	lower	similar
Mental health	higher	similar	similar	similar
Hearing	similar	similar	similar	higher

Source: RBL, Profile and Needs: Comparisons between the Ex-Service Community and the UK population, 2006

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

Complex Case and Neurological Injury

5.7 The South West has one of the units for treating this type of injury: Hasler Company, based at Devonport Dockyard, was established four and a half years ago to primarily look after trauma injuries sustained in Afghanistan. Around 300 personnel have been treated and supported, mainly serving with the Royal Marines and the Royal Navy, although a small number of locally based Army and RAF injured personnel have been cared for as well. The main categories of injuries are:

- triple amputees
- below knee amputees
- neurological (including spinal)

5.8 All cases require long and protracted care pathways. Increasingly, non-battle injuries are being seen and these are mainly:

- poly trauma from road traffic incidents
- training related, including falls
- complex back pain with neurological complication
- Sports related

Post the Afghanistan conflict, head injuries are most prevalent.

5.9 Of non-injury illness, 10-15% of patients have complex mental health problems ranging across:

- Post-traumatic stress disorder
- Bipolar
- Psychosis
- Aspergers
- Recurrent depression

5.10 Alcohol misuse is an issue in many of the diagnoses used as a self-medicating coping strategy. Symptoms may only arise as an evolving mental health presentation once physical health needs have been stabilised.

5.11 Between 30 - 40% of the cases have an amputation following chronic regional pain. There is an issue of amputation being seen as the 'normal treatment' due, mainly, to advances in the improvement of prosthetics giving a better quality of life. Consequently, there are frustrations from no amputee lower limb injured, who see amputees getting a better and quicker service.

Unmet Needs

5.12 A number of needs, that will also have ongoing funding costs for the NHS, have been identified:

Tinnitus: hearing impairment

Terminal illness: leading to death in service. Estimated between 100 - 200 personnel nationally needing shared care from NHS primary care services but also receive support from the Defence Medical Service (DMS).

Fertility treatment: DMS fund up to National Institute of Clinical Excellence (NICE) guidance level. Criteria need to be agreed for NHS commitment. Mainly arises from blast injuries of which 22/90 patients will be discharged into NHS remit; 10 of whom have complex mental health problems.

Chronic fatigue syndrome: an emerging need.

5.13 The main aim for Hasler Company is to achieve the best possible rehabilitation; then, once a plateau is reached, the medical discharge process is initiated and transition from Defence Medical Service into NHS undertaken.

Mental Health of Veterans

5.14 Research suggests that most people "do not suffer with mental health difficulties even after serving in highly challenging environments" (Fossey 2010, Page 2). However, some veterans face serious mental health issues. The most common problems experienced by veterans (and by the general population) are:

- depression
- anxiety
- alcohol abuse (13%)

5.15 Probable Post Traumatic Stress Disorder (PTSD) affects about 4% of veterans. Each year, about 0.1% of all Regular service leavers have been discharged for mental health reasons (Fear et al 2010).

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

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

- Experiences during an individual's period of service with the Armed Forces: there is a link for all service personnel between exposure to combat and the risk of developing mental health problems. This may explain why young, male members of Infantry appear to be particularly at risk (Murrison 2010).

- Transition period from military to civilian life which, for some, can be extremely challenging. People who have been medically discharged receive a comprehensive range of special services to assist with the transition back to civilian life. People discharged for psychiatric reasons are followed up by the Defence Mental Health Social Work Service for up to a year to ensure smooth handover to NHS care.

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

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

- Of service personnel who leave the Forces after serving a sentence in the Military Correctional Training Centre, 50% were in debt with no settled housing six months after discharge. Just over half had a mental health problem, the most common being alcohol dependency (Fossey 2010).

- Members of the Reserve forces who had been deployed to Iraq and Afghanistan had higher rates of PTSD compared to those who did not experience conflict, and compared to members of Regular forces. Reserve forces may experience differences in comradeship and support, with Regular personnel more likely to remain with fellow service personnel for longer periods following deployment which may offer a stronger degree of support (Kings Centre for Mental Health 2010).

- Use of alcohol: alcohol is frequently used and is readily accessible to serving personnel with evidence that rates of 'hazardous drinking' (Page 30) are higher than amongst the general population (Fear et al 2009). Younger males from the lower service ranks are associated with the heaviest use.

Table 14: 2011/12 Incidence of Mental Health Problems in the Armed Forces

ICD-10 Grouping	2011/12		
	Number	**Rate[1]**	**95% CI**
All	5 404	*27.7*	*(27.0 - 28.5)*
Cases of Mental Health Disorder	3,970	*20.4*	*(19.7 - 21.0)*
Psychoactive substance use	287	*1.5*	*(1.3 - 1.6)*
of which due to alcohol	278	*1.4*	*(1.3 - 1.6)*
Mood disorders	962	*4.9*	*(4.6 - 5.2)*
of which depressive episode	870	*4.5*	*(4.2 - 4.8)*
Neurotic disorders	2,442	*12.5*	*(12.0 - 13.0)*
of which PTSD	273	*1.4*	*(1.2 - 1.6)*
of which adjustment disorder	1,561	*8*	*(7.6 - 8.4)*
Other mental disorders	279	*1.4*	*(1.3 - 1.6)*
No Mental Disorder	1,434	*7.4*	*(6.9 - 7.7)*

Source: DASA (Health Information)

Issues for Commissioners

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

5.18 Young male veterans are associated with other risk factors, such as leaving services early and excess alcohol use. Identifying young male veterans is key to ensuring potential alcohol-related disorders are highlighted and addressed early. This may mitigate adverse associations between alcohol and crime or homelessness.

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

5.20 In addition to appreciating the specific mental health conditions experienced by veterans, recognition of the stigma associated with such disorders in this population group also needs to be highlighted. Although stigma surrounding mental health disorders is by no means unique to this population, the culture associated with the Armed Forces may be associated with a greater degree of shame in seeking help for such conditions. In particular, some individuals may view it as 'weak' to seek help and others may be concerned about the impact on any future career options, military or otherwise. Mental health services should ensure they recognise the detrimental effect such stigma may have on veterans' willingness and ability to seek help for mental health conditions (Murrison 2010).

5.21 Primary care and mental health care staff should recognise and understand the challenges posed by the Armed Forces' culture as it is thought to be key to removing some of the barriers veterans perceive in accessing health care, particularly for mental health services. The joint RCGP, RBL and Combat Stress publication aims to promote better understanding of the specific needs of veterans amongst primary care staff and should be promoted amongst all local health providers. (Royal College of General Practitioners et al 2010)

National Developments for Veterans' Mental Health Care

5.22 Following the successful pilots of specialist mental health services for military veterans from 2008 to 2010, came a report by Dr Andrew Murrison, MP called 'Fighting Fit: a mental health plan for servicemen and veterans' (Gov.uk 2010) to uphold the promises of the Armed Forces Covenant. Recommendations from that report included an uplift in specialist mental health clinicians to work with military veterans; an e-learning package for GPs and the Big White Wall, an online mental wellbeing website.

- The Royal College of GPs website now offers the e-Learning package Veterans' Health in General Practice, which is free to all primary healthcare professionals and can be accessed on the RCGP website: www.rcgp.org.uk

- The Big White Wall has won a number of innovation awards and remains a very accessible option for mental health information and support on the internet. It offers the first month free for all military personnel and veterans: www.bigwhitewall.com

- The National Veterans Mental Health Network was established and constitutes 10 regional services across England, as well as services covering Wales and Scotland, which provide specialist assessment and treatment for veterans. These are minimally funded hence the small teams will also link in with local services, supporting their delivery of treatment by offering training, consultation and clinical supervision. They also form vital links between the NHS, service charities and the MoD to enable a more joint working approach in dealing with the mental health of military veterans. The local service for the South West Peninsula is the South West Veterans Mental Health Service. This service accepts referrals from veterans, families, healthcare workers, MoD or service charities: www.swveterans.org.uk

Local NHS Services Including Improving Access to Psychological Therapies (IAPT) Services

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

Combat Stress

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

5.25 It is common for veterans to seek help and to suffer PTSD; for their condition to be complex and be related to exposure to multiple traumas during their time in the Armed Forces. In addition, an individual's mental health needs are frequently compounded with additional needs (eg relationship, welfare and financial issues). It is important, therefore, to ensure that veterans are able to access the full range of support services for their needs in order to adequately address their mental health problems.

Musculo-Skeletal Disorders

5.26 Along with mental health conditions, musculo-skeletal disorders are a key issue for the health of veterans, which is perhaps not surprising given the physical nature of their work in the Armed Forces, along with the potential risk of injury. As highlighted earlier, veterans aged between 16 and 44 years report higher rates of musculo-skeletal conditions than their counterparts in the general population. A study of United States veterans found they are more likely to report 'doctor-diagnosed arthritis' than members of the general population. (Fear et al 2009)

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

5.28 Perhaps more commonly focused on is the risk of serious injury, particularly limb injuries, associated with time spent in the Services. For wounded or injured serving personnel, the DMS and MoD provide an extensive range of services covering treatment and rehabilitation.

5.29 The provision of healthcare passes on discharge from the DMS to NHS providers. For those veterans who have received prosthetic limbs from the DMS for injuries related to their time in service, the Government has confirmed that the NHS will provide replacement prostheses that are at least an equivalent standard to those issued by the DMS. This is likely to have a substantial impact on local NHS providers, particularly as the number of veterans returning from active conflicts continues to increase. At present, no data systems exist to enable an assessment to be made of the current number of veterans receiving NHS prosthetic services in the Peninsula.

Help For Heroes (H4H)

5.30 The Naval Service Recovery Centre, Plymouth, is one of four Help for Heroes (H4H) Recovery Centres in the UK. The others are: Tedworth House, Wiltshire; Chavasse VC House, Colchester, and Phoenix House, Catterick. H4H offer opportunities to take part in sporting; leisure; therapeutic activities; education courses; life skills courses and access to welfare advice and support.

5.31 H4H's Charitable Objective states that, "we look after wounded injured and sick (WIS) serving personnel and their dependants, and also WIS veterans and their dependants". The term 'veterans', in this instance, refers to any Service men or women who have become wounded, injured or sick (WIS) during or as a consequence of their service.

5.32 The Plymouth resources are contained in two buildings: Parker VC and Endeavour. Parker VC contains a fully DDA compliant accommodation unit comprising 60 single cabins plus six family rooms. It also houses a multi-purpose briefing/conference/teaching room and has interview rooms and breakout areas. Endeavour houses a 25 metre, temperature controlled swimming pool; a large rehabilitation gymnasium with physiotherapy stations; strength and conditioning equipment; a climbing wall; space for wheel chair basketball or adaptive volleyball. (Height from ceiling to floor is 8.3 metres). There is also:

- a 12 metre by 12 metre hydrotherapy pool
- eight fully equipped physiotherapy/complementary and alternative therapy/consulting rooms
- a large barista style cafeteria
- support hub, office space (use available to partner charities, support organisations)
- two interview rooms

How Do Veterans and Their Dependants Access the Facilities?

5.33 Initially by referral; either self-referral or through support organisations or charities, the Help For Heroes website or email to: plymouth.supporthub@helpforheroes.org.uk. A 'Request for Support' form will be sent out and a keyworker will contact the individual to ascertain their needs. The service user will be asked to take part in a wellbeing psychological assessment which is normally conducted by telephone. In addition, if appropriate, their GP or other medical practitioner may be contacted to ascertain their medical issue and confirm that it is due to, or as a result of, service reasons. Additionally, military details (service number; unit; length of service; medical discharge date, if appropriate) will be taken and verified with the Veterans' Agency. Once completed, the individual will be invited into the Naval Base or visited elsewhere to discuss what support, if any, can be offered.

5.34 There is a weekly programme of events held each Friday specifically focusing on veterans and their dependants. Further details can be obtained from the email address above or on the following link: http://www.helpforheroes.org.uk/how-we-help/recovery-centres/plymouth-devon/

Key Issues Relating to the Provision of Health Services for Veterans

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

5.36 Additionally, the responsibilities of all NHS services to meet the commitments set out by the Government, including priority access to NHS treatment for conditions related to a veteran's time in the Services, must be realised at a local level. Central to this is ensuring all local healthcare providers are aware of these commitments and responsibilities. A publication by the RCGP, RBL and Combat Stress offers a guide for General Practitioners. Ensuring such documents are promoted throughout primary care services is vital to enable GPs to offer appropriate advice and treatment to veterans.

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

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

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

5.40 As part of the Needs Assessment carried out by the Peninsula group to assess the number of veterans currently referred to NHS services via the priority access route, the possibility of 'tracing' veterans via the Secondary Uses Service (SUS) was explored.

5.41 Although veteran status may be recorded in the individual's referral, there is currently no system of identifying veteran status via the SUS system. The RBL has also highlighted this fact, at a national level, stressing that, without the means to audit the number of priority referrals, the demands on the NHS cannot be assessed. An audit tool to allow such an assessment to be made will require introduction at a national level.

5.42 Finally, current information systems do not allow the automatic transfer of veterans' medical records from the DMS to NHS on discharge. GPs are able to request a veteran's complete record from the DMS but this, again, relies on awareness that an individual patient is a veteran. Where this is possible, GPs should be encouraged to request the whole record to enable a complete picture of a veteran's medical history can be developed.

6. Reservists

6.1 The Future Reserves 2020 White Paper (Ministry of Defence 2011) sets out the Government's intentions to increase the Reserve Force alongside the reduction in full time serving personnel.

6.2 The experience of existing reserve units is that relatively small numbers have physical health needs. In terms of mental health, there are cases of reservists who, post deployment, can take up to two years to return back to their baseline mental and emotional state. The stigma associated with mental health can make it difficult for an individual to put their hand up and self-refer to an agency they can trust.

6.3 The de-mobilisation phase will become an increasingly important time for reservists who, within the space of a few days, move from active service back to civilian/family life. Adequate support to address both physical and mental issues that may arise needs to be offered. The isolated reservist who is not in contact with their peers is potentially more vulnerable to health problems. At the same time, help and support needs to be available to families during both periods of mobilisation and demobilisation. Other factors that need to be considered and addressed are:

- education for employers, schools, health professionals and police about the potential health and wellbeing impacts on reservists
- developing peer networks to offer advice, guidance and advocacy in accessing support services.

7. Governance

7.1 The nature of the health and wellbeing issues facing some veterans provide a rationale for inclusion in the Joint Health and Wellbeing Strategy and therefore aligning governance arrangements to the Health and Wellbeing Board.

8. Conclusions and Observations

Conclusions

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

8.2 The majority of available information does relate to the mental health issues of veterans, although physical health is also noted to be important. National commitments to ensuring adequate provision of services within the healthcare setting exist and offer some guidance for local provision. However, although local needs assessments are able to highlight some of the key issues facing the veteran population, they are severely limited in their ability to identify specifics relating to the veteran community due to a lack of reliable data.

8.3 Observations are set out below.

1. To ensure that information about, and access to, services for veterans, reservists and their families is readily available.
Observation 1.1 - Improve data collection by: **a) Encouraging all GP practices to use the same Read codes relating to veteran status when registering new patients.** *There is no national agreement on which Read code to use but Xa8Da is advocated by the Department of Health and cited in RCGP guidance. However, practices use different primary care clinical record systems and this particular code will not be appropriate for all Peninsula practices.*
b) Encouraging the recording of veteran status for all referrals to secondary care for conditions relating to military service. *Although veteran status may be recorded in the individual's referral, there is currently no system of identifying veteran status in the Secondary Users System (the commissioners' anonymised view of the hospital and community patient systems).*
c) Encouraging the recording of veteran status on registers of partner organisations, such as local authority registers of homelessness acceptances. *Identifying veteran status on homeless acceptance registers would enable better estimation of the number of homeless veterans in the Peninsula thereby enabling an appreciation of the burden of need on housing services and related health services.*
d) Dis-aggregating local-level data on the veteran community from nationally held sources, such as DASA (Defence Analytical Services Agency). *The recent provision of data by resettlement town for service leavers (outflow data) provides a more detailed estimate of the size of the local veteran community than has been available previously. However, there are data gaps and more data about the service leavers is needed to allow a more accurate estimate of the number of injured or wounded veterans resident in the South West Peninsula.*
Observation 1.2 - Communication of need and numbers well in advance of transition from Defence Medical Service to NHS will be important to inform commissioning intentions, particularly for the following conditions: • **complex case (mainly neurological) management 24/7/365** • **mental health issues, with alcohol a compounding factor** • **primary care support whilst in service for certain cases** • **prosthetics** • **continuing support for cognitive injuries (learning disabilities)**
Observation 1.3 - Promote information about NHS services, including GP registration, as well as other sources of support amongst the veteran community by: a) When registering for NHS services, veterans and reservists should be encouraged to identify their status.
b) Encouraging veterans and reservists to register with an NHS GP and identify their veteran's status.
c) Promoting other sources of support available in the Peninsula.
Observation 1.4 - Provide support to reservists and their families by: **a) Encouraging veterans and reservists to identify their status when registering children at school.**
b) Delivering education inputs, as appropriate, in key settings, eg schools and workplaces on the potential impact on reservists and their families.
c) Providing access to operational stress management records and programmes, where appropriate, and peer networks for reservists and veterans.
Observation 1.5 - Enhance local support networks to address the needs of pupils, parents and staff in schools in relation to Armed Forces pupils and produce a Devon Passport for armed forces, veterans and reservist children.

Observation 1.6 - Improve data collection processes for veterans to ensure early identification and direction to appropriate support in line with the Jobcentre Plus covenant objectives.
Observation 1.7 - Identify personnel leaving the service who indicate they had a permanent home contact address in the South West Peninsula and the service leavers who indicated they were settling in the local authority areas of the South West Peninsula.
Observation 1.8 - Ensure local directories have up-to-date information on local mental health, substance misuse and domestic violence and sexual abuse support services.
2. To ensure that the needs of veterans, reservists and their families are specified in contracts so identification and support is mainstreamed.
Observation 2.1 - Promote the education and training of GPs and other healthcare providers.
Observation 2.2 - Promote the uptake of the Royal College of General Practitioners 'on line' training package by GPs.
Observation 2.3 - Specifically include 'Have you ever served in the Armed Forces?' as a question on the registration of new patients with GP practices and subsequently request veterans' complete medical records.
Observation 2.4 - In order to comprehensively address the issues of veterans in the Criminal Justice System and utilise the NHS mental health and police diversionary schemes, develop a veterans' support programme as an alternative to custodial sentencing so as to meet the challenges of the Transforming Rehabilitation agenda and to further promote enhanced partnership working. *(The Veterans Change Partnership is seen as a suitable model for such provision. This proposal aims to provide an intensive and comprehensive joined up programme of rehabilitation, linking to all associated agencies and funding streams).*
Observation 2.5 - Promote the Veterans in Custody Support (VICS) scheme in prisons in the Peninsula.
Observation 2.6 - Raise awareness of veterans' mental health needs with health and social care staff in primary and community care settings and ensure local directories have up-to-date information on local mental health support services.
Observation 2.7 - Implement the agreed procedures with local authority housing teams to ensure veterans are made aware of sources of local and national support at an early stage in their transition to civilian life.
Observation 2.8 - Promote veterans' employment and housing advice peer support networks, eg the Exeter and Plymouth hubs and Veterans 2 Veterans groups, and establish links to local services, ie benefits
Observation 2.9 - Identify the prosthetic requirement for the Clinical Commissioning Groups in the South West Peninsula.
Observation 2.10 - Explore with partner or sister charities, NHS and local authorities, amongst others, how to utilise the Help for Heroes resources to provide non-clinical rehabilitation support for wounded, injured and sick veterans in Plymouth.
Observation 2.11 - Promote access to the armed forces, veterans and reservists hubs in Exeter and Plymouth.
Observation 2.12 - Commissioning organisations to ensure the collection and recording of armed forces status is a specific requirement of contractual arrangements with providers.
4. To ensure the case is made for service commissioners to recognise needs early and provide support before problems become embedded.
Observation 3.1 - Develop a Peninsula-wide Veterans Action Plan.
Observation 3.2 - Establish appropriate governance arrangements to measure the impact of an action plan.
Observation 3.3 - Include veterans in other NHS Peninsula needs assessments and audits, eg mental health and suicide.
Observation 3.4 - Promoting the registration of veterans and reservists with primary care and community services.
Observation 3.5 - Promote partnership working across all agencies to produce a co-ordinated response to the health, housing, employment, education, welfare and criminal justice (H2E2WCJ) challenge.

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APPENDIX A

Numbers on All Armed Forces Pension Scheme; All War Pensions Scheme and All Armed Forces Compensation Scheme by Postcode Area

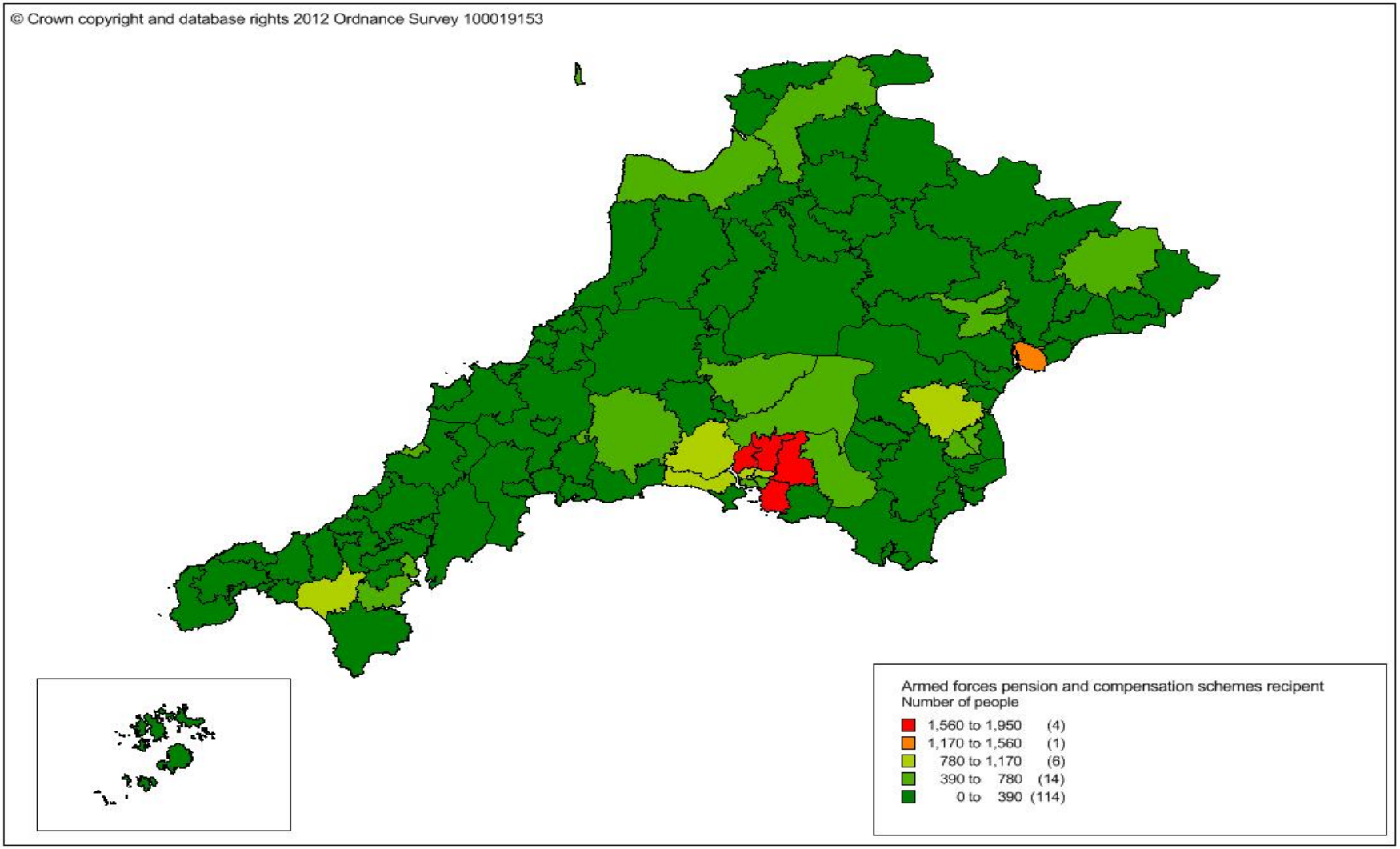
Postcode district	All AFPS	All WPS	Disablement Pension	War Widower	All AFCS
TR1	175	90	65	25	~
TR10	100	40	35	5	0
TR11	390	145	125	20	~
TR12	195	50	45	10	45
TR13	745	165	145	15	5
TR14	255	105	85	20	~
TR15	195	90	80	10	~
TR16	140	45	40	5	0
TR17	20	10	10	~	~
TR18	180	105	85	20	~
TR19	60	30	25	5	0
TR2	95	40	30	10	~
TR20	110	35	25	5	0
TR21	10	10	10	0	0
TR22	~	0	0	0	0
TR23	~	0	0	0	0
TR24	~	0	0	0	0
TR26	80	50	35	10	0
TR27	150	60	50	10	0
TR3	195	55	50	10	~
TR4	105	45	40	~	0
TR5	45	20	15	5	0
TR6	40	15	10	~	0
TR7	375	115	100	15	0
TR8	135	50	35	15	5
TR9	135	35	25	5	~
PL1	420	170	145	20	65
PL10	110	30	20	10	0
PL11	640	175	155	15	20
PL12	760	210	185	25	~
PL13	135	65	55	10	0
PL14	455	125	110	10	~
PL15	195	80	70	10	0
PL16	25	5	5	~	~
PL17	260	75	65	10	0
PL18	135	45	45	~	0
PL19	380	120	105	15	0
PL2	825	265	235	30	75
PL20	350	100	85	15	0

Postcode district	All AFPS	All WPS	Disablement Pension	War Widower	All AFCS
PL21	465	150	125	20	~
PL22	30	25	20	5	0
PL23	55	15	15	0	0
PL24	85	40	30	10	0
PL25	245	85	60	25	~
PL26	220	85	75	10	5
PL27	140	45	35	10	~
PL28	75	20	15	~	0
PL29	5	5	5	~	0
PL3	830	280	235	40	10
PL30	110	40	35	5	0
PL31	150	60	45	10	~
PL32	30	15	15	0	0
PL33	10	10	10	~	0
PL34	10	5	~	~	0
PL35	5	~	~	0	0
PL4	485	180	160	20	~
PL5	1,280	460	395	60	5
PL6	1,385	505	450	50	60
PL7	1,200	385	345	45	10
PL8	175	40	30	5	0
PL9	1,210	365	315	45	20
EX1	125	75	55	20	0
EX10	200	125	105	25	~
EX11	70	40	35	~	0
EX12	95	60	45	15	~
EX13	125	60	50	10	0
EX14	290	120	100	20	0
EX15	210	90	75	15	0
EX16	260	110	85	25	~
EX17	170	55	50	5	0
EX18	35	10	5	~	0
EX19	40	15	15	~	0
EX2	330	190	160	25	10
EX20	180	70	55	15	0
EX21	30	20	15	~	~
EX22	75	40	30	5	~
EX23	130	65	50	15	~
EX24	40	20	15	5	0
EX3	75	30	25	5	0
EX31	315	110	90	20	60
EX32	245	80	60	20	~
EX33	255	75	55	20	~

Postcode district	All AFPS	All WPS	Disablement Pension	War Widower	All AFCS
EX34	115	50	40	10	~
EX35	10	5	~	5	0
EX36	60	30	25	5	0
EX37	35	15	10	~	0
EX38	65	25	25	~	~
EX39	345	150	120	30	~
EX4	280	185	160	30	~
EX5	190	100	90	15	0
EX6	135	65	55	15	0
EX7	135	75	60	15	0
EX8	895	475	420	55	125
EX9	120	70	55	15	0
TQ1	240	140	110	25	~
TQ10	75	20	15	5	0
TQ11	45	15	15	~	0
TQ12	575	270	225	45	~
TQ13	265	120	100	20	~
TQ14	205	115	85	30	~
TQ2	280	140	115	25	~
TQ3	270	150	115	35	~
TQ33	~	0	0	0	0
TQ4	165	100	80	20	0
TQ5	215	115	85	30	~
TQ6	170	40	40	~	10
TQ7	220	70	60	10	~
TQ8	20	5	~	~	0
TQ9	145	55	45	10	0

APPENDIX B

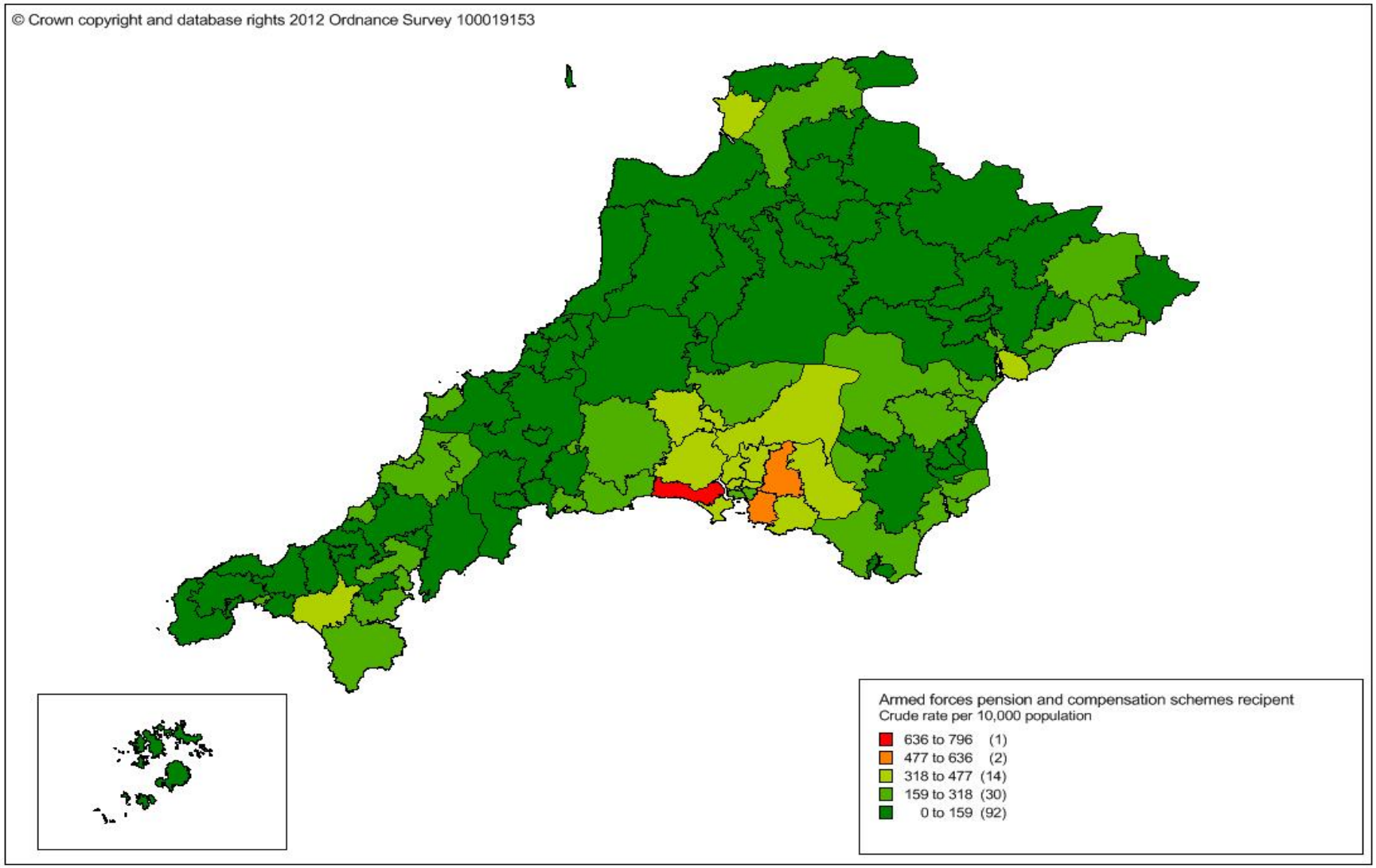
Map Showing All Armed Forces Pension Scheme; All War Pensions Scheme and All Armed Forces Compensation Scheme by Postcode Area



Source: DASA

APPENDIX C

Map Showing All Armed Forces Pension Scheme; All War Pensions Scheme and All Armed Forces Compensation Scheme as a Crude Rate by Postcode Area



Source: DASA and ONS 2011 Census population by postcode