

Evaluation of RCGP Veteran Friendly GP Practice Accreditation programme

Executive Summary

October 2026, version 5

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Key messages

- The Veteran Friendly GP Accreditation Programme (VFGP), led by the Royal College of General Practitioners (RCGP) and commissioned by NHS England, now spans more than 4,400 GP practices in England.
- According to Census 2021 data, there are around 1.85 million veterans living in England and Wales and about 15,000 people leaving the Armed Forces each year, general practice is the main point of contact for health care after transition to civilian life.
- This national mixed-methods evaluation – the largest yet undertaken on the programme – drew on responses from 972 accredited practices (553 full survey completions), real-world eLearning assessment data and qualitative interviews with practice staff, veterans, family members and system leaders.
- Accreditation is associated with sustained changes in frontline primary care staff behaviour. Almost all surveyed practices now ask new registrants about Armed Forces history, around two thirds also ask existing patients, and most use SNOMED codes and searchable registers to record veteran status.
- Practices report tangible process improvements: about 47% noted better identification of veterans, 44% better recording, 27% better engagement and 17% earlier referrals since accreditation.
- Perceived quality of care has improved over time. Across all years, 64% per cent of respondents rated veteran care as “better” or “much better” since accreditation, while only a single respondent reported deterioration.
- The updated Veterans’ Health eLearning module shows large knowledge gains: pre-course assessments averaged around 45% and post-course assessments around 79% across more than 1,000 pre- and post-course attempts.
- Despite this progress, veteran status remains under-recorded in some larger practices; referral volumes to specialist services such as Op COURAGE and Op RESTORE are

low; waiting-time information is poorly understood; and regular audits to highlight the number of veterans registered in the practice are not yet routine.

- Equity gaps persist for “silent cohorts” including older veterans, female veterans, lesbian, gay, bisexual, transgender, and queer or questioning veterans (LGBTQ+), those who are homeless or involved with the criminal justice system and reservists who are less likely to be identified or coded and may carry significant unmet needs.
- System-level constraints, especially weak information flows between Ministry of Defence (MOD) and NHS systems, the absence of a spine-level veteran identifier and incomplete transfer of veteran status between primary and secondary care, limit the full realisation of accreditation benefits.
- The evaluation concludes that the VFGP Programme has evolved from an early innovation into a mature national programme that has shifted practice culture, improved coding and identification routines and strengthened the foundations for personalised veteran-inclusive care. However, further work is required to embed veteran-focused quality improvement, consider ways to improve the flow of information between i.e. MOD or secondary care and NHS and close persistent equity gaps.

Background and policy context

Veteran health has moved steadily up the national agenda in England. The Armed Forces Covenant sets an expectation that those who serve or have served, and their families, should face no disadvantage in accessing public services and may receive priority care for conditions attributable to service.

Within this context, primary care has a central role. Many veterans do not volunteer their service history to clinicians and historic evidence shows that non-disclosure can lead to missed opportunities for tailored care, early intervention and access to dedicated pathways.

Recognising these gaps, NHS England asked the RCGP in 2019 to design and implement the VFGP Programme. The programme provides a practical way for practices to operationalise the Covenant Duty by:

- Systematically identifying and coding veterans on clinical systems
- Raising awareness of service-related health needs and wider psychosocial issues
- Improving use of dedicated NHS services such as Op COURAGE (mental health and wellbeing), Op RESTORE (physical health and wellbeing)

Primary care networks (PCNs) were introduced into the National Health Service in England as part of the NHS Long Term Plan, published in January 2019.

PCNs build on existing primary care services and enable greater provision of proactive, personalised, coordinated and more integrated health and social care for people close to home. Clinicians describe this as a change from reactively providing appointments to proactively caring for the people and communities they serve.

Each of the 1,250 PCNs across England are based on GP registered patient lists, typically serving natural communities of between 30,000 to 50,000 people (with some flexibility).

They are small enough to provide the personal care valued by both people and GPs, but large enough to have impact and economies of scale through better collaboration between GP practices and others in the local health and social care system.

PCNs are led by clinical directors who may be a GP, general practice nurse, clinical pharmacist or other clinical profession working in general practice.

Over 99% of general practices are part of a PCN, who sign up to the Network Contact DES which details their core requirements and entitlements.

From July 2025 the introduction of the Neighbourhood Health Service will reinforce a new way of working for the NHS, local government, social care and their partners including PCNs, where integrated working is the norm and not the exception. Some places have already made progress in developing an integrated local approach to NHS and social care delivery. The full vision for the health system will be set out in the 10 Year Health Plan, including proposals to help make this emerging vision for neighbourhood health a reality, informed by existing work and public, staff and stakeholder engagement.

By October 2025, more than 4,400 practices in England had gained veteran-friendly accreditation.

The Veteran Friendly GP Practice Accreditation Programme

The accreditation programme is deliberately designed to be accessible. Practices commit to:

- Identifying and coding veterans using standard SNOMED codes
- Maintaining a veteran register
- Nominating a Clinical Lead within the practice
- Promoting awareness of veteran status among staff
- Signposting and referring to dedicated NHS pathways where appropriate.

The RCGP supports practices with an accreditation pack, online resources and eLearning modules on veterans' health. Accreditation is voluntary but strongly encouraged through national policy signals, including references in the NHS Long Term Plan and Armed Forces Covenant reports.

Earlier evaluations in 2021 and 2022 reported enthusiastic reception, early improvements in coding and better use of mental health pathways, while also highlighting challenges around identifying long-registered veterans and sustaining staff training.

Why this evaluation was undertaken

By late 2019 the VFGP programme had moved from early rollout to national scale. NHS England and the RCGP therefore commissioned a third, more comprehensive evaluation to understand whether:

- Early coding and awareness gains had been sustained and deepened
- Accreditation continued to change team behaviours and practice systems

- Veterans, especially underserved groups, experienced better visibility, access and continuity of care
- Educational resources were delivering measurable knowledge gains at scale
- The programme was well positioned for long-term sustainability beyond the current commissioning period.

The call for this third evaluation also responds to the wider “veteran health evidence gap” identified by the King’s Centre for Military Health Research, particularly around everyday interactions in primary care, trust and continuity, and the experience of groups such as female veterans and LGBTQ+ veterans.

How the evaluation was carried out

The Self-Care Academic Research Unit (SCARU) at Imperial College London School of Public Health led a 10-week mixed-methods evaluation following NHS England’s Evaluation and Insight Framework and Medical Research Council guidance on complex interventions.

The design combined:

1. Quantitative analysis

- Aggregated pre- and post-assessment data from the updated Veterans’ Health eLearning module (launched January 2025).
- A national online survey sent to all 4,430 accredited practices; 980 responses were received; 972 practices consented and 553 completed the full survey.

2. Qualitative research

Semi-structured interviews and focus groups with three groups:

- staff in accredited practices
- veterans and adult family members registered with accredited practices
- system leaders, including NHS England Armed Forces health leads, Integrated Care System representatives and national veteran Clinical Champions

3. Implementation frameworks

- RE-AIM (Reach, Effectiveness, Adoption, Implementation, Maintenance) to understand the programme’s scale and impact.
- The Consolidated Framework for Implementation Research (CFIR) to explain variation in engagement, capability and depth of change across practices.

The study was approved by Imperial College London Research Ethics Committee and followed agreed standards for data security, pseudonymisation and confidentiality.

What we found

A mature national programme with extensive reach

Accreditation now covers more than 4,400 practices, with rapid expansion since 2022. Among survey respondents nearly 30% were accredited in 2024 and over 20% cent in 2023, indicating continued uptake rather than plateau.

Surveyed practices spanned all 42 Integrated Care Boards (ICB), list sizes and deprivation levels. Around half of practices reported 50 or more registered veterans, with larger practices more likely to report higher numbers but also more likely to be unsure how many veterans were on their lists, which is a signal of under-identification at scale.

Initial barriers to accreditation were broadly consistent across years:

- Low awareness of the programme, reported by about 31% of respondents
- Limited time and capacity (around 25%)
- Difficulty identifying veterans in existing lists (around 26%)
- Smaller proportions citing IT or coding constraints (about 9%) and staff turnover (around 6%).

Key enablers included the presence of a local advocate (e.g. a local Clinical Lead, an RCGP Veteran Clinical Champion and/or other Veteran Champion (around 36%), clear RCGP guidance (around 27%) and strong links with local veteran communities (around 27%). Over time, reliance on individual champions decreased slightly as processes became more embedded, though champions remained important for higher-fidelity sites.

Changes in practice behaviour, systems and culture

The evaluation provides strong evidence that accreditation has altered how practices organise care for veterans. Compared with earlier evaluations, there has been a shift from ad hoc recognition to structured routines:

- Around 94% of respondents reported routinely asking new registrants whether they have served in the Armed Forces.
- Around 66% extend the question to existing patients through recall and opportunistic contacts.
- Around 66% ask opportunistically in consultations when clinical cues arise.
- 87% use SNOMED codes to record veteran status and 88% per cent maintain searchable veteran registers.

These practices meet the minimum requirements for implementing the Covenant Duty within primary care and represent a substantial maturation compared with 2021-22, when many sites struggled to identify long-registered veterans.

GP Practice staff who responded to the survey reported that, since accreditation, the following improvements in process and outcome changes were observed:

- better identification of veterans (47%)
- registration of veteran status on the GP IT system (electronic health record) (44%)
- better engagement with veterans (27%)
- earlier referrals to specialist services (17%)
- better care planning (13%)
- gains in shared decision making (10%).

Overall, 64% of GP Practice staff who responded to the survey rated the quality of care for veterans as “better” or “much better” since accreditation; 36% perceived no change and only one respondent reported deterioration. The association between year of accreditation and perceived improvement was statistically significant, with the proportion reporting “better” or “much better” rising from about 44% for 2018 accreditations to nearly 78% in 2023.

Yet these gains are not fully embedded in governance. About 22% of practices reported running veteran-specific audits or quality-improvement cycles. Where such cycles were in place, 76% of respondents reported improved care quality compared with 61% in practices

without veteran-focused quality improvement (QI), and this association was statistically significant.

Qualitative data show that accreditation has cultural as well as operational effects. Staff described the programme as “legitimising” conversations about service history and “breaking the silence” around veteran identity, contributing to a sense of organisational pride and a clearer shared purpose. At the same time, many participants highlighted sustainability pressures linked to workload, turnover of Clinical Leads and competing priorities.

Education, learning and staff capability

The updated Veterans’ Health eLearning module is a central mechanism for building capability. Aggregated assessment data show:

- 1,261 pre-course assessment attempts with a mean score of about 45%
- 1,107 post-course attempts with a mean score of 79%

This represents an improvement of around 35 percentage points in knowledge scores between pre- and post-course assessments. While the dataset reflects attempts rather than unique individuals, it provides the first quantitative evidence that the programme’s learning component is associated with substantial knowledge gain at scale.

At practice level, engagement with the eLearning is variable:

- 15% of practices reported no staff having completed the module
- 30% estimated that only one tenth of staff had completed it
- 3% reported full completion by all staff
- About one third were unsure of completion rates

Even so, 54% of respondents agreed that the eLearning had led to positive behaviour change for veteran patients, with only a very small minority disagreeing. Preferred formats strongly favoured brief, bite-size resources and webinars, reflecting time pressures in primary care and the need for flexible, modular training models.

These findings suggest that while the educational content is effective for those who complete it, there is headroom to extend coverage beyond Clinical Leads to wider multidisciplinary teams, especially reception and administrative staff who are often first points of contact.

Referral pathways and service navigation

Awareness and use of dedicated veteran pathways have improved but remain uneven. Among all GP Practice staff survey respondents, 42% were aware of Op COURAGE and 37% of Op RESTORE. Among those completing the full survey, awareness rose to about 68% and 59% respectively, indicating that more engaged practices have higher pathway awareness. When asked about ease of referral:

- 46% rated referrals to Op COURAGE as “easy” or “very easy”
- 41% said the same for Op RESTORE.

Most practices reported making fewer than five referrals to veteran services per month. 70% of respondents were unsure about typical waiting times. Qualitative accounts from staff and system leaders point to multiple factors behind these referral volumes: uncertainty about eligibility thresholds; variation in local service configuration; lack of feedback on outcomes; and broader issues around under-identification and veteran reluctance to disclose distress.

Veterans themselves described experiences of both smooth and fragmented navigation. Some reported helpful signposting to Op COURAGE or orthopaedic services; others encountered staff who were unaware of specialist options, leading to standard referrals when dedicated alternatives existed.

Veteran and family experiences of care

Interviews with veterans and family members (n=18 total) provide an important counterpoint to organisational perspectives. Although the number of participants was modest, the accounts offer rich detail on recognition, trust and equity.

Key themes included:

- **Identification and visibility** – some veterans were clearly recognised and coded as such; others described repeated failure to register their service status or saw it recorded in one part of the system but not in another.
- **Transition and identity** – veterans spoke about the psychological impact of leaving a highly structured military environment, feeling “unknown” or “on their own” once they stepped outside the gates, and the importance of primary care in recognising this transition shock.
- **Trust and disclosure** – historical experiences, including discrimination against LGBTQ+ personnel and contentious operations such as those in Northern Ireland, shaped levels of trust in institutions. Some veterans remain reluctant to disclose service history or mental health difficulties because of these legacies.
- **Family and carer burden** – spouses and family members described significant emotional and practical responsibilities but reported that these roles were rarely visible in coding structures or consultations.

Overall, veterans recognised the value of practices that were overtly veteran-friendly, where staff routinely asked about service, understood referral options and made time for holistic conversations. However, they also pointed to variation between practices and to persistent gaps in continuity, especially at points of transition between services.

Equity, silent cohorts and structural gaps

The evaluation highlights systematic inequities in who is identified as a veteran and who benefits from improved care. Several groups are consistently under-recognised:

- older veterans who have never disclosed service or who regard it as clinically irrelevant
- female veterans, whose service is often overlooked socially and institutionally
- LGBTQ+ veterans affected by historic criminalisation and ongoing distrust
- homeless veterans and those involved in the criminal justice system
- reservists moving between military and civilian health systems
- families and bereaved relatives.

These gaps arise from a mix of societal narratives (who is seen as a veteran), system design and practical constraints (limited outreach beyond registered and housed patients). Veteran and system-leader interviews emphasised that some of the most vulnerable individuals (e.g. homeless veterans not registered with any GP practice) remain effectively invisible to current identification mechanisms.

System and implementation context

RE-AIM and CFIR analysis shows that:

- **Reach** is strong at practice level, with more than 4400 accredited practices and survey responses from 972 sites across all ICBs. Yet reach at patient level is incomplete, especially for female veterans, older veterans, LGBTQ+ veterans, reservists and widows.
- **Effectiveness** is evident in improved identification, coding, pathway awareness and knowledge gains from eLearning, with perceived care quality highest in practices that run veteran-specific QI cycles or have active champions.
- **Adoption** has accelerated since 2022, driven by champions, peer networks, Commissioning Support Unit (CSU) and Integrated Care System (ICS) advocacy, but remains sensitive to workload pressures and awareness levels.
- **Implementation** is high-fidelity for core tasks (asking the question, coding, maintaining registers) but more variable for deeper elements such as confident referral, family identification and systematic documentation at point of care.
- **Maintenance** of veteran-focused routines is vulnerable to staff turnover, bandwidth constraints and uncertainty about funding beyond 2027, with mature sites showing embedded culture change and early-stage sites remaining heavily dependent on Clinical Leads.

At system level, limitations in MOD–NHS interoperability, the absence of a spine-level veteran identifier and inconsistent transfer of veteran status between primary and secondary care were repeatedly highlighted. These issues currently undermine continuity and create additional work for practices and veterans alike.

Implications for policy and practice

The evaluation indicates that the VFGP Programme is not just a branding exercise but an important lever for implementing the Armed Forces Covenant Duty and advancing personalised care within the NHS.

By making service history visible at the point of care, accreditation helps shift primary care in three ways that align with the NHS “three shifts”:

1. **From reactive to proactive care** – systematic case-finding, opportunistic questioning and targeted outreach enable earlier identification of need, particularly around mental health, chronic pain and transition-related difficulties.
2. **From episodic to personalised, longitudinal care** – consistent coding means each encounter is contextualised by a fuller understanding of the veteran’s life history, supporting trauma-informed dialogue, shared decision making and continuity.
3. **From hospital-centred to community-anchored care** – improved awareness of pathways such as Op COURAGE and Op RESTORE, combined with social prescribing and community links, allows issues to be addressed in primary care and community settings before crisis escalation.

However, the evaluation also shows that further system strengthening is needed if accreditation is to deliver its full potential.

Key implications include:

- Importance of embedding veteran status into routine quality improvement and performance monitoring, not just registration templates
- Need to extend training to whole teams, with particular attention to reception and administrative staff
- Requirement for clearer, and more visible standardised referral guidance and closed-loop communication between practices and specialist services
- Urgency of addressing equity gaps for silent cohorts through better coding, targeted outreach and gender-sensitive practice
- Strategic case for resolving MOD–NHS information failures and implementing a persistent veteran identifier that travels with the patient across settings.

Priorities and actionable insights

Drawing on survey data, eLearning outcomes, qualitative insights and implementation frameworks, the evaluation identifies five, interlocking priorities and actionable insights for commissioners, system leaders and professional bodies.

1. Consolidate and deepen implementation in primary care

- Support practices to move beyond initial accreditation towards routine veteran-specific audits, QI cycles and dashboards at practice and Primary Care Network (PCN) level.
- Encourage the use of veteran metrics in annual quality reviews and ICS performance frameworks.
- Facilitate peer learning between mature and early-stage sites, using experienced Clinical Leads as mentors.
- Encourage take-up of the free, NHS England, national Armed Forces healthcare training and education programme that will equip busy NHS staff with specialist insight, knowledge and resources to provide the best care possible to the Armed Forces community.

2. Expand whole-team education and capability

- Continue to increase staff awareness and knowledge of Op RESTORE and Op COURAGE e.g. how to refer and eligibility
- Embed the Veterans' Health eLearning module within mandatory or strongly recommended training cycles for GPs, nurses and allied professionals.
- Develop lighter modules for reception and administrative staff, aligned with the preference for bite-size and webinar formats.
- Promote team-based learning huddles where staff review veteran cases, share experiences and revisit referral options.

3. Strengthen identification and coding, including families

- Implement automated prompts in EMIS and SystmOne at key touchpoints – registration, long-term condition reviews, flu clinics and NHS Health Checks – asking whether patients have served in the Armed Forces.
- Encourage ICBs to run regular population searches, text campaigns and opportunistic case-finding to identify veterans who have never disclosed service.

4. Enhance referral pathways and feedback loops

- Commission closed-loop referral systems so that practices receive confirmation of acceptance, triage decisions and progress updates, reducing uncertainty and supporting continuity.
- Encourage ICS-level Veterans' Directories that bring together NHS, Ministry of Defence and charitable services into a single, regularly updated resource.

5. Close equity gaps and make silent cohorts visible

- Develop targeted outreach strategies for older veterans, female veterans, LGBTQ+ veterans, homeless veterans, those with criminal justice involvement, reservists and families, co-designed with veteran and voluntary-sector organisations.

- Integrate an explicit equity lens into future training, communication materials and data monitoring, including disaggregated analysis of coding and referral patterns.
- Provide guidance on gender-sensitive and trauma-informed communication, recognising historic discrimination and mistrust.

Strengths, limitations and future research

This evaluation has several strengths:

- Scale – with responses from 972 accredited practices, including 553 full survey completions, it is the largest dataset assembled on VFGP and covers all 42 ICBs
- Methodological breadth – integration of survey data, real-world eLearning assessments and qualitative interviews with staff, veterans, families and system leaders
- Timing – assessment after full national rollout and in a post-pandemic environment, giving a more realistic picture of routine practice
- Theoretical framing – explicit use of RE-AIM and CFIR strengthens explanatory power and policy relevance.

Limitations include the possibility of non-response bias (more motivated or higher-performing practices may have been more likely to participate), reliance on self-reported referral and quality data, limited numbers of veteran and family participants, and the lack of linked individual-level data connecting training, coding and clinical outcomes.

Future research opportunities include:

- Longitudinal studies tracking how improved identification and coding translate into clinical outcomes, service use and long-term wellbeing for veterans and families
- Detailed examination of under-served groups, especially female veterans, LGBTQ+ veterans, reservists and homeless veterans
- Evaluation of implementation strategies such as incentivised QI cycles, automated prompts and data-linkage solutions
- Exploration of how VFGP programme can contribute to preparedness for future conflicts by providing scalable, data-enabled infrastructure for rapid response to new waves of veteran need.

Conclusion

The RCGP Veteran Friendly GP Accreditation Programme has matured into a national asset for veteran health. It has expanded rapidly, is widely adopted across England and has driven measurable improvements in how practices identify, record and respond to those who have served. Veterans' health needs are now more visible in primary care than at any previous point, and staff knowledge and confidence have strengthened, particularly where eLearning and QI cycles are embedded.

At the same time, the evaluation shows that work remains to be done. Silent cohorts are still under-recognised, referrals to specialist pathways are modest, and structural information failures continue to disrupt continuity. The central challenge for the next phase is therefore not to expand accreditation alone, but to deepen fidelity, strengthen whole-team capability, address equity head-on and resolve system-level barriers.

If these priorities are pursued, the VFGP Programme can continue to serve as a cornerstone of an integrated, personalised and equitable system of care for veterans and their families – and as a key element of the UK's preparedness for the health consequences of future military operations.