SUPPORTING ARMED FORCES IN ACUTE HOSPITAL SETTINGS

Westminster Centre for Research in Veterans

University of Chester

Evaluation Report

CONTENTS PAGE

ABBREVIATIONS. 3

FOREWORD 4

EXECUTIVE SUMMARY 5

BACKGROUND 10

INTRODUCTION 12

AIMS & OBJECTIVES 19

METHODOLOGY 20

RESULTS 28

DISCUSSION 62

LIMITATIONS 74

RECOMMENDATIONS 74

CONCLUSIONS 76

REFERENCES 78

APPENDICES.......... 83

EVALUATION TEAM 100

Abbreviations

AF	Armed Forces
AFA	Armed Forces Advocate
AFC	Armed Forces Community
AFCFT	Armed Forces Covenant Fund Trust
DMWS	Defence Medical Welfare Service
ED	Emergency Department
KPI	Key Performance Indicators
MH	Mental Health
NHSE	National Health Service England
PH	Physical Health
PHC	Primary Healthcare
SHC	Secondary Healthcare
SU	Service User
UK	United Kingdom
VCHA	Veterans Covenant Healthcare Alliance
VTN	Veteran Trauma Network

Foreword

Anna Wright, CEO

Armed Forces Covenant Fund Trust

The Armed Forces Covenant Fund strives to fund innovative projects that can deliver longer term sustainable changes for Armed Forces Communities.

Under this programme we wanted to explore whether different approaches of support for veterans when they are accessing care through a hospital setting could improve longer term outcomes; particularly for older veterans.

The 'Supporting Armed Forces in Acute Hospital Settings' initiative enhanced care for veterans and their families during hospital stays across the UK. This collaborative approach between the Covenant Fund, NHS England, and NHS Improvement launched 17 pilot projects, offering grants to employ Armed Forces Advocates (AFAs) who ensure tailored support for veterans from admission through discharge; with an additional, specialist project in Northern Ireland. Each Armed Forces Advocate, within each setting, provided additional support and co-ordination with services and Armed Forces charities, supporting the veteran through to discharge and beyond.

These projects have explored different approaches to the challenges of how to best support veterans; raising awareness of specific needs for veteran communities; and encouraging veterans to feel confident in sharing their experiences and accessing wider help.

We were particularly pleased to note the longer-term sustainable benefits of this programme. Some projects were able to show more cost-effective ways of providing support which will offer savings through helping reduce hospital stays and improving access to support within the wider local community.

This external evaluation explores the wider impacts of this programme, and its key findings are that having an AFA embedded in an acute care NHS hospital Trust raised awareness of the needs of the veteran community across staff working in hospitals. The programme delivered significant benefit to veterans and their families who appeared to feel valued and appreciated with acknowledgment of their Armed Forces service; and there is evidence that the projects were able to collaborate with external organisations to meet veteran's needs within the community. Veterans and their families valued the support that they received through the projects.

We also note that this evaluation has helped to increase our understanding of the needs of older veterans, and barriers that exist for them to be able to access support. We hope that the learning from these grants will continue to embed and improve outcomes for veterans and enhance awareness of the needs of Armed Forces Communities more generally.

Executive Summary

Introduction

In 2021, the Armed Forces Covenant Fund Trust (AFCFT) and NHS England and Improvement awarded almost £2 million to a pilot project to help support veterans in acute hospital settings throughout the UK. A total of 16 NHS Trusts were awarded funding to recruit an Armed Forces Advocate (AFA) or equivalent post-holder within their acute NHS Hospitals Trust. The University of Chester's Westminster Centre for Research in Veterans (The Centre) were also funded to provide an independent evaluation, which commenced in February 2022 and ended in January 2024.

There was no defined job description for the AFA appointment, but rather general guidance of what the role would fulfil and the experience that the individual in post would need to have. This included undertaking and formulating risk assessments, staff supervision and an understanding of policies and procedures surrounding the armed forces community. This decision was taken in order to give the NHS Trusts (or equivalent) the autonomy to shape the role as was needed within their organisation. However, there were some key aspects that several of the roles shared, namely a common goal of improving the support of inpatient veterans within an acute hospital setting. Whilst many post holders went beyond this remit, the majority were able to: identify and visit patients at their bedside to support them as needed; train members of staff within the hospital to increase knowledge and awareness of the needs of veterans; to highlight the support that is available for the veteran community and also to promote a general camaraderie within this community.

Embedding AFAs in Acute Hospital Settings

The Armed Forces Advocate Role was piloted across the UK to ascertain the benefits, challenges, and future recommendations for this appointment. The 16 Trusts that were awarded funding included two in Scotland, two in Wales and twelve across England that provided a wide geographical distribution. Whilst Northern Ireland was awarded funding for a project to run a veteran's advice line under this grant, this was evaluated separately from the AFA role due to the difference in support provision and need.

Conducting the Evaluation

The evaluation of the AFA role aimed to highlight improvements in health outcomes for members of the armed forces community upon the introduction of an AFA. To achieve this, multiple components of data were required. For veteran patient data, AFAs were required to enter information into the "Armed Forces Advocate Portal" and provide details about patient demographics, service history, hospital admissions information and referral information. This portal was a duplication of DMWS's portal, existing for the sole use of the evaluation. The data collection portal and the

responsibility for data collection was with the DMWS. Once the AFA input data into the portal, that data became available to the University of Chester Centre through technological programs which allowed anonymised access to the data as a secondary party.

Service users, and family members of service users, had the opportunity to provide feedback on their time in the hospital, including the impact, knowledge, and support of the AFA. This feedback was given in the form of a short questionnaire. In addition, to capture the impact of staff training, a questionnaire survey were created to record the confidence of staff in their knowledge of the armed forces community and the covenant legislation both before and after training. Staff were also asked for their job role and grading to understand the engagement from across the grant holders.

The evaluation team also coordinated a quarterly E-Bulletin whereby AFAs had the option to provide updates. These newsletters contained information provided by NHSE, AFCFT and the evaluation team. Furthermore, monthly webinars were organised by the evaluation team alternating between a webinar that all AFA's attended, and presentations given by two AFA's, the evaluation team and AFCFT and regional webinars where AFA's were split into approximate groups of four to allow more open discussion surrounding progress and allowing AFA's to share best practice.

At around the halfway point of the programmes, each of the 17 grant holders were visited. The intent was for the Centre staff to meet with senior representatives from the organisations (Chief Executive, Chair of Trustees) and key staff. This was to discuss any outstanding issues and ensure that the AFAs were being supported and to maintain momentum.

Results

During the evaluation, survey data was collected regarding 2512 acute hospital care veteran patients, and this provided insight into their demographics (age, gender), their needs, admissions, referrals processes and previous help-seeking behaviours. Visit logs were also recorded and showed AFA's made on average 4 visits per veteran patient. Survey data captured 106 veteran responses, 30 family responses and 1352 staff training pre/ post responses. Qualitative data was captured via 30 interviews and 4 focus groups.

The data revealed the mean age of veterans was 75, most of whom were male (97%). Of these, 78% were retired and only 10% were in full time employment. Forty-five per cent had completed National Service and most had served in the Army (81%).

The most common reason for admission into hospital was physical ill health (81%) with most entering via emergency care (60%). However, only 5% (N=117) had needs identified as attributable to their time in service. Prior to hospital admission, most veterans (20%) had sought support from their GP, and upon discharge out of hospital, most were referred to national charities (33%). Survey data revealed the AFA role was positively received by veteran patients and their families, they felt supported and

believed the AFA role had a positive impact on them. Staff surveys indicated that 1352 staff had received training with nurses and/ or Band 6 staff most likely to be involved in that training, with evidence to positively indicate improvements in knowledge, awareness and understanding of the AFC present post-training.

The interview and focus groups revealed the positive impact the AFA had upon veteran patients, their families and the wider hospital community in addition to the challenges faced by AFAs which were largely related to establishing the role, workload and identifying veteran patients.

Summary and Recommendations

This evaluation identified multiple perspectives of the AFA role including those of veterans, their families, NHS hospital staff and AFAs themselves. These perspectives illustrated the impact of AFAs within an acute hospital setting, identified the needs of veteran patients and demonstrated how the role was utilised to improve education and knowledge surrounding the Armed Forces Covenant. The evaluation was also able to identify levels of understanding about the Armed Forces Community of staff working within a hospital setting, confirming improvements in knowledge of the staff working within the hospitals which occurred as a direct result of the staff training AFA's delivered.

Older males who had completed National Service were a key representation of the veteran patients requiring acute hospital care. Importantly, this is a population who have until now, been particularly hard to reach. Therefore, this initiative has been able to identify previously unknown needs of older veterans. Also, whilst identification of veteran patients is not without its challenges, there are ways to overcome this as evidenced by some NHS Trusts within this evaluation who have embedded veteran identification into electronic admission systems.

To ensure future sustainability of the AFA role, there is a need to ensure the focus on identifying veterans remains prominent within the hospital setting, whether that be through digital systems, staff asking patients whether they have served or other identification tools which have been embedded by NHS Trusts such as poppy badges and stickers. This will also aid in identifying veteran's needs. Consideration of the AFA job role is also important, and whilst a key benefit of this role is the broad remit it can offer to veterans, it is also important to recognise that the AFA role extends into the community and the job specification should therefore reflect this, in addition to a need for flexible working hours. Incorporating standardised specifications within their job role will ensure KPIs can be monitored and impact measured. A key recommendation from this evaluation is that staff training should be considered as being mandatory and be consistent in content, as this would provide improve staff knowledge, awareness and remove the responsibility from the AFA to ensure staff are educated about the Armed Forces Community.

Overall, the results indicate that having an AFA embedded in an acute care NHS hospital Trust has raised awareness of the needs of the veteran community across staff working in hospitals. There is evidence that it has been of significant benefit to

veterans and their families who appeared to feel valued and appreciated with acknowledgment of their Armed Forces service. AFAs have advocated on many issues including timely discharge processes and collaborate with external organisations to meet veteran's needs within the community. Key outcomes of this evaluation have highlighted the benefits associated with having AFA's embedded in acute hospital settings, indicated the challenges AFA's experience and offered recommendations for sustainability and future delivery of the initiative.

Results Highlights

98%

of SU's and family members rated the support as **'good'** or '**very good'**.

"I think we're a lifeline, that link between the Trust and the veteran community and I think losing that would have quite a detrimental impact on a lot of people" WW

1352

staff received training to improve their knowledge and understanding of the Armed Forces Community.

92%

of staff felt comfortable speaking to a veteran after training compared to 63% pre-training.

89%

of staff knew what services were available to refer veterans on to following training, compared to 22% pre-training.

'This service is invaluable. It is huge support to veterans who feel let down and cast aside by the system. It gives relief to the families who have had to cope alone.'

Background

In 2021, the Armed Forces Covenant Fund Trust (AFCFT) awarded almost £2 million to help support vulnerable veterans in acute hospital settings throughout Great Britain. The Supporting Armed Forces in Acute Hospital Settings programme was jointly funded by the AFCFT and NHS England and NHS Improvement to support pilot projects to better support veterans and their families when they are in a NHS hospital setting. Eligible hospitals could apply for a grant for a project that would focus on improving support to veterans who are receiving treatment as an inpatient within that hospital. This involved employing an Armed Forces Advocate (AFA) to provide leadership, support and co-ordination within the hospital and with non-statutory services within the Armed Forces charity sector; whilst shaping improvements that could benefit the wider Armed Forces community.

A total of 16 NHS Trusts were awarded funding to recruit an Armed Forces Advocate (AFA) or equivalent post-holder within their acute NHS Hospitals Trust (See Figure 1). The Westminster Centre for Research in Veterans (The Centre) provided the independent evaluation of the project, which commenced in February 2022 and data collection concluded in January 2024.

In Northern Ireland, an aligned but independent award was provided to the Northern Ireland Veterans Support Office to establish a The Veteran's Adviceline for Statutory Professionals (VASP) Service. The Adviceline is open to statutory professionals, the community and voluntary sectors seeking advice, and they would be signposted to Veteran organisations and State Welfare Services available to support Veterans and their families. This included advice on State Benefits, War Disablement Pension advice, Service/Preserved Pensions advice, physical, mental, and emotional support referrals to assistive Veteran organizations. This evaluation of this initiative will be presented as a stand-alone report.

Westminster Centre for Research in Veterans | University of Chester

Grantholders

1. University Hospitals Dorset NHS Foundation Trust
2. Warrington and Halton Teaching Hospitals NHS Foundation Trust
3. Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust
4. East Suffolk and North Essex NHS Foundation Trust
5. East Lancashire Hospitals NHS Trust – A University Teaching Trust
6. James Paget University Hospitals NHS Foundation Trust
7. Manchester University NHS Foundation Trust
8. South Tyneside and Sunderland NHS Foundation Trust
9. Airedale NHS Foundation Trust
10. Gloucestershire Hospitals NHS Foundation Trust
11. Frimley Health NHS Foundation Trust
12. Milton Keynes University Hospital NHS Foundation Trust
13. NHS Wales GIG Cymru – Bwrdd Iechyd Prifysgol Betsi Cadwaladr University Health Board
14. GIG Cymru NHS Wales – Bwrdd Iechyd Prifysgol Caerdydd a'r Fro – Cardiff and Vale University Health Board
15. NHS Lothian
16. NHS Greater Glasgow and Clyde
17. VASP – Veterans' Adviceline For Statutory Professionals

FUNDED BY:

Introduction

There are an estimated 1.85M veterans residing in England and Wales (MOD, 2020; ONS, 2022). Census data (ONS, 2022) reveals the highest proportion of British Armed Forces veterans tend to cluster near existing Armed Forces bases given many veteran families choose to settle in areas near to their final posting. See Figure 1. The veteran community represents 3.8% (almost 1 in 25) of the total population aged 16 or over. Of these, 76.3% (N=1.41M) previously served in the regular forces, 19.5% (N=361,000) in the reserve forces, and 4.3% (N=79,000) served in both the regular and reserve forces (ONS, 2022). Census data also showed that of the total British Armed Forces veteran population in England and Wales, 13.6% (N= 251,400) were women (compared with 53.1% of the non-veteran population) and 86.4% were men (N=1,601,705). Almost one-third (31.8%, N= 589,640) of veterans were aged 80 years and over, reflecting those with National Service and War Service from 1939 to 1963. This can be compared with 5.1% (N=2,380,350) of people who were aged 80 years and over in the non-veteran population. Over half of veterans (53.0%, N=982,365) were aged 65 years and over. This compares with 21.6% (N=10,080,950) people who were aged 65 years and over in the non-veteran population.

Census data also reported that 27.5% (N= 509,645) of veterans in England and Wales said that their general health was very good whilst 36.9% (N=682,995) said that their general health was good. A quarter of veterans in England and Wales said their health was “fair” (24.2%, N=448,720). The proportion who said they had bad health was 8.6% (N=160,190) and 2.8% (N=51,660) of veterans said they had very bad health. This pattern was apparent across England and Wales although the non-veteran population showed a different pattern, with non-veterans more likely to say they have very good health and less likely to say they have very bad health. However, the veteran population is older than the non-veteran population.

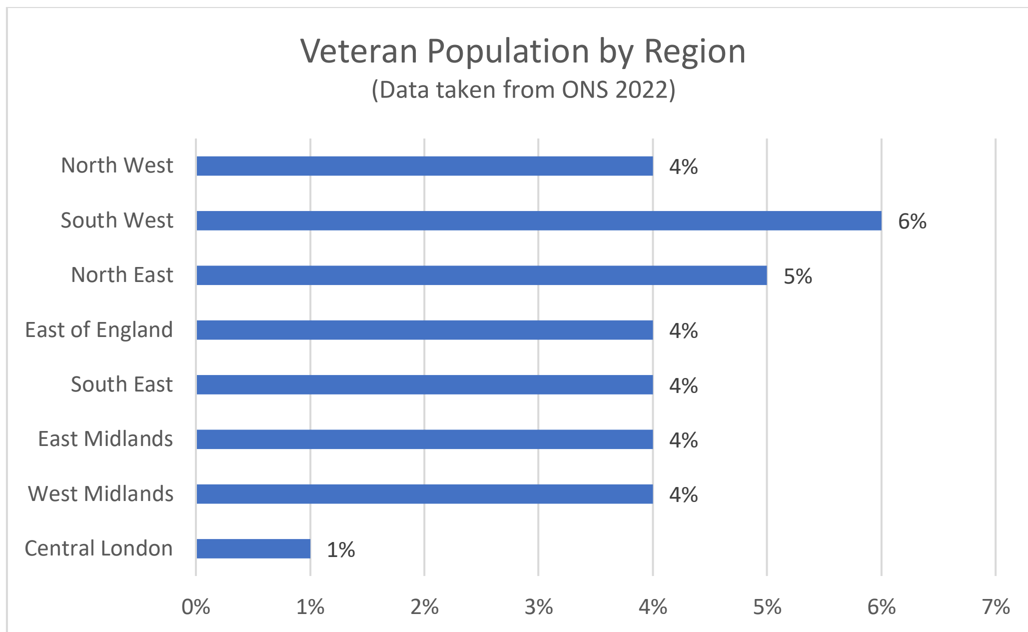


Figure 1. Data taken from ONS; veteran population by region

The Armed Forces Covenant

The Armed Forces Covenant became enshrined in law in 2011 (MOD, 2022a), stating that no member of the armed forces community of serving personnel (Regulars and Reserves,Veterans and their families) should face disadvantage because of their service. The Armed Forces Covenant covers areas such as housing, employment, and healthcare, with veterans receiving priority treatment for any health conditions that are attributable to their service. A veteran is defined as anyone who has served in the British Armed Forces for a minimum of one day, including those who served as regulars, reservists, those in training and those who operated under national service. Building on the progress of the Armed Forces Covenant, in 2022, the Armed Forces Covenant Duty (MOD, 2022b) was introduced and became a legal obligation for certain public bodies, particularly in areas such as healthcare, education, and housing, to consider the Armed Forces community and to assist in removing any disadvantages they face within their policy and practice. In relation to healthcare, these disadvantages may relate to veterans and/or their families experiencing more challenges in accessing healthcare, or delays in receiving treatment compared to non-veteran patients (NHS, 2020; 2021). Other challenges might include a lack of awareness in healthcare providers about the specific needs of the veteran community and how their military service may have caused or contributed to health conditions (Simpson & Leach, 2022). Similarly, healthcare providers may not be fully aware of the military specific services which exist for veterans and their families (Finnegan & Randles, 2022), or there may be delays in the passing of information between healthcare systems.

Mental health

Serving military personnel have been identified as having a high prevalence of mental disorders (Finnegan & Randles, 2022). In the British Armed Forces, depression is the most common mental health (MH) disorder (Finnegan & Randles, 2022), with the Ministry of Defence (MoD, 2022c) reporting that 12.7% of the British Armed Forces were seen in military healthcare for an MH-related reason with 2.7% being seen by a specialist MH clinician. Prior research also estimates that approximately 6-22% of UK veterans experience MH difficulties including Post Traumatic Stress Disorder (PTSD; 6.2%), common mental disorders (CMDs; 21.9%) like anxiety and depression, and alcohol misuse (10%). The demands of military service impact on personnel both during (serving) and after service (veterans) and can contribute to a deterioration of physical and/or MH (Williamson et al., 2023). Specific occupational stressors, such as deployment history and combat experience, play a role in the risk of mental disorders and alcohol use disorder amongst veterans. These stressors were compounded by other factors including childhood adversities, which appear to be higher in UK veteran populations compared to the general population (Williamson et al., 2023).

Physical health

With almost 50% of veterans over the age of 65 years and nearly one third over 80 years old, (ONS, 2022), then the physical health needs are likely to be comparable to those of the general ageing population. Difficulties with mobility, visual and hearing impairment and factors that negatively impact on self-care can become problematic for older veterans (Royal British Legion, 2014; Williamson et al., 2019). More generally, veterans have been observed to have a lower mortality risk relative to the general population (Oster et al., 2017). This has been referred to as the 'healthy soldier effect', resulting from the high physical health standards of entry into the armed forces (McLaughlin et al., 2008). However, research suggests an erosion of the healthy soldier effect in veterans of contemporary conflict (Bollinger et al., 2015). Furthermore, the intense physical activity associated with serving in the Armed forces means veterans may be at greater risk of developing musculoskeletal injury (Sammito et al., 2021).

The charitable sector offers specific support for serving personnel, veterans and their families with physical health needs. One report indicates this sector, consisting of 121 charities, administered £103M in one year for physical health alone (Doherty et al., 2018), twice that of MH, housing and education combined. Only 17% of the veteran charities responsible for physical health deliver services directly administered by a health-care clinician, demonstrating a need for the third sector to work in close collaboration with NHS professionals for an effective delivery of support (Doherty et al., 2017).

Primary healthcare

To support veterans, there has been considerable statutory and non-statutory investment in military veteran health services in recent years (Bacon et al., 2022). However, some veterans were unaware of the potential health and social care benefits of disclosing their veteran status to their GP (Finnegan et al., 2018). Within Primary Healthcare (PHC), although GP practices are required to record whenever a patient identifies themselves to be a veteran, in 2018 only 8% of veterans were estimated to be correctly coded within PHC, theorising that awareness of the need and benefits of doing so is minimal (Simpson & Leach, 2015, Finnegan et al., 2018;). With the introduction in England of the RCGP Veteran-Friendly Practice Accreditation Programme in June 2019, this has since improved (Finnegan et al., 2022; Simpson & Leach, 2022). This RCGP programme was launched as part of an NHS 10-year plan to improve veteran engagement with PHC providers. Accreditation allows practices to better identify, treat, and refer veterans, where appropriate, to dedicated NHS services, thereby demonstrating motivation and commitment to ensuring veterans and their families are provided with better patient-centred care within GP practices (Finnegan et al., 2022). It has also assisted the NHS in being able to meet the health commitments of the Armed Forces Covenant.

The RCGP recommends the use of a single 'Military Veteran' code on PHC records, however there are several different code options relating to military service that can be applied, and it is at the discretion of the staff member who is recording the information to choose the appropriate code. This is one of the many challenges that prevent the coding of veteran status from working seamlessly, and research indicates that 47% of GPs did not know how many veterans were registered in their practice. As of March 2024, 3145 GP practices have achieved veteran friendly accreditation (RCGP, 2024). Subsequent research aimed to identify effective initiatives to increase veteran registration in UK primary healthcare (PHC) practices and through simple initiatives over a 6-month period, increasing the number of veterans identified by just over 200% (Finnegan & Randles, 2022). So, whilst there have been palpable improvements in registration, the level of connectivity available has not translated into secondary healthcare.

Secondary healthcare

There is no national marker to identify veteran patients in secondary healthcare and identification of veterans relies on PHC coding (Leightley et al., 2023). This prohibits knowledge, understanding and evaluation of the healthcare needs of those who have served in the Armed Forces. In 2014, the Chavasse Report was published and focused on improving Armed Forces' and veteran care while raising NHS standards (NHS, 2014). The report, based on findings from visits to veteran orthopaedic patients, recommended establishing a support network of hospitals. The resulting Veterans Covenant Healthcare Alliance (VCHA) works closely with NHS England, service charities, and the Ministry of Defence. Within Secondary Healthcare (SHC), the VCHA is a group of NHS providers including acute, MH, community and ambulance trusts that have agreed to support the

armed forces community (NHS, 2024). This is achieved through a Veteran Aware accreditation model which encourages providers to identify patients with an armed forces background. Their original remit was to accredit all NHS Trusts in England, but through the NHS Long Term Plan (NHS, 2020), VCHA has since expanded to Hospices and the Independent Care Sector with a similar scheme available for the accrediting of care homes.

Other secondary healthcare initiatives aimed at improving care for veterans includes Op RESTORE: The Veterans Physical Health and Wellbeing Service, formerly known as the Veterans Trauma Network (VTN). Op RESTORE brings the service in line with other Armed Forces healthcare services provided by the NHS in England (NHS, 2024) including:

- Op COURAGE: The Veterans Mental Health and Wellbeing Service
- Op NOVA: Supporting Veterans in the Justice System
- Op COMMUNITY: Armed Forces Community Support, helping to build a recognisable suite of services for families of serving personnel and veterans

Op RESTORE uses a network of both civilian and military consultants, along with welfare support from military charities to support a veteran's health using a holistic approach. Whilst Op RESTORE cannot shorten NHS waiting times, it seeks to ensure the veteran 'waits well' and is seen by the most appropriate clinician for their needs. However, this service is only available in England. Op COURAGE subsumed under one heading three programmes that offered MH and well-being support for veterans with differing levels of need. The Transition, Intervention and Liaison Service (TILS) offered support to veterans who were perceived to have a low level of need. Followed by the Complex Treatment Service (CTS) which included community/ voluntary and third sector services. To support veterans with complex MH issues who may require inpatient services, a final component was the High Intensity Service (HIS) that was introduced in November 2020. This enhanced service was provided by the New Care Models for MH Services and delivered by MH care collaboratives, comprising of organisations from the NHS and independent and third sectors. This method links MH commissioning pathways to ensure coordinated decisions are made across provider collaboratives. The rationale being that collaborative partnership is the most effective way to make collective decisions to improve MH outcomes for veterans.

Older adults in hospitals

Research in the civilian sector has highlighted deficiencies in the care that older adults requiring inpatient care in hospitals receive (Francis, 2019, Care Quality Commission, 2019). Staffing levels contribute to this (RCN, 2012), resulting in some poor patient experiences, and as patient experience is recognised as the third pillar of healthcare (Institute of Medicine, 2001), driving change in this area is inherently important if the NHS are to deliver patient-centred care. Research has sought to discover ways in

which care for the older generation can be improved with Barnicot et al., (2020) revealing older adult patients value basic personal care and supportive communication during their inpatient stays. However, with low staffing levels (Unite the Union, 2023), these needs may not be met. A scoping review has revealed that older adults live with unmet care needs related to their physical and psychological health and lack understanding of services and care pathways (Abdi et al., 2019), it should therefore be considered that healthcare staff within hospitals can act as a gateway to improving knowledge and understanding about the services available for older people.

Furthermore, as a consequence of the poor care older adults in acute hospital settings may receive, the quality of care dying patients obtain may also be affected, with research suggesting access to high-quality palliative care is inadequate for most people living and dying with serious illness (Sleeman et al., 2021). With research reporting 45.7% of patients die in hospitals (Pivodic et al., 2016), further improvements are required in the care of end-of-life patients.

Specialist elderly veteran care provision

Given the greater need for support to older veterans when compared to the older civilian population (Williamson et al., 2019), it is important that specialist support for the elderly veteran population exists. Broughton House is a residential care home situated in Salford, Manchester which offers an enriching and safe environment for elderly veterans (Broughton House, 2024). Broughton House offers nursing, respite and residential dementia care for veterans and offers support to their families too. The Royal Hospital Chelsea, the home of the Chelsea Pensioners also offers accommodation and care to veterans over the age of 66 (Chelsea Pensioners, 2024). The type of care offered includes nursing care, social care, rehabilitation, and welfare support. However, at present, no such specialist support exists within the remit of the NHS.

Military Sector Charities

In 2023, there were 1,733 armed forces charities, comprising 0.9% of all registered UK charities (Howarth & Doherty, 2024). Charities are not set up to supplement or replace statutory provision rather they exist as independent support for those whom they were founded to serve. However, a number of perceived notions surround the armed forces charity sector. These include that there are too many armed forces charities, newly formed charities within the sector have created unwarranted competition and have taken income away from more established charities and that there is little co-ordination of such charities (Cole et al., 2020). However, research illustrates a perceived lack of understanding in civilian providers of healthcare support for veterans (Finnegan & Randles, 2022), meaning that veterans may be more likely to engage with military charities.

Help-seeking

Although reporting a high prevalence of MH disorders, help-seeking behaviour in veterans is poor (Finnegan et al., 2022). Barriers to help-seeking behaviour included stigma, military culture of stoicism and self-reliance as well as deployment characteristics such as combat exposure. Facilitators of help-seeking include the destigmatisation of MH help-seeking and MH treatment as well as the involvement of other veterans in treatment pathways (Finnegan et al., 2022). For PH needs, there is little literature which explores help-seeking across MH and PH (Ashwick & Murphy, 2018) although it is well known that understanding of priority treatment and the principles underpinning the Armed Forces Covenant are not understood by healthcare providers which would suggest challenges when veterans access healthcare for PH (McGill et al., 2019). Furthermore, the belief that there would be a lack of understanding from civilian healthcare means that veterans may be more likely to engage with a veteran specific service, even if their health implications are not service-related. However, veterans were generally unaware of what services were available to them (Mellotte et al., 2017). This, combined with poor understanding of the benefits associated with sharing veteran status with healthcare providers means that there remains much work to be done in terms of ensuring the needs of the veteran population are met.

Advocates

Advocates within health and social care settings provide support to vulnerable or disadvantaged people. Their objective is to ensure the patient's voice is heard and that they are treated respectfully and fairly. In addition, advocates can provide support in relation to discharge from hospital, ongoing care plans, accompany patients to appointments and liaise with external organisations where required (NICE, 2022). Having an AFA embedded within a hospital setting aimed to reduce isolation faced by veteran patients, offering unique insight into their previously unknown need and to have their veteran status documented, supported and their care co-ordinated accordingly.

With the identification of veterans who present in acute healthcare settings and an increased awareness of the support available by healthcare staff, better patient-centred care can be achieved. The patient-centred care model targets multiple determinants of health including physical, emotional, mental, social, spiritual, and environmental influences (Coulter et al., 2016; Giusti et al., 2022). Important features of patient-centred care include increasing the engagement of patients in care and shared decision making between patients and clinicians. Research shows that patient-centred care approaches to health care delivery improve health outcomes, increase patient satisfaction, and enhance help seeking behaviour (Edgman- Levitan et al., 2021).

Project Aims and Objectives

The aim of this research is to evaluate improvements in health outcomes for a member of the armed forces community upon the introduction of a AFA.

The objectives are to:

a) Identify the impact the AFA and a veteran-friendly hospital has for the hospitalised veteran and their family, including end-of-life care.

b) Explore the relevance to the quality of life for the veteran regarding the principles outlined in the UK's Armed Forces Covenant.

c) Measure the response of the hospital staff in their engagement (such as attending specific training) and response to the AFA initiative.

d) Demonstrate the importance of this AFA initiative for the Armed Forces Community whilst assessing the evidence to promote sustainability for future funding.

Methodology

The Armed Forces Advocate Role was piloted across the UK to ascertain the benefits, challenges, and provide future recommendations regarding this appointment. Sixteen Trusts were awarded funding to employ an AFA role. This included two in Scotland, two in Wales and twelve across England. Whilst Northern Ireland was awarded funding for a project to run a veteran's advice line under this grant, this was evaluated separately from the AFA role due to the difference in support provision and need.

Armed Forces Advocate Role (or Equivalent)

There was no defined job description for the AFA appointment, but rather general guidance of what the role would fulfil and the experience that the AFA would require. This provided the NHS Trusts with the autonomy to shape the role as was needed within their organisation. However, there were some key aspects that several of the roles shared, namely a common goal of improving the support of inpatient veterans within an acute hospital setting. Whilst many post holders went beyond this role, the majority were able to identify and visit patients at bedside to support them as needed, train members of staff within the hospital to increase the awareness of the needs of veterans and to highlight the support that is available for the veteran community and also to promote a general camaraderie within the community. The role extended to include undertaking and formulating risk assessments, staff supervision and an understanding of policies and procedures surrounding the armed forces community.

The Devolved Nations

It is important to note that whilst the term AFA will be used throughout this report, roles within the devolved nations of Scotland and Wales differed from those within England. These roles were funded by AFCFT, whilst the roles within England were funded by NHSE. Two health boards in Wales were awarded funding and the appointments took on a more strategic approach, instead focusing on the policies, procedures, and community engagement with additional staff, such as welfare officers from DMWS, providing bedside support to veterans. In Scotland, there were also two NHS health boards that were awarded funding, both of these health boards utilised their funding to fund welfare officers and managers within the DMWS. Whilst all four of these roles have provided information on the service users that have been impacted by this funding, it may not be through direct involvement from the AFA (or equivalent) role.

Data Collection Tools

For patient data, post holders were required to enter information into the "Armed Forces Advocate Portal." This included information on patient demographics, service history, hospital admissions information and referral information. service users were given an SU number when entered into the AFA portal, which allowed linking with any feedback and to communicate any issues, whilst still maintaining anonymisation.

The DMWS had full responsibility for the data collection portal and data collection. Once the AFA input data into the portal, then data was accessed through "Insomnia,"

which allowed the University of Chester evaluation team to download SU information in an anonymised and amalgamated format. To prevent double entry, post holders in Scotland and Wales, who were employed by DMWS, were able to utilise the DMWS portal, data of which could also be downloaded via the "Insomnia" program. Notepad ++ was also utilised to compare with previous data extractions to ensure that any updates to SU cases on the AFA portal were also updated in the evaluation data.

Service users, and family members of service users, had the opportunity to provide feedback on their time in the hospital, including the impact, knowledge, and support of the AFA. This feedback was given in the form of a short questionnaire consisting mostly of Likert scale questions, with the opportunity to provide open-text responses on any positive impact of the AFA role, and any improvements that could be made. The evaluation team were provided with a link to the surveys where responses were live and anonymised.

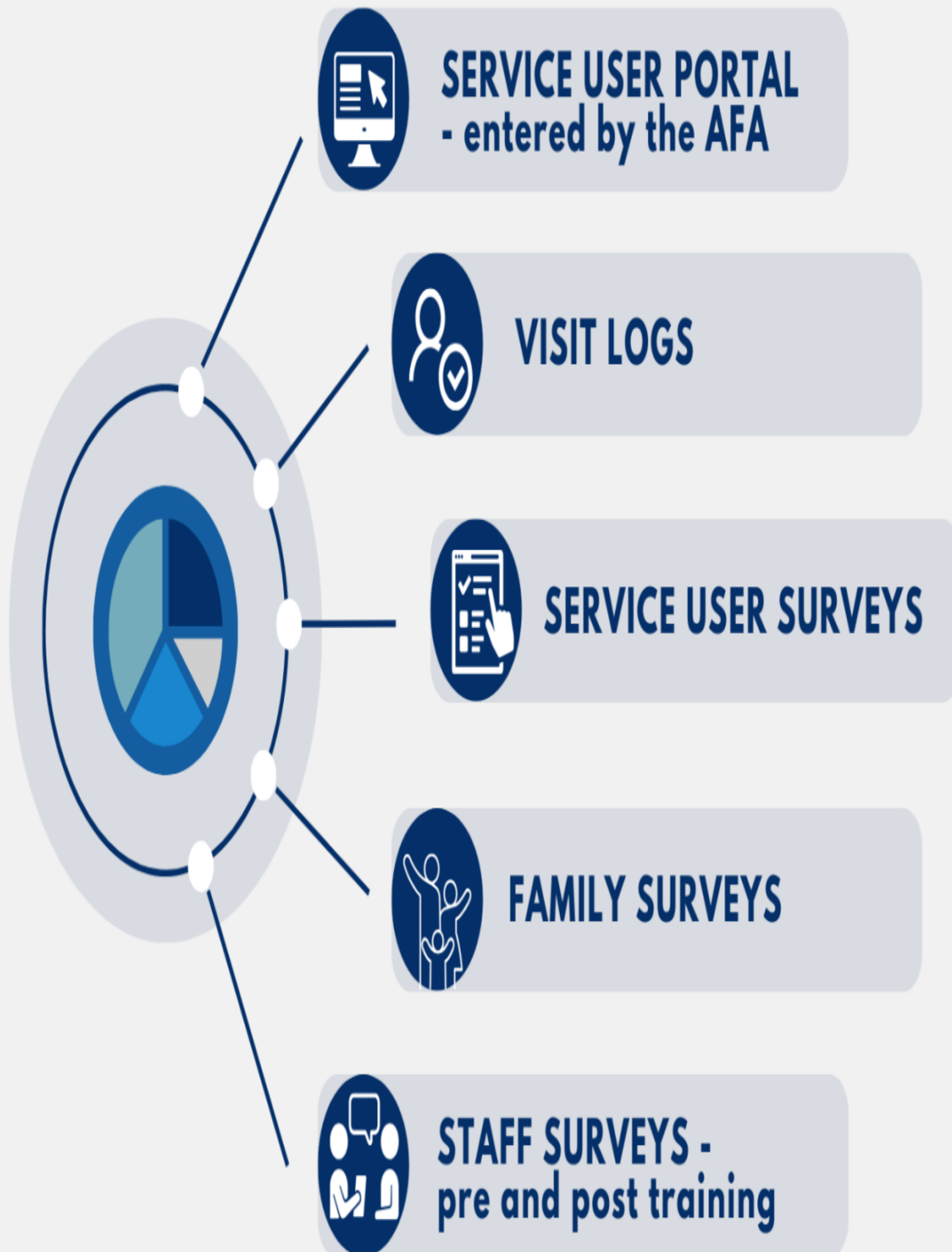
In addition, to capture the impact of staff training, surveys were created by DMWS to record the confidence of staff in their knowledge of the armed forces community and the covenant legislation both before and after training. This was achieved using a questionnaire consisting of mainly Likert scale questions. Staff were also asked for their job role and grading to understand the engagement from across the pilot scheme hospital grant holders. In addition, staff also had the opportunity to provide open-text feedback. The data was accessed periodically by the evaluation team and was entered into SPSS IBM Statistics 27 for analysis.

Qualitative Data

Following a contract change notice, the responsibility for qualitative data collection moved from the DMWS to the Centre. Interviews were conducted with 30 staff from 15 trusts (or equivalent), these being the AFA's and one additional person who had collaborated with or been directly impacted by the AFA initiative. Semi-structured interviews facilitated the option to provide an in-depth exploration of the knowledge, perceptions, and views of those working within the programme. The interview schedule aligned with the study's aim and objectives and was designed to discover the benefits and challenges associated with the AFA role. The thirty 1:1 interviews were conducted between 2022 and 2023 via MS Teams. Interviews were audio-recorded and transcribed verbatim. The participant's demographic information, such as job role and responsibilities were also captured within the interviews.

Four focus groups were conducted throughout December 2023 and January 2024. These offered the opportunity to validate the results of the interviews. Participants were presented with the interview themes and discussions were held around whether they agree that these were a true reflection of the AFA role impact and challenges. The focus groups included the post holders and staff members that work either internally or externally with the AFA (or equivalent). AFAs from some NHS Trusts were unable to attend the focus groups. See Table 18 for those in attendance.

DATA SOURCES



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Grant Holder Engagement

E_Bulletins

In addition to the data collection tools, the evaluation team also coordinated a quarterly E-Bulletin where AFAs had the option to provide updates. These offered the opportunity for the Centre to share some preliminary results, NHSE and AFCFT would provide updates and all AFA's (or equivalent) were invited to provide current progress. These E-Bulletins are available online (Westminster Centre for Research in Veterans, 2024). The intent was to share the E-Bulletins both within the Trust and externally with organisations such as NHSE, Integrated Care Boards and Third Sector Military Charities. An example of an E-Bulletin can be seen in Appendix A, though all are available to view on the Centre's website. A large majority of the AFA's (or equivalent) chose to engage with this activity and were able to share this E-Bulletin to showcase the impact of the role throughout their internal and external networks. The Centre received highly positive feedback regarding this piece and how enjoyable and interesting it was to read.

Webinars

The Centre conducted monthly webinars with the AFAs (or equivalent). Starting with a "Full" webinar whereby information was given from AFCFT and the evaluation team to the AFA's and /or anyone within the projects. The first webinar took place on the 6th of April 2022. Furthermore, monthly webinars were organised by the evaluation team alternating between a webinar that all AFA's attended, where presentations were given by two AFA's, the evaluation team which presented preliminary evaluation results to enhance motivation, and regional webinars where AFA's were split into approximate groups of four. See Table 1. This allowed for a more open discussion surrounding progress and allowing AFA's to share best practice. These were very well attended and gave the AFAs an opportunity to highlight their positive achievements, share challenges faced, improve connectivity and learn from each other.

Grant Holder Visits

At around the halfway point of the programmes, each of the 17 grant holders were visited. See Table 2. The intent was for the Centre staff to meet with senior representatives from the organisations (Chief Executive, Chair of Trustees) and key staff. This was to discuss any outstanding issues and ensure that the AFAs were being supported and to maintain momentum.

North Regional Group
Manchester University NHS Foundation Trust
Warrington and Halton Teaching Hospitals NHS Foundation Trust
East Lancashire Hospitals NHS Foundation Trust
Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust
East Regional Group
Airedale NHS Foundation Trust
East Suffolk and North Essex NHS Foundation Trust
James Paget University Hospitals NHS Foundation Trust
South Tyneside and Sunderland NHS Foundation Trust
South Regional Group
Milton Keynes University Hospital NHS Foundation Trust
Gloucestershire Hospitals NHS Foundation Trust
Frimley Health NHS Foundation Trust
University Hospitals Dorset NHS Foundation Trust
Celtic Regional Group
Betsi Cadwaladr University Health Board
NHS Greater Glasgow and Clyde
NHS Lothian
Cardiff and Vale University Health Board

Table 1: Regional Webinar Groupings

Roadshows

Roadshows were hosted by the AFCFT. These events provided a chance for all AFA's (or equivalent) to come together for more organised discussions and presentations. They were joined by the AFCFT, NHSE, and senior representatives from organisationss such as the ICBs that may be in a position to support the project moving forward after the pilot phase. The Centre presented preliminary findings at both roadshows to provide an overview of the current evaluation progress. AFA's (or equivalent) were encouraged to break out into groups for discussions and to feedback

to the room. The first roadshow took place on the 4th of April 2023 in Chester with the second taking place on the 30th of January 2024 in Glasgow. See Figure 2.

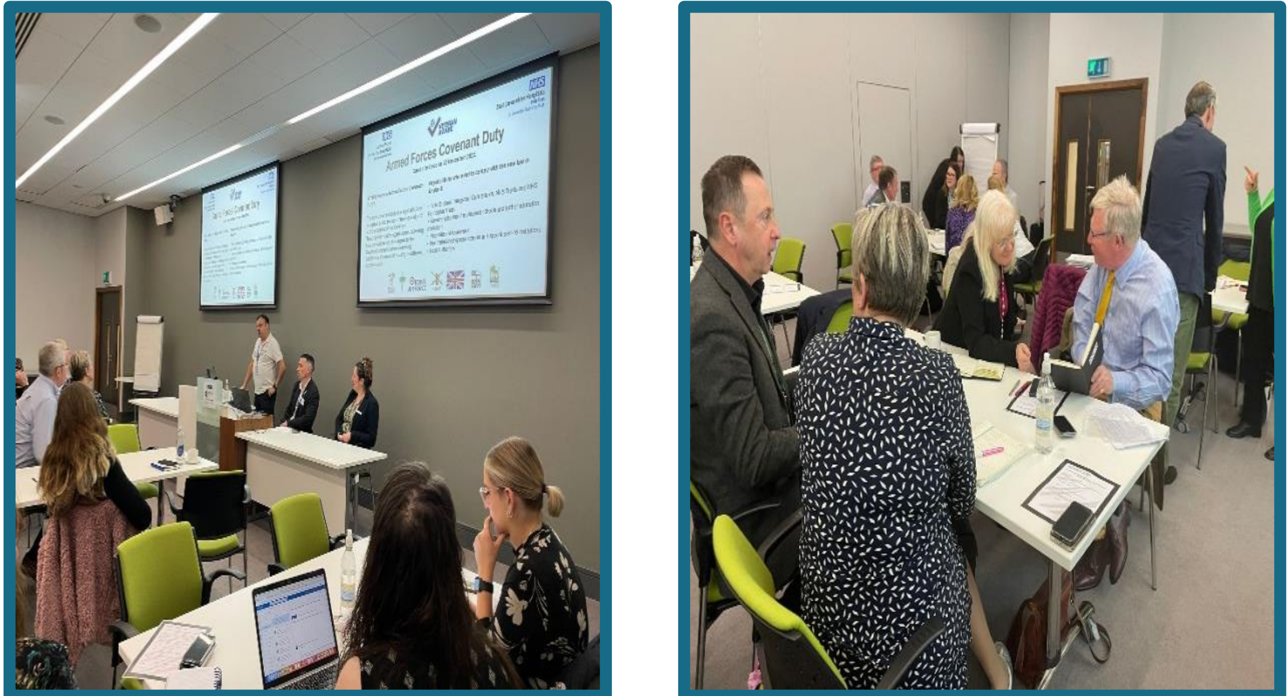

Figure 2: Images from the Supporting Armed Forces in Acute Hospital Settings Roadshow

Educational Module

To facilitate staff training, the Centre also created a Moodle Module which includes 6 original chapters from the Centre's AFCFT funded "Introduction to the Armed Forces Community" (Westminster Centre for Research in Veterans, 2022). A pre and post knowledge test was also included to ascertain improvements in understanding, and trainees were able to complete the Module at their own pace and in any order they chose. If both tests and all chapters were completed, the trainee received a certificate. Some NHS Trusts have chosen to integrate this module into their own internal intranets such as East Lancashire, Dorset, East Suffolk and North Essex and South Tyneside and Sunderland. Also, the module is being used by the VCHA approved hospitals.

AFA's encouraged staff to complete a survey both before and after completing a training session. The surveys included statements which staff were asked to what extent they agree with them. They were also asked to grade what they believe to be their knowledge of the AFC both before and after training. However, East Lancashire

Hospitals Trust also utilised an existing online training module which they integrated the surveys into.

Data Analysis

Interview data was analysed using a modified Grounded Theory approach (Glaser & Strauss, 1967; Charmaz, 2014; Finnegan, 2014). This inductive methodological approach intends to secure the participants' views of their world (Punch, 2014). Grounded Theory consists of a structured and systematic guideline for gathering, synthesising, analysing, and conceptualising qualitative data to construct a theory grounded in the data from which it was developed and enabling the identification of issues from the staff members' perspective. The study team has extensive experience of utilising this approach in both serving and veteran populations (Finnegan et al, 2014; Finnegan et al 2018; Finnegan et al, 2020a; Finnegan et al, 2020b, Finnegan et al, 2024).

All questionnaires were downloaded from JISC online surveys portal in an anonymous and confidential format and entered into SPSS version 27.0 (IBM SPSS, 2021) Analysis of the survey data utilised descriptive and inferential statistics. Descriptive statistics included frequency distributions and percentages to summarise demographics, service history, social networks, employment, living arrangement. Inferential statistics included correlations to facilitate identification of relationships between variables, t-tests to identify differences across variables. Where relevant, infographics and data visualisations are used to present the quantitative data. Small amounts of written free-text responses from the questionnaires were collected and analysed using Content Analysis (Burnard, 2008). All qualitative data was organised and coded using the NVivo software package V.12. All data was triangulated to gain a more comprehensive view of the data.

Triangulation and Development of Theoretical Model

Triangulation refers to the combining of methods, theories or observations to increase the reliability and validity of findings (Noble & Heale, 2019). In the case of this research, methodological triangulation occurred between the quantitative AFA portal data and survey data, the qualitative interviews and focus groups. Findings were triangulated to create a theoretical model to highlight the overall impact of the AFA role within acute hospital settings.

Name	Project Title	Key Delivery Location	Start Date of AFA (or Equivalent)
England			
Manchester University NHS Foundation Trust	Veterans Integrated Hospital Care Programme	Manchester	13/12/2021
Milton Keynes University Hospital NHS Foundation Trust	Armed Forces Covenant Trust Lead	Milton Keynes	28/03/2022
University Hospitals Dorset NHS Foundation Trust	UHD Armed Forces Community Advocate	Poole	28/03/2022
Gloucestershire Hospitals NHS Foundation Trust	Armed Forces Integrated Inpatient Service	Gloucester	28/03/2022
Warrington and Halton Teaching Hospitals NHS Foundation Trust	Joining Forces to Improve Experience	Warrington	01/04/2022
East Suffolk and North Essex NHS Foundation Trust	Delivering Armed Forces Health Advocacy	Colchester	04/04/2022
East Lancashire Hospitals NHS Foundation Trust	Armed Forces Veteran Support Officer	Blackburn	11/04/2022
James Paget University Hospitals NHS Foundation Trust	Making Veterans Visible	Great Yarmouth	09/05/2022
Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust	Armed Forces Programme Delivery Lead	Wigan	01/07/2022
Frimley Health NHS Foundation Trust	Armed Forces Covenant Lead Officer	Camberley	02/08/2022
Airedale NHS Foundation Trust	Delivering Best Care to Veterans	Keighley	06/09/2022
South Tyneside and Sunderland NHS Foundation Trust	Veterans Advocates within STSFT	Sunderland	10/10/2022
Devolved Nations			
Betsi Cadwaladr University Health Board	North Wales Veterans Healthcare Collaborative	Bangor	18/04/2022
NHS Greater Glasgow and Clyde	Veterans Hospital Support Glasgow	Glasgow	30/06/2022
NHS Lothian	Lothian Veteran Support	Edinburgh	30/06/2022
Cardiff and Vale University Health Board	C&VUHB Great Care for Veterans	Cardiff	03/04/2023

Table 2: Organisations Awarded Funding.

Results

The following results provide an overview of the demographics, service history and hospital data of the veterans under the care of the AFAs.

Veteran Service User Information

A total of 2512 entries were input into the portal during the evaluation. Demographic information is shown in Table 3.

Demographics

		%	N
Gender	Male	96.6	2425
	Female	3.4	85
	Non-binary	/	1
	Missing data	/	1
		Years	
Age	x̄	75	
	Range	19-104	
		%	**N**
Ethnicity	UK/ British	98.5	1424
	Other	1.5	18
	Missing data	/	1070
Religion	Christian	72.6	585
	Buddhist	.2	2
	Hindu	.1	1
	Muslim	.2	2
	Other	.5	4
	Prefer not to say	4.2	34
	Missing data	/	1706
Sexual Orientation	Heterosexual	98.2	1157
	Bisexual	.3	3
	Homosexual	.5	5
	Other	.1	1
	Prefer not to say	1	12
	Missing data	/	1334

Table 3. Demographic information

VETERAN SERVICE USER INFORMATION

Gender

97% Male
3% Female

Ethnicity

British 99%
Other 1%

Sexual Orientation

98% Heterosexual

Age

Average age 75
Range 19-104

Religion

73% Christian

Employment

Of the N=1310 who answered the question about their working pattern, 78% (N=1023) were retired, 10% (N=134) were in full time employment, 5% (N=70) on long term sick, 5% (N=69) unemployed, with 1% (N=14) employed on a part-time basis. A small number of occupations were recorded and are shown in the word cloud below. There were no significant differences between employment and gender $F(1,747)=2.88$, $p=.090$). See Figure 3 and Word Cloud 1.

Figure 3. Working pattern

Word Cloud 1. Job roles

Carer Status & Children

Veterans in hospital were asked whether they were a primary carer for any children under 18, a disabled child or adult, or an older person. No veteran participant identified as a carer, and no information was provided about whether the veteran had children or whether they provided financial support for them.

Health Status

There were 7% (N=52) of veterans recorded as having no disability. Physical health needs were more prominent than MH needs; 81% (N=599) of veterans stated they had a PH need compared to 17% (N=125) who had a MH need, 12% (N=85) had a hearing impairment, 6% (N=43) had a cognitive impairment and 3% (N=25) 'other' health issues. See Figure 4.

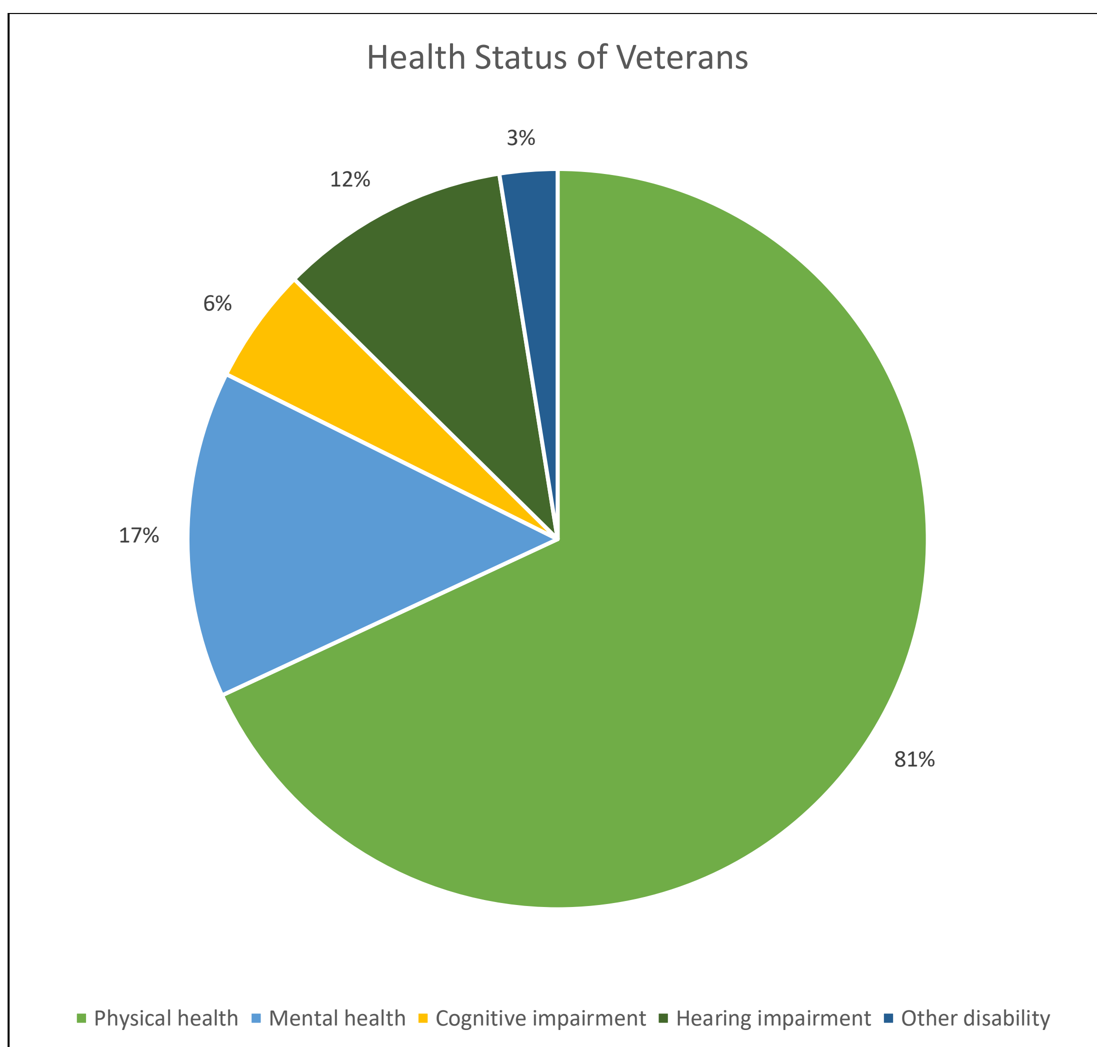

Figure 4. Health status

Service History

Of the N=1379 veterans who answered the question about National Service, 45% (N=624) had completed National Service. Most veterans had served in the British Army (80.8%, N=1843), followed by RAF (11.9%, N=271), Royal Navy (5.4%, N=123), Royal Marines (1.3%, N=30), Merchant Navy (1.1%, N=24). See Figure 5. Most veterans had served in the infantry (25.1%, N=201), RLC (10.5%, N=83), Royal Artillery (6.4%, N=51) and REME (5.7%, N=45). See Figure 6. Figure 6.

Forty-three per cent of veterans left service as a Private soldier (43.4%, N=271), followed by Lance Corporal (18.1%, N=113), Corporal (14.7%, N=92), Sergeant (10.7%, N=67) and Staff Sergeant or equivalent (3.4%, N=21). There were fewer Officers with .3% (N=2) having left as a 2nd Lt, .2% (N=1) as a Lt, 1.6% (N=10) Captain, 1.8% (N=11) Major, .3% (N=2) Lt Col and 1.1% (N=7) a Col. See Figure 7.

The mean number of years served was 9; Range 1-42; Median 6; Mode 2.

Deployment history

Of the N=772 who answered the question about operational tours or deployments, 68.7% (N=530) had completed an operational tour. Of these, N=103 stated how many tours they had deployed on, with a range from 1-15, $\bar{x}$ 1.

Most deployed to Northern Ireland (24%, N=162), Iraq (12%, N=82), Afghanistan (10%, N=70), Falklands (6%, N=37), Balkans (5%, N=30) and Sierra Leone (1%, N=4). Forty per cent (N=267) of veterans stated they had deployed to 'other' locations. These included mainly non-operational deployments including Aden, Hong Kong, Singapore, Malaysia, Angola, Belize, Borneo, Cyprus, Egypt, Germany, Iceland, Indonesia, Korea, Lebanon, Libya, Malta, Normandy, Vietnam and the West Indies. See Figure 8.

A chi-square test reported no significant relationship between deployment and MH $X^2(2,N=472=2.99,p=.224)$ or physical health $X^2(2,N=472=1.07,p=.587)$.

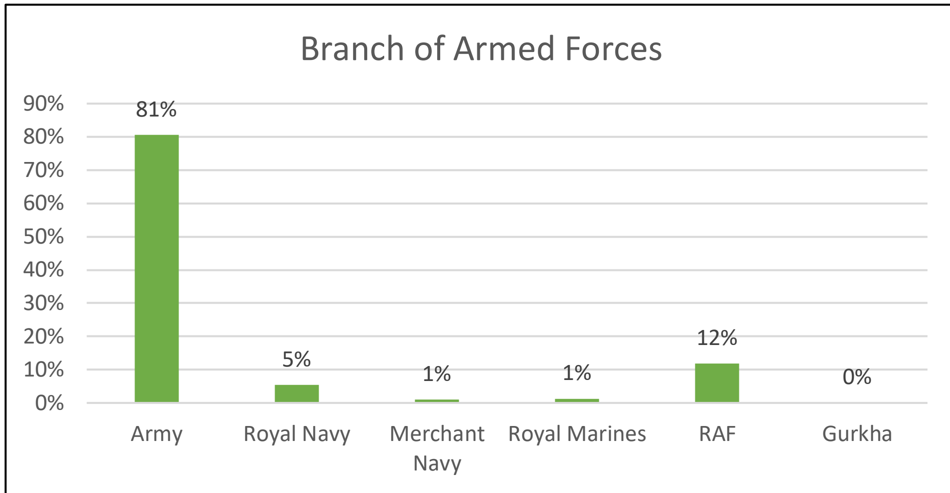

Figure 5. Branch of AF

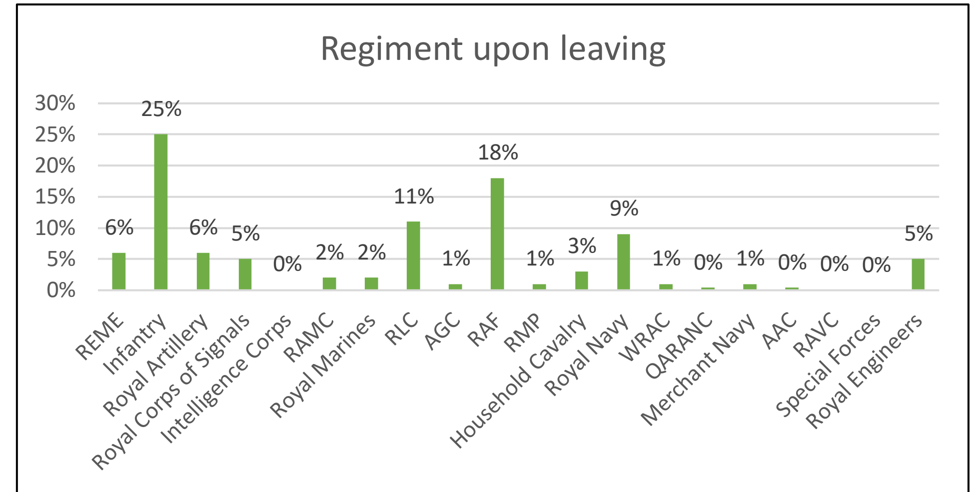

Figure 6. Regiment upon leaving

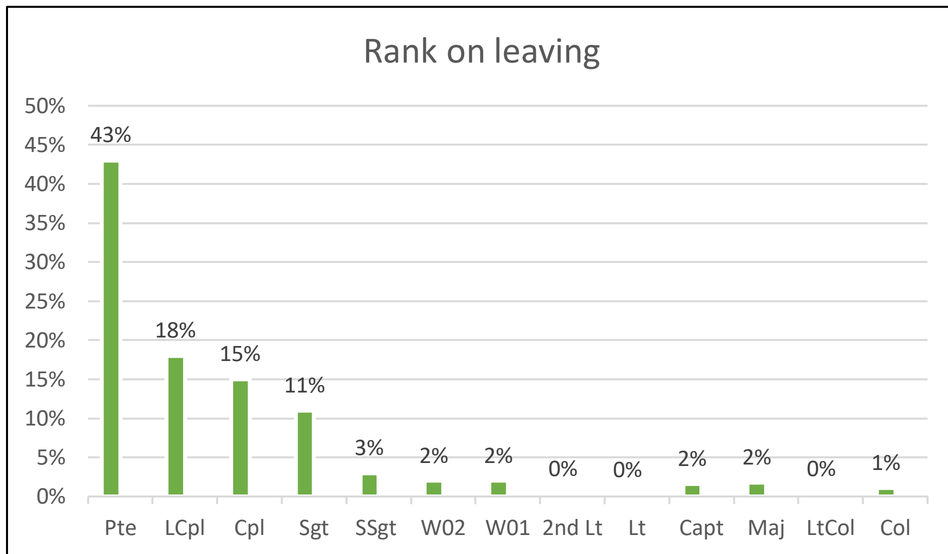

Figure 7. Rank on leaving

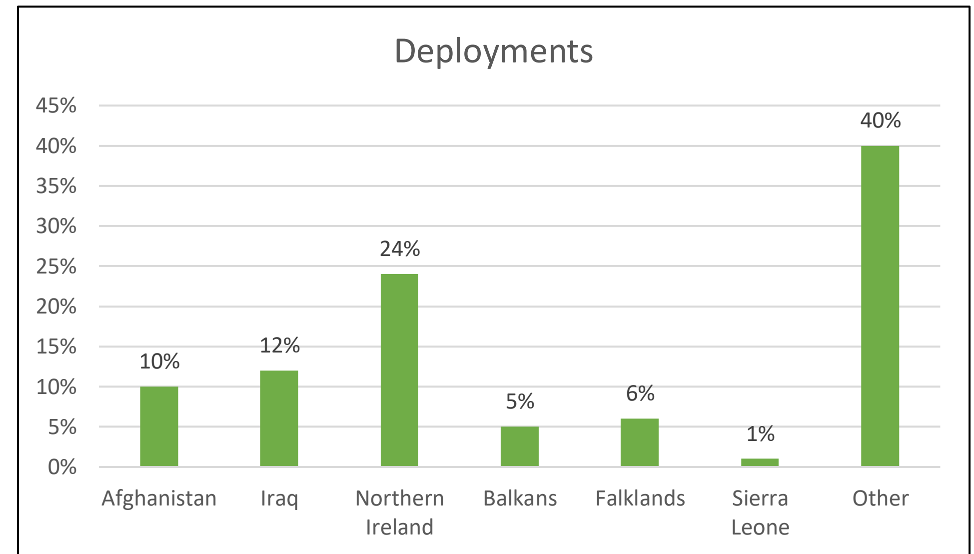

Figure 8.. Deployments

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PATIENT INFORMATION

78%

Retired
10% Employed

81%

Physical Health need
17% Mental Health need

45%

Completed National Service

81%

Served in the Army
43% left as Private or equivalent

67%

Completed an operational tour

34%

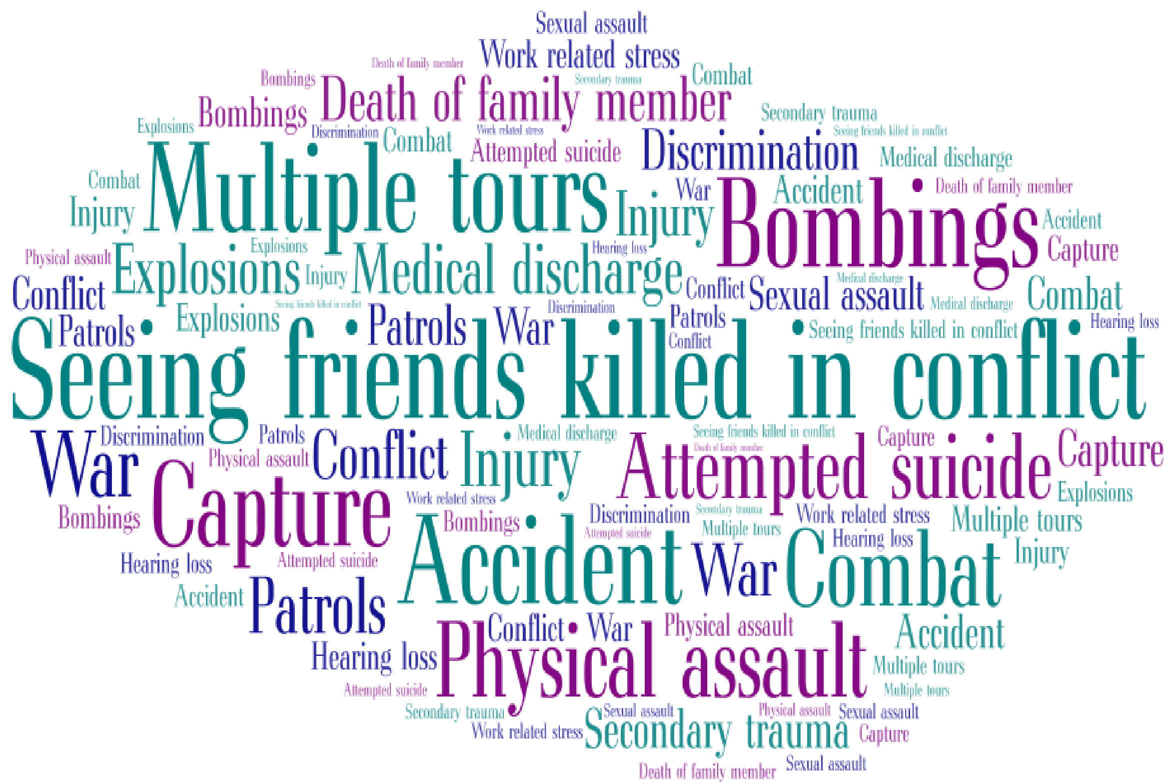
Had been exposed to a traumatic event

62%

Admitted due to general illness

Traumatic events

Of the N=548 veterans who answered this question, 34% (N=188) had been exposed to what they perceived to be a traumatic event. Types of traumatic events were reported by some veterans and are shown in the Word Cloud 2.



Word Cloud 2. Types of traumatic events

When asked to state their reason for discharge from service, most veterans stated it was the end of their contract (62%, N=429), followed by PVR (15.3%, N=105), Medical Discharge (14%, N=96), Other (5.7%, N=39), Retirement (2.3%, N=16) and 0.3% (N=2) were discharged due to unstable temperament. Of those who were medically discharged, 11.3% (N=76) were discharged on PH grounds and 1.9% (N=13) on MH grounds. There were no significant differences between reason for leaving and gender ($F(1,670)=.365$, $p=.546$) although there was a significant difference between age groups and reason for leaving ($F(1,670)=3.97$, $p<.05$) with those in the age category 71 years old and over more likely to report a medical discharge or end of contract as their reason for leaving. Veterans in the age category 18-30 years old were least likely to have been medically discharged. See Figure 9.

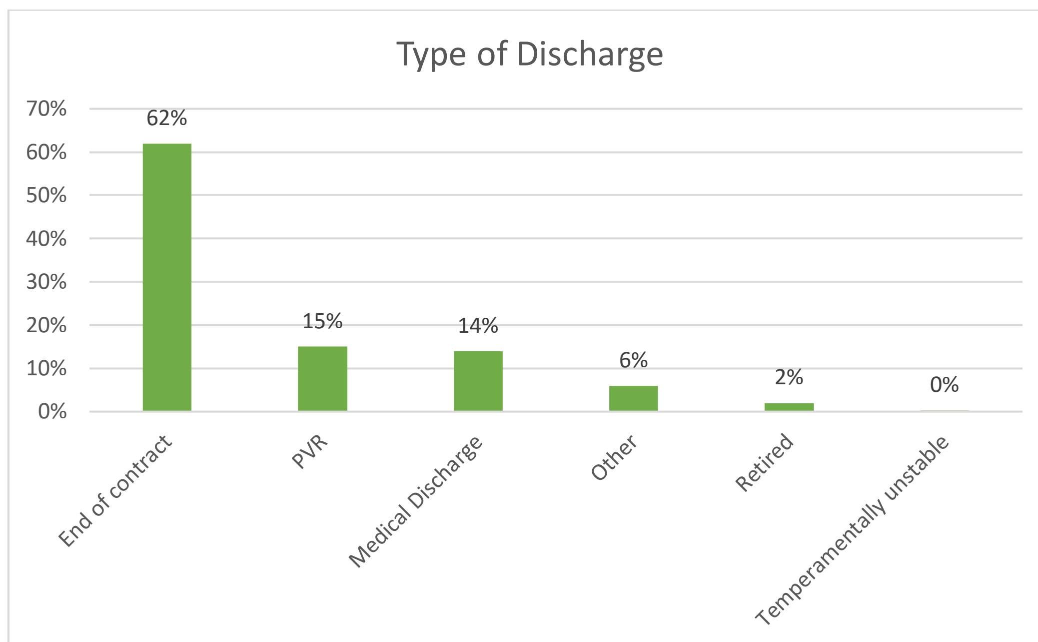


Figure 9. Type of discharge

Pensions

Three per cent (N=72) of veterans were in receipt of a war pension. Of these, 86% (N=62) received a war disablement pension, 21% (N=15) received a Guaranteed Income Payment from the MOD which they classed as a pension and/ or had received a lump sum under the Armed Forces Compensation Scheme, 1% (N=1) received a War Widows pension. Of these, only 2% (N=2) were females in receipt of any form of pension.

Hospital Admission and AFA referral

Of those with a disability recorded, most reported physical ill health (81%, N=599), MH problems (17%, N=125), hearing impairment (12%, N=85), visual impairment (6%, N=46), cognitive impairment (6%, N=43) and 'other' (3%, N=25). See Figure 10.

There was a significant difference between veterans age and MH status ($F(1,698)=.495$, $p<.05$) with those aged 31-40 years old being more likely to report MH difficulties than other age group (67%, N=14). Those in the 61-70 age group were more likely to report PH needs than other age groups (87%, N=90). Those in the age group 31-40 years were more likely to report cognitive impairment than other age groups. Visual impairment was highest in those over the age of 70 (8%, N=38). Hearing impairment was highest in the age group 18-30 (20%, N=10 and over 71's (15%, N=67).

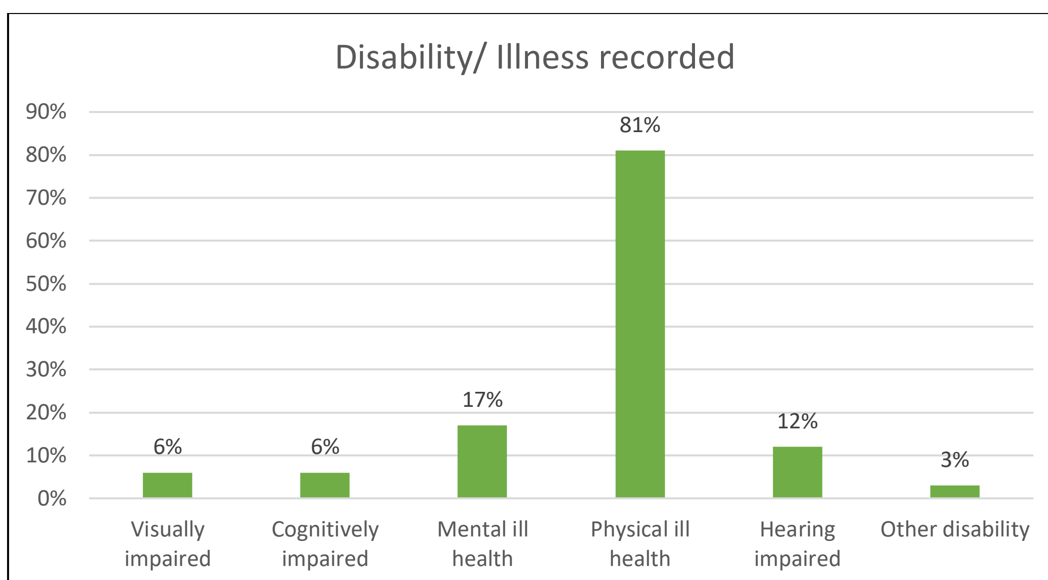


Figure 10. Illness recorded

Of those patients where safeguarding issues were recorded, 28.1% (N = 50) were listed as having MH problems and this was most prevalent in the 31-40 age bracket (69%, N=9), with 19.1% (N = 34) having dementia, 34% (N=31) of these from within the 71+ age bracket. Alcohol misuse was 11.2% (N=20) and was most prevalent in the 41-50 age bracket (29%, N=5). See Table 4.

Safeguarding	%	N
Aggression	9.4	8
Alcohol Misuse	11.2	20
Substance Misuse	1.7	3
Dementia	19.1	34
Mental Health	28.1	50
Mental Capacity	7.9	14
Suicide/Self Harm	7.3	13
Missing		2370

Table 4. Safeguarding concerns

Data was input for 27% of veterans (N=681) in relation to their type of admission into hospital. Most veterans were admitted into emergency care (60%, N=411), followed by emergency blue light (21%, N=146), an elective procedure (10%, N=71), planned care (6%, N=41), palliative care (2%, N=11) and admissions via the emergency

assessment unit were .1% (N=1). Emergency care was highest in those over 61-70 (53%, N=55) and 71+ (66%, N=265). See Figure 11.

Of the 667 (27%) veterans who provided information about why they were admitted into hospital, most stated admission was due to general illness (62%, N=413), followed by injury at home (12%, N=78), general injury (10%, N=65) or an elective procedure (8%, N=54). See Figure 12. 'Other' admission reasons are shown Word Cloud 3.

Word Cloud 3. Admission reasons 'other'

Organisations who referred veterans to the AFA were recorded by 97% (N=2424) of AFAs. This showed that most AFAs recorded referrals from other departments within the hospital (92%, N=2227), followed by other healthcare practitioners (3%, N=62), third sector organisations (1%, N=35), the veteran themselves (1%, N=35) or the Local Authority (1%, N=19). See Figure 13.

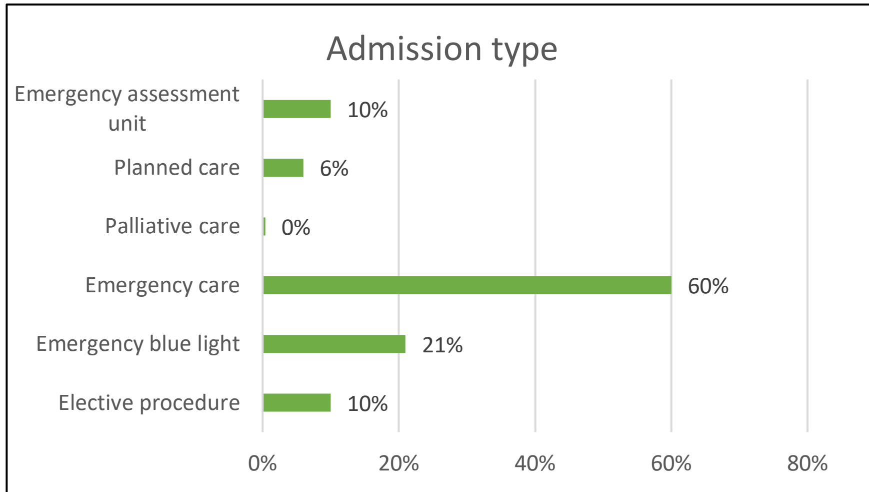


Figure 11. . Admission type

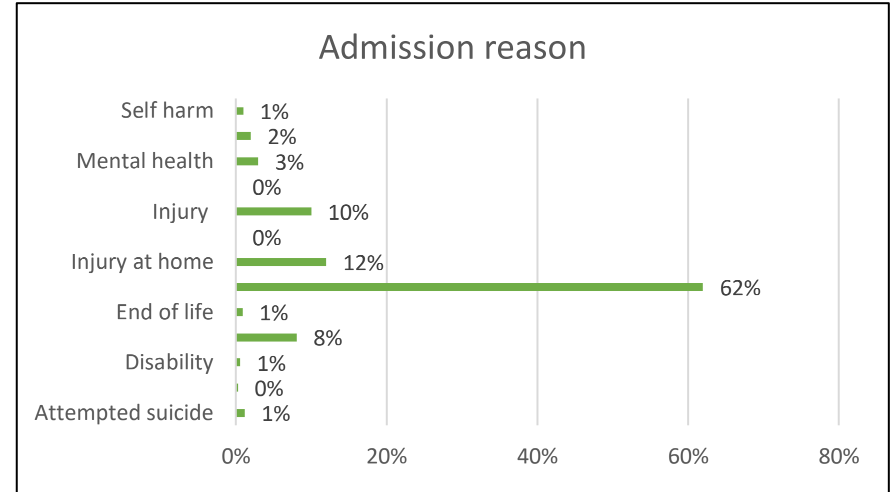


Figure 12. Admission reason

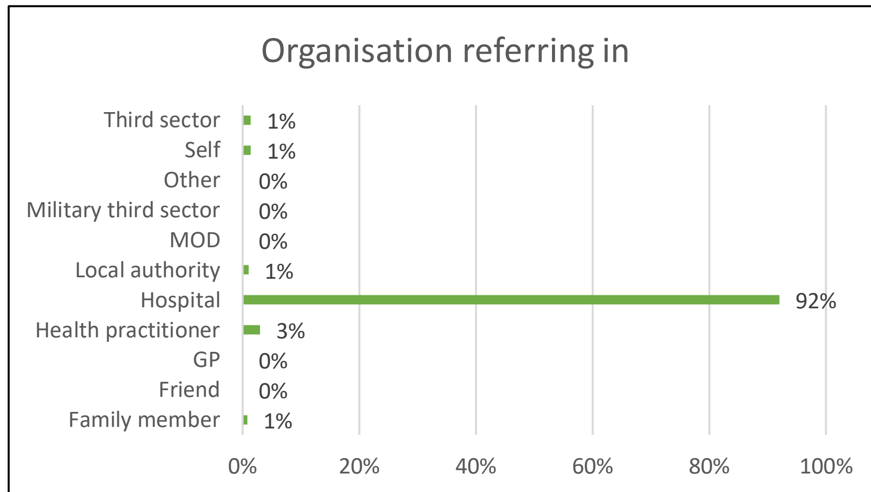


Figure 13.. Organisation referring in

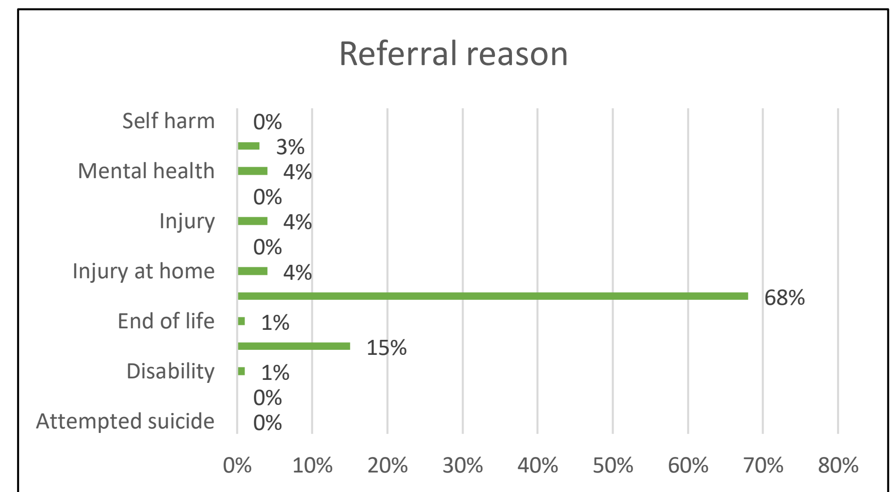


Table 16. Referral reason

Only 14% (N=341) of AFAs recorded the way in which referrals were received. Most referrals were recorded via electronic report (49.3%, N=168), email (21%, N=72), during ward visits (6%, N=21), verbally (6%, N=19) and EPR notifications (5%, N=18). Of the 96% (N=2422) of AFAs who stated why the veteran had been referred, most noted illness (68%, N=1648), elective procedure (15%, N=354) and injury at home (4%, N=106). Only 5% (N=117) of referrals were service attributable. *Missing data was 92*. Of the 98% (N=2467) of AFAs who reported the type of support veterans required, 87% (N=2144) of veterans were signposted and 13% (N=323) declined support. After referral to an AFA, veterans were seen on average 1 day later by the AFA. Referral reasons are in Figure 14.

Veteran Service User Help-Seeking Behaviour and Social Interaction

Figure 15 shows where veterans had previously sought support. Not all AFAs completed this question, and sources of support could be ticked more than once. Therefore, the following data presented in relation to previous help-seeking is based on percentages of those who answered the question. The most common source of support was from the NHS (42%, N=310), GP (30%, N=216) and Charities (22%, N=161). Charities which were accessed are shown in the word cloud below. 'Other' included Local Council, Royal Institute for Blind People and a Social Prescriber. See Word Cloud 4.

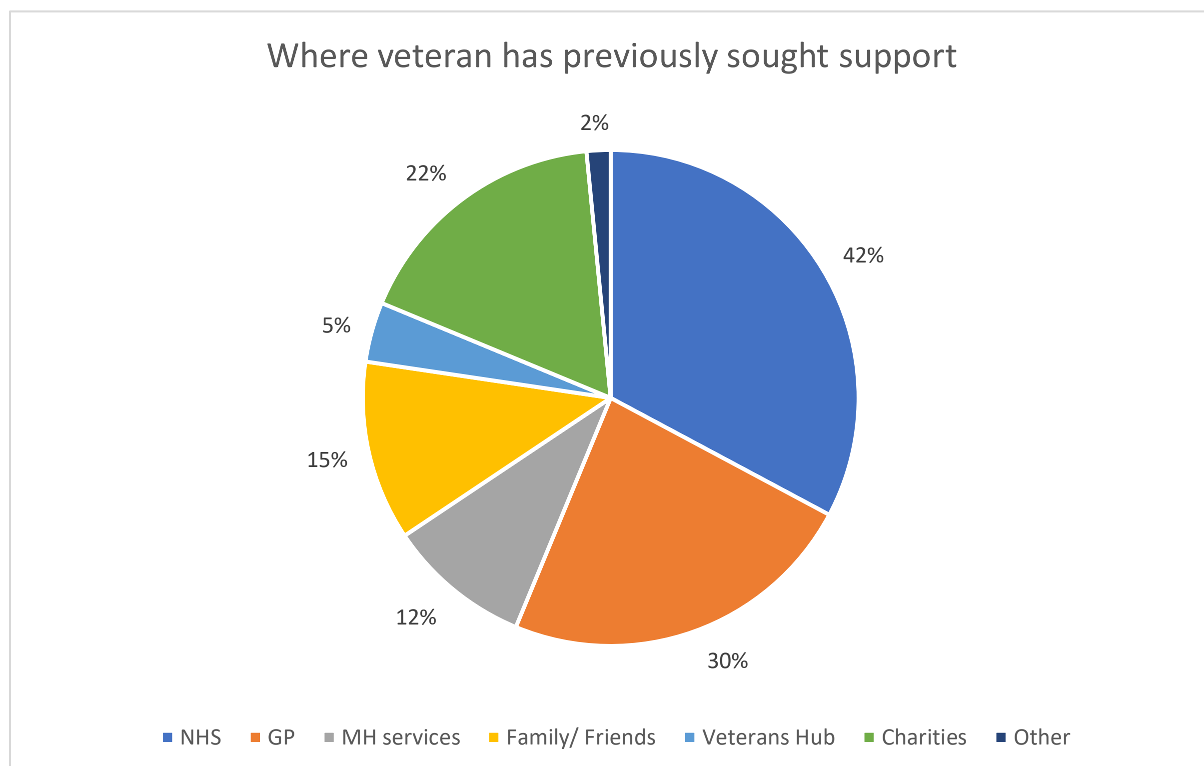
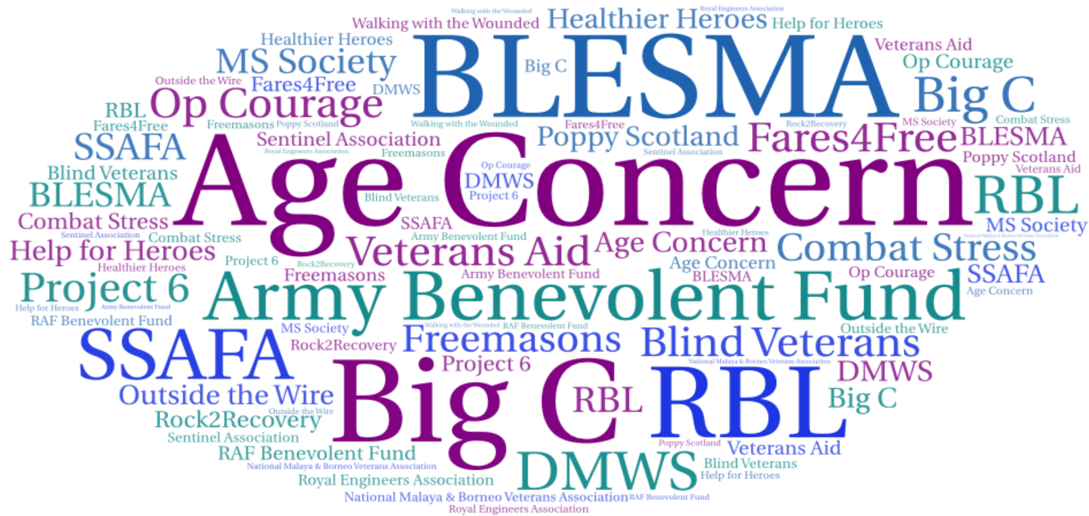


Figure 15. Prior support



Word Cloud 4. Where support has been sought

Of the 32% (N=230) of veterans who had not sought help before, most were unaware of the support that was available (71%, N=164), followed by not knowing where to go (50%, N=116), feeling they did not need help (46%, N=106), being unaware of the one day veteran status inclusion criteria (40%, N=91), 22% (N=50) found it hard to ask for help and 18% (N=41) found it difficult to seek help. Six per cent (N=13) of veterans stated there were 'other' reasons for delaying help-seeking such as being too stubborn, being anxious when discussing the military, unable due to alcohol dependency, feeling unentitled as did not deploy, unsure of eligibility due to type of discharge. Respondents could provide more than one answer, with the results in Figure 16.

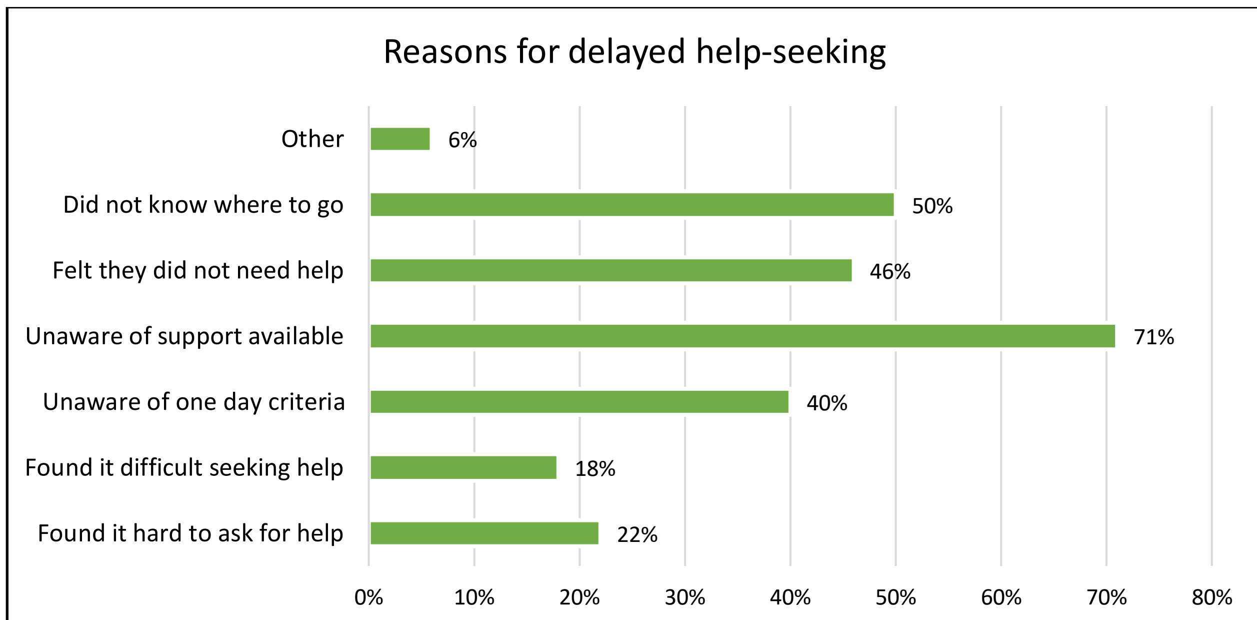


Figure 16. Delayed help-seeking

Not all veterans provided information about who they sought support from prior to being admitted into hospital, of those who did, 20% (N=78) had received support from their GP prior to admission into hospital, 14% (N=56) had received help from a charity, 11% (N=28) from a family member, 7% (N=28) from a spouse/ partner, 7% (N=28) of veterans had provided support to themselves prior to admission into hospital, 4% (N=17) 'other' and 3% (N=11) from a friend. 'Other' types of support received included Regimental Associations. Fifty-four per cent (N=209) of veterans who answered this question had not received any previous support. See Figure 17.

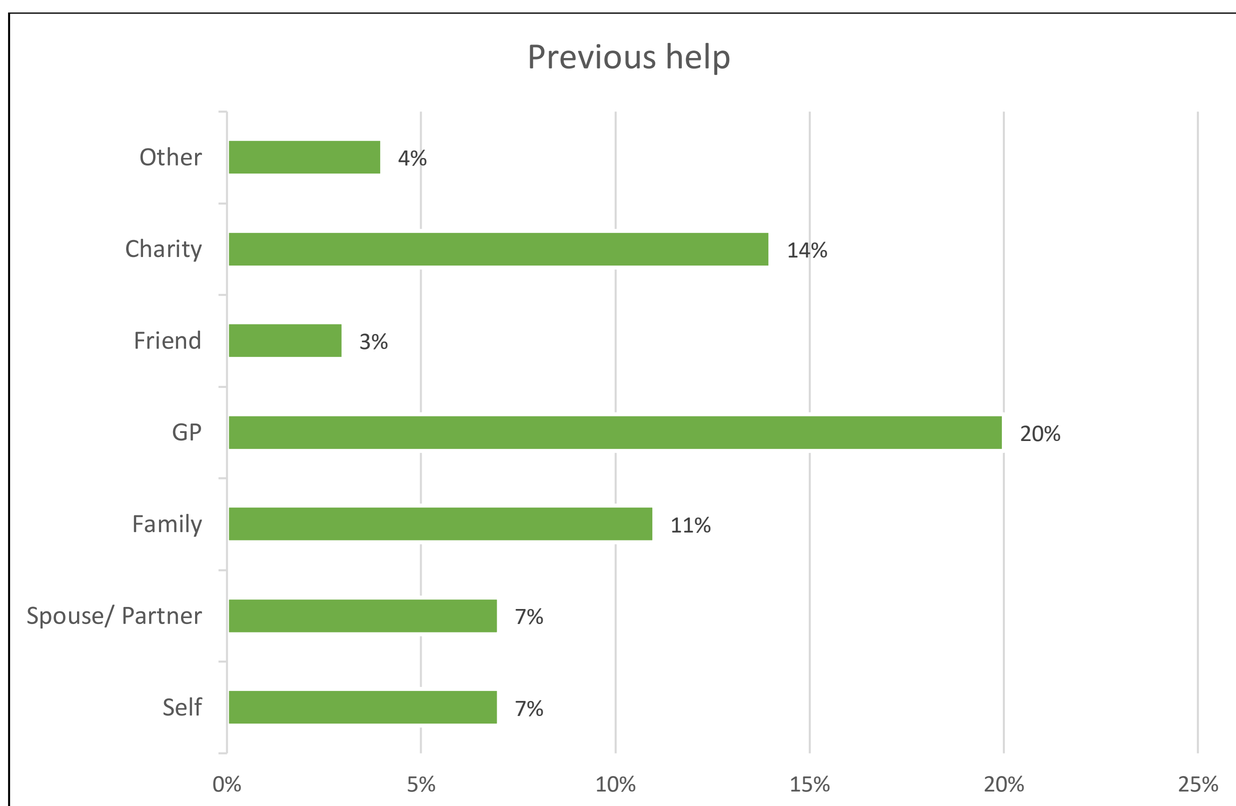


Figure 17. Previous help sought

Seventeen per cent (N=422) of veterans felt they had other people to rely on. Of these, 58% (N=341) met three times a week or more, 29% (N=172) met once or twice a week, 6% (N=35) every few months, 4% (N=24) once or twice a month and 3% (N=16) stated 'other' which included having a carer or support 'as and when' it is required. See Figure 18.

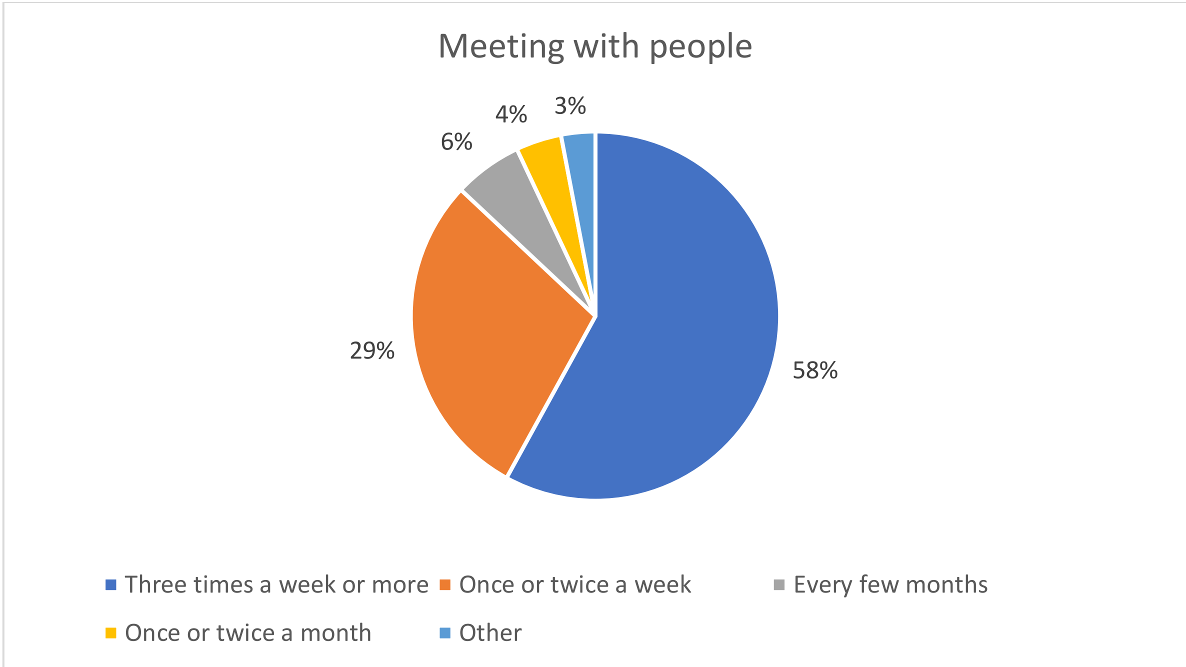


Figure 18. Meeting with people

Six per cent (N=144) of veterans were members of clubs or societies. Types of clubs or societies were reported are shown in Table 5.

Club/ Society	**Frequency N**
Veterans Associations/ breakfast clubs	52
Sporting clubs	41
Military charities	10
Hobby clubs	6
Church	5
Freemasons	4
Gym	2
Non-military charities	1
Coastguards	1
Total	122

Table 5.. Clubs & Societies

Discharge and Referrals

Veterans spent a mean number of 25.91 days in hospital (SD 40.14; Range 1-272). The mean number of days AFA's spent supporting a veteran was 37.45 (SD 59.29; Range 1-504). AFA's also 'followed up' closed cases (where veterans had been discharged from hospital), AFA's spent a mean number of 15.28 days on follow up cases (SD 30.34; Range 1-189).

Referrals to national charities were the most common type of onwards referrals (33%, N=100), followed by local charity referrals (30%, N=89), 29% (N=88) of veterans received information packs, 11% (N=32) were referred to Op Courage, 4% (N=11) to Regimental Associations, 2% (N=7) to the VTN and 13% (N=38) to 'other' organisations which included Age UK, Admiral nurses, other military charities, local councils and local breakfast clubs. Referral organisations utilised by AFA's are shown in the Figure 19.

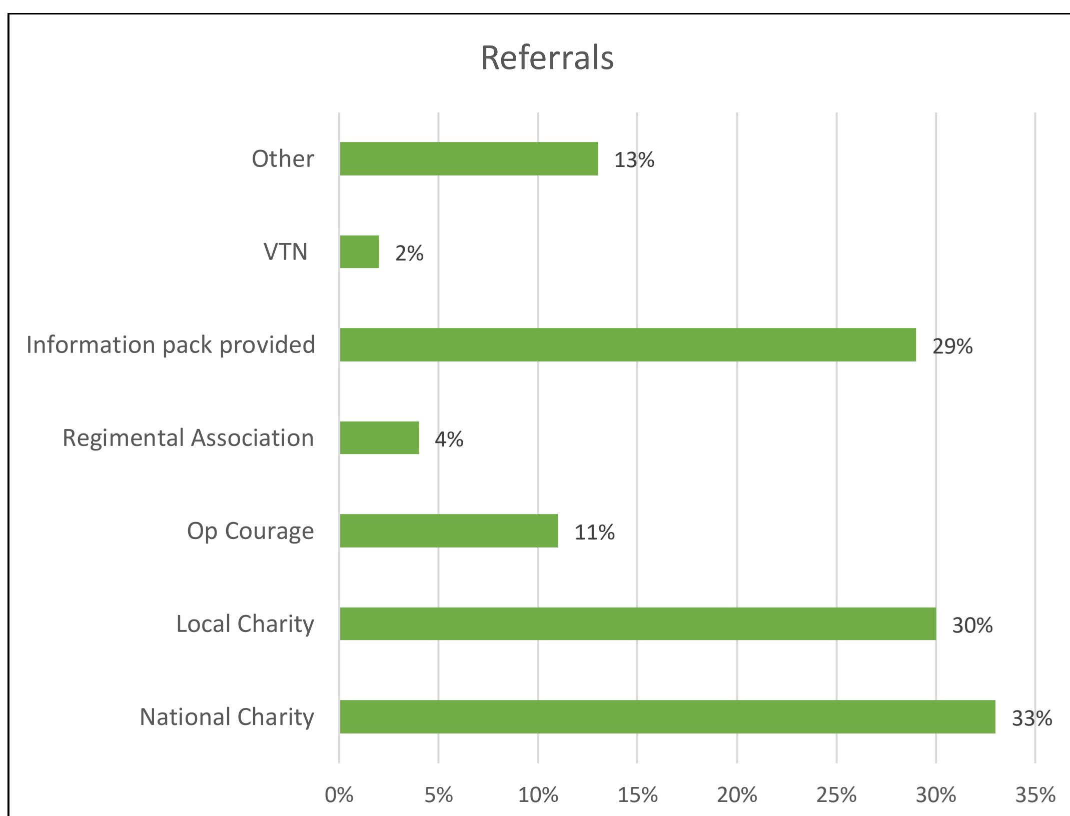


Figure 19. Referrals onwards

A&B HSCP Transforming Together
Argyll & Bute Health & Social Care Partnership

Armed Forces Community HQ

AGAMEMNON Housing Association

age UK

Armed Services Advice Project

ALWAYS A RIFLEMAN

Army Widows' Association

Army Benevolent Fund

ASAP Armed Services Advice Project

BIG C Cancer Charity
— EST. NORFOLK 1980 —

VETERANS CLUB
COMMUNITY TRUST

Blesma
THE LIMBLESS VETERANS

City of BRADFORD
METROPOLITAN DISTRICT COUNCIL

BRAVEHOUND

BritishRedCross

citizens advice bureau

carers' resource
you care for them, we care for you

Cruse Bereavement Care

F4H
Taking Control of Tomorrow

COMBAT STRESS
FOR VETERANS' MENTAL HEALTH

DMWS
Defence Medical Welfare Service
Supporting the frontline

Department for Work & Pensions
Armed Forces Champions

ERSKINE
Caring for Veterans since 1916

Fares4Free
Don't wait for November to Remember

GARELOCHHEAD STATION TRUST
MILITARY VETERANS AND COMMUNITY SUPPORT

GLASGOW'S HELPING HEROES

HAIG HOUSING
HOMES FOR THE VETERAN COMMUNITY

HH Healthier Heroes
SERVING OUR COMMUNITIES

HELP for HEROES

NHS
Veterans' Mental Health High Intensity Service

CELEBRATING 10 YEARS 2013 2023
Launchpad

MAST
Multi-Agency-Support-Team

Glasgow City HSCP
Health and Social Care Partnership

MK Milton Keynes City Council

NHS
Lancashire & South Cumbria
NHS Foundation Trust

MNWB
MERCHANT NAVY WELFARE BOARD

OpCOURAGE

OpNOVA

OpRESTORE

poppy scotland

PRIORY
HEALTHCARE

Royal Air Force Benevolent Fund

Renfrewshire Council

RFEA THE FORCES EMPLOYMENT CHARITY

THE RIPPLE POND
YOUR FORCES FAMILY NETWORK

NHS
The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

ROCK 2 RECOVERY
Saving Lives. Changing Lives.

stoll housing and helping Veterans

The Royal Engineers Association

THE ROYAL NAVAL BENEVOLENT TRUST
SERVE A DAY, SUPPORTED FOR LIFE

Royal Star & Garter
Care with courage

ROYAL SIGNALS ASSOCIATION

SCOTTISH VETERANS RESIDENCES

ssafa
the Armed Forces charity

Talking Points

VIP | VETERANS FIRST POINT

VG VETERANS' GATEWAY

WALKING WITH THE WOUNDED
Supporting Those Who Served

WOODY'S LODGE
SEA . AIR . LAND

VETERANS IN CRISIS
SUNDERLAND

Visit Logs

AFA's were able to record when they visit a veteran patient on the ward (See Table 6), and to write comments on the patient's progress and needs. There were newly identified patients as veterans and therefore they have less visits recorded onto the portal. Furthermore, there is evidence that visits occurred from the AFA but were not recorded, in part due to visit logs being completed retrospectively. Visit log comments left on the portal have been categorised and supporting quotes have been presented in Table 7 illustrate the patient/ AFA interaction.

Number of Visits by AFA	N
Mean	4
SD	4.46
Range	1 – 51
Missing	2140

Table 6. Visit log information

Category	Sub-Category	Supporting quote
Challenges	Discharge	*"Service user ready to leave hospital. Waiting for care package to be put in place before he can leave. SSAFA have been contacted. Need to chase up where we are regarding care package."*
	Family	*"Been trying to contact service user's daughter but they are not answering phone. Service user was discharged with needs met so just wanted to know if it was through one of the contacts I made."*
	Hospital	*"Service user feels let down by the NHS, service user feels deflated."*
	Service user	*"I popped in to see Service user, he was dosing and seemed confused, he was not making any sense."*
Discharge	Death	*"Service user's wife very happy with support she has received since Service user's death. Everything she wanted for the funeral was done by the Royal British Legion and Walking With The Wounded."*
	Planning	*"Met up with service user before he was discharged into nursing home. Managed to get him some money from the RBL to buy toiletries to take with him. Service user very happy and thanked me for all my support."*
	Follow up	*"Phone call to check if Service user needed any support. None required. Await referral from SSAFA."*
Engagement	Type of support	*"Visited Service user with member of the British Red Cross. We are picking some bits up from his son and will drop them back off. Told SU I would see him in the afternoon."*
	Military service discussion	*"Service user happy to talk about time in military and life after"*
Health & Well-Being	Referrals & Liaising	*"Spoke to BLESMA regarding support for SU. Have passed on Service user's details and they should contact him this week. Have messaged Service user to keep him updated."*
	Needs of patients	*"Service user lost limb during service. Wife trying to get help from local council. Will make referrals on their behalf."*
Veteran Identification	Who identifies?	*"Service user identified via the ward nurse who had heard about the service."*
Personal circumstance	Home life	*"Service user feels like he needs a care home or assisted living. We discussed RBL care homes and he was very open to this."*
	Finances	*"Each time he has to take time off, he loses money and has to return to work before he is fully recovered. Will see if there is any support that may help when Service user is ready for discharge."*
	Community engagement	*"isolation due to old age ill health- referred to Hub but no befriending service available locally."*

Table 7. Visit log analysis

Analysis of visit log data revealed the needs of veteran patients were mostly related to housing, finances and community engagement. Veterans were requesting assistance with readjustments in the home to suit their needs, rehousing to different areas and families requesting support in having their veteran family member moved to a care home. Finance related needs were the result of veterans requiring support with benefits and pensions, including help with rent payments and financial support for medication not available on the NHS. Community engagement related needs were based on veterans feeling isolated and wanting to engage with like-minded individuals.

Service User and Family Feedback

A total of 136 surveys were completed by service users and/ or family members. Of these, 78% (N=106) were completed by service users, 23% (N=30) were completed by family members. See Table 8. Survey data responses are in Table 9.

Trust	Service user N	Family member N
University Hospitals Dorset NHS Foundation Trust	2	/
Gloucestershire Hospitals	1	/
East Suffolk and North Essex	4	1
James Paget University Hospitals	74	22
Milton Keynes University Hospitals	12	3
South Tyneside and Sunderland	1	/
Airedale	1	/
Betsi Cadwaladr University Health Board	3	1
NHS Greater Glasgow and Clyde	7	3
NHS Lothian	1	/
Total	106	30

Table 8. SU & Family survey completion

Question	Type	SU	Family
The Armed Forces Advocate improved my/my family members care whilst in hospital.	Mean	4	5
	SD	0.81	0.79
The support provided by the Armed Forces Advocate had a positive impact on me /my family.	Mean	4	5
	SD	0.73	0.86
The Armed Forces Advocate helped to improve my/family member discharge from hospital.	Mean	4	4
	SD	0.82	0.96
How would you rate the support you/family member received during your time in the hospital?	Mean	4	4
	SD	0.78	0.93
Overall, how would you rate the information that you/family member received during your time in hospital?	Mean	4	4
	SD	0.72	0.88
Overall, how would you rate the treatment provided by the hospital?	Mean	4	4
	SD	0.86	0.80
How would you rate the hospital facilities (for example: location, access)?	Mean	4	4
	SD	0.90	0.81
AFA: Their knowledge of the specific challenges faced by members of the Armed Forces community?	Mean	5	5
	SD	0.53	0.63
AFA: Their sympathy and compassion?	Mean	5	5
	SD	0.48	0.34
AFA: Being effective and responsive?	Mean	5	5
	SD	0.52	0.56
AFA: Their ability to refer you/family member to relevant support organisations?	Mean	5	5
	SD	0.57	0.56
How would you rate the overall support provided by the Armed Forces Advocate?	Mean	5	5
	SD	0.51	0.85

Table 9. Survey data

Eighty-two per cent (N=113) of those who completed the survey knew how to make a complaint, these were 84% (N=90) service users and 75% (N=23) family members. In addition, 56% (N=60) of service users stated that they had received additional support with 12% (N=13) stating that was "some" additional support and 57% (N=17) of family members stated they had received additional support with 13% (N=4) stating that was "some" additional support. Table 10 shows the type of additional support veterans and their families received.

	Service user N	%	Family member N	%
Home assessment	7	10	/	/
Live in care	2	3	/	/
Care package	40	57	13	65

Table 10. Additional support

Survey respondents also provided open responses about 'other' types of care the AFA had put in place for them. This included follow up calls, equipment, signposting, and MH support. Fifty-six per cent (N=76) of survey respondents were referred onwards to support organisations. See Table 11.

Referral to	Service user N	%	Family member N	%
Welfare organisation	43	75	10	66
'Other' organisation	33	57	7	54

Table 11. Referrals

Ways in which this support was considered to help included: blue badge entitlement, general support and education about what services are available, financial assistance, care packages.

Overall support from the AFA was positively received with 98% (N=135) rating the support as ‘good or ‘very good.’ See Figure 20.

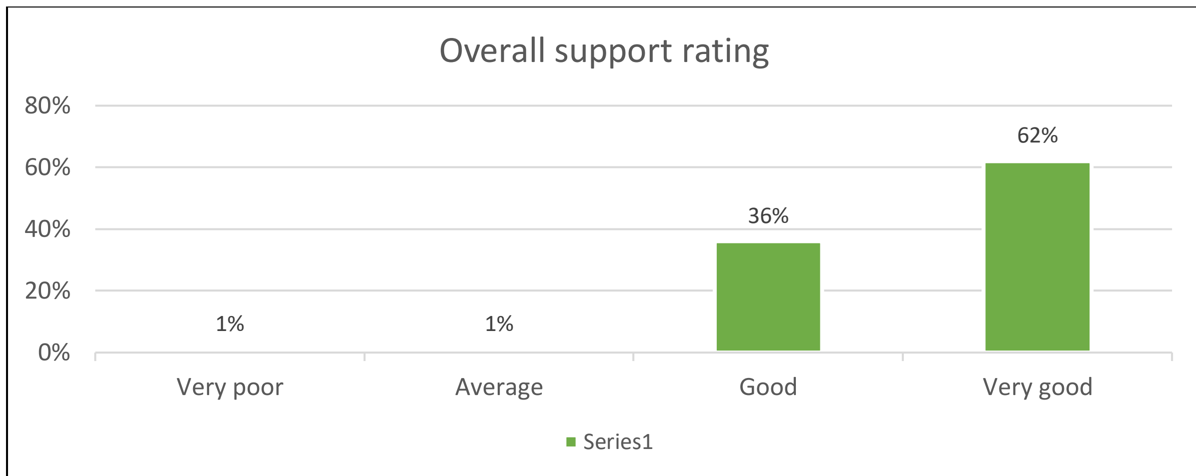


Figure 20. Support rating

Positive aspects of the AFA role

Survey respondents noted positive aspects of the service. See Table 12.

Category	Sub-category	Frequency (N)
Engagement	Having someone to talk to	67
	Timely support	30
	Empathy	21
	Feeling listened to	21
	Involving family	18
	Talk openly about service	17
Support	Learning about support availability	27
	Availability post-discharge	11
	Referrals to other services	8
	Help with discharge planning	5
	Keeping up to date	5

Table 12. Positive aspects of AFA role

Service User and Family Feedback

“The support and advice had a hugely positive impact and has restored some faith in the UK system”

It was life-changing for our family”

“I have never heard of them before. More people should know about them and their amazing work”

I was able to talk about things I’ve had on my mind for 60 years. [AFA] sat with me and helped me feel better about things that happened a long time ago”

“I have been able to discuss the challenges of my service with someone who understands”

Potential improvements to the AFA role

Survey respondents indicated potential improvements to the AFA service. See Table 13.

Category	Sub-category	Frequency N
Promoting role	Raising awareness	37
	More AFA's needed	13
Support	Greater opportunity for engagement	12
	Post-discharge support	5
	Alternative format for blind veterans	4

Table 13. Suggested improvements

Staff Training

In total, portal data revealed 1352 staff received training from AFA's to improve their knowledge and understanding about the Armed Forces Community. In some instances, staff did not complete a survey prior to training but did complete a survey post-training. Furthermore, not all staff who were trained completed surveys at all. See Table 14.

Trust	Type	N
University Hospitals Dorset NHS Foundation Trust	Pre	7
	Post	4
James Paget University Hospitals	Pre	468
	Post	462
Gloucestershire Hospitals	Pre	16
	Post	52
East Suffolk and North Essex	Pre	366
	Post	266
East Lancashire Hospitals	Pre	35
	Post	41
Wrightington, Wigan and Leigh	Pre	48
	Post	42
Milton Keynes University Hospital	Pre	24
	Post	32
Airedale	Pre	0
	Post	47
Manchester University Hospitals	Pre	18
	Post	17
Cardiff and Vale University Health Board	Pre	50
	Post	42
South Tyneside and Sunderland	Pre	6
	Post	1
Total Number of Staff Trained		1352

Table 14. Number of Pre and Post Staff Training Surveys Split by NHS Trust.

Job titles and banding of those completing the training were recorded. Most staff that completed the training were Nurses (43%, N=511). The top five job titles are shown in Figure 20. Other job titles included Dentistry, Surgery, Chaplaincy, Midwifery and Diagnostics. However, 156 cases were missing the job title. See Figures 21 & 22.

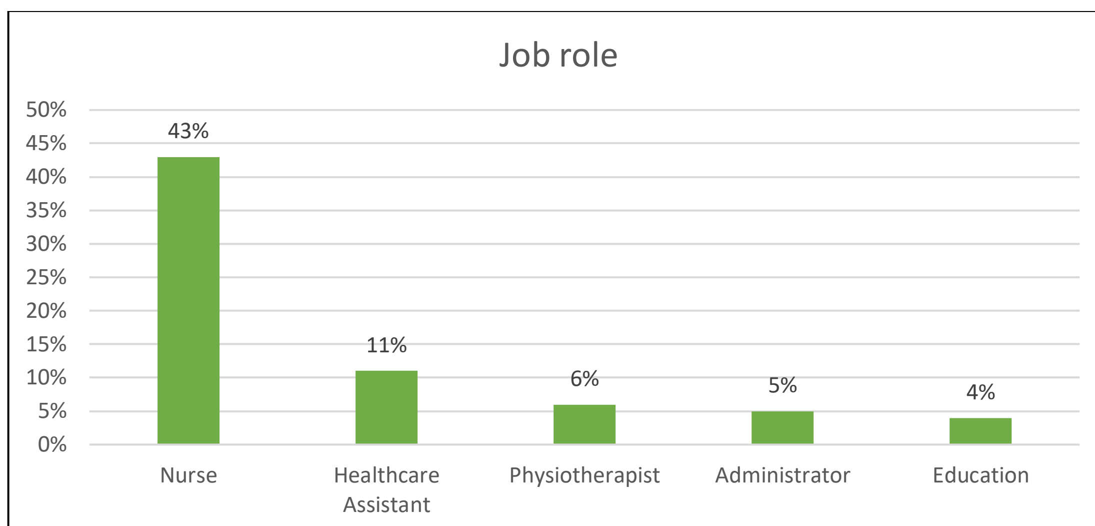


Figure 21. Job role

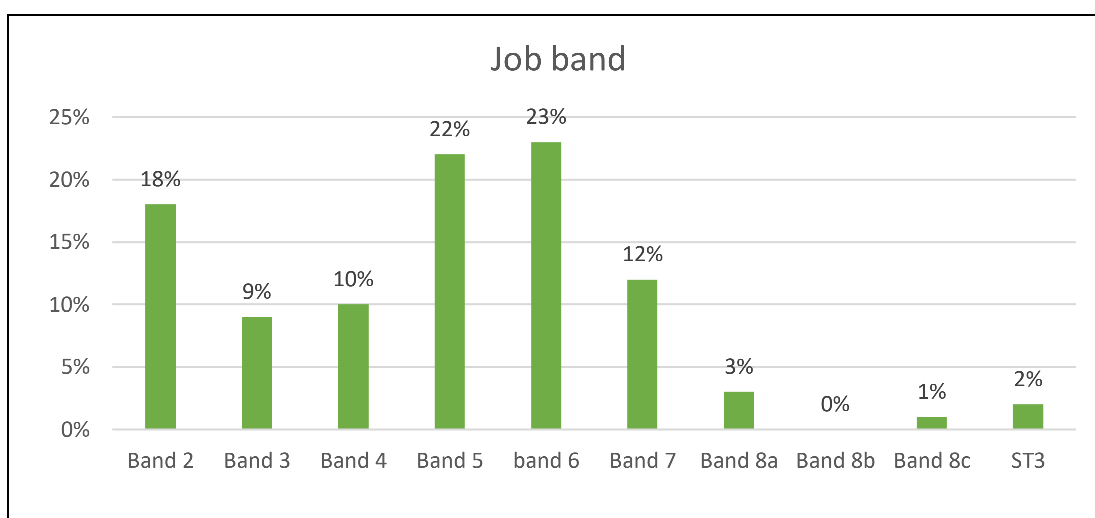


Figure 22. Job Band

Of the 1352 staff who were trained, pre-training 63% (N=654) of staff felt comfortable when speaking to a veteran, compared to 92% (N=1546) after their training. This was a significant relationship X^2(16,N=697=324.45, p<.05). This was a similar finding across the data with just 22% (N=224) of staff knowing what services were available to refer veterans onwards to pre-training whereas post-training, this figure increased to 89% (N=899). This was found to be significant X^2(16,N=693=65.07, p<.05). Pre-training, 24% (N=250) of staff felt their understanding of the Armed Forces was very poor, reducing to .4% (N=4) post-training and understanding of the Armed Forces rose from 22% (N=227) pre-training to 84% (N=838) post-training.

The ratings of the survey questions ranged from 1 to 5. Table 16 shows the average scores pre and post training with members of staff and the standard deviation (spread) of the scores. All scores indicated post training improvements. However, lack of any longitudinal scores mean that those improvements cannot be tracked over time. See Table 15.

Staff Training Feedback

The positives

"Teaching was good and clear"

"I did not know this support was available. The training today has been very helpful"

"Brilliant session, really informative"

"Such an important role within the community"

Suggested improvements

"Further training following on from this introduction would be useful"

"Some questions are not clear enough to give a concise answer"

"Need a special class and more timing and booklets for proper understanding"

"The statistics used were useless as they were about serving personnel and not veterans"

"Maybe consider a longer session with more time to talk"

"I felt uncomfortable in this session. As a nurse it goes against my code of conduct to ask a patient's background...being a veteran has no relevance to their nursing need and everyone should be treated the same way"

"The nature of the course may imply that serving is all doom and gloom. As a veteran, I know this is far from the truth. This needs to be communicated to those who have never served"

Question	Type	Before	After
I feel comfortable when speaking to a veteran	Mean	3.84	4.44
	SD	1.02	0.70
I feel confident in signposting a veteran	Mean	3.11	4.39
	SD	1.24	0.71
I know how to access support within the hospital	Mean	3.11	4.53
	SD	1.29	0.65
I know who to access support from within the hospital	Mean	3.18	4.53
	SD	1.30	0.65
I know what services are available locally relating to the Armed Forces covenant/veterans	Mean	2.47	4.30
	SD	1.25	0.74
I know who the local stakeholders are relating to the Armed Forces covenant/veterans	Mean	2.28	4.14
	SD	1.24	0.858
How would you grade your knowledge of the Armed Forces community?	Mean	2.48	4.01
	SD	1.19	0.87
I know who my peer support workers are	Mean	2.66	4.19
	SD	1.29	0.85
I have an awareness of the Armed Forces Covenant	Mean	2.32	4.35
	SD	1.30	0.76
I understand what the Armed Forces Covenant is and why it has been implemented	Mean	2.32	4.39
	SD	1.30	0.74
How would you grade your understanding of the Armed Forces Services?	Mean	2.55	4.18
	SD	1.21	0.77

Table 15. Pre/ Post scores

Qualitative Interviews

A total of thirty interviews were conducted with both AFA's (or equivalents) and one additional individual from each Trust (or equivalent) who had worked closely with the AFA (or equivalent). This could be a hospital staff member, a staff member of an external organisation that the AFA (or equivalent) had utilised or a family member of a veteran who had been an inpatient in the hospital. See Table 17.

Interviews lasted for a total of 41.10 minutes (Range 16.18-69.01 minutes). Analysis of the data revealed four key themes: AFA Role, Family members, Positive impact, Challenges faced. See Table 18.

Focus Groups

Four focus groups were conducted throughout December 2023 and January 2024, and included the post holders and staff members that work either internally or externally with the AFA. These offered the opportunity to validate the results of the interviews. Participants were presented with the interview themes and discussions were held around whether they agree that these were a true reflection of the AFA role impact and challenges. See Table 16.

Focus Group Themes	Category	Sub-category
Understanding	General understanding of Armed Forces Community	Hospital staff lack knowledge about needs of veterans
	Senior Leadership Team 'buy in'	Don't understand importance of initiative
Education	Educating hospital staff about the role/ who to go to	Staff unaware how to signpost
	Raising awareness/ promotion	Continuous efforts to maintain engagement
	Training	Difficult to continue trying to recruit staff

Table 16. Focus group analysis

Triangulation

Bringing all the information together into a theoretical model to illustrate the impact of the AFA is in Figure 23.

Pseudonym	**Gender**	**Military Connection**	**Role**
AA	M	Veteran	AFA (or equivalent)
AB	F	Reservist	AFA (or equivalent)
AC	F	Veteran Family Member	Volunteer and Family Member
AD	F	Reservist	AFA (or equivalent)
AE	M	Veteran Family Member	DMWS Staff Member
BB	F	Veteran	AFA (or equivalent)
CC	M	None	Trust Engagement Officer
DD	F	Veteran	Armed Forces Community Link Worker
EE	F	Veteran Family Member	Family Member and Hospital Nurse
FF	M	Veteran	AFA (or equivalent)
GG	M	Veteran	AFA (or equivalent)
HH	F	None	High Intensity Service Staff Member
II	F	None	AFA (or equivalent)
JJ	M	Veteran	AFA (or equivalent)
KK	M	Veteran	Trust Portering and Security
LL	F	None	AFA (or equivalent)
MM	M	None	Trust Equality and Diversity Staff Member
NN	M	Veteran	Armed Forces Support Officer
OO	F	Serving Partner	AFA (or equivalent)
PP	F	Veteran	AFA (or equivalent)
QQ	M	None	SSAFA Staff Member
RR	F	Veteran Partner	Armed Forces Community HQ Staff Member
SS	F	Veteran	AFA (or equivalent)
TT	M	None	Trust Corporate Workforce Staff Member
UU	M	Veteran	AFA (or equivalent)
VV	F	Veteran Family Member	Trust Dementia Nurse
WW	M	Veteran	AFA (or equivalent)
XX	M	Veteran	Trust Therapy Support Worker
YY	F	None	AFA (or equivalent)
ZZ	F	None	Deputy Manager Armed Forces Organisation

Table 17. Information of Interview Participants

Theme	Category	Sub-category
Armed Forces Advocate Role	The role itself	Characteristics Establishing the role Identifying veterans Expectations Patient engagement
	Support provision	Type of support
	Educating others	Raising awareness Staff training
	Collaboration	Internal External
Family Members	Engagement	Positive relationships Requesting support
	Support needs	General support Palliative care support
Positive Impact	Patients	Social support Feeling valued Discharge process
	Wider hospital community	Knowledge & Understanding
Challenges Faced	Workload	Working hours Prioritising Multiple sites
	Understanding of AFC	Trust Patients & families
	Identifying veterans	Reliance on other staff
	Referrals & Signposting	Gaps in service provision
	Staff training	Not mandatory

Table 18. Interview analysis.

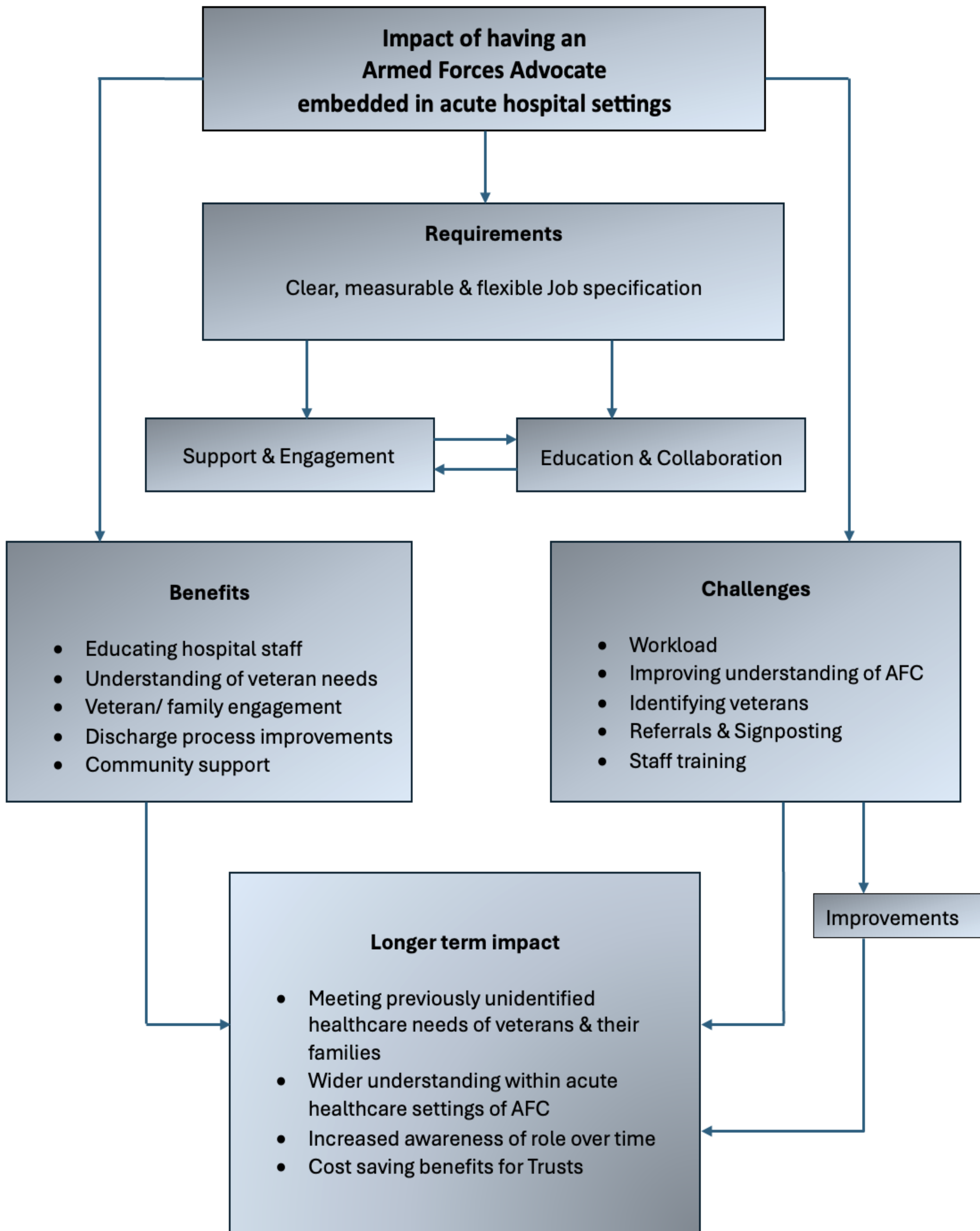


Figure 23. Grounded Theory Model illustrating the impact of AFA's in acute hospital settings

Discussion

In 2021, the Armed Forces Covenant Fund Trust (AFCFT) awarded almost £2 million to help support veterans in acute hospital settings throughout the UK. The Supporting Armed Forces in Acute Hospital Settings programme was jointly funded by the AFCFT and NHS England and NHS Improvement to support pilot projects to better support veterans and their families when they are in a hospital setting. An independent evaluation of this programme commenced in February 2022, ending in January 2024. Quantitative data captured information from 2512 veteran patients during the evaluation, providing insight into the demographics of the veterans requiring acute hospital care, their needs, admissions and referrals processes in addition to previous help-seeking behaviours. Visit logs were also recorded and showed AFA's made a mean number of 4 visits per veteran patient. Survey data captured 106 veteran responses, 30 family responses and 1352 staff training pre/ post responses. Qualitative data was captured via 30 interviews and 4 focus groups.

The data revealed the mean age of veterans was 75, most of whom were males (97%). Of these, 78% were retired and only 10% in full time employment. Forty-five per cent had completed National Service and most had served in the Army (81%). Census data (ONS, 2022) shows that 87% of the veteran community were male, with 13% being female. The high proportion of National Service veterans within this evaluation offers an explanation as to why there are more males in this evaluation than we would expect to see according to the Census data. However, women veterans were under-represented.

The most common reason for admission into hospital was physical ill health (81%) with most entering via emergency care (60%). However, only 5% (N=117) had needs attributable to their time in service. Prior to hospital admission, most veterans (20%) had sought support from their GP, and upon discharge out of hospital, most were referred to national charities (33%). Survey data reveals the AFA role was positively received by veteran patients and their families, they felt supported and believed the AFA role had a positive impact on them. Staff surveys indicated that Nurses and/ or Band 6 staff were most likely to be involved in training, with improvements in knowledge and understanding of the AFC present post-training.

The following discussion is predominantly based on qualitative data from staff interviews and focus groups and will illustrate the impact of the AFA role on the veteran patient, their families, and the wider NHS Trust.

AFA Feedback

AFA Role

“The main thing is a lot of staff don’t know that we exist. We had to do an awful lot with our comms department, get things out on our intranet and weekly bulletins. A whole host of things to try and get word out that we were there to support veterans” FF

Positive impact

We supported him with a blue badge application and an alert alarm at home. These are things that would happen with the discharge team but we were able to speed that up and help him with the paperwork” BB

Challenges faced

“I’ve been asked to do presentations everywhere, all sorts of things, all the admin too, and see 300 patients, making up a pack to give to each patient- just making ten takes an hour, maybe a couple of hours by time you’ve printed things off and put them together. It’s very time consuming for one person” FF

Family members

I spoke to the wife and daughter to see what support I could offer” SS

AFA Role

For me personally, I find it a lot easier having that military background because you have that camaraderie straight away” AA

Characteristics

The AFA (or equivalent) role was considered distinctive in that having an understanding of the military was necessary although it was not perceived to be an essential requirement that AFA's must be a veteran themselves, similar to other veteran health services related research (Finnegan et al., 2022; 2023). However, if an AFA was a veteran themselves, it was perceived by staff interviewees that this helped veteran patients relax, and speak more freely to the AFA because they immediately feel understood. AFA's themselves felt this helped to build a relationship with veteran patients,

"For me personally, I find it a lot easier having that military background because you have that camaraderie straight away." AE

There were, however, certain characteristics that were considered necessary for the role. These included strong communication skills, resilience, patience and compassion,

"Good communication skills...proactive as well, you want someone who's walking the walk, happy to engage with the clinical team and the ward, the veteran…we just need someone to engage with the staff and the veterans within the Trust." KK

Understanding the needs of veterans was also important within the AFA role, being able to communicate fostered the ability to build a relationship, but enhancing that relationship with emotional understanding was considered more effective,

"You definitely need to be a people person, a social chameleon, you've got to be able to go on to a ward and speak to a 21-year-old like you would a 90-year-old. You've got to understand them emotionally, you've got to understand how they're feeling." JJ

Establishing the Role

In addition to learning about the NHS and for those without a military background, learning about the culture of the military, was highly important; an issue prominent in previous literature (Brommelsiek et al., 2018). However, AFA's also managed the responsibility of promoting the initiative in addition to the direct support they provided to veteran patients. This was something AFA's found challenging and time-consuming,

"Trying to find out where the AFC are in the area and where our Trust covers. Then I identified the RBL branches and contacted them to see if I could pop along because they all use this hospital… the problem is you end up getting roped in as a member. I also attended breakfast clubs and coffee mornings, engaging with the local community to get the word out there." AA

It was also a demanding task ensuring other staff within the hospital were aware the role existed,

"The main thing is a lot of staff don't know that we exist. We had to do an awful lot with our comms department, get things out on our intranet and weekly bulletins. A whole host of things to try and get word out that we were there to support veterans" FF

Having separate roles for engaging with veteran patients and for delivering training, promoting awareness and engaging with the wider hospital community should be considered in the future delivery of the programme. In addition to making preparations in the early stages of the role being embedded within hospitals, to provide effective support, AFA's were required to begin building networks both within the Trust and externally,

"The partnerships with the ICB led to invitations, like [ORGANISATION], meeting key individuals. From a regional perspective, I link in with [AFA NAME], I attend monthly network meetings with [CITY COUNCIL]. We link in everywhere." BB

The breadth of how the AFA's engage is enlightening with AFA's discussing how they deliver presentations to as many organisations as possible to raise awareness and let people know the programme exists,

"I gave a brief to 112 Warrant Officers, I briefed them on what we do." JJ

These ways of promoting and establishing the role were not set out in job descriptions and meant that it was the responsibility of the AFA's themselves to consider how to connect with local communities.

Identifying veterans

Identification of veterans is largely reliant on administrative or clinical staff asking patients on admission whether they have ever served. AFA's have attempted numerous different routes to identify veterans. Some NHS Trusts have been successful in adding a mandatory question into the electronic admissions process and these have seen improvements in the recoding of veteran status,

"We were getting 3 or 4 a week identified. I've worked with IT to make that a mandatory question and veteran ID has increased by 2500%." OO

NHS Trusts utilising the electronic identification process then send an automatic alert to the AFA and from there, AFA's were able to visit and engage with the veteran patient. In some NHS Trusts, once veterans were identified, with the veterans consent then poppy badges were placed on the patient's bed aiming to instil a sense of pride in these patients, to prevent patients with dementia from having to repeat their story and informing all staff of the patients veteran status.

Some NHS Trusts have also been able to identify staff members who were a part of the AFC as a direct result of this programme and some AFA's were actively seeking out veteran staff members to form an AFC network within the hospital,

"We now identify through our recruiting process. The Trust didn't used to so what we do now is send out weekly messages asking those from the Armed Forces Community to identify themselves to me if they wish to." AA

The positive ripple effect of networks such as these were perceived to provide an additional support group for veterans within the hospital,

"That full network of staff provides an awareness because you now have all these colleagues who maybe before didn't shout about being a veteran or a Reservist, and then it just kind of grows upon itself." CC

Managing expectations

Many veteran patients lacked an understanding of the Armed Forces Covenant and it was the role of the AFA to ensure patients were aware of the legislation. The AFA aimed to help veteran patients to manage their expectations of the Armed Forces Covenant and to understanding the AFA roles. Other types of expectation management related to general admission and discharge processes,

"On two occasions I've been called to A&E because veterans have gone in there and demanded priority service, and I've had to go and be the devil's advocate." JJ

Other times, veterans misunderstood the type of support AFA's could provide in relation to support provision outside of the hospital setting,

"I said I don't have any influence on you getting a new flat from the council, I can only shape the information sharing and signposting. Sometimes they paint me in a picture as some sort of Saviour, and that's not my role." PP

Given this initiative was a pilot, it is important to note that as the role progressed and awareness continues to grow, veteran patients are informed during initial engagement the AFA's remit is, and what their support capacity is. However, that these patients had specific problems that they clearly need support with indicates the importance of the AFA role and highlights areas for further improvement.

Patient Engagement

Even when no specific assistance was required, the AFA's reported that most veteran patients were willing to engage with them and were interested to hear, and grateful to know, that veterans were being supported in hospital settings through this initiative. AFA's reported that veterans were happy to talk openly about their military service, as were their family members. When a problem has been identified, there was only a handful of cases where veterans were unwilling to accept support from the AFA and this was usually because they had a supportive family. Although there were some

veteran patients who indicated they did not want any connection to the military and therefore declined the offer of support. AFA's reported a need to persevere and were aware that it would take time to build relationships with veteran patients,

"Sometimes it takes a couple of visits to build that rapport, you don't get it straight away." AB

Engaging with veterans often required resilience and a passion to ensure their needs were being met. AFA's would guarantee veterans and their families, even if support had been declined, that they were aware that they could be contacted should they require help going forward. Building relationships meant AFA's were able to identify the veteran's needs and support them even after their death,

"I've got RBL standard bearers at funerals and had the Royal Anglians attend a funeral for a gentleman as well." AA

AFA's were also required to think unconventionally about ways in which to engage with veteran patients,

"We've got an old suitcase and old boots and some old-fashioned uniforms of my Dad's, I'll take it to their beds and it's just a great way to sit and talk." VV

However, quantitative data from the AFA portal indicated that 6% (N=46) of the veterans in this evaluation experienced visual impairment, to what degree it is unknown. Nevertheless, it is important to note that all types of illness should be factored into engagement and that veterans who experience visual impairment may be less able to engage than those who do not. This is further supported by Service user survey data whereby sight loss is described as an issue which requires further attention to improve the initiative.

Family members

Engagement

Families were also happy to engage with AFA's, and in some cases, were often more involved with the AFA than the veterans themselves. This is evident in non-veteran literature whereby families are willing to connect with healthcare and this can enhance engagement (Goodridge et al., 2018). This was due to sometimes older veterans having relatives who acted as informal caregivers, and some veteran patients did not have the mental capacity to engage with the AFA. Families were reported as being happy to contact AFA's themselves to discover more regarding the AFA role and what support they might be able to provide. AFA's felt they had mostly positive relationships with families and believed they were well supported too,

"The majority of patients I've dealt with, I have a lot of contact with families, and I've actually been there to support the families as well. So, it's not just the veteran benefitting from our services, the families have as well." AD

Support needs

Similar to some veterans, some family members declined support. AFA's presented the reasons for this, with some relating to how families may not want to engage once a veteran has died,

"It seems once the veteran passes away, they don't want anything to do with you anymore, and you respect that and just step away." AA

However, there were instances of a requirement for support for bereaved families with some AFA's providing information about families' needs,

"She mentioned he had memorabilia from his time in the Forces and how he had been quite keen for it to be on display somewhere, so I put her in touch with [ORGANISATION] and they were able to liaise about displaying his memorabilia." II

Other families engaged with the AFA in relation to their own necessities; some simply needed someone to talk to whilst others had more specific needs,

"I was contacted by a safeguarding officer who had a Gurkha wife on the ward, she was unaware of the Gurkha community, so I had to explain the Gurkha tier of hierarchy and their culture. The fact that the husband could be taken out of the quarter and placed in alternative accommodation- I was able to help her and assist with that." GG

AFA's were highly understanding and knowledgeable of veteran's needs and were confident in supporting them. However, only 5% (N=117) of veteran patients in this evaluation had support issues which were related to their time in service. While this may appear low, it is likely explained by the mean age of veterans (75 years) in this evaluation, which is further supported by the fact most veterans were admitted into hospital for general illness (62%, N=413). Moreover, there was no relationship between PH or MH and deployment, which would support the idea that in the main, the veterans identified in this evaluation were admitted to hospital due to ageing health needs. This then illustrates the importance of identifying younger veterans in hospitals in the future. However, most referrals to AFA's came from emergency care (60%, N=411) and emergency services (21%, N=146). It would be useful to focus future efforts on identifying veterans under 65 years of age who are admitted into other departments. This would mean increased efforts to promote the initiative across different departments. If younger veterans who had support needs related to their time in service were identified, this might mean different networks should be established based on their requirements.

Positive Impact

Patients

AFA's discussed the positive impact their role had within the NHS Trust, the hospital staff, the veteran patients along with their families. AFA's described the ripple effect of the role and how this had led to Armed Forces networks being established within NHS

Trusts, identifying staff members who were members of the AFC, and described how useful this is was in raising awareness of veterans in general throughout the hospitals. Some NHS Trusts established AFC coffee mornings within their hospitals and other AFA's discussed the importance of considering how electronic identification of veterans was of great benefit. Identification of veterans had also improved via the use of poppy badges previously mentioned. AFA's had also helped in improving the knowledge of the AFC in other staff members which subsequently had a positive impact upon the veterans themselves. Examples of what impact AFA's could do were discussed,

"We had a veteran who just laid in a hospital bed for almost a year, alcoholism and MH issues which had gone untreated for many years. We were able to connect him with the people he served with, we got RBL involved with extra support for him…although his health deteriorated and he passed away, we feel we were able to help him reconnect and that was something he hadn't had for many years." AA

Overall, 98% of veterans said they were happy with the support they had received from the AFA and most of the time, AFA's were able to expedite veteran's needs. Some AFA's described how they facilitated earlier discharge from hospital through different types of support. Some offered practical support with paperwork, other liaised with external organisations to facilitate care at home,

"We had her knee operation wait reduced from 72 weeks to 12 weeks. She's had it done, she's back at work. It made the world of difference to her." LL

Wider hospital community

Interviewee participants offered their view surrounding the expansion of support from AFA's beyond the hospital environment. Some AFA's attended out-patient appointments with veterans, others visited them in the community and tried to identify what could be done to prevent veterans being admitted back into hospital. Social prescribing has previously been identified as a means of support for the veteran community (Boulter et al., 2023), providing support for the AFA's perspective in this evaluation. AFA's also worked to identify new initiatives within the community. AFA's discussed the potential impact of the role not continuing and felt this would have a very negative influence upon the veteran community,

"I think we're a lifeline, that link between the Trust and the veteran community and I think losing that would have quite a detrimental impact on a lot of people." WW

Challenges Faced

Workload

AFA's felt that the initial implementation of the initiative was slow, and this led to a feeling of frustration. Once the initiative was rolled out, staff felt they were working

excess hours to establish the role which took its toll on their own family life and commitments. However, staff were passionate about supporting veterans and understood veterans were not just in need during typical working hours and therefore some staff committed to working evenings and weekends,

"My phone goes off at 11 o'clock at night and my husband will say why are you answering that? But if I know he [veteran] is at home vulnerable, he may be slightly confused. I can't not answer the phone to him because he might have fallen, so there's an element where you don't switch off." PP

This would suggest that flexible working could be of great benefit to AFAs within their role and allow them to work during hours which are mutually beneficial to both themselves and the veteran patient. Staff also felt the role was a lot for one person to manage; the expectation to support veterans, promote the initiative, liaise with external organisations, keep family members up to date, attend meetings, deliver presentations,

"I've been asked to do presentations everywhere, all sorts of things, all the admin too, and see 300 patients, making up a pack to give to each patient- just making ten takes an hour, maybe a couple of hours by time you've printed things off and put them together. It's very time consuming for one person." FF

There was also discussion surrounding staff sickness whereby AFA's then felt under greater pressure when staff were absent. The navigation and delegation of workload was at times demanding; with AFAs reporting feeling tired and at times, emotionally drained, especially when veterans they had engaged with had died,

"When they pass, I find that quite challenging…I don't know how doctors and nurses do it all the time." AA

An added challenge was dealing with the initiative at a strategic level. AFA's felt it was difficult to navigate the NHS policies which were an unexpected addition to the job role, though a few commented that once the strategic side was in place i.e. identification, referral pathways, connections etc., that the workload became easier.

"You've got the frustrations of the NHS system and red tape and bureaucracy to deal with. Although that can be frustrating, it's very rewarding." KK

Understanding of AFC

Whilst staff training were predominately advantageous, it was a not without its difficulties in that AFA's were responsible for recruiting staff onto the training courses, presenting an additional demand on their time. Furthermore, improving understanding of the AFC within NHS Trusts was considered highly challenging. This evaluation illustrates the effectiveness of staff training with improvements observed across all areas of knowledge, awareness and understanding, with improvements of 22% to 84% pre/ post staff training. However, for those staff who do not have the capacity to attend staff training, their understanding of the AFC is likely comparable to the 22% reported

pre training, highlighting the reduced levels of awareness staff may have. Importantly, some AFA's reported a resistance from some clinical staff to engage with the initiative,

"From the doctor's point of view, well why don't we have this for everybody, so it's about informing them of the Armed Forces Covenant." AA

Raising awareness with veterans and their families about the initiative, alongside staff training was considered demanding; combined with staff who did not understand the AFC made the role of the AFA more challenging. This should be considered as a recommendation going forward for future delivery of the initiative whereby the job specification should ensure inclusion of the key educational delivery required in this role.

Identifying veterans

Identification of veterans was considered a significant challenge within this role. As many veterans are unaware and of the health benefits associated with disclosing their veteran status to healthcare professionals (Finnegan & Randles, 2022), veteran status disclosure meant that staff must ask the question of the patients being admitted but AFA's recognised that this was not ideal as staff were often at maximum capacity,

"Especially from the ED, if they're absolutely rammed with 100 people in the A&E department, so half the time they don't get chance to ask the question because they've got more pressing things to think about." FF

When considering 60% of veterans were referred in via the ED, this is an important consideration for identification of veterans within the ED.

As previously mentioned, some NHS Trusts have worked to embed veteran identification into their electronic admissions system, for whom this system works extremely well. However, electronic recording systems did not remove all challenges. AFA's discussed how different departments use different systems so whilst veteran status was recorded in one department, it may not be recorded in another,

"We have multiple hospital systems, so we have an ED department that will pick up a veteran on the system but if you went to radiology, it would be a totally different system, then outpatients would have a different system." SS

Moreover, for AFA's without this system, identification was much more difficult. This meant AFA's were reliant on clinical admissions staff asking whether their patients were veterans which was perceived to be a challenge,

"We have to ask them again at ward level once they are admitted because they use a different system, so there is duplication of work and this is frustrating for staff." PP

Referrals & Signposting

A significant part of the AFA role involves networking, collaborating and signposting; ensuring that veterans were well supported once discharged from hospital. Referrals

to national charities were most common in this evaluation at 33%, followed by 30% to local charities. This may be due to national charities being more well-known but there are advantages to local charities as these may be able to offer more specialised support for veterans and indeed, for those veterans who reported feeling lonely and isolated. AFA's were responsible for forging relationships with multiple organisations who might be able to offer ongoing support to veteran patients but some AFA's felt referrals to military charities to be difficult at times,

"I tried to refer to [ORGANISATION] on my first referral but they were low on case workers, so they came back and said they couldn't support so I went back to [ORG]." BB

Some AFAs reported that the referral process to external organisations were extremely lengthy and others that the referral process was too invasive, particularly for older veterans. AFA's were aware that referral lengths varied across regions which resulted in the perception that veterans faced a '*postcode lottery'* in terms of support provision; a known issue across the health sector (Graley et al., 2011; Russell et al., 2013). Other specific difficulties were in relation to homelessness and MH, an issue which the delivery of Op FORTITUDE aims to address (MOD, 2022). AFA's felt support for homeless veterans was lacking and MH support from NHS services were difficult to engage with,

"I try and ring up and speak to different professionals within the NHS Mental Health services but they aren't very forthcoming, I don't know if they don't understand the role of AFA's, maybe the role isn't seen as important?" NN

This was a difficulty expressed by several AFA's, particularly in the early stages of the initiative whereby other health professionals were unaware of the AFA remit and there was a perception that maybe their referrals were not taken as seriously as those in clinical professions. Although as the evaluation progressed, AFA's did feel a change whereby those who they submitted to because quicker at accepting referrals because they understood the remit of the AFA. There were also perceived challenges for patients with dementia as AFA's felt support in this area was particularly limited. However, this was viewed as a generic gap in provision and not military specific. Referrals for veterans who required assistance with home improvements applications to accommodate their health needs were also perceived to be difficult.

Data from the AFA portal and Service user surveys showed that just 17% (N=422) of veterans felt they had people to rely on and only 6% (N=144) were members of clubs or societies. Visit log analysis also revealed veteran patients struggled with loneliness and isolation and AFA's worked hard to facilitate engagement with community groups. It is therefore of great importance that there are continued efforts to promote community engagement in a bid to reduce isolation in veterans.

Staff training

Improvements were observed post-staff training in relation to all aspects of knowledge and understanding of the veteran community, with greater improvements being observed in relation to appreciating what services were available for veterans. Understanding improved from 22% to 84% as a direct result of the training provided, illustrating how important staff training is. AFA's were keen to embed the staff training as mandatory staff training, with some NHS Trusts successfully doing so. However, some AFA's spent several months enquiring about this. The belief was that some NHS Trusts felt that there were too many mandatory packages already, which led to AFA's feeling a sense of responsibility to promote the importance of this training to senior NHS staff,

"They just said we can't add to people's burden of what they have to do already from an e-learning perspective so I'm trying to roll it out through the intranet, through the nursing directorate of wards, so yeah it's a big task." DD

Other AFA's spoke about their attempts to embed the staff training into new staff induction, but similar to general staff training, there seems to be difficulties due to the amount of mandatory training already required on new staff induction,

"It appears that in all NHS Trusts the induction package has a considerable amount of things in it already so they just don't have the capacity or the time to allow me a slot." JJ

Most of the staff who were trained were nurses (43%, N=511). Whilst this is unsurprising given they workforce composition of NHS hospitals, there remains a remit to improve knowledge of veterans and raise awareness of the initiative across all career employment groups, and it would be useful to focus recruitment on other job roles within hospitals. Doing so would mean staff across all departments, across different clinical, administrative and support job roles and bands, would have greater knowledge which would subsequently improve how the needs of veteran patients and their families are met.

Focus Group data

Four AFA focus groups were held between November 2023 and January 2024. The focus groups offered the opportunity for participants to hear the findings from the interviews and provide further discussion surrounding these findings. Analysis of focus group data supported the interview findings, thus validating and strengthening the qualitative component of this evaluation.

Limitations

As a pilot initiative, the job specifications lacked standardisation and were instead, intentionally broad. This meant that without Key Performance Indicators (KPIs), it is hard to make direct comparisons across the different grant holders. Furthermore, whilst the evaluation was limited to inpatient veterans, many AFA's discussed going beyond this role and whilst this was mostly captured during the qualitative stage, there was much that perhaps the AFA had influence upon but was not captured in this evaluation.

Recommendations

1	**Identifying veterans**	**Electronic veteran Identification**	NHS Trusts which have successfully embedded this method of identification have shown its effectiveness. NHS Trusts should consider standardising this identification tool.
2		**Standardised veteran ID tool (e.g., poppy badge/ sticker)**	Some Trusts created poppy badges and stickers as a veterans' identification tool. This was well received by veteran patients and should be considered by all NHS Trusts. This would aid in promoting awareness of veterans throughout hospitals and should keep the initiative at the forefront of all clinical staff member's minds.
3	**Veterans needs**	**Supporting blind / sight loss veterans**	Visit logs suggested the needs of veterans with sight loss were not being met. Future delivery of the initiative must incorporate suitable materials for veterans with sight loss.
4		**Defining clinical, practical & community needs**	Some AFA's facilitated earlier discharge and advocated for timely surgery, others were able to assist with helping veterans complete paperwork or help them with preparing to live at home. There should be clear reporting of which bracket of need veterans have, this will assist with determining specific needs by area, and help in determining which networks are required in each area.
5	**Job specification**	**Flexible working hours to meet needs of veterans**	Patients require support 24/7. For veterans, identifying them on admission means they may require support outside of 'normal' working hours. This should be taken into consideration and AFA working hours, which should consider flexibility to ensure veterans can reach them in extended hours.
6		**Recognition that role extends beyond hospital setting**	Staff provided support post-discharge and were often involved in discharge planning. This meant at times, staff are required to visit veterans in the community. This should be considered for potential incorporations in future job specifications.
7		**Standardised job specification**	As the job specification was intentionally broad upon rollout of this initiative, AFA's across different NHS Trusts offered a

			different remit. The findings of this evaluation illustrate the general roles and responsibilities, and these should now be reflected within future job specifications.
8		**Consider separate roles for those promoting initiative and those directly supporting veterans**	AFA's found it challenging to establish the role: taking on promotion, networking, awareness, education, and support provision simultaneously. The establishment of an armed forces network for staff would be beneficial.
9		**Collaborating with local charities**	Efforts should ensure positive utilisation of Charities, including smaller local charities. These were less utilised within this evaluation and may be of great benefit to older veterans who report feeling lonely and/ or isolated. They can also help in promoting a timely discharge.
10	**Consideration of Impact**	**Clinical supervision**	Staff at times felt emotionally drained, particularly when dealing with patients receiving palliative care. Staff should be provided with supervision within the hospital setting.
11		**KPI's**	If job specifications become standardised, this will permit the use of reporting templates and KPI's to measure output and effectiveness.
12	**Staff training**	**Link staff**	Mandatory staff training build on a consistent module regarding the armed forces community should be considered in addition to online educational models. Departments and Wards to identify a "link" worker to provide local ownership with better knowledge.
13	**Monetary benefits**	**Health Economics**	A cost benefits analysis would help determine if this initiative is cost effective. The report provides examples of timely discharge and connectivity with Charities that may reduce the burden on the NHS, resulting in higher cost savings over the cost expenditure of employing an AFA.
14	**Research**	**Long Term Impact**	A co-production research study to look at the long-term impact of being supported by an AFA.

Table 19. Recommendations.

Conclusions

This independent evaluation of the ‘Supporting Armed Forces in Acute Hospital Settings’ initiative provides an in-depth insight into the positive impact the AFA role has within acute hospital settings. Multiple perspectives including veterans, their families and NHS hospital staff illustrated the impact of AFA’s, and how the role was utilised to improve education and knowledge surrounding the Armed Forces Covenant as well as general understanding of the Armed Forces Community. The evaluation confirmed improvements in knowledge and awareness of staff working within the hospitals which occurred as a direct result of the staff training AFA’s delivered. These results highlight the benefits associated with having AFA’s embedded in acute hospital settings, indicate the challenges AFA’s experience, offer recommendations for sustainability and future delivery of the initiative.

Older males who had completed National Service were a key representation of the veteran patients requiring acute hospital care. Importantly, this is a population who have until now, been particularly hard to reach. Therefore, this initiative has been able to identify previously unknown needs of older veterans. Of these, many were admitted to hospital by emergency services for physical health and illness related needs. Many of these patients required support post-discharge and AFA’s were able to assist in doing so. In terms of clinical need, AFA’s were able to proactively advocate for clinical interventions, discharges, and ongoing care in the community. Therefore, this evaluation would have benefitted from a costs benefits analysis to determine the perceived savings in healthcare costs which could be considerable. Also, whilst identification of veteran patients is not without its challenges, there are ways to overcome this as evidenced by some NHS Trusts within this evaluation who have embedded veteran identification into electronic admission systems. Once veterans were identified, there was evidence of considerable efforts to ensure they felt valued and aware that they could access support, guidance, and signposting from the AFA. It would be useful going forward to consider involving veteran patients in co-production methods to determine other ways in which the initiative might be improved.

AFA support was extremely positively received by veteran patients and their families as well as the staff, and targeted and specific training whereby knowledge and understanding of the Armed Forces Community had improved across many areas. Interviews and focus groups were able to capture the challenges AFA’s experienced, proving a useful component of this evaluation in identifying key recommendations for future delivery of the initiative. With continued effort to sustain this role, awareness will continue to improve and the needs of veterans who may until now, have not been considered, could well be met.

Overall, the results indicate that having an AFA embedded in an acute care NHS hospital Trust has raised awareness of the needs of the veteran community across staff working in hospitals. There is evidence that it has been of significant benefit to veterans and their families who appeared to feel valued and appreciated

acknowledgment of the armed forces service. AFA’s have advocated on many issues including timely discharge processes and collaborate with external organisations to meet veteran’s needs within the community. The delivery of staff training has raised the profile of veterans and led to constructive HR policy changes. There has been a positive ripple effect of the AFA support both for those who require support, and those who provide it. Importantly, this initiative has also engaged the extremely hard to reach older veteran and their families population and provided them with the support they need.

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Appendix A - E-Bulletins

Westminster Centre for Research in Veterans

THE ARMED FORCES COVENANT FUND TRUST

SUPPORTING ARMED FORCES IN ACUTE HOSPITAL SETTINGS

E – BULLETIN

NOVEMBER 2023

UNIVERSITY OF CHESTER

PROJECT EVALUATOR

Update from Kate Salem, Senior Researcher

Welcome to the sixth E-Bulletin for the Evaluation of the Supporting Armed Forces in Acute Hospital Settings Programme.

We will be closing data collection for the evaluation at the end of January 2024. The data is providing a veteran profile of those who the Armed Forces Advocate is engaging with, and details are presented in this report. The feedback from veterans and family members, as well as the staff training surveys, also remain vital to help to further understand the impact of this role.

We have now completed the interview stage of the evaluation and are conducting online focus groups throughout November and December which will aid in strengthening the findings from the interviews. Four focus groups will be held with staff involved in the strategic provision of this programme in addition to the Armed Forces Advocates themselves. These focus groups are validatory in nature and will provide further clarification and opinion from those involved in delivering the programme.

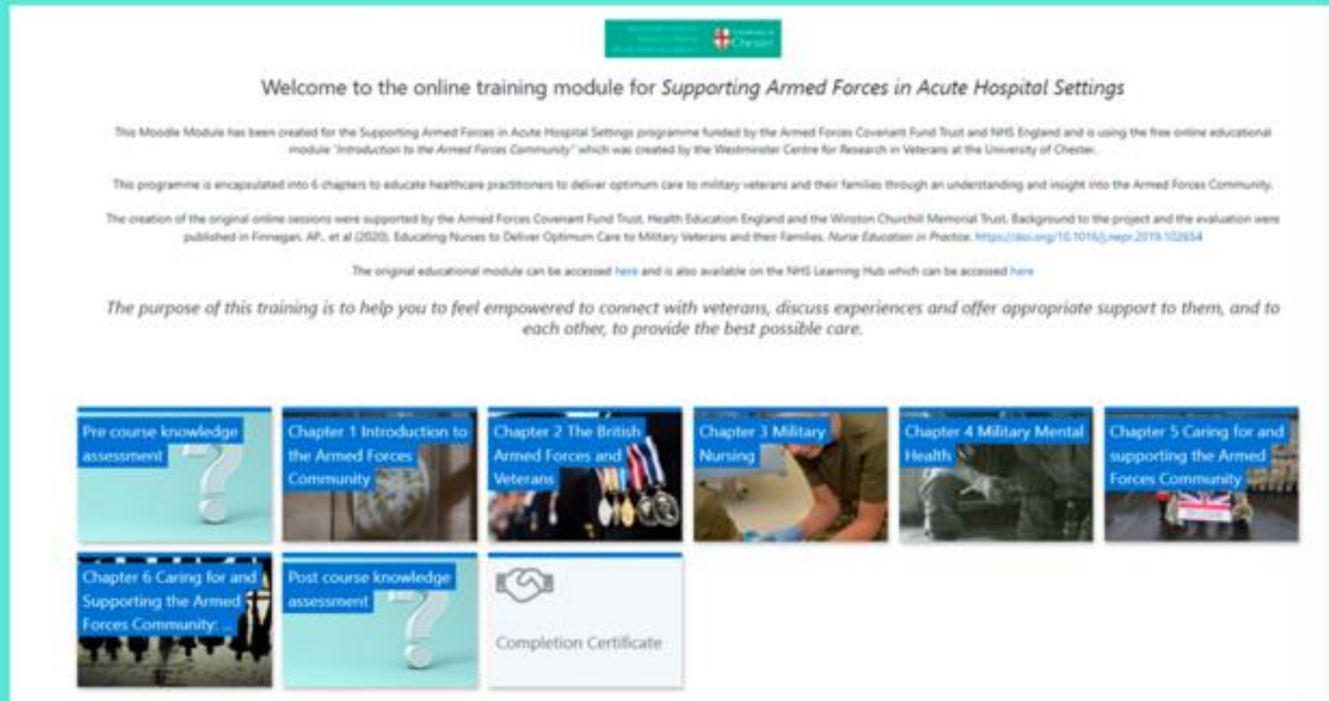
We have received case studies from each of the NHS Trusts involved in this pilot study. These will help demonstrate the impact that the Armed Forces Advocate has had on the veteran community within the hospital.

The Northern Ireland programme provides an advice line which initially aimed to provide a signposting service for professionals who are involved with veterans as patients. However, this service has evolved and is now accessed by veterans themselves and their family members. As part of the evaluation, the specific needs of those calling for advice and the type of advice which they are seeking can be identified. Northern Ireland continues to receive phone calls and identify the gaps in their reach, ensuring that presentations are given throughout the region, in numerous different organisations on what the advice line can offer.

As the project draws to a close, we will be hosting the final regional webinars in December.

EDUCATIONAL MODULE

The Westminster Centre for Research in Veterans educational module has been adapted into a Moodle Module which you can access here. Originally created for student nurses, but has been found to be incredibly useful to numerous healthcare staff and professions.



This module consists of videos which are designed to be able to be viewed at leisure. We have also included a pre and post quiz which tests knowledge before and after using the module. These quizzes are completely optional for staff. If the staff would like a completion certificate they must complete all chapters and quizzes.

Chapter 1 Introduction to the Armed Forces Community

Welcome to Chapter 1.

This chapter gives an overview of all that is contained in this online module and introduces you to the what the Armed Forces Community means.

Approx 8 minutes.

Please check the tick box once you have watched the video

ARMED FORCES COVENANT FUND TRUST

Update from The Armed Forces Covenant Fund Trust (AFCFT)

As we near the conclusion of this pilot programme, the Armed Forces Covenant Fund Trust would like to take a moment to extend heartfelt congratulations to each and every one of you.

Your dedication and efforts throughout this initiative have brought about remarkable positive changes in care and education within NHS settings. The impact you have contributed to will undoubtably pave the way for ongoing success and continued support for our Armed Forces Community. Each of you has played an integral role in driving this significant change.

Congratulations are also in order for those who have successfully secured continuation funding!

Additionally, we would like to take this opportunity to express our gratitude to Grace, who departed from the role in November. We wish Grace the very best for her ongoing work within the NHS.

"We have an update to share regarding the Northern Ireland VASP service. Due to a reported underspend at the end of Year one, the Trust have worked with The Somme Nursing Home, to agree a grant variation to re-distribute their funding. Consequently, the fantastic work by the VASP will now continue until March 2025."

Final preparations are currently underway for the Scotland roadshow event. Shortly, you will receive an email containing the detailed agenda for the day's proceedings and instruction on how to sign up for the waiting list or virtual session. This will provide you with an opportunity to secure your spot for the upcoming event.

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Appendix B- Case studies

CASE STUDY

Mr Orton served in the Royal Air Force (RAF) as a Driver for 13 years, across the UK Mainland, Germany and Hong Kong. He deployed on many operational tours throughout his service, before retiring to become a private driving instructor. However, shortly after his discharge from the RAF, Mr Orton suffered a detached retina and had ongoing visual impairment issues in both of his eyes.

In May 2023, Mr Orton contacted the Armed Forces Lead at Betsi Cadwaladr University Health Board (BCUHB) in North Wales, requesting assistance as he had waited nearly two years for Cataract surgery in both eyes.

Mr Orton proudly reports that on the initial day of contact with BCUHB, his Armed Forces Lead was able to generate an initial contact appointment with Ophthalmology the same day, and a week later attended a Pre-Op appointment and his surgery was scheduled.

Mr Orton underwent his Cataract surgery within two weeks later, returning home to recover extremely content with the service provided by the Health Board, commencing with the input of his Armed Forces Lead. Mr Orton will now return to the initial point of entry on the waiting list and await his second cataract surgery accordingly.

University of Chester

CASE STUDY

In June 2022 as part of ESNEFT's Armed Forces week celebrations, we hosted our first veteran awareness event at Colchester hospital. As a Trust we felt this was a great opportunity to advocate for our armed forces community, whilst raising awareness of the newly formed Armed Forces Advocate role.

Representatives from Op Courage, Walking with the Wounded and Combat 2 Coffee (C2C) were invited to join forces - working in partnership we shared information on the support and services available.

During the event it became apparent very early on that this also offered the valued opportunity for listening ears and a safe space.

It's suggested that 'Veterans are generally very proud and are not always forthcoming when asking for help, particularly with the added confusion of not knowing where to go for support or advice'. Potts, (2021, P.19)

This was most notably evident when reaching out to X who became visible to the team.

In this situation the conversation was initiated with X by simply offering a hot beverage. Following the uptake of this offer and speaking with X, they identified as a veteran, talking about their previous military career and sharing that they had recently returned from the 40th Anniversary of the Falklands conflict. Taking the time to listen and hear, it became apparent that X may benefit from the offer of further support - working in partnership, we were able to initiate this on the day.

Following the positive impact and many important conversations had during this event, we immediately started planning for our future events.

Since June 2022 we have hosted a further four veteran awareness roadshows. Our most significant to date was during the festive season. C2C were commissioned to visit 13 ESNEFT sites over a two-week period. Throughout this period, we were also joined by representatives from OP Courage and Blind Vets UK.

In total 3500 staff members visited the stands, and a further 2000 brew bags were distributed to key clinical areas which included mental health signposting information.

This offer also had a wider reach to members of the public - during one site visit the team spoke to a parent who had lost their son by suicide. He was a veteran with two young children. We were able to listen and hear and see how this tragedy not only had affected them but the wider family.

Why am I sharing this? The positive outcomes of these events have enabled ESNEFT to build on and strengthen the forged relations working with partners - who have all had a positive impact on my role as the AFA and the service and support we provide in the Trust.

The key lesson learnt is that although we may feel we have visibility, we still to be mindful and continuously working towards breaking down many of the barriers which may prevent those coming forward who may require assistance, guidance and support.

Westminster Centre for Research in Veterans

CASE STUDY

Patient XPF is a former Parachute Regiment Soldier who suffered a stoke in Aug 22 and was admitted to Frimley for around 8 weeks for treatment before being moved to our community ward at Farnham for another 8 weeks prior to be discharged at year end to home for continuation of treatment.

Having returned home XPF was readmitted to Frimley for a bout of Pneumonia which took several weeks to pass. They then suffered a fall requiring admission and recently was readmitted with Gastro concerns.

Since the stroke he has been receiving physiotherapy from The NHS and is now able to walk but does not have full or considerable use of his Arm which is impairing his ability to dress himself, a skill he is relearning.

Throughout this The Armed Forces Lead (AFL) has been in direct contact with both his wife and The Local Parachute Regiment association to highlight when XPF is admitted and ensure that any administration his wife needs as well as a support network for visitors is established. The AFL visits XPF each time they are admitted and ensures they are receiving the required level of support both internally and externally, often briefing his carers on his background and the work we do with Veterans.

XPF continues to recover but the NHS has now reached a point where it will not continue his physio and he would greatly benefit from additional support to try and improve the use of his arm as whilst he can walk the use of his arm would enhance his quality of life and improve his recovery pathway. This is currently being investigated to see if any additional physiotherapy can be sourced and we have advised them that The Stoke Society or GP Surgery maybe able to assist.

XPF's patient experience, morale, and his recovery is undoubtedly enhanced by the supporting network he has around him and the AFL intervention and connection, The Parachute Regiment Association, and his family are instrumental in this.

Westminster Centre for Research in Veterans

CASE STUDY

Robert was a 64-year-old RAF veteran who suffered life changing injuries in December'23 when he fell from the 2nd floor window of his flat. He was referred to DMWS Welfare Officer Sam Wilke at Glasgow's QEUH by a member of the Trauma Unit.

At first Robert didn't want to talk to Sam, he was traumatised and very unwell both physically and mentally. After a few weeks, when Robert was making progress, he reached out to Sam and said he was ready to talk. During his five months in hospital, Sam provided an extensive range of help to Robert who has a very limited support network. As well as providing sustained emotional support, she arranged for him to receive a visit from Glasgow's Helping Heroes to talk about financial issues, she liaised with the occupational therapist and physio about his care and played a key role in preparation for his discharge.

The physical injuries Robert sustained resulted in loss of one leg and damage to the other: leaving him wheelchair dependent. This prevented the return to his 2nd floor flat. Determined to help Robert find suitably adapted alternative housing and remove this hurdle to discharge, Sam made applications to several organisations on his behalf. As a result, the Scottish Veterans Residences offered Robert accommodation at Bellrock Close in Glasgow, a fabulous facility which provides transitional accommodation and wider support focused on the veteran's health and wellbeing, and future housing needs. Robert was discharged from hospital in May'23 and moved into his new flat. He is now in a place where he can continue to improve and be independent, while receiving support from people who understand his needs and the challenges ahead.
Robert said "I am very thankful for all the support I have received; I couldn't have managed on my own. Huge thanks to everyone who has helped me get to where I am now. The service from DMWS was over and above expectations."

Westminster Centre for Research in Veterans

CASE STUDY

Lee is a 42-year-old Army Veteran who served 5 years in the Royal Signals. He saw active service in the Balkans and left the Military as a Cpl.
Lee met his girlfriend locally and settled in the Great Yarmouth area. Upon leaving the military Lee went and worked offshore for a few years before deciding to set up his own web business.
He lives with his 3 children and partner. Lee is self-employed and his partner does not work. Up to this point, Lee has been in good health and has not had any financial problems. He has a large family and good social support network.
Lee is well known within the community for his work with the local youth football team and local swimming club.

Lee was referred to the AFA at JPUH in November 2022 by a Nurse working on the ward he had been admitted to. He presented very low in mood, stressed and worried. Lee had been suffering from back pain for a few months before deciding to go to hospital Emergency Department.
After some tests it was confirmed that he had cancer, Lee's partner was with him at the time, and both struggled at first to take in the information. They began to worry how this would impact the family, especially as they would now have no money coming in. They were unclear of what options for support they had and were concerned they would not be able to manage.
The main priority was to try and source some emergency funding for the family to stop them worrying about finances and enable them to concentrate on Lee's treatment and care. The second priority was to ensure the family had all the information and maintained a positive outlook.
The AFA explained his role to the family, built up a repour with them before getting all Lee's military information. AFA then assessed the needs and contacted the RBL ILA.
The AFA had already established good connections with the RBL ILA so was able to ensure the referral was emailed to the correct person, so support could be established as soon as possible. The referral was sent as urgent and quickly received by the RBL. They contacted the family and sent £500 in food vouchers to the partner to help with the short term, until a meeting with a case manager could take place the following week. After a meeting with the case manager, it was agreed that the family would receive regular food vouchers and help would be given towards household bills and specialist equipment that may be required for Lee in the future. AFA also contacted two local charities who agreed to supply funds to help family purchase a special type of wheelchair. AFA continued to visit Lee everyday he was in hospital.
The family had been through a lot and know it was a long journey to recovery for Lee. However, they remained positive now they had the support in place and were able to focus on each other and Lee's recovery. The AFA visited Lee during his hospital stay and attended appointments over the following 6 months to help Lee to remain positive and he admitted it helped give him the determination he needed to fight.

Our conversations were always positive and the family could not be more thankful for the support they have received. They admit they would have not known where to go for support if they AFA hadn't helped. Lee is determined to beat his cancer and hopes one day to volunteer at the hospital, working alongside the AFA to support other Veterans.

Westminster Centre for Research in Veterans | University of Chester

CASE STUDY

After a long happy career in the Army, Dave fell on hard times. The support he received in his final weeks at MKUH brought back memories – and friends – and rekindled the connection between former Army colleagues.

Dave joined the Army in 1974-1994, leaving as a Warrant Officer. As a leader and manager, he took great pleasure in looking after more junior soldiers. After 20 years, and multiple tours of Northern Ireland, he reluctantly left having served a full career.

Civvy Street was hard for Dave. Like many, he lost contact with his military brethren over the years. His civilian friends could never understand the unique experiences, many of them distressing, that often came with service during that time.

He didn't know how to ask for help, who to ask, or what was available to him. His suffered relationship breakdown and he became disconnected from his family. Hidden struggles with mental health drove him towards alcohol and he became increasingly socially isolated, more so during the pandemic. His lifestyle led to physical disabilities and mobility issues.

In 2022 Dave was very seriously injured in a housefire and spent many months in a burns unit. He was transferred back to Milton Keynes Hospital and shortly after arriving was visited by the Armed Forces Advocate, who engaged with the local authority, adult social care, housing and the RBL in support of his situation.

A visit from one of the hospitals new Armed Forces Volunteers was arranged. The connection was immediate. They had served in the same unit and knew many of the same places and events. With his permission, the volunteer reached out to former members of Daves Squadron, and he was able to speak to them from his hospital bed. Dave was even re-connected with Bob, his former roommate from basic training in 1974, which brough tears of joy. The Armed Forces support and friendship brought Dave much happiness in his final weeks as they reflected on times past, shared memories and the good old days. Dave came alive during the volunteers many visits, laughing and smiling for the first time in many months.

Dave was discharged into a hospice for his final weeks. The volunteer continued to visit and offered to help Dave with an end-of-life plan, something he had not felt motivated to do previously. Dave passed away with no known family, and would have had a PH funeral, but the AFA and volunteer rallied the local veteran community and arranged for RBL Standards, pall bearers, a Bugler for The Last Post, a military Padre to officiate and over a dozen local veterans to attend. Former colleagues attended from as far away as Essex and Leicester, and a small wake was held afterwards.

Military humour compelled Dave to request AC/DC's 'Highway to Hell' for his send off, but he was surrounded by his military brothers and sisters in arms who will remember him.

Westminster Centre for Research in Veterans

CASE STUDY

NHS
South Tyneside and Sunderland
NHS Foundation Trust

- 58 Year Old Male
- Veteran of Royal Navy (Submariner) – Served between 1987 and 1991
- Discharged due to mental health issues following trauma after leak whilst submerged at sea
- Previous mental health support in Sussex which stopped as a result of Covid-19 pressures
- Currently employed as forklift driver a medium sized local company
- Moved into area 6 months prior to hospital admission

Presentation and Admission
Patient admitted early hours of 25/7/23 following overdoes subsequent to domestic dispute and now homeless following dispute. Had contacted supervisor at work whilst in distress to say he couldn't attend work.

Referred to Armed Forces Healthcare Lead (AFHL) via electronic patient notification same day patient admitted.

Due to circumstances surrounding admission, patient didn't have any items from home with him. Given toiletries donated by ASDA Community team specifically to support veteran inpatients. Referral made to veterans Launchpad with a view to assessing accommodation needs. Signposted to Op Restore but patient being seen by hospital PLT so no formal referral made at time.
Patient informed AFHL he was keen to stay in employment. AFHL contacted employer who is a signatory of Armed Forces Covenant and explained with consent details of admission and that patient keen to remain in employment and discussed any support as a signatory of covenant for veteran in continuing in employment would be appreciated.

Patient was able to confirm that he was still employed after speaking to employer subsequent to AFHL call. Whilst this did mean that he wasn't eligible for accommodation support from Launchpad, the patient was able to secure rented accommodation.

Patient felt that his mind had been put at ease, particularly with regards to his employment as he enjoys his work and speaks highly of the organisation. He felt he had been supported and had been provided with a safety net had he not been able to secure private accommodation.

Patient left hospital with contact details for local and national organisations and is confident that he knows how to access veteran specific support going forward should he need to and has been referred by PLT to local mental health services for PTSD.

Westminster Centre for Research in Veterans | University of Chester

CASE STUDY

Case Study 1 – MSK

This case study highlights the journey of a female veteran staff member and patient of the Trust who was waiting double knee surgery. The patient had served 22 years in the Army and had wear and tear on knee joints and had aggravated their knees through a fall.The patient became aware of the work of the Armed Forces Advocate via the various communications in the Trust and departmental training sessions and contacted the AFA to identify any support that could be offered. As a result, their case was clinically reviewed, and a level of prioritization was afforded which reduced the waiting list time from over 70 weeks to 12 weeks.This had a significant impact on improving the mobility and general health and wellbeing of the patient who had a successful surgery and was able to return to work and continue to enjoy social activities again. Their story was presented to the Trust Board in April 2023.

Case Study 2 – Dementia

This case study surrounds a male patient with dementia who was confused and agitated on admission to Ward A8. The staff noted that he was a veteran and that he seemed to be regressing to his service days in his periods of confusion. The staff were aware of the support available from the AFA and requested support. A veteran member of staff who is part of the Armed Forces Veterans Staff Network visited the patient and spend time learning about his service history and hobbies.As a result, he was able to educate the staff with respect to possible factors that could trigger the patient due to his deployment in Northern Ireland in the 1970's. This information helped the staff to better understand and adapt to the patient's needs, being mindful of loud noises and bright lights.The AFA also produced a memory book based on the patients' hobbies and interests which the staff used to talk to and calm the patient.

Westminster Centre for Research in Veterans

CASE STUDY

83 year old Veteran, served in the Army as a Lance Corporal.

Referral received from OT staff member within th trust

SU was admitted to hospital through illness. Through regular visits with SU it was found that SU suffered with cognitive ability and was found to be quite lonely. No local damily, as his only active family member lives in Australia (Nephew).

Regular visits to SU as he had no local family or friends to visit. (Nephew living in Australia)
Liased with discharge team to keep up to date with discharge plan, and to keep SU up to date with discharge plan.

Supported Referral to Cardiff Veterans Breakfast Club to keep up social intergration. Liased with Annie from the breakfast club to arrange travel and transport back and for.

SU was discharged with appropriate care plan in place. He has been able to access the community via The Cardiff Veterans Breakfast Club and is doing well there. I have been advised he's a valued member of the club and is very much enjoying his time there. His Nephew was able to be put at ease knowing his uncle would no longer be lonely.

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CASE STUDY

An SAS Veteran who will be known as Patient B, was admitted to the Manchester Royal Infirmary following an ambulatory admission with complaints of shortness of breath. Patient B was admitted to a ward within the hospital following a diagnosis of Chronic obstructive pulmonary disease.

Prior to Patient Bs admission they had been residing in Europe when they became unwell and was admitted to a hospital abroad. Patient B then had to be repatriated to the UK because of their illness, as the landlord of the rented accommodation decided to sell the property, and it transpired that Patient B no longer had the right to remain in country.

Patient B was repatriated to the UK via the Royal British Legion (RBL) and housed in temporary accommodation. A few weeks later, Patient B became unwell again and was admitted to the Manchester Royal Infirmary due to shortness of breath.

Patient B was referred to the Veterans Integrated Hospital Care Programme Manager following a referral from an Operational Manager, as the patient was highlighted as a homeless Veteran, who was medically fit within the Discharge Team.

With verbal consent the Veterans Integrated Hospital Care Programme Manager had a conversation with Patient B, to understand if any additional support and housing solutions could be offered. Patient B talked about their service life and was immediately able to form trust with the Veterans Integrated Hospital Care Programme Manager due to their shared military service history. This was a huge positive as the nursing staff had reported the patient to be verbally aggressive and abrasive. Unfortunately, Patient B was unable to disclose personal life due to severe cognitive impairments, and it became clear after twice-weekly visits that Patient B could not remember who the Veterans Integrated Hospital Care Programme Manager was. In addition to this Patient B was not able to complete basic hygiene tasks and there was evidence of self-neglect. Following this information, a Deprivation of Liberty Safeguards and an Independent Mental Capacity Advocate assessment was arranged to facilitate a safe discharge from hospital.

The Veterans Integrated Hospital Care Programme Manager liaised with RBL for understanding of Patient Bs background to support a safe discharge. Their input was vital in understanding the extensiveness of Patient Bs cognitive impairment, as they had no relatives or friends to liaise with. Following a conversation with the RBL caseworker, it became apparent that Patient Bs health decline was due to self-neglect during their residency in Europe and temporary housing placement in the UK, after understanding that both properties had been neglected, and promoted a hospital admission on both occasions.

With this information the Veterans Integrated Hospital Care Programme Manager was able to support the discharge team build a profile, to arrange for accommodation at a specialist Veteran Dementia Residential Home, that had been located by the Veterans Integrated Hospital Care Programme Manager. The discharge team were able to arrange for funding with the local authority and Patient B was safely discharged from hospital, and has had no admissions since.

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CASE STUDY

NHS
Gloucestershire Hospitals
NHS Foundation Trust

Patient T is a veteran who transferred from Brighton after suffering a fall.

History of alcohol misuse, which has dominated most of his adult life. Also served time in prison and hasn't really been able to find his feet since leaving the Army over 30 years ago.

His main reason for wanting to come back to Gloucestershire, was to reconnect with his estranged daughter, and find some sort of support network within the county.

My initial referral was to Op COURAGE, as he was suffering with events from Op BANNER (NI), and needed MH support for this. He also had no fixed address, so I contacted the armed forces champion within the council, who recommended myself to get in contact with the local MP.

After an initial email, I was contacted by a case worker, who wanted to take on Patient T's case. After 3 weeks, housing was found for him, which enabled him to be discharged from the hospital sooner.

Now, Patient T is recovering well, and enjoying being a grandparent. Overall, he was very appreciative of the services given by the AFAs whilst he was an inpatient.

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CASE STUDY

A 63 year old female Veteran was referred to DMWS from NHS funded/led Veterans First Point (V1P). The veteran was seeking support with Transport to the Astley Ainslie Hospital for a course of treatment with pain management. Due to the employment of the Veterans Partner he is not always able to provide transport and support her during these visits. Public Transport would involve several changes of Busses and would not be ideal due to her medical condition and mobility.

This allowed DMWS and Fares 4 Free under our partnership as part of the NHS Lothian Led Scottish Veterans Wellbeing Alliance under the Veterans Places , Pathways and People Programme funded by the Armed Forces Covenant Trust from the Veterans Mental Health and Wellbeing Fund to support the veteran.

The Veteran has now been attending her Hospital Appointments which is having a benefit to not only her physical wellbeing but also to her mental wellbeing. The assistance she is receiving is also ensuring that valuable appointments for these clinics are not being wasted or having Did Not Attend's.

The veterans is also being supported by a DMWS welfare officer who has carried out home visits and provided a listening ear and allowing the veteran to talk about her military service and anxieties from this time. This work is also being carried out in tandem with the ongoing support from V1P for the veteran.

This case is an excellent example of several alliances and partnership within the NHS and 3rd sector working together in support of this Veteran.

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CASE STUDY

A World War Two Veteran is to be granted his "final wish" to return to the beaches of Normandy, thanks to help from the Armed Forces Healthcare Service provided by Wrightington, Wigan and Leigh Teaching Hospitals NHS Foundation Trust (WWL).

The veteran was identified on admission to the hospital using the newly updated mandatory question which was put in place as a result of work undertaken by the Armed Forces Lead. The veteran, Mr Belcher, was referred to the ward's Armed Forces Champion, who contacted the Armed Forces Lead for support.As the champion, Joanne, cared for Mr Belcher, his daughter, Lyn, revealed he was a D-Day Veteran and, after a short stay at the Royal Albert Edward Infirmary, Wigan, Joanne went in on her day off to check in on him and discovered he was waiting for his daughter to take him home.

Mr Belcher, who carries a Royal Marines Lifetime Membership Card, regaled Joanne with stories of his time in the service but disclosed that he could no longer find his medals and also how Mr Belcher's final wish was to visit Normandy on the 80th Anniversary of the D-Day Landings next June to pay respect to his fallen pals.

With help from the Armed Forces Lead and Armed Forces Community HQ CIC, based at Molyneux House in Wigan. Joanne investigated how they could locate Mr Belcher's medals and later contacted the Royal Marines to enquire about how to help him make the trip to Normandy.

The Royal Marines returned the call and offer Mr Belcher and his daughter a place on next year's anniversary trip – fully funded, making his final wish come true. Additionally, historians at the Armed Forces Community HQ, were able to confirm that he had been awarded the 1939-1945 WWII Star Medal, France and Germany Star, Pacific Star and Italy Star and have made arrangements for the medals to be represented to Mr Belcher – something we are hoping to do as part of the next Armed Forces Champions meeting in September.

WWL's Armed Forces Healthcare Lead commented how proud she is of Joanne's commitment to Mr Belcher's care, adding; "Joanne is a shining example of why our Armed Forces Champions are so important to the Trust. Our Armed Forces Community often have lots of needs that are not always health related, and Joanne has shown why we need to be approaching our Veterans with a view to providing holistic care."

University of Chester

Acknowledgements

Thank you to all the Trusts (or equivalent) and the AFA's for engaging in the evaluation, without the data we would not have been able to provide evidence of the impact of the role on the armed forces community. Thank you for the support of the AFCFT in completing this evaluation, particularly of the project team; Rachel Smith, Gemma Calvert and Rachel Storr. Thank you also to Dr Becky Randles who made significant contributions to data collection, analysis and project progress during her employment at The Westminster Centre for Research in Veterans

About the Centre

The Westminster Centre for Research in Veterans are part of the University of Chester. Our mission is to support the military community through innovative and high-quality research, educational provision, and community engagement. Our vision is to provide subject matter expertise and a focal point of consultation to our partners within the Northwest of England for the betterment of military veterans and their family's wellbeing. We hope to support a vibrant, inspirational, and innovative learning environment to provide a rewarding academic experience to University of Chester personnel and academic partners; Clinical, welfare and military staff who provide care or services to the military community; Local authority partners engaged in the care and support of veterans; as well as the veteran population.

We aim to grow a robust research profile that will have a positive impact on veteran's health and healthcare at regional, national and international level. This profile will embrace new technologies and creative methodologies to address issues that negatively affect the wellbeing of the military population.

Contact

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Westminster Centre for
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RESEARCH TEAM

PROFESSOR ALAN FINNEGAN PHD RN FRCN FRSA CF FAAN

Director of the Centre and Professor of Nursing and Military Mental Health. Alan is a Registered Nurse (Adult) and Registered Nurse (Mental Health). Since commencing at the University of Chester in 2016, Alan has been appointed as the principal investigator for over 30 research projects including awards from the NHS, Armed Forces Covenant Fund Trust, Forces in Mind Trust, Health Education England and Business.

KATE SALEM BSC MRES MBPSS

Kate is Senior Researcher here at the Centre. With a background in Psychology, Kate is experienced in conducting mixed-methods research and has led on multiple research projects related to health and well-being in the Armed Forces Community. In this project, Kate was responsible for final data collection and analysis, and writing up of the final report. Kate is also the wife of an Army Veteran and is currently undertaking her PhD which explores the impact of veteran's mental health experiences on their partners.

LOTTIE AINSWORTH-MOORE

Lottie joined the Centre in January 2019. She is a military spouse of a currently serving Officer and has previously worked for military charities. Her principal role within the Centre is Project Administrator where she is working on various evaluations with the Armed Forces Covenant Fund Trust and the NHS. Lottie was responsible for Grantholder engagement and communications, e-bulletins, hosting monthly webinars, creating the Moodle Module and preparing graphics for the report.

KATE SAWYERS

Kate is the spouse of a serving officer in the Royal Marines and joined the Centre in 2021 to provide administrative support across several different studies. For this evaluation she assisted with the inputting of data into SPSS databases in preparation for final analyses to be completed. She also contributed to the production of the infographics for this report.

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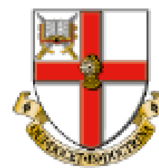
Research in Veterans



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