"We are duty-bound to improve residential care for working age veterans..."

UNDER-SERVED

Louis Reynolds
Ally Paget

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A note on terminology

Traditionally, a 'residential home' or 'care home' has referred to housing with a care aspect, usually with communal living and dining areas, separate bedrooms, and care staff on site. A 'nursing home' or 'care home with nursing' has referred to the above, but with an on-site registered nursing component to cater for more complex health needs. The Care Quality Commission defines care homes as offering 'accommodation and personal care for people who may not be able to live independently. Some homes also offer care from qualified nurses or specialise in caring for particular groups such as younger adults with learning disabilities.' Unless otherwise stated, this report will use the terms 'residential care' or 'care home' broadly to refer to care homes without reference to the level of nursing support they provide.

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Louis Reynolds
Ally Paget
October 2015.

As this report makes clear, while estimates of the size of the group are small, the actual number of working age veterans in residential care is simply not known; it is therefore difficult to judge the scale of the problems they face. The majority of recently injured are well supported and live largely independent lives, but there is clearly a group which needs a higher level of assistance through residential care. My own experience in funding residential care suggests that a great deal can be achieved at a relatively modest cost, whether it be through establishing a network to share best practice, or merely by recognising that working age veterans can have very different social and emotional support needs, which in turn can be met in ways subtly distinct from those required to meet the needs of the general population.

Some wider themes have also emerged from this report that resonate with the work of the Armed Forces charity sector in many other areas: data sharing; identification of veterans; regional champions; lived experiences. These are all aspects of the social sector that can be improved through greater collaboration of service providers, and a far better understanding of the size, situation and unsatisfied needs of a relevant population.

At Forces in Mind Trust, we seek to generate an evidence base, and then to use it to influence others and to contribute to policy discussions. Demos has provided a credible and balanced set of recommendations that deserve consideration by all those involved in supporting working age veterans in residential care, policy-makers and service deliverers alike.

Air Marshal Chris Nickols
Director of Forces in Mind Trust and
Controller of the Royal Air Benevolent Fund

Executive summary

The end of military operations in Afghanistan in 2014 brings to a close over a decade of significant conflict in the Middle East. The human cost of recent engagements has been great; between 2001 and 2014, 21,756 servicemen and women were medically discharged from the Armed Forces for physical and mental health reasons, with 840 sustaining serious or very serious physical injuries or illnesses in recent conflicts.[1]

Thanks to advances in medical technology, unprecedented numbers of ill and disabled ex-service personnel are returning, surviving, and doing much more than surviving – benefiting from rehabilitation, and adapting to a 'normal' (if very different) civilian life. But for a minority whose injuries are the most severe and whose care needs are complex, the barriers are greater. They require specialist rehabilitation and ongoing care, and some receive this (at least temporarily) in a residential setting – a care home or nursing home.

While the UK's involvement in the last 13 years of conflicts has been a source of great controversy, the need to support veterans has enjoyed a much broader consensus. This fact is attested to by the creation of new Armed Forces charities like Help for Heroes and the publication of the Armed Forces Covenant.

This report concerns two groups of working age veterans (or 'ex-service personnel') in residential care – those who have been injured or become ill during their service, and those who have acquired an illness or been injured after their service. Veterans who become ill or are injured have specific needs, and are also entitled to the care and support provided by veterans' charities, including veterans' care homes. Yet connecting them to these services is difficult, for a broad range of reasons. The UK's ex-service personnel have had a wide range of service histories, from those who served in

Northern Ireland and the Falklands, to those returning from the most recent conflicts in the Middle East; from those who served for days or weeks to those whose careers spanned decades. Individuals also have a wide range of injuries and illnesses, from traumatic brain injuries to progressive neurological conditions. Many of those with physical injuries – who are the focus on this report – will also be affected by mental illness, which can be more prevalent in the veteran population.

Severity of needs is not the only factor determining whether people are cared for in residential settings or in the community, though it is an important one – a fact reflected in the complex needs of the veterans we encountered. Personal choice, eligibility for local authority funded social care, and availability of informal care from family and friends all play a part.

Care in its modern sense is not about being 'looked after' in an institution. It is about being supported to achieve what an individual wants, to live as independently as possible, even in the context of a care home. That means individuals receiving empowering, personalised care, in keeping not only with the conditions of that individual, but with their aspirations and priorities. For this small group of veterans, who have often experienced such rapid transformation in their lives, individualised and empowering care is particularly important.

This report is the first detailed examination of ex-service personnel, a small, poorly understood group, and thus relatively 'invisible' to policy-makers tasked with planning and funding care. It looks at the care they need, the care they receive, and how they generally come to receive it. It looks at their priorities – the aspects of care they value and the aspects they would like to change – and at the challenges faced by those who seek to provide that support. Ultimately, this report presents a series of recommendations for Armed Forces charities and for government concerning how this care can be improved.

Methodology

For this report, we conducted eight in-depth interviews with working age veterans in residential care, with diverse care needs and spanning a range of ages, as well as one with a veteran's mother. We also carried out semi-structured interviews with 15 staff involved in supporting veterans, from those on the front line (nursing staff) to those in strategic roles (chief executives of Armed Forces charities). We further conducted site visits to two Armed Forces charity-run care homes, and submitted requests under the Freedom of Information Act 2000 to Veterans UK (the body responsible for the administration of Armed Forces pension schemes, compensation payments and veteran welfare support through the Veteran Welfare Service) and the Care Quality Commission (the regulator of health and social care services in England). In addition, we reviewed journal articles, reports and evaluations concerning residential care provision for disabled people of working age in general, and of veterans in particular.

Findings

This report focuses wholly on working age veterans in care homes. However, a number of the observations and recommendations presented in this report are not only applicable to this group, but have implications for the working age population in care more generally.

Who working age veterans in residential care are

This report goes some way to establishing a clearer picture of the working age veteran population in the UK. We found the following:

- The total number of working age veterans in the UK is unclear. As part of our research, we spoke to or were made aware of 33 veterans in residential care, living in care homes run by ten different charities; however, this is a partial and non-representative sample, purely consisting of those veterans we were able to identify through Armed Forces charities.

There are certainly many more working age veterans in residential care. It is important to note that there are reasons to believe that the number of working age veterans in the UK might grow over the next few years, despite the conclusion of recent conflicts.

- Around two-thirds of the working age veterans we came across had left the Armed Forces and were subsequently injured or became ill, and around a third were injured or became ill during their service in the Armed Forces.

- Working age veterans in residential care range in age from 24 – the youngest veteran in residential care we interviewed – to 65. While they are predominantly men, there are also female working age veterans in residential care.

- Working age veterans in residential care suffer from a range of injuries and illnesses. Around two-thirds of working age veterans we were made aware of had suffered traumatic injuries, while a third suffered from long-term illnesses and conditions. Those who are injured or become ill during their service are more likely to have suffered traumatic injury, while those who are injured or become ill after their service are more likely to have neurological, genetic or other long-term conditions.

- The care pathways used by working age veterans entering residential care vary significantly depending on various factors – including whether someone enters residential care during or directly after service in the Armed Forces – and chance. Some entered residential care through informal processes, others through formal pathways, for example through social services.

- Our report focuses primarily on veterans in Armed Forces charity-run care homes; it is less clear how many working age veterans might be in generalist residential care. However, given the informal pathways that have often led veterans to veteran-specific residential care, there is reason to believe that

some working age veterans who would benefit from residential care in a home run by an Armed Forces charity are unaware of the option.

The challenges working age veterans in residential care face

Our research identifies the key challenges facing working age veterans in residential care, from the perspective both of those involved in the care of working age veterans in the UK and of the veterans themselves. This report further identifies a number of systemic issues that complicate efforts to support working age veterans in residential care effectively. These are the main observations we made during our research about the challenges of working age veterans in residential care:

- Many of the challenges facing working age veterans in residential care are those associated with care for a small population group more broadly. These include the tension between the desire to be close to family, the need to access centres of specialist care, the desire to be within a veteran community and the desire to live with people of a similar age.

- Those working age veterans in residential care we spoke to were generally happy with the quality of care they received, and were generally positive about the staff and organisations running the care homes in which they live.

- The most significant problem highlighted by the veterans and other key stakeholders was how much younger they are than most residents in the care homes in which they live. In many cases, one or two working age veterans lived as part of a much older population in a care home. For many, this lack of peers leads to loneliness and isolation, in some cases further leading to depression and declining medical conditions.

- While many working age veterans highlighted the range of activities organised by their care home staff, these activities were often focused on the larger, older general population of the home, leaving working age veterans under-stimulated.

- Many but not all working age veterans in residential care – particularly those who had been members of the Armed Forces for a longer period – said that being part of a wider veteran community was an important part of their wellbeing. Some expressed a desire to interact more with other veterans their own age, or veterans facing similar challenges.

- The importance of familial support varied between veterans, but their situations often put pressure on familial relations. In some cases, families had moved to be closer to the care home a working age veteran was living in. Many of the working age veterans we spoke to had experienced a breakdown of their marriage or relationship as a result of their injury or illness.

Recommendations

Drawing on our research and the best practice we identified, we make the following six recommendations:

1. Veterans UK should work with Armed Forces charities to establish and maintain a database of all UK veterans in residential care.

Working age veterans in residential care are not recorded or registered in any database or by any single organisation. Consequently, as a group they are essentially invisible to the state and to many of the third sector organisations capable of providing the support they need. In common with other small groups, their lack of visibility makes it difficult for service providers and policy-makers to understand or address their needs in any systematic way.

We propose that Veterans UK, with the support of the Ministry of Defence (MOD), should establish and maintain an up-to-date database of all veterans in residential care, across both veterans' and non-specialist care homes. Armed Forces charities should be full and active partners in this process, contributing knowledge, expertise and their own valuable data. Once established, the database should be accessible

to Armed Forces charities and government services, and there should be an expectation that they use it to inform the effective and equitable allocation of resources across all veterans in this group. The database should record ex-service personnel by age, permitting an accurate understanding of the specific characteristics of those aged under 65.

2. Health and social care professionals should proactively identify veterans with whom they come into contact.

Health and social care professionals should seek to identify and record the veteran status of individuals they come into professional contact with, and assist in directing them to appropriate support. Through these efforts the particular care needs of veterans as a group would be more thoroughly considered, and awareness increased among veterans of the health and social care resources available to them. This proactive 'Do ask, do tell' policy should be of particular benefit to the group of veterans who become ill or injured after leaving the Armed Forces, who receive care through mainstream NHS and social care services rather than the MOD, and are less likely to be put in touch with available support.

3. Every local authority in the UK should have a designated 'Armed Forces and Veterans Champion' with a combined remit for health, social care, housing, employability and education.

As care and support is increasingly devolved to a local level, the already small group we are concerned with is at risk of becoming still less 'visible'; there may be no more than one or two veterans in any local administrative area, for example. The bulk of gathering intelligence on, planning for, and championing working age veterans' needs will need to be done at a national level. Nonetheless, it is imperative that veterans' needs are represented, holistically and in the place where they live.

Currently, every NHS board in Scotland, every local health board in Wales and every clinical commissioning group (CCG) in England has a designated Armed Forces Champion.[2]

Likewise, all four devolved nations have Jobcentre Plus Armed Forces Champions to assist service families to find employment.[3] Only Scotland has an Armed Forces and Veterans Champion in every local authority – a local councillor with specific responsibility for championing veterans in the local area on issues such as access to housing.[4] We propose a single, local champion role which combines all the areas of need stipulated in the Armed Forces Covenant, including health, social care, education and housing. Champions should be expected to consider the particular needs of working age veterans as a group, and to represent and proactively seek the views equally of those living in their own homes and those living in residential care.

4. A best practice network in residential care for veterans should be established, and a best practice guide produced.

Both veterans and providers whom we spoke to agreed on the main barriers to providing high-quality care for working age veterans. Above all, they identified the age disparity between working age veterans and the general care home cohort, and the difficulty in catering for younger veterans' different tastes, expectations and needs for social interaction. At the same time, we saw and heard of examples of settings overcoming these barriers – through flexibility, personalisation, and the provision of opportunities for social interaction outside the care home (sometimes with service experience as a uniting theme). Moreover, we are aware of a wealth of good practice in personalisation and community links in the general care home community, on which all settings with a working age veteran in their care could draw.

We therefore propose the creation of a best practice information sharing network, specifically addressing residential care for working age ex-service personnel. This could be usefully facilitated by the Confederation of Service Charities (Cobseo), and should include individual care homes, care home providers, sector umbrella bodies and the Care Quality Commission. This network would bring specialists and generalists in working age residential care together. It would further serve as the vehicle for the production of a best practice guide focusing

in particular on innovations and successful initiatives for meeting the social and emotional needs of working age veterans in residential care.

5. Armed Forces charities should sponsor an annual 'Veterans' Voices' review of veterans in residential care.

We propose the institution of an annual review of (all) veterans in residential care, with the aim of capturing their concerns and experiences. In practice, the review might involve a combination of survey, interviews and group consultation. The voice of veterans under 65 should receive equal representation with the majority, over-65 population. The review would help to gauge residential care settings' performance in meeting veterans' less tangible needs – like that for social interaction, and a sense of purpose. Its findings should feed into the work of the proposed best practice network (see recommendation 4 above) and should be presented to the Minister of State for Defence Personnel, Welfare and Veterans.

We envisage that one of the larger Armed Forces charities, or a coalition of charities, would be best placed to sponsor this review, though we would like to see it have the full support of NHS England (through its 'Public Voice' work-stream) and Healthwatch England, the national consumer champion for health and social care.

6. Residential care settings should conduct skills audits for their working age residents, encouraging contribution to the care home and wider community.

A rapid loss of independence associated with sudden illness or injury, especially where it necessitates a move to residential care, can be particularly distressing for people of working age. This may be even truer of ex-service personnel, many of whom have a self-concept based on their physical capability, independence and service of others. Our research suggests that a lack of opportunity for engagement with others in the home, or with the wider community outside the home, can contribute to a sense of boredom and isolation among this group, and even precipitate a deterioration in their condition.

For many years there has been a focus in social care on what people cannot do – their limitations and medical needs – rather than what they can do and their personal goals. This is slowly changing across the sector in line with person-centred care and a shift from 'deficit-based' to 'asset-based' approaches to care. We saw examples of this approach in some care homes, where veterans were employing their individual skills – undertaking photography around the home, or tending the gardens.

In a care home setting, just as in a business, or any other setting in which people live or work together, conducting a skills audit simply involves identifying the particular skills and assets that each individual brings. Providing opportunities for veterans to contribute, particularly where those contributions are associated with social opportunities or the concept of service, has significant potential to transform the social and emotional wellbeing of working age veterans.

1 Background and context

The number of working age veterans who need, who will in the future need, or who currently receive care in a residential setting is relatively small. As a result, these veterans have hitherto been largely overlooked in both research and policy. This report will attempt to address that oversight, investigating the characteristics of this population, and using evidence of their experiences and preferences to inform recommendations for how residential settings can better meet their needs in future. Before that, though, we must establish what we know already, what it is important for us to know, and why. This chapter explores why so little is currently known about working age veterans in residential care and why this dearth of knowledge is a barrier to effective care. It further explains the factors which make understanding this group more important now than ever.

Estimating the number of working age veterans in residential care

It is important to be clear whom exactly we are talking about when we discuss 'working age veterans in residential care'. We use the term to refer to 16–65-year-olds, who live permanently or semi-permanently (for the foreseeable future, rather than a time-limited period of rehabilitation) in residential or nursing care facilities, and who have served in any branch of the Armed Forces, for any length of time – from a few weeks to several decades.

There is no complete national database or register of veterans generally in the UK. It is impossible to identify from any Armed Forces source the number or characteristics of working age veterans, and still less those who might require, or already be receiving, residential care.

Furthermore, existing data do not permit an accurate estimate to be made of this group. An Armed Forces charity director of care told us:

There is no way that anyone can get accurate data on veterans in residential care. It's a very difficult population to actually track. The only way we can make any type of estimate of the size of the community is [through] a slice of the population survey.

The MOD holds information on three UK-resident veteran cohorts, in each case as a result of general pension provision or compensation to which veterans are entitled as a result of illness or injury.[5] These cohorts comprise veterans who receive a War Disablement Pension under the War Pension Scheme, veterans who have been awarded compensation under the Armed Forces Compensation Scheme, and veterans who receive a pension under the Armed Forces Pension Scheme (the Armed Forces' general pension provision).[6] Some of these pension and compensation data are broken down by age and location.

In addition, since 2003, the MOD has also recorded the illnesses or injuries sustained by those who have been medically discharged from each branch of the Armed Forces, through its Joint Personnel Administration System and medical discharge papers (called 'FMED 23s').[7] The number (though not the nature) of serious or very serious injuries has been collected since 2001.[8] Medical discharge records should cover all or almost all of those individuals who were injured or became ill prior to leaving the Armed Forces between 2003 and the present.

None of the above sources provides an adequate basis on which to estimate the group we are interested in. First, not all personnel who sustain an illness or injury in service need long-term residential care. More importantly, as we shall see, these data do not account for those who have acquired support needs *after* leaving service – who, as we shall see, account for the larger number of veterans using residential care.[9]

The nature of the data collected by the MOD reflects its principal responsibilities with regard to ex-service personnel, which have historically been confined to the distribution of pensions and compensation. Other services or support for veterans have been spread across the NHS, local authorities, and a broad range of third sector organisations of varying size. More recently the MOD has played a more active role through Veterans UK and its partnerships with Armed Forces charities such as Help for Heroes and the Royal British Legion. Arguably, this historical dispersal of responsibilities has dis-incentivised the central collection of statistics on the ex-service population.

The best and most detailed estimate of the UK's veteran population and its characteristics is the 2014 *UK Household Survey of the Ex-Service Community*.[10] This survey, conducted by Compass Partnership, the Forces in Mind Trust and the Royal British Legion, suggests that there are 6.1–6.2 million members of the ex-service community as a whole, including veterans and their partners, husbands and wives, widows, widowers and children. Within this wider group, there are 2.8 million veterans, approximately 1.1 million of whom are aged 16–65).[11] Although a unique and valuable resource, the utility of the household survey is limited, as one service charity chief executive explained:

Establishing accurate statistics on and analysis of the disposition of the ex-service family is very difficult. The Royal British Legion have undertaken a lot of meaningful research on the Armed Forces community, and canvassed a lot of people for their report. Their estimate is the best, because frankly it's the only quality estimate out there. But if you look at the overall picture it establishes, the margins of error are still pretty enormous.

Most importantly for our purposes, the household survey excludes people living in residential care, hospitals, prisons or other communal establishments. The survey authors estimate the size of this 'hidden population' as being between 190,000 and 290,000,[12] a figure based on 2011 Census figures for the

number of people living in communal settings, and an earlier estimate that some 80 per cent of people in residential care were at one time veterans or their direct dependants, largely as a result of the high levels of military service among the Second World War and National Service generations.[13] However, because this estimate is based on a generation-specific effect, it is not useful for our purposes. It should be noted that, given sufficient resources, it *is* possible accurately to survey communal establishments; the 2011 Census provides a replicable methodology for doing so.[14]

Likewise, there are no systems within health and social care services for routinely identifying and recording veteran status. Unless they have been discharged from the Armed Forces on medical grounds, individuals are not identified as veterans on their medical records. According to the 2011 Census, there were 61,266 working age people in care and nursing homes in England and Wales,[15] but residential care facilities are not obligated – either for the Census or for any other purpose – to collect information on how many veterans are in their care.

Counting the number of beds in residential care settings operated by services charities would provide an indication of the total number of veterans in specialist residential care, but would not tell us their age (important, as under-65s would be in a minority), and would not capture those living in non-specialised residential care.

The importance of understanding the working age veteran population

The group whom this report concerns are in the unenviable position of straddling two little-known groups. As discussed in the previous section, the makeup of the ex-Services community – particularly once individuals exit the remit of the MOD – is not well understood. In addition, in the general population, there is a stark contrast between the wealth of research into residential care for older people (who make up the vast majority of care home and nursing home residents) and that

for working age disabled people. In the latter case, a lack of information has contributed to slow progress in high-quality, personalised care for the population who need it. A lack of data about a particular group drives a lack of focused research into their needs and preferences, and this in turn inhibits the efforts of those who would, or should, advocate for them, plan, design, deliver and evaluate effective support. It also presents a barrier to the effective management of resources by Armed Forces charities. As one services charity chief executive put it: 'If we want to more effectively support the needs of veterans, an identification of the actual population, and a robust interrogation of the market is what is needed.'

Across health and social care, but particularly in residential care – a setting where people can expect to spend several years of their lives, and where they are likely to be contributing to their care costs, and so can reasonably expect to exercise consumer choice – 'personalised' care (tailored to the individual) is synonymous with quality.

Working age veterans in residential care represent a particularly vulnerable group. Their impairments are typically among the most severe suffered by veterans. Moreover, like other small groups with specialised needs, they run a high risk of being overlooked; it is a challenge for them to exercise a collective 'voice'. As care and support is increasingly devolved to a local level, the group risks becoming still less 'visible'; there may be no more than one veteran in a CCG area.

This lack of visibility is problematic, because it makes it more difficult to ensure that the care pathways they use are effective, that residential care meets the needs of working age veterans, and that sufficient resources are dedicated to their care.

While the overall number of working age veterans is very small in the context of either the veteran population in the UK or the working age population in residential care, their numbers have grown as a result of recent conflicts and advances in medicine. This makes understanding their needs all the more important.

Advances in medical care

The human cost of recent conflicts has been great. In military operations since the 2001 invasion of Afghanistan, the UK Armed Forces have sustained 633 fatalities, 840 very serious or serious injuries or illnesses, and 11,044 injuries.[16] Yet the proportion of injured service personnel surviving injury and illness in conflict has increased substantially since conflicts like the Falklands War in 1982. Improvements in medical processes, best practice and processes at almost every level of medical treatment have saved countless lives.

During the course of the conflicts in Afghanistan and Iraq, the survival rates of British soldiers sustaining serious injuries has improved substantially. In 2003, the combined case-fatality rate (the ratio of fatalities compared with the combined population of killed and injured) for British soldiers serving in Afghanistan and Iraq was 54 per cent. By 2006, this rate had declined to 38 per cent, by 2009 to 20 per cent, and by 2012 to 16 per cent.

With a rising survival rate among seriously wounded soldiers, the proportion of soldiers returning to the UK with missing limbs, traumatic brain injury and other disabilities has increased. Hundreds of service personnel underwent amputations as a result of operations in Afghanistan and Iraq and were discharged from service between 2001 and 2014, while 107 service personnel underwent multiple amputations as a result of injuries sustained in these conflicts, and 616 British soldiers have incurred brain injuries as a result of injuries sustained in Afghanistan alone, 22 of which were severe. Thousands of British service personnel have been treated at the Royal Centre for Defence Medicine and the Defence Medical Rehabilitation Centre at Headley Court since the start of the conflicts in Afghanistan and Iraq.

It is also worth considering the fact that those who currently receive care and support at home may need to move to a care home or nursing home in the future, because of comorbidities, deterioration of their condition, or changes in the capacity of their family and friends to provide informal care.

The Armed Forces Covenant and its future

The Armed Forces Covenant, enshrined in law in the Armed Forces Act 2011, formalises a long-standing social contract between the Armed Forces and wider British society. It places new duties on the government to safeguard and in some cases prioritise health and social care for military personnel:

The Armed Forces community should enjoy the same standard of, and access to, healthcare as that received by any other UK citizen. Personnel injured on operations should be treated in conditions which recognise the specific needs of Service personnel... Veterans should receive priority treatment within the NHS where it relates to a condition resulting from their Service, subject to clinical need; while those injured in Service, whether physically or mentally, should be cared for in a way which reflects the Nation's moral obligation to them, while respecting that individual's wishes.[17]

These requirements extend beyond active service personnel and into the veteran community. However, while the specific obligations of the nation to veterans who become ill or injured during their service is clear, the obligation to veterans who require a need for support after leaving service is less so:

The Covenant involves an obligation for life. In accessing services, veterans should expect the same level of support as any other citizen in society. Pension schemes should be fair and appropriate to the particular circumstances of Service personnel. All veterans should be able to access advice and in some cases additional support from the MOD and other government departments, and the charitable sector, although access may be affected if they do not reside in the UK. Those injured in Service or [who] have a health condition relating to Service should receive additional support, which may include a financial element depending on circumstances.[18]

It is certainly orthodox to suggest that veterans might have distinct needs which the state should cater for – particularly given the unique role and contribution of the Armed Forces, and the risks and sacrifices associated with service.

Yet it is not uncontroversial to argue that society has a distinct moral obligation to *all* veterans that it does not have to other citizens. The fact that the terms of the Covenant are left open to interpretation raises potentially significant questions. As the size and profile of the veteran population changes, and service charities try to keep pace with that change – all against the continued backdrop of tightened public funding – it makes sense to ask if everyone is equally entitled to the Covenant's protection.

Our research indicates that most working age veterans with residential care needs fall into the latter, less clear-cut category of individuals who have become ill or sustained an injury *after* leaving the Armed Forces. The over-65 veteran population is also shifting; Second World War veterans are now in the minority, and national servicemen – whose service careers have, in the main, been shorter and less intensive – make up the greatest number.

A large proportion of specialist support for veterans is provided through services charities. As separate entities from the state, charities are, of course, entitled to decide who their beneficiaries are, and set eligibility criteria for their services accordingly. Most of the service charities operating care homes whom we consulted for this research took an inclusive approach, opening their doors to anyone who had ever served in the Armed Forces in any capacity. Beyond doubt, they were providing a valued – and often irreplaceable – service to all the beneficiaries we spoke to.

The Armed Forces Covenant represents a step change in how the UK plans and delivers care for veterans. But if the UK is to meet its obligations under the Covenant – and to do so sustainably into the future – more work is urgently needed. The Covenant raises questions about who should benefit. These can only be solved by better information about who our veterans are, and what they need.

2 The characteristics of working age veterans

This chapter describes the working age veteran population in residential care, laying out who they are, their illnesses and injuries, and their service histories. This chapter seeks to establish a clearer picture of the characteristics of this population, before chapter 3 examines their experiences, needs and priorities when it comes to residential care and the challenges that they face.

As discussed in chapter 1, there are no existing estimates of the number of working age veterans in residential care. Due to the relatively 'hidden' nature of this group, it proved challenging in this research to identify and gain access to individual ex-service personnel for interview. Despite attempting to make contact with a number of 'generalist', non-veteran charity care homes, we were unsuccessful, with one exception, in sourcing interviewees resident in these settings. We were instead reliant primarily on Armed Forces charity providers. We recorded interviews with 33 working age veterans resident in ten such settings, which is an informal and non-representative sample of working age veterans in residential care, and our observations should be understood in that context. We hypothesise that there are likely to be many more veterans aged under 65 in non-services care homes – a still more hidden population. Their experience may be different, and although we have not been able to meet anyone in this group, we have tried to include them within the scope of our conclusion and recommendations.

Armed Forces charities excel in providing flexible residential care. Many working age veterans enter residential care as part of a transitional, 'step-down' arrangement before returning to independent living. They may be waiting for home adaptations, or a move to more suitable housing, while some undergo rehabilitation – for example, being trained to adapt

to loss of their sight at Blind Veterans UK's Brighton Centre. Others may spend periods of time in care homes for respite. The chief executive of one service charity described the wide range of support it provides:

We currently have two veterans who are of working age; they have disabilities that prevent work, and have been with us since they were in their mid-50s. We also have other members who are not in our care, because their disabilities are very severe – for example brain injuries – and they need high-intensity nursing; a lot of them are in local authority care through the health service. We've got those who are at home but get care from outside on a daily basis, so they're disabled and independent but they are receiving care as well. Then we've got those who need care for an intense, finite period; we probably have half a dozen emergency cases that we will place in the home because we know that they'll be able to convalesce there. Then let's say a veteran comes out of an operation on their limbs, or there are other difficulties: we'll set them up in the home for a time, until they are ready to go again.

This research has focused purely on long-term veterans of residential care. We did not examine veterans undergoing temporary, transitional or respite stays, and do not include them in the described sample of 33 working age veterans in residential care examined as part of this research.

Care homes run by veterans' charities accept veterans injured during service or as a result of their service, and those who after a career or even a short span in the Armed Forces left and were then injured or became ill. Around a third of our research sample of 33 fell into the former group, and the remaining two-thirds into the latter group; providers whom we interviewed confirmed that this ratio was in line with their experience of the wider working age veteran population.

There are reasons to believe that, even setting aside the conflicts in Afghanistan and Iraq, the number of working age veterans requiring long-term residential care might grow. A significant proportion of the working age veterans in residential care we came across suffer from non-combat related

injuries, as a result of either accidents during military service, or long-term conditions such as progressive neurological disease. Moreover, there is the probability that the conditions of a number of veterans currently living independently might deteriorate, or that those currently cared for by parents and family might need residential care in future. An Armed Forces charity chief executive described this:

One of the things that concerns us is that there are people with severe injuries coming back from conflicts, who are alive but would not have been alive ten years ago, who are being cared for by their parents. These parents might not be able to care for them for that much longer. We are asking ourselves the question, 'Who looks after those veterans when they are in their 40s?' We have a number of members who would fall into that category, and of course you can add to that those whose bodies take wear and tear as they manage their conditions, who might need us in the future.

Approximately a third of our sample was made up of people with a range of long-term or degenerative conditions, most of which were not likely to be more prevalent among veterans than the general population.[19] These conditions included Huntingdon's disease, multiple sclerosis (MS), early-onset dementia and Wernicke–Korsakoff syndrome (severe cognitive impairment often linked to alcoholism). The remainder – the larger group – had suffered trauma of some kind – primarily acquired brain injuries, but also paralysis, and loss of limbs or limb function. While these sorts of injury are more common among veterans, not all of them had been sustained during service; road traffic accidents were equally frequent causes of injury.

Within the veteran population as a whole, the majority who sustain traumatic injuries do not go into residential care; many are able to live independently, sometimes with informal care from friends and family. Consequently, those requiring residential care can in general be expected to be those with the most severe physical injuries or traumatic brain injuries. This was confirmed by our small sample, and also by at least one director of care in a national service charity:

The number of working age veterans in residential care will be small... It is probably those veterans who have sustained a brain injury who need more care than those who are amputees, in terms of physical injuries, because they are the ones who are likely to be the most dependent.

There was a range of ages within our sample, which included ex-service personnel from every decade of their working lives, from their early 20s to their early 60s. As might be expected, the younger veterans were more likely to have sustained their injuries during service, whereas older veterans were more likely to have acquired their needs after leaving the Armed Forces. This was confirmed by one care manager we spoke to:

A lot of younger residents will have been discharged from the military because of their physical condition and come straight to us, whereas the older residents are more likely to have been out of the military for some time.

Even the members of this small group differed widely in their characteristics: age; the nature, origin and severity of their conditions; and personal circumstances. They also entered into residential care as a result of different routes or 'care pathways', which are the subject of the next chapter.

3 Pathways to residential care

A 'care pathway' is the sequence of interventions undertaken by professionals during an individual's care. From the point of view of the person receiving care, it can be thought of as their 'journey from A to B' – in this case, from a period of service in the Armed Forces to a residential care setting. Where a care pathway functions well, the individual receives the right information and support (whether information or direct care) at the right time.

This chapter outlines the key challenges associated with institutional knowledge, signposting and the effective coverage of the whole veteran population, before the next chapter explores the actual experience of working age veterans in residential care.

Care pathways for the group we are concerned with can take two main forms, depending on whether their residential care needs are acquired while they are in service, or at any point after they have left. The care pathway of the first group (the smaller group, as we saw in the previous chapter) is, at least initially, defined by their relationship with their service arm (the Army, the Royal Navy or the Royal Air Force) and the Veterans Welfare Service (VWS). Henceforth, we refer to this group as individuals 'incapacitated during service'. Members of the second group, which we refer to as those 'incapacitated after service', do not have contact with the MOD or VWS, and arrive in residential care via the health and social care systems.

Care pathways: incapacitated during service

The care pathways that exist for working age veterans leaving the Armed Forces (permanently or temporarily) as a result of illness have changed significantly over the last few years. These changes have largely been stimulated by the recent conflicts in Afghanistan and Iraq, and the increased need

to process and support personnel injured in those conflicts effectively. In particular, significant improvements have been made to Armed Forces recovery capabilities – the processes by which injured or ill Armed Forces personnel are cared for and prepared for a return to either active service or civilian life.

The Defence Recovery Capability (DRC) is a collection of care and rehabilitative resources, including residential facilities, designed to support ill and injured personnel in their return to service within the Armed Forces or through their medical discharge and into civilian life. A joint initiative operated by the MOD, the Royal British Legion, Help for Heroes and other third sector partners, it became fully operational in mid-2013. Personnel remain the responsibility of their own service arm, and each service has its own recovery pathway: the Naval Service Recovery Pathway and the Army Recovery Capability (ARC), established in 2010, and the processes coordinated by the RAF Personnel Recovery unit.[20]

Before the development of these new, more holistic and better-resourced care pathways, Armed Forces leaders were largely reliant on informal channels. We spoke to one RAF veteran who had been through discharge over ten years ago, before the new pathways were developed, following a serious head injury. He and his mother described how they had found the care home he was currently resident in through word of mouth:

Veteran: *My father found it.*

Mother: *He found it by accident really. I went to a solicitor's... Someone there, their father-in-law was in [another care home]. My husband went to have a look at it, but they couldn't fit him in, but they recommended this place, and so I came and had a look, We thought it was a good place for him.*

The development of the DRC and of formalised pathways in all three service arms has led to the MOD as a whole having greater involvement in the provision of care and support for ill and injured veterans. Previously, mainstream, non-military

services played a larger role in managing veterans' recovery. For example, the MOD now runs personnel recovery units, which cater to service personnel preparing for a return to active service and to those leaving the Armed Forces as a result of their injury. Personnel recovery units are open to veterans on a case-by-case basis.[21] An Armed Forces charity interviewee explained:

The system was very different before the Defence Recovery Capability, which has only existed for the last few years. Personal recovery units didn't exist, and veterans would have come through mainstream services rather than the MOD, because the MOD wasn't as much engaged in that process as they are these days. The reality of care has changed dramatically in the last five to ten years. There are a whole range of things which have played into this, not least of which is the survivability of those with complex injuries. That's one of the reasons why the Defence Recovery Capability was established.

This is reflected in the experience of veterans who have engaged with the new, more formal system. One young veteran we spoke to had been seriously injured as a result of an IED explosion in Afghanistan. He shared his experience:

At the very beginning of my injury I was in Birmingham's Queen Elizabeth Hospital. Then I went to Putney [The Royal Hospital for Neuro-disability]. Then as I recovered I went through a few other medical places with the Armed Forces… And then after a while I came here [to a care home run by a service charity]. The nurses and doctors, they suggested to me I should come here. That's why I'm in here.

Thus, care pathways for the 'incapacitated during service' group vary by service arm. The Army, the largest service arm and the one in which most working age veterans in residential care have served, provides for ill and injured personnel under the ARC, with access to DRC resources as required.

All soldiers are assigned a personnel recovery officer, who acts as a single point of contact for that individual and his or

her family, and coordinates the agencies involved in their recovery or transition to civilian life.[22] Officers may assist with practical arrangements, such as organising home adaptations for personnel with acquired disabilities. Personnel recovery officers remain in touch with a soldier for three months following a medical discharge, providing a valuable bridge between the Army and civilian life. Ex-soldiers also have access to a range of other resources to assist their transition, including the Recovery Career Service, which guides soldiers into civilian careers in partnership with many charities and private companies from the Army Benevolent Fund to the National Trust to IBM.[23]

If a serviceperson is identified early on as likely to need longer-term care and support after their discharge as a result of physical or psychological disability, then an anticipatory referral is made to the VWS, under the Tri-Service Welfare Referral Protocol.[24] The VWS then works with the appropriate charities and civilian services to organise a package of care for that serviceperson on their discharge. An official from the VWS told us:

Every service leaver who either has an enduring welfare need or is classified as a serious injured leaver can be referred to Veterans Welfare Service up to 12 weeks prior to discharge to allow us to review their needs and ensure the best level of support is in place prior to discharge.

Referrals under this protocol usually apply to the most severely injured service-leavers, for example those with head injuries requiring extended hospitalisation or those with severe, complex multiple injuries.

Once the individual has been discharged, responsibility is largely transferred from their service arm to the VWS (though certain arrangements such as adaptations made by in-service welfare managers remain the responsibility of the relevant service arm). The transfer involves a meeting with the veteran and sometimes also their family. VWS input continues as long as required in any particular case, and should involve

the 'facilitation of appropriate engagement with relevant organisations or agencies'.[25] In practice, this most often means directing the veteran to services provided by local authorities or veterans' charities. A representative from the VWS explained:

If any of our veterans whom we had a working relationship [with] were in need, our welfare managers would investigate the local support systems in place and be aiming to signpost the veteran to the options available to them... We work with local authorities and council to increase awareness of us and the support we can provide. We also work in partnership with service charities to provide support to veterans... Our relationships with them allow them to refer a veteran who they believe may need our support and vice versa.

Armed Forces charities are an integral part of the DRC, performing several functions, from core funding (in excess of £100 million that went into the development of the ARC came from charitable sources)[26] to providing employability support, specialist centres for rehabilitation and long-term residential care.

However, the connections between those leaving the Armed Forces in need and the charitable services and support available to them are not perfect. Some of the service charity representatives we spoke to suggested that parts of the DRC were not aware of their organisations or what they offered, as the following comment by one of them illustrates:

Our connection to the Armed Forces when it comes to working age veterans is just through the people we've worked with, or who we've been out to a seminar with – where we've been able to network with those people. In fact I have people from a personnel recovery unit coming down soon, and that was based on a chance call. A person from that PRU called our nursing home, they didn't understand what she wanted, and they put her through to me. As soon as I started talking about what we did, she said, 'Why didn't we know about this before?' I'm sure we are missing loads of people.

Nonetheless, at least one charity – Blesma, The Limbless Veterans – reported that it had no difficulty making contact with Armed Forces leavers:

We don't have the problems of access to beneficiaries that a lot of Armed Forces charities talk about, and I'll explain why. People ask, 'How does a potential beneficiary leaving the Armed Forces access you as a provider?' When the soldiers come through the hospital at Birmingham, we're there, and they are then on the books. There is the odd one or two we miss, but even then word of mouth gets around and we catch up with them.

The chief executive ascribed this to the high profile of the charity, the distinct and recognisable nature of limb loss as a condition, and the charity's close involvement with the DRC.

The chief executive of a veterans' care home explained that the most effective relationship between service charities and the Armed Forces could often be a combination of formal relationships supplemented by informal links:

We work very hard to maintain our links with the three services. In fact, on our governing body, we have three serving very senior medical officers. So there [are] good connections there, and we keep tabs with the rest of the ex-service community and we try to forge and maintain links with places which are dealing with today's current serving folk.

Cooperation between Armed Forces charities and the MOD has improved significantly in recent years. Largely as a consequence of this, care pathways for people incapacitated during service are clearer and more comprehensive than those for former personnel who become ill or injured after service. We explore their journeys in the next section. Nonetheless, in some cases, professionals involved in supporting Armed Forces personnel through a transition to civilian life appear not to be aware of the full range of available sector support. Informal connections and word of mouth are still too often the first port of call, which raises the possibility that some Armed Forces leavers are not getting the support they need and are entitled to.

Care pathways: incapacitated after service

The care pathways that exist for ex-service personnel who become ill or injured after their service are less clear and less formalised than those for servicemen and women incapacitated during service. These veterans are nevertheless entitled to the specialist care provided by Armed Forces charities, and can in some cases be supported by the MOD; for example, veterans can be treated in personnel recovery centres if their case is approved.

In the absence of a DRC equivalent for those who are not currently serving, ex-service personnel are dealt with as civilians, through universal health and social care systems. In our research sample, most veterans who fell into the 'incapacitated after service' group had learned about the setting where they lived through either informal channels or social care services.

One of the veterans we spoke to described how a social worker connected her with a veterans' care home she currently lives in after her condition deteriorated:

I was diagnosed in 2007 with primary progressive MS and it went from sort of the occasional tripping over, and then one walking stick, to two walking sticks, to a wheelchair, and then being totally immobile. It was a social worker who actually found this place for me. I had heard of it before, I had seen some adverts around the city, but it was a social worker that found a place here for me.

Another, who had initially used a specialist care home for respite, eventually moved there full time:

I suffered two subarachnoid brain haemorrhages… I came here on respite originally a couple of years ago, and I went home and I was buzzing, because it catered for all of my needs, it was everything I wanted. They would take me out on trips; they had a social recreation department where I could paint; I continue my photography because I'm an avid photographer, and I thought yeah, this is the place for me.

As these two relatively positive experiences demonstrate, signposting works well where health and social care professionals are well informed. However, because of their specialist nature, and the small, dispersed nature of the veteran population, services run by Armed Forces charities (which include residential care homes) are not always local to those who need them. This may reduce the likelihood that social workers are aware of their existence – and, consequently, the likelihood of veterans incapacitated after service being appropriately signposted. Charities themselves were aware of this as a problem, as illustrated by this comment from a volunteer coordinator:

There are numerous people who we could have helped earlier, who say they didn't know we existed or that we were an option. We definitely need to get our name out there to the veterans who need us... There must be more we can do in terms of signposting.

Moreover, ex-servicemen and women in this group may be unaware of their entitlement to specialist veterans' residential care – nor is this the sort of information health and social care professionals can reasonably be expected to have. In fact, most Armed Forces charities offer help to a veteran without a minimum service requirement, so national servicemen and women, or people who had short military careers decades earlier, are entitled to their care.

Barry Le Grys, the chief executive of Blesma, was confident that Blesma was picking up every veteran coming directly out of the Armed Forces, but was not confident that every veteran needing residential care was aware of what Blesma could offer:

Where we don't have every member, it's where those [sic] lose their limbs when they have left the service, through a car accident and that kind of thing. Through our profile in places like NHS limb centres, practice managers and such like, we will have people say, 'Well you've lost a limb and you used to be Armed Forces, get in touch with Blesma and ask.'

Without the right information about available support and their entitlements to it, there is a risk that ex-service personnel are forced back on services that are inappropriate for their needs. One nurse in a veterans' care home recounted a particularly poignant example:

The lady who is with us now, was previously in a dementia facility. She does not have dementia. She was put into a dementia care home because there was nowhere else for her. It's hard to think that's the situation we are in… We were lucky that we were able to get her a position in this home.

The chief executive of one charity which provides independent housing for veterans in Scotland related the issue more broadly to veteran housing charities:

There are something like 58 housing charities who are members of Veterans Scotland, all listing different criteria for different kinds of support available for veterans. Each one of those charities varies how they operate and all fulfil an important function. They're set up because no one else is providing that particular strand of work. Each one of those charities is aware of the other charities. The problem is that the veterans themselves don't know where to go, as there is not an effective single entry point.

In the absence of robust data on how many working age veterans in both groups (those incapacitated during service and those incapacitated after service) need residential care, how many of them access it, and how they get there, it is difficult to evaluate with any certainty exactly how well these care pathways function. The picture is also incomplete without information on veterans in non-specialist residential care. However, both of the main care pathways have shortcomings. Signposting is a major challenge in either case, indicating a need for better information among both specialist agencies (the MOD and DRC) and the general health and social care workforce. Where care pathways fail, ex-service personnel

are at risk of unnecessary delays in accessing care, receiving inappropriate care, or not having their needs met at all. Our research indicates that this risk is greater for the larger, 'incapacitated after service' group.

4 The experience of working age veterans in residential care

This chapter explores the experience of working age veterans in residential care from the perspectives of the veterans themselves, as well as the staff involved in planning, delivering and directly providing care. Almost without exception, those we spoke to were satisfied with the medical aspects of the care they received, however we identified five commonly reported issues, all of which relate to veterans' social and emotional wellbeing:

- the risk of social isolation and boredom associated with being a young person living in a setting where the majority of residents are much older (we use 'age disparity' as a shorthand description)
- the distress associated with a sudden change in the ability to manage independently, which is particularly acute for a young person and even more so for service personnel recently in the prime of their career
- the strong desire for socialisation outside the care home, which is again felt particularly keenly by young people in residential care, and the difficulty of providing for that
- the importance that most veterans in residential care associated with being part of the veteran community, and the opportunity that represents for social activity
- the pressure on the families of working age veterans in residential care, and the emotional discomfort associated with this pressure

These factors represent challenges that are difficult to overcome, and opportunities that are difficult to exploit. In some cases, the severity of a veteran's disability or the limitations of a care home's resources mean that some of these problems are

very hard to resolve. Ultimately, however, these key concerns and desires, as expressed by the veterans themselves and those working closely with them, must be addressed.

Throughout the chapter, we identify examples of best practice in meeting care home residents' needs holistically. Some of these examples are drawn from the wider (non-veteran) residential care arena, from which we believe specialist settings can learn.

Age disparity

The most significant challenge highlighted by the working age veterans we spoke to was the age disparity between them and the rest of the care home residents. Our interviewees were invariably either the only under-65s, or else one of a small handful, within a larger community of much older veterans. In the course of our research, we were made aware of only one specialist veterans' care home with more than ten working age residents. Several people described the sense of social isolation this engendered:

Interviewer: *What was it like, being in a home with lots of older people?*

Veteran 1: *Depressing.*

Mother: *It was really, because they were very elderly. But it was the only place we could get him in at the time. He was in [hospital] for two and a half years, when he first came down. It was very isolating... Luckily his dad was alive then, he used to take him out... We used to hire that car on a Saturday so we could take him out.*

Another working age veteran, one of very few veterans at a residential care home with a much older population, described how he would like the opportunity to be around people his own age:

I am around old people, but me, I am only a youngster... I would like to be around people of my own age, youngsters. There are not any youngsters here; I think I'm in here because the injury hurt my head very hard.

A third, particularly unhappy veteran we spoke to suggested that a lack of interaction with other young people was a key cause of his unhappiness:

Well I certainly don't have a 'holiday experience'... I don't have a lot of visitors, and more socialising with people like me would improve my outlook on life.

Another suggested that younger veterans might benefit from their own area and dedicated activities within a care home, pointing, in particular, to demand for access to better quality internet and digital services:

Yes, it might sound petty or whatever, but things like Wifi and Sky and television or those digital channels with the sport... I think [the care home management] maybe need to look at their policies and get them updated really. More things for younger people really would be my main aim. I think they need to look at a separate wing for younger people or whatever, just deal with them slightly differently from older people.

Providers themselves were also acutely aware of age disparity as a major challenge for this group of beneficiaries. One member of staff observed:

I know from the perspective of working age veterans it can be quite difficult for them because obviously they're surrounded by people that can be a lot older. So for example, our working age residents ranged from the late 40s to the late 50s, so to come into a situation where you've got residents ranging normally from your mid-70s up to your 100s, it can be quite difficult for them. There's a gap in taste when it comes to music, activities, recreation and even food.

Indeed, the problem is more than a gap in taste. As well as leading to boredom, the lack of appropriate social stimulation can even have an adverse impact on younger residents' wellbeing. A staff member at an Armed Forces charity care home described an example of this:

If we get the younger people in here, they don't want to stay here. It's an old people's home, and they're bored. One young gentleman comes to mind; he actually ended up becoming very isolated in his room, because he was only coming downstairs to the lounge area when he knew there were younger people in, who he could relate to, who he could talk to. It was difficult to see it, because that young man was just isolating himself more, and more, and more.

This issue affects older veterans too. The rising average age and the shortening length of stay of care home residents means that the age gap between someone in their early 60s and older care home residents can be significant. An Armed Forces charity chief executive commented on this:

What has changed over the last couple of decades is that the mean age of the elderly entering residential care has got higher and higher, and the time they spend in residential care has got shorter and shorter. What you are really saying is, when people go into residential care now, it really is twilight years. In fact, it's two years [on average]. Our average age now is 89½. If you are running a residential establishment, and you have someone of working age, even aged 60, that's a pretty big gap; its 30 years. You try organising a Christmas function around that one.

Many care homes work to provide working age veterans with at least a small amount of age-appropriate social activity. However, it is much harder for a home to establish a peer or social group appropriate to a particular veteran's age.

Of course, this age disparity is not just a problem for veterans. The 2014 Commission on Residential Care, for

which Demos was the secretariat, observed issues concerning the placement of young people among much older populations in residential care:

In some extreme cases, disabled adults in their 20s and 30s are still being accommodated alongside much older, frailer people with very different needs and aspirations, because of the limited choice in some parts of the country of appropriate housing with care for disabled people.[27]

One chief executive was clear that residential care, where the average age of residents is so much higher than that of most veterans, is not an ideal place for working age veterans to be:

Back when this home was set up during the Great War... it was looking after young guys coming back from the front, with an average age of 22. The average age now is 87. We continue to make it clear that our doors are open to younger people, but the reality is that the younger generation of those needing that high-intensity nursing and care tend to try and do it in the community. What they don't want to do, and you wouldn't blame them, is live in an environment where the average age is 87.

Yet there are those working age veterans for whom residential care continues to be the best place to meet their preferences and needs. The small size of this care group and their specialist needs can make it difficult to provide individuals with their own space, as was previously the case in the Armed Forces charity home described by a staff member below:

We have a five-bed disabled wing; in the past four or five years we have had younger wounded veterans in there, but we have none now. It's not the right place for them. While we have a physiotherapy and hydro-therapy wing attached to that, it's sat in the middle of the care home. The average age in a care home these days is about 85 years old. If you are sat in an old people's home, it's just not the right place for a younger person. This wing was five beds in a nearly 80-bed facility. Those that we did [admit] have complex needs, and, if truth be told, they couldn't find anywhere else for them to go, because they were really complex.

Of course, while these difficulties must be acknowledged, there is no excuse for a lack of person-centred care and individualised support, and there are plenty of best practice examples of how to accommodate differing needs, tastes and preferences within a single setting.[28] Encouraging care homes to share best practice when caring for working age veterans, and developing structures through which to distribute best practice, could play an important role in ensuring that what can be done is being done.

Best practice: person-centred care among an older population at the Royal Star and Garter care home

In a number of care homes we came across there was only one working age veteran in a home with a significantly older population. In some of these homes, the measures described to us that had been taken to provide social opportunities could be regarded as inadequate. In other cases, a person-centred approach had enabled care home staff to safeguard the social and emotional wellbeing of the veteran in some respects. The Royal Star and Garter care home presented a good example of person-centred care provision among an older population.

The Royal Star and Garter, which caters overwhelmingly for a particularly elderly population, was very flexible in its provision of care to a single working age resident, recognising and accommodating his particular social needs and priorities. The care managers found him a room away from the main part of the home with a patio area, in order to provide him with a different environment and a greater feeling of independence. They also ensured that there were in-house social activities that appealed to him, and facilitated his engagement with his former service arm. While they did not isolate him from the home, his care managers endeavoured to create a space more appropriate for a working age person.

Social activities outside the care home

Related to the importance of age-appropriate activities for working age veterans in residential care is the importance of providing opportunities for veterans to engage socially outside

the care home. The desire for more involvement in activities outside the home was flagged up to us by a number of the veterans we interviewed. This can be particularly challenging with working age veterans, not least because of their often severe impairments. A number of veterans we spoke to highlighted the value of even small activities outside their care homes. One described how she felt younger veterans benefited from activities outside the care home, and how she wanted to be able to partake in such activities more frequently:

I think for a lot of the younger veterans who need 24-hour care its more difficult, but I think that they need more stimulation than just what can be provided in the care home, with other young people... There is this befriending service which I've asked my sister to look into to see how much it would cost. I could maybe go out a bit more, go to the pictures or something like that. One gentleman here goes to an art class once a week, and someone comes and says 'Hi' and he gets to go out and about.

Another veteran originally from Nepal made trips into the community outside the care home, giving him a chance to engage with young people from his cultural background:

I like it but I would like them to be of my age, youngsters. There is only one chance to meet youngsters, those of my own language, and it's in the Nepalese restaurant in [town]. I go there for Friday when I can.

This need is not just felt by working age veterans in residential care. In fact, it could be argued that a veteran identity provides an excellent vehicle through which to connect the residents of a veterans' care home to the wider community, an opportunity for social engagement outside the home that many veterans' care homes are keen to exploit. A nurse told us about the activities at the care home where she works:

[Being a veterans' care home] gives a bit of a theme to some of the things that we do at the home, particularly with our social and recreation activities. Recently, over the last couple of years, we've

had a lot of celebrations, year anniversaries etc. That's obviously very important, and every year we have a remembrance service in November. And again, that's very important for these people, to be able to pay their respects, and be able to do something together in the community to remember.

The head of care at one care home similarly described how they used the veteran status of the residents as a way of engaging socially in the wider community:

One of our younger people cannot actually communicate at all, but those who are more physically able, yes they would absolutely meet up with the wider community and younger people. We take the opportunities we can to undertake social activities outside of the centre. For example, when we go up to the Cenotaph on Remembrance Day, we stay up in a hotel and we make it a social event.

While many of the veterans we spoke to were hungry for more opportunities to interact with the wider world outside their care home, a few veterans felt that their social needs outside the care home were well catered for. These veterans were sometimes involved in the activities of other veteran charities. One told us:

I've gone to places I would never have been, I went to Twickenham three times, I watched the Six Nations, I've been to Buckingham Palace twice, I've met the Queen. Yesterday I was in Portsmouth... I went to Fontwell Racecourse and had a wonderful day. All of that was paid for by the Not Forgotten Association, who look after us.

Another working age veteran suggested:

I think some of the younger veterans that are going to be coming through won't find this sort of establishment to their liking, basically because I think they need more stimulus in their life to keep them going.

Best practice: facilitating social engagement at Queen Alexandra Hospital Home

While all of the veterans' care homes we researched offered social opportunities, with some care homes using the veteran status of the residents as a basis for social engagement in the wider community, Queen Alexandra Hospital Home represented a particularly strong example of best practice as a result of the use of volunteers.

At the Queen Alexandra Hospital Home, the use of external volunteers, organised by the home or engaged with through another Armed Forces charity, is key to the social and emotional wellbeing of working age veterans. Volunteers are recruited and coordinated by a specific member of staff, and, in addition to fundraising for the home, undertake social activities with the veterans. The use of regular volunteers presents opportunities for working age residents to socialise with a range of people, many of whom had an Armed Forces connection, and to interact meaningfully with the wider community. At the same time, by working closely with other veterans' charities, such as the Not Forgotten Association, Queen Alexandra Hospital Home is able to present veterans with regular leisure and recreation opportunities outside the home, from concerts to sports events or just days out. Several veterans at the home described in warm terms the variety of social opportunities and events that were regularly on offer.

The effective use of volunteers to facilitate social engagement at Queen Alexandra Hospital Home provides a clear and replicable example of best practice in this area.

Those running veterans' care homes are aware of the social benefit of young veterans' engagement in the wider community, particularly with other young people, and often facilitate such activities when they can. However, in some cases, the physical condition of working age veterans and the age of the rest of the veteran population of which they are a part can limit their capacity to communicate at all. As one care manager explained:

It's very important that you try and help them live a life, but they're often very limited because of their physical disabilities. The younger residents that I have here now are actually physically not able to participate that much in recreational activity. When they could, what we did was try to facilitate them meeting up with other younger people. Most of the activities in the [care home] are designed for older people, because of the age of the general population. For those who are more physically able, we'd help them meet up with the wider community and younger people.

Rapid change in level of independence

A number of the veterans we spoke to said that a rapid change in their social role was one of the most difficult things about being a working age veteran in residential care. Many had in a very short period of time gone from having active, working lives in the Armed Forces to being dependent on support from others to meet their daily needs. Many found this change difficult. Of course, a rapid loss of independence is distressing to anyone, especially a young person, who acquires an illness or disability. Yet it can be compounded for a working age veteran by the loss of a clearly defined social role, by the loss of the prestige associated with being a serving member of the Armed Forces, and by a relatively rapid transition from military life – where a premium is placed on physical capacity and capability, as well as selfless contribution to a greater goal – to civilian life. A senior nurse in a veterans' care home explained this transition as it applies to working age veterans succinctly:

I've seen people come in here with horrendous injuries, where they have stepped on an IED in Afghanistan and lost both their legs and their sight, at 20 years of age. They thought they were going to be in the military until they were 45, and suddenly their career [is] over... Trying to pick up the pieces of life after you've been injured is hard. When people get to their 70s and 80s, they feel like they shouldn't be working anymore. They've done their bit, and paid into society. Whereas the young people will be expecting that they will be able to

pay into society, will be able to contribute, will be able to do their part and play their role. But if you have been severely physically disabled and lost your job, then there can be a loss of dignity, a feeling of less value, less worth.

A working age veteran we spoke to explained the difficulty that he had had adjusting to life in a care home after he quite rapidly became ill:

My career progressed very rapidly and I was headhunted to go and lead a department in a specialist school, for kids with severe learning difficulties. Unfortunately I was on school holiday, went out to play golf, and had my first brain haemorrhage. So my post-Army career came to a very quick end, before it really started... It took a lot of adjustment, coming out of your former life, and going into an institution, where all my needs are catered for. I found that difficult to adjust to; I still do sometimes.

This veteran also described how he had dealt with the loss of his career through becoming a photographer, which, in a powerful example of best practice, the care home he lived in had encouraged and used as the basis for his contribution to life in the care home:

Photography plays a big part in my life. I took my first picture at seven, now I've got my own website, I contribute to a lot of blogs, I sell images to Flickr and quite a few sites, and I do photography for the home.

Best practice: asset-based approaches to care

Our research identified a number of examples of best practice related to asset-based approaches to care within Armed Forces charity residential care homes – approaches to care that focused not on what a veteran could not do, but on what they could do, and how that could contribute to their wellbeing.

At one Armed Forces charity-run care home, some residents contributed to the operation of the care home

in a manner that fulfilled their interests as well as providing them with social opportunities and a sense of purpose, with one working age resident for example undertaking photography on behalf of the home. At another home, a working age resident worked in fundraising and communication for the home, while a previous working age resident had helped with gardening. At the Royal British Legion Industries Village in Aylesford, working age residents were given jobs as part of their recovery, with the wider village – encompassing older and younger veterans, with various needs and transitional and permanent residency – based around the operation of a factory business as a route to recovery and transition to civilian life. In each case, these jobs and roles, from simple tasks to more formal appointments, made an important contribution to the social and emotional wellbeing of working age veterans. Another veteran described how he felt a loss of dignity as a result of his worsening condition:

I was getting care in my home, but basically there was just me and my other half who was having to do a lot more than normal... I felt I lost my dignity a little, but here they recognise that you do have dignity still and try their best to accommodate you.

A member of care staff at an Armed Forces charity described how they work to counteract the feelings of disempowerment that veterans might feel by building back up their practical capabilities and independence:

It can be quite difficult to feel that you are not a burden on others, especially if you are from the Armed Forces. They were the people who defended the country, and now they might feel like there is not much that they can do. But you'd be amazed how little it takes to combat that feeling. We might start small, and say, 'why don't you send your family an email?' We'll teach them how to use a computer, or read their own bank statements. That means so much, they don't have to get someone else to help them do it. And you give them the equipment they need to make themselves a cup of tea, and they can do that themselves. That kind of stuff can make them feel

that they are capable, that they can achieve things. Younger people do not want to be a burden particularly, and so this particularly helps them.

This example shows not only how important it is to increase the independence of veterans in residential care, but also how vital it is to the emotional and social wellbeing of a working age veteran to ensure that they do not feel a burden. In the context of new and often severe disability, it is important to highlight what a working age veteran can do, and to provide opportunities for them to contribute to the care home in which they are a resident, and the wider community, in any way they can.

The veteran community

It was a huge source of pride for many of the veterans we spoke to that they were part of the veteran community. Often, the fact that the home they were in was run by an Armed Forces charity, and that their fellow residents were veterans, was a source of pride. It gave them a sense of camaraderie, membership and self-worth that was important to their wellbeing. One veteran put it:

It is very important to me as veterans are like-minded and we understand each other. There is great comradeship between people that have served. I could not get this in any other home.

Another summarised why he felt it was important that he was part of the veteran community in care:

It's about the soldiers' mentality. If someone loses an arm or leg, we'd rip the mick out of each other and call them one-armed bandits. It's our way of coping, it's nice to have that. I think it's important to remember where you and the other veterans came from, keep the grassroots of the care home, remember why it was formed, keep that veteran ethos. Our chief executive is ex-military, our matron's ex-military, and it's important that we have that.

Another veteran also commented on the affinity between members of the veteran community:

I think it is quite important that it's a veteran home, because you've got people that really are on the same wavelength. I don't know how to describe it really... because you're on the same wavelength, you laugh at adversity together, and things like that, whereas most people wouldn't understand why you're laughing at things like that.

A number of veterans were still involved in their old regiments or service arms. One, who formerly served in the Royal Logistics Corps, described with joy how he is still in contact with his old colleagues:

I was in Aldershot two or three days ago, for my regimental birthday. They come and take me to the regimental birthday. We do it every year.

A senior nurse at a veterans' care home described how the connection between young veterans in residential care could play an important role in their social wellbeing:

Young veterans tend to have the same hobbies, the same interests, the same sense of humour... Often they will have served in the same conflicts or in similar situations, depending on what they were doing in the Forces, and so there is a rapport that helps bring them together.

Yet as one Armed Forces charity chief executive explained, while being a veteran was an important factor, its importance should not be exaggerated. Other aspects of commonality, like age, were ultimately more important in a practical sense:

Ignore the fact they have those specific needs which they can't satisfy themselves, just think of it as a group of people, a group of ex-military people. It doesn't matter that some of them are in wheelchairs. There will be moments where they'll all sit there and have a beer and share camaraderie and mix the interests of the

younger and the older, comparing life as a marine in 1940 to life as a marine in 2015. There is great respect in both directions. They'll all sit down and have a great chinwag and a reminiscence, but quite quickly the younger ones will start looking at their watch and thinking, 'right, it's time to go and do some young people things'.

However, being a veteran and being involved in the veteran community is an important source of pride for veterans in residential care, and a useful basis for social engagement and mutual support between veterans. A chief executive described how his charity's model used this veteran bond in its operation:

We know who our beneficiaries are, and they know who we are. We don't run case files on members; our members are members for life. Either they have intense needs, or they are a contributor. We are very strongly behind the principles of members supporting members. Members are supplied with support, and that support is member delivered. Over time, they may well be both.

Familial support and relationships

Almost all the working age veterans we interviewed told us that their illness or injury had put significant pressure on their family life. Frequently their changing circumstances had led to marital breakdown. For some, this was clearly still a source of great sorrow. In a number of cases, the immediate reason for a veteran's entry into residential care was a breakdown in their partner's ability to cope with the unasked for responsibility of providing often very intense care. One veteran told us about how her condition put pressure on her marriage:

When I left the Armed Forces I was pregnant. We moved around a lot with my husband still being in the Army. I was diagnosed with primary progressive MS. Later I had to go into residential care for two weeks... because my husband was gone off on a deployment and he was my main carer. That's when social workers became involved, because that was when we realised that the marriage was really broken down, and I was putting too much pressure on him.

I was getting care in the home but basically there was just me and him and he was having to do a lot more than normal. When my condition worsened, I moved into here.

Another veteran described how the pressure on his wife as well as the severity of his condition had led him to move into residential care full time:

My wife has a high pressure career. As the carers were leaving at the end of the week, she was taking over that role and looking after me on the weekend. It got to a point where my wife couldn't really cope any more, holding down her job and looking after me, it got too much. Not just for her but for me as well, because I wasn't getting the stimulus, I wasn't able to get out and about as much as I'd like. I was having constant seizures, day in day out, sometimes two or three times a day.

In most cases, the families of working age veterans in residential care continued to make sacrifices to facilitate their care, for example moving to be close to a certain care home. Indeed, more than half of the veterans we spoke to told us that their family had moved to be closer to their care home. The family of the veteran from Nepal had moved to the UK to be closer to him. In another case, a veteran's mother had moved to be near the care home:

We've got a flat just down the road we've bought now, so I stay there and I can come and see him. I come down all the time. I'm only just recovering from cancer myself, I'm on the road to recovery now, but I haven't been here much this year. And my daughter comes down. She looks after all his affairs.

A head of care told us about a veteran's wife who did not live in the area where her husband was living who would come for several weeks at a time to be with him. Although the strain under which families can be placed by the onset of severe impairment in one of their members is often very considerable, the positive impact of family support – where that support is sustainable – can be profound:

The other younger resident doesn't have a lot of familial interaction, because his family don't live in the area, though his wife does try to come down fairly regularly. She comes and stays with us for a few weeks, because she lives so far away. She will come down when she can and spend a few days chatting with him, being with him and taking him down to the communal areas to participate in social events, and that does always give him a massive boost. You can see it long after she's gone.

No reform can fully alleviate the burden felt by the families of severely ill or injured veterans who require residential care. However, some small practical changes – such as providing financial support for the immediate families of working age veterans who have to move across the UK in order to access specialist care – could reduce pressure on families. It should also be noted that our moral obligations under the Armed Forces Covenant extend to the families of veterans:

Those who serve in the Armed Forces, whether Regular or Reserve, those who have served in the past, and their families, should face no disadvantage compared to other citizens in the provision of public and commercial services. Special consideration is appropriate in some cases, especially for those who have given most such as the injured and the bereaved.[29]

It is not clear how the damage done to families by sudden and serious illness or injury might be alleviated further, but certainly the pressure on the families of working age veterans should be considered.

Many of the problems highlighted in this chapter, like the age disparity between veterans in residential care, or the pressure on families, are complex, and influenced by intractable factors such as the limitation of resources or the severity of an individual veteran's disability. Yet there are a number of ways in which the experience of young veterans in residential care could be improved, through instigating relevant best practice methods or improving signposting and information management. The experiences of veterans

explored in this chapter are in numerous important ways intrinsically related to key tensions and difficulties in the provision of care to working age veterans on an institutional and sector-wide level. These tensions and challenges are explored in the next chapter.

5 Sector-wide issues in care provision

There are a number of structural tensions at the heart of the provision of residential care for working age ex-service personnel. As we have seen, the small size of the population concerned is a challenge in itself. In addition, there are further tensions that providers must navigate – care close to home is desirable, as is the opportunity to interact with people of a similar age and background, but just as important is access to specialist services for the specific injuries (eg. limb loss, traumatic brain injury) that disproportionately affect personnel incapacitated during service. This chapter explores these broader challenges, which stretch beyond the experiences of individual interviewees, before we present our recommendations for how the social needs and wellbeing of working age veterans might be improved.

Within the complex landscape of Armed Forces charities there are a number of national centres providing specialist care – for example, the Queen Alexandra Hospital Home in West Sussex (which provides care for physically disabled veterans of all ages), the Blackpool home run by Blesma and Blind Veterans UK's rehabilitation centre in Brighton. Often, ex-service personnel come through these centres for a short-term transitional stay. But those who can expect to need residential support in the longer term face a difficult choice between the highest quality, specialist care and the desire to remain close to family. The impact of this choice was laid out in the previous chapter: families forced to move, and veterans living away from their families or opting for less specialised care closer to home. One chief executive commented:

All of us operating care homes would tell you that there is a catchment area attached to all of this placement as well as other considerations. People don't like moving too far from their own

community or family. If your family is in the north east, you don't want to be sent off to a place of care in Devon.

This tension affects veterans of all ages (including over-65s) with specialist care needs, though those of working age face the additional challenge of the age disparity between themselves and the majority of care home residents.

Considering the 'age disparity' problem in isolation, the obvious solution would seem to be a dedicated care home for veterans under 65. On the face of it, this should address many of the issues identified in the previous chapter – the challenges for providers of catering to different generations' tastes and expectations for their surroundings and activities, and avoiding social isolation among younger residents and its negative impact on health and wellbeing. However, the major barrier here is the diversity of need, and the level of specialist need, among the younger cohort of veterans.

It is worth quoting at length from two interviews with providers grappling with this three-way trade-off between geography, age disparity and specialism of care. One told us:

In my opinion, I think it would be much more appropriate to have a specific place to look after people who need residential care from a certain age group, so that you can set up social activities that satisfy all the residents, younger and older. But that adds another level of difficulty. Blind Veterans helps veterans cope with how to live without sight, Blesma deals with a totally different type of rehabilitation. Even though it would better to cater for their social needs, putting young veterans with these diverse needs together I don't think would be a good idea, because of their diverse care needs. Perhaps they could all be in the same site, but in different facilities.

Another described the problem with putting working age veterans who need care in one place:

The overall cohort of working age veterans in care is small. You could take the sort of Soviet approach and say, 'Therefore, why don't the charities get together, and put all of those people in one place designed for working age veterans, to focus the programme, engagement and activities you run there?' That would make some sense. For example, everyone in the North West [would go] to Blesma, if you are in the middle of the country Star and Garter, if you are in Scotland, Erskine, Royal British Legion across the country. We do a bit of it now; if another home has facilities or a care capability we don't have that someone needs we refer them to that, if there is a regional issue we will always say to the family, 'Why don't you try there and see if that works?' But the issue you would then hit is the specialism of care.

While the current situation where younger veterans live among a population of much older veterans is problematic, a solution that gives them the best quality of medical care, proximity to their family and a peer group of younger residents is exceptionally difficult to achieve.

Ultimately, the objective from the perspective of the veterans, the VWS and charities is not to be in residential care at all. One senior veterans' charity officer told us:

These days, the drive is to not put people into residential care until they absolutely have to. In my experience, even some of the most complex trauma patients are not in residential care; I'm aware from my previous experience in the MOD that even some of those with the most complex care needs are being cared for 24 hours a day in their own homes.

Nonetheless, for ex-service personnel as for the general disabled working age population, residential care continues to be the most appropriate type of care for some – and some require care of a specialist nature. If the location of these homes and the small size of this group means therefore that younger veterans have to live within a population of older veterans, potentially far away from their families, we need to consider more thoroughly how to meet their social and psychological needs. In the face of these challenges, flexibility in the delivery of care and support is crucial.

Connecting veterans with the care they need

The other great challenge highlighted in our research is that of how best to connect veterans to the care they need, a challenge addressed effectively in Lord Ashcroft's *Veterans' Transition Review*.

Chapter 3 of this report looked at the care pathways – the journeys taken from being a serving member of the Armed Forces to receiving long-term residential care – that exist for ex-service personnel of working age. We found that there were two main pathways depending on the group that veterans fell into: those incapacitated during service, and those incapacitated after service. While there is a need for improved information and signposting across the board, care pathways appear to function better for the former group than for the latter. As the transition from service to civilian life has become formalised, with the development of the DRC and the work of the VWS, younger personnel leaving service today are better connected to support services than previous generations. By contrast, it is far more difficult to effectively signpost veterans within general medical pathways to veteran care resources than it is to direct a veteran leaving the Armed Forces to those resources through the VWS directly.

This problem is compounded by the reluctance of many veterans to seek and take up help. As Lord Ashcroft concluded in his recent review of transition support for veterans:

[This group's] pride, their view of themselves as self-reliant individuals, the fact that they have endured serious hardships on operations, and the feeling that others must be in greater need than them contribute to making them reluctant to seek help.[30]

The Ashcroft review further raised the possibility that the large number of veterans' charities, and the sheer range of available support (general and specialist) might actually contribute to the difficulty connecting with the help needed. *The Veterans' Transition Review*, which found 350 veterans' charities in the UK, surmised, 'Given that only 14% of Service Leavers fall into the vulnerable category, there is in effect one charity for every

eight Service Leavers each year that are actually likely to need help.'[31] This large number of separate charities reflects the level of specialisation of care and support available to veterans in the UK. It is easy to regard such a stark statistic as evidence that the sector is over-resourced. Yet where there is a serious lack of accurate information on beneficiaries – as with the veteran community – that forms a significant barrier to the effective management of resources. The key problem is clearly not the volume of help available, or the good will and desire to help veterans, the scale of which is attested to by the rapid growth of charities like Help for Heroes, but connecting veterans to the help they need. The 2015 follow-up to *The Veterans' Transition Review* suggested that the work of Cobseo had gone some way towards unifying the sector and had helped to 'bring charities together on themes that were previously uncoordinated'.[32] Despite this organisational progress, it remains the case that veterans are often not signposted effectively towards the appropriate support or care services.

Solving this problem requires better information management on the part of the government and the third sector, better signposting for the veterans themselves, and better coordination between Armed Forces charities to ensure that all veterans – in particular the much smaller group who are under 65 – receive the help that they need.

The establishment of coordinating organisations such as Cobseo and Veterans Scotland represents a partial solution to this issue, but more could be done within these frameworks to share information, both between the charities themselves and with MOD partners in the VWS. Moreover, the picture is still confusing from the perspective of individual veterans themselves. *The Veterans' Transition Review* recommended the creation of a 24-hour contact centre as a single point of contact, with a dedicated website bringing together the VWS and veterans' charities. Within this framework, a 'single joint tracking and management system' could be exploited, as well as a directory of accredited Armed Forces charities, managed by Cobseo. However, Ashcroft's 2015 follow-up report

suggested that other means of simplifying signposting for veterans in need might be more effective.[33] While Demos supports efforts to improve signposting, an important pre-requisite for such efforts is the improvement of the evidence base regarding the veteran population. It is crucial to understand the size and needs of the working age section of the veteran community, and to know and share best practice in meeting veterans' needs in the round. An Armed Forces charity chief executive we spoke to explained the importance of obtaining evidence:

Generally speaking, to define and resource an effective pathway to help, it is very important to invest in gathering evidence to clearly define exactly how big this market of veterans in need actually is. Until that happens, no one can be sure that their resourcing decisions represent a sound return on investment.

Even where Armed Forces charities enjoy significant resources, if they lack information these funds either do not reach everyone they should or do not go towards providing the services for which there is the greatest demand or need. The result is 'piecemeal' support, as well described by this Armed Forces charity volunteer coordinator working in a care home:

We get a lot of financial support from various associations and charities, and some of them come in and chat to their 'own'. But it's very much a piecemeal effort. We've got an Armed Forces charity volunteering group and that's to try and address that problem, to try and get something going for the veterans. It is good for the residents, to have that close-knit community, so they can have a chat and that sort of thing. It's been really helpful for our veterans and the community as a whole. They get forgotten about, to be honest. And if they do want something like a one-to-one session, it's really having to come out of their own pocket.

The Armed Forces Covenant was established in order to set out the relationship between the nation, the state and the Armed Forces, and to reaffirm the moral obligation that we have to

members of the Armed Forces and to veterans. There was a sense among providers whom we interviewed that the practical impact of the Armed Forces Covenant on care for veterans had been minor. As one Armed Forces charity chief executive argued, this is not a criticism of the Covenant, but an acknowledgement of the difficult environment in which it has been introduced:

The Armed Forces Covenant has not really changed things, but made things more complex. That's not because local authorities do not see the issue or acknowledge the service of veterans, or do not value it. It's because they are under a lot of financial pressures in the current climate. It's wider than the Covenant; it's about social services under pressure. There are big economic plates shifting in the country that are having a bigger impact.

There is a strong argument to be made that local authorities, NHS trusts and other government agencies and authorities should be provided with specific guidance on how they can best fulfil the moral obligation that we have to members of the Armed Forces and to veterans in the context of resources that have been strained by reduced budgets.

Ultimately, improving the social and emotional wellbeing of working age veterans in residential care, and ensuring that veterans who might require residential care are aware of the help that is available to them, both involve connecting those in need to the resources that can help them.

Conclusion and recommendations

This report has highlighted a number of areas for improvement in what residential care currently offers ex-servicemen and women of working age:

- the lack of data on veterans generally, and on those in residential care specifically, which has a significant negative impact on the planning and resourcing of services
- the lack of awareness among veterans and health and social care professionals of entitlements to support and availability of support
- the more substantial lack among awareness among those who become ill or disabled after leaving the Armed Forces, who lack a dedicated care pathway
- working age veterans, and those involved in providing residential care for them, suffering from some of the same problems as other small groups in care, such as low visibility and muted patient voice, and from the practical constraints small care groups suffer from: tensions between service specialisation and geographical spread, and between whether services are designed around specialist needs or around age
- the negative impact on families that sudden severe injury and illness can have (which is not a problem confined to veterans), and the fact that this can be worsened by the geographic distance between specialist care facilities and where a veteran's family might live
- the significant discrepancy in age between working age residents of care homes and the average resident (again, not a problem confined to veterans)

These issues break down into three core areas:

- ensuring that working age veterans, as a small group, are seen, heard and understood
- connecting them, equitably, with the care that is available to them and that they are entitled to
- making certain that the care they receive is personalised and of a high quality

The management of information across government and the third sector sits at the heart of these areas, and must be a part of the solution. At the same time, the Armed Forces Covenant provides a licence to ask more of government departments not primarily involved in the care of veterans, and incentivises them to consider the needs of veterans more fully.

Drawing on our research and the best practice we identified, we make the following six recommendations:

1. Veterans UK should work with Armed Forces charities to establish and maintain a database of all UK veterans in residential care.

Working age veterans in residential care are not recorded or registered in any database or by any single organisation. Consequently, as a group they are essentially invisible to the state and to many of the third sector organisations capable of providing the support they need. In common with other small groups, their lack of visibility makes it difficult for service providers and policy-makers to understand or address their needs in any systematic way.

We propose that Veterans UK, with the support of the MOD, should establish and maintain an up-to-date database of all veterans in residential care, across both veterans' and non-specialist care homes. Armed Forces charities should be full and active partners in this process, contributing knowledge, expertise and their own valuable data.
Once established, the database should be accessible to Armed Forces charities and government services, and there should be an expectation that they use it to inform the effective and equitable allocation of resources across all veterans in this group. The database should record ex-service personnel by

age, permitting an accurate understanding of the specific characteristics of those aged under 65.

Lord Ashcroft's *Veterans' Transition Review* and its follow-up report recommended establishing a single point of contact for veterans, or otherwise simplifying access to the support offered by veterans' charities.[34] We support the idea of a single 'gateway' to support, but emphasise that improving data needs to be the absolute priority.

Establishing accurate data on the veteran population is the key to better planning and resourcing across the sector. For the sub-group that we are concerned with, under-65s in residential care, the proposed database would present the first accurate picture. Furthermore, it would provide a platform for data to be shared effectively between Veterans UK and Armed Forces charities – crucial to overcoming the signposting problems that prevent veterans from connecting with the help they need in an often complex landscape.

2. Health and social care professionals should proactively identify veterans with whom they come into contact.

The inadequacy of data on the veteran population (especially, but not limited to, those of working age) limits the ability of service providers to target potential beneficiaries. To connect with each other, veterans and Armed Forces charities are reliant on formal referrals and less formal signposting. Veterans incapacitated during service benefit from a fairly formalised referral pathway, and are more likely to be put in touch with the relevant support, though awareness on the part of the MOD and individual service arms of available charitable support was sometimes lacking. Veterans who become ill or injured after service may not know about available support, or that they are entitled to it. Rather than the MOD or their former service arm, ex-servicemen and women in this group are in contact, in the first instance, with mainstream NHS and social care services.

We therefore recommend that all health and social care professionals should seek to identify and record the veteran status of individuals they come into professional contact with,

and assist in directing them to appropriate support. Through these efforts the particular care needs of veterans as a group would be more thoroughly considered, and awareness increased among veterans of the health and social care resources available to them.

The Veterans' Transition Review recommends issuing service-leavers with an identifying 'veteran's card', bearing a telephone number and website as a single point of contact for assistance and support.[35] Formally maintaining some contact with service-leavers is a positive step, but our research shows that it is ex-service personnel who become ill or injured some time after leaving the service who are most likely to fall foul of the reliance on informal signposting. The proactive 'Do ask, do tell' policy that we propose should be of particular benefit to the 'incapacitated after service' group. By putting the onus on health and social care professionals to make veteran status part of the conversation, this measure would increase the reach of veteran support to those who are unsure or unaware of their entitlements or who might simply be too proud to ask.

3. Every local authority in the UK should have a designated 'Armed Forces and Veterans Champion' with a combined remit for health, social care, housing, employability and education.

In common with other small groups with specialised needs, veterans – and in particular the smaller sub-group of working age veterans – run a high risk of being overlooked. As care and support is increasingly devolved to a local level, the group is at risk of becoming still less 'visible'; there may be no more than one or two veterans in any local administrative area, for example. For this reason, the bulk of gathering intelligence on, planning for, and championing working age veterans' needs will need to be done at a national level. Nonetheless, regardless of the national picture, every working age veteran lives in a locality, in a community – and that applies whether their place of residence is their own home or a residential care home. It is challenging, but imperative, to make sure that veterans' needs are represented, and represented in the round, in the place where they live.

Currently, every NHS board in Scotland, every local health board in Wales and every CCG in England has a designated Armed Forces Champion.[36] Likewise, all four devolved nations have Jobcentre Plus Armed Forces Champions to assist service families to find employment.[37] Only Scotland has an Armed Forces and Veterans Champion in every local authority – a local councillor with specific responsibility for championing veterans in the local area on issues such as access to housing.[38] Given the importance of a holistic consideration of veterans' needs, and the challenges associated with scale, further fragmentation of representative functions is not ideal. Instead, we propose a single, local champion role, which combines all the areas of need stipulated in the Armed Forces Covenant, including health, social care, education and housing. Champions should be expected to consider the particular needs of working age veterans as a group, and to represent and proactively seek the views equally of those living in their own homes and those living in residential care.

4. A best practice network in residential care for veterans should be established, and a best practice guide produced.

In the course of this research we spoke to a number of working age veterans in residential care, and a number of care providers. There was consensus among them on a number of issues which made high-quality care challenging to deliver. Above all, they identified the age disparity between working age veterans and the general care home cohort, and the difficulty in catering for younger veterans' different tastes, expectations and needs for social interaction. At the same time, we saw and heard of examples of settings overcoming these barriers – through flexibility in the use of accommodation, personalised care where staff took the trouble to deploy residents' assets in the service of the care home community, and opportunities provided for social interaction outside the care home (sometimes with service experience as a uniting theme). Moreover, we are aware of a wealth of good practice in personalisation and community links in the general care home community, on

which all settings with a working age veteran in their care could draw.

We therefore propose the creation of a best practice information sharing network, specifically addressing residential care for working age ex-service personnel. This could be usefully facilitated by Cobseo, and should include care homes run by Armed Forces charities, generalist care home providers, and umbrella bodies like the National Care Forum, the Social Care Institute for Excellence and Care England, and the Care Quality Commission. This network would bring specialists and generalists in working age residential care together. It would provide a forum in which to identify and share best practice for working age veterans in residential care, as well as working age residents in care homes in general.

This network would further serve as the vehicle for the production of a best practice guide focusing in particular on innovations and successful initiatives for meeting the social and emotional needs of working age veterans in residential care.

5. Armed Forces charities should sponsor an annual 'Veterans' Voices' review of veterans in residential care.

As previously discussed, the smaller and more hidden the group, the more it struggles to have its voice heard. To address this deficit, we suggest the institution of an annual review of (all) veterans in residential care, with the aim of capturing their concerns and experiences. In practice, the review might involve a combination of survey, interviews and group consultation. The voice of veterans under 65 should receive equal representation with the majority, over-65 population.

Complementing the collection of 'hard' data on numbers and location of veterans in residential care (see recommendation 1 above), the review would help to gauge residential care settings' performance in meeting veterans' less tangible needs – like that for social interaction, and a sense of purpose. Its findings should feed into the work of the proposed best practice network (see recommendation 4 above) and should

be presented to the Minister of State for Defence Personnel, Welfare and Veterans.

We envisage that one of the larger Armed Forces charities, or a coalition of charities, would be best placed to sponsor this review, though we would like to see it have the full support of two important public bodies: Public Voice, the work-stream within NHS England which ensures that the views and experience of the public are embedded into all levels of commissioning and provision of NHS services,[39] and Healthwatch England, the national consumer champion for health and social care.

6. Residential care settings should conduct skills audits for their working age residents, encouraging contribution to the care home and wider community.

A rapid loss of independence associated with sudden illness or injury, especially where it necessitates a move to residential care, can be particularly distressing for people of working age. This may be even truer of ex-service personnel, many of whom have a self-concept based on their physical capability, independence and service of others. Our research suggests that a lack of opportunity for engagement with others in the home, or with the wider community outside the home, can contribute to a sense of boredom and isolation among this group, and even precipitate a deterioration in their condition.

For many years there has been a focus in social care on what people cannot do – their limitations and medical needs – rather than what they can do and their personal goals. This is slowly changing across the sector in line with person-centred care and a shift from 'deficit-based' to 'asset-based' approaches to care. We saw examples of this approach in some care homes, where veterans were employing their individual skills – undertaking photography around the home, or tending the gardens.

In a care home setting, just as in a business, or any other setting in which people live or work together, conducting a skills audit simply involves identifying the particular skills and assets that each individual brings. Understanding this can be

transformative – giving self-worth to the individual and self-sufficiency to the community, and often providing a salutary reminder of the artificial nature of distinctions between the 'helpful' and the 'helpless', the 'doer' and the 'done-to'.

Providing opportunities for veterans to contribute, particularly where those contributions are associated with social opportunities or the concept of service, has significant potential to transform the social and emotional wellbeing of working age veterans.

The lives of working age veterans can be transformed by the support on offer from government departments, Armed Forces charities, and wider civil society. Despite their often great levels of need, the small and hidden population in residential care have for too long been almost invisible to policy-makers. These reforms in how we share information, connect people with support, and tailor that support to individuals' needs could significantly improve the situation of both current veterans and those who will leave the Armed Forces in the future.

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The Armed Forces Covenant 2011 cemented the obligations of government and civil society to all those who have served their country. Yet there remain some groups of ex-service personnel about whom not enough is known. This report looks at one such group: working age veterans in residential care.

Based on interviews with veterans aged under 65 in care home settings and with care providers, this report explores the nature, needs and preferences of this small but significant population. It finds that a lack of data and inadequate signposting hamper efforts to connect individuals to the support they need. Ill and injured ex-service personnel may face difficult choices between specialist care and less suitable provision closer to home. Where they are the only young person in a setting designed for much older residents, their personal preferences or needs for social interaction too often go unmet.

The report makes recommendations for how government and care providers, working closely with Armed Forces charities, can ensure this group is better served – through better data collection, proactive identification, and drawing on best practice in personalised care from across the wider residential care sector.

Louis Reynolds and Ally Paget are Researchers at Demos.

FiMT forces in mind trust

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