



Adult Social Care in the Armed Forces Community

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Introduction

Adult social care supports people to live well, and as independently as possible. The support offered includes washing, dressing, preparing meals and help getting out of the house. For many people, at some point in their lives, they will need social care support, provided by friends and family or formal services. For members of the Armed Forces community, social care needs can often be greater in scale, distinct in character, or shaped by conditions that wider care systems may not be equipped to recognise.

The Royal British Legion (RBL) is the UK's largest Armed Forces welfare charity, supporting the Armed Forces community for over a century. RBL is central to the social care landscape for this community. Through direct service provision, RBL operates and funds specialist care homes, delivers an Independent Living Advice service to help Armed Forces community members remain safe and independent in their homes, and provides Admiral Nurses in partnership with Dementia UK to support families of those living with dementia. RBL also supports the Veteran

Friendly Framework (VFF), a national accreditation programme run in partnership with Royal Star & Garter that helps care homes identify and meet the needs of Armed Forces community residents, many of whom are spouses, partners, and other adult family members. RBL works alongside statutory and third sector partners to influence social care policy and practice across the UK.

This report sets out why adult social care for the Armed Forces community demands urgent attention. The extension of the Armed Forces Covenant's statutory 'due regard' duty to social care through the Armed Forces Bill 2026, and the ongoing work of the Casey Commission on Social Care, represent significant opportunities to address long-standing gaps. Drawing on our service provision, engagement with lived experience, and policy knowledge, RBL aims to offer insight that can support this important change.



The Scale of Need



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Data from the 2021 and 2022 Census¹ and RAND Europe's population projections² commissioned by the Royal British Legion provide the clearest picture to date of the demographics of the Armed Forces community. In 2026, there are approximately 1.73 million veterans living in Great Britain. This is down from 2.63 million in 2014 and aligns with projections for further decline to 1.06 million by 2045³. Whilst the number of veterans is falling, the proportion who are of working age is rising, from around 50% today to approximately 55% by 2045. This means the nature of social care need within the community will shift significantly over the coming decades.

Findings from the 2021 England and Wales Census data show that 211,850 (11.4%) of veterans in England & Wales reported bad or very bad health, while 594,354 (32%) were disabled under the Equality Act definition⁴.

For many veterans, disability will be age-related. However, a slightly greater proportion of veterans than non-veterans are disabled, even when adjusting for age, sex and location (32% for veterans, 30% for non-veterans). In Scotland, 44% of veterans identified as disabled in Census 2022 (these percentages should be interpreted separately, as the question phrased in the census varied slightly)⁵. At the time of the Census, an estimated 26,500 veterans were living in care homes in England & Wales, however veterans were proportionately less likely to live in residential care than age-matched non-veterans, suggesting that a significant number may not be accessing appropriate care⁶. Partners of veterans carry a substantial and often invisible caring responsibility: 18.9% provided unpaid care according to Census 2021⁷.

The nature of need within the veteran community is shaped by the demands of military service.

Musculoskeletal disorders are consistently one of the two leading causes of medical discharge from the UK Armed Forces affecting mobility and daily living from mid-life onwards, often in combination with other conditions⁸. Hearing impairment affects veterans at a higher rate than those who have never served: veterans are 2.3 times more likely than non-veterans to experience hearing loss, and 1.6 times more likely than non-veterans to experience tinnitus. Those who have deployed on operational tours are twice as likely to experience hearing loss as those who have not⁹. Mental health conditions, including PTSD, have social care implications as they can affect capacity to maintain relationships, manage daily routines, and live independently. The most recent King's Centre for Military Health Research Phase 4 cohort study found that rates of probable PTSD amongst ex-serving personnel now stand at approximately one in ten (11% of ex-serving regulars), with rates of almost one in five amongst those who served in combat roles in Iraq or Afghanistan¹⁰. While not directly comparable, rates of PTSD in the general population are around 4%.

1. England & Wales Census 2021; Scotland Census 2022.
2. RAND Europe (2026). Projections of Armed Forces Community Demographics 2025–2045. Commissioned by The Royal British Legion.
3. Galley & Slapakova (2026). Forecasting the Support Needs of the Veteran Community in Great Britain, RAND Europe, pp.6-12.
4. Census 2021 (England & Wales), ONS.
5. Census 2021, National Records of Scotland.
6. Census 2021 (England & Wales), ONS
7. Galley & Slapakova (2026). Forecasting the Support Needs of the Veteran Community in Great Britain, RAND Europe, pp.14-16.
8. Ministry of Defence, UK Armed Forces Medically Discharged Statistics 2024
9. Royal British Legion (2025), Understanding the Impact of Hearing Impairment on Working Age UK Armed Forces Veterans
10. Sharp et al. (2024), Health and Wellbeing Study of Serving and Ex-Serving UK Armed Forces Personnel: Phase 4, KCMHR / Office for Veterans' Affairs.

Evidence of Need

The findings in this report draw on a systematic review of over 50 published research and policy sources, alongside ten engagement activities carried out between October and December 2025. Those activities included three roundtables and seven one-to-one or small group discussions with approximately 30 organisations across the UK, among them veterans and family members with lived experience of adult social care, Armed Forces Liaison Officers and Champions, specialist and mainstream care providers, third sector organisations and policy officials from devolved governments. Throughout this report we will be using the term ‘interest-holders’ rather than ‘stakeholders’ when referring to those who participated in our engagement activities¹¹.

Seven themes emerged consistently across both the research evidence and the engagement, and interconnect to reinforce one another. For example, data gaps prevent

commissioners from identifying need, and short-term funding prevents providers from building expertise. As a result, those in the Armed Forces community who require social care only often access appropriate support at crisis point, though earlier intervention could have mitigated issues. Whilst cost and quality of care did not emerge as distinct standalone themes, they surface consistently across the findings. It is worth noting that this may reflect the profile of those we engaged with, rather than an absence of concern and RBL recognises these as significant issues across the wider sector. The £1,000 vs £2,000 per week gap between contract rates and actual delivery costs mentioned by interest-holders illustrates the direct relationship between funding adequacy and quality of provision. The recommendations that follow speak directly to the sustainability and adequacy of care for the Armed Forces community.



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11. Akl, E.A. et al. (2024) ‘“interest-holders”: A new term to replace “stakeholders” in the context of Health Research and policy’, *Cochrane Evidence Synthesis and Methods*, 2(11)

Key Themes

1. Covenant Obligations Are Not Being Met

The Armed Forces Covenant ('the Covenant') is the nation's promise that members of the Armed Forces, veterans, and their families should not face any disadvantage due to their Service, and provides for special consideration in certain circumstances, such as for those who have been injured or bereaved. The Covenant was introduced as part of the Armed Forces Act 2011 after a successful campaign led by the Royal British Legion and Poppyscotland. The Armed Forces Act 2021 later introduced a legal duty ('the Covenant Duty') to give 'due regard' to the principles of the Covenant for organisations responsible for providing local healthcare, education, and housing services, such as local authorities, governing bodies of schools, and NHS bodies.

The Armed Forces Bill 2026 includes provision to expand the Armed Forces Covenant Duty further into law, beyond its current scope. This means that bodies within scope, both now and in its future iteration, must pay 'due regard' to the principles of the Armed Forces Covenant when developing policy and services. Both national and devolved governments, and social care as a policy area, are expected to come within scope of this Duty as part of this Bill¹². This is a significant and welcome development. However, the duty of due regard does not dictate outcomes, meaning that bodies within scope must evidence consideration of the needs of the community, but are not required to achieve specific results.

Engagement found wide variation in how local authorities interpreted the existing, limited Duty. Compliance ranged widely, and there is little evidence of poor implementation being challenged. A local councillor and Armed Forces Champion stated, "Lip service to the Armed Forces Covenant - some authorities nominally comply but lack practical implementation." - It was clear from the engagement roundtables that, where the current Duty had limited impact in areas of health and housing, the provision of social care was consequently affected. It is important to note that the statutory Covenant Duty has applied to health bodies including NHS trusts, integrated care boards, and health boards as well as local authorities since November 2022. Variable implementation has been observed across both, and the perception that the Covenant is solely a local authority responsibility risks health bodies failing to interrogate their own obligations with sufficient rigour. The extension of the statutory Covenant Duty to cover social care through the Armed Forces Bill 2026 is a

significant opportunity, but it will only deliver meaningful change if accompanied by clear operational guidance, adequate resourcing, and accountability mechanisms that move beyond nominal compliance to tangible outcomes for the Armed Forces community.

2. Inconsistent and inaccessible support

Several interest-holders indicated that accessibility to support for the Armed Forces community varied in both standards and accessibility, depending on location. Geographic barriers are particularly acute in rural areas with elevated veteran populations but sparse service provision - Moray, rural Wales, Cumbria, the Scottish Highlands were some of the areas identified within our engagement with interest-holders. In these areas, services were characterised as difficult to access and providers are limited, but the Census tells us these areas have higher than average veteran populations.

Standard 9am–5pm service models from care providers were also considered to exclude working-age veterans and carers, particularly women with caring responsibilities. As one interest-holder stated:

"High veteran population but thin caseworker coverage — one person covering a vast geographic area."
- Engagement participant, Moray.

Addressing this variation in access to services requires both national minimum standards for how social care services identify and support the Armed Forces community and targeted investment in under-served areas, particularly in rural regions with high veteran populations and sparse service coverage.

Accessibility to support for independent living is further hindered by barriers to accessing home adaptations. Disabled Facilities Grants (DFGs) contribute to home adaptation costs to facilitate safer, independent living. Whilst councils administer DFGs, the means-testing criteria to determine eligibility are bound by legislation. As a result, for those in receipt of military compensation for a service-related injury, illness or bereavement, all or most of their compensation is treated as income. RBL's own research found that four in five councils were still treating military compensation as income as recently as 2022, and while RBL has since worked with over 50 councils to address this, the problem remains widespread¹³.

12. Akl, E.A. et al. (2024) "'interest-holders': A new term to replace 'stakeholders' in the context of Health Research and policy", *Cochrane Evidence Synthesis and Methods*, 2(11)

13. Royal British Legion. Credit their Service. Available at: <https://www.britishlegion.org.uk/about-us/our-campaigns/campaigns/credit-their-service>

Councils are only able to disregard military compensation in full if they have an established discretionary scheme for housing adaptations, but applicants must undertake the formal process for a DFG in the first instance. For the Armed Forces community, this presents a significant financial barrier to effective social care within the home, and breaches principles of the Armed Forces Covenant.

3. Settling in Unfamiliar Places

Military service often requires frequent relocation, with many serving personnel typically moving every two to three years¹⁴. This means that by the time veterans leave service and settle permanently, they have often spent years moving between assignments rather than putting down roots in any one place. It is frequently identified by service providers that veterans, and their families, often settle in areas where they have no family connections, established social networks, nor familiarity with local services. They may have received support in a previous area - through a charity, a GP familiar with veteran health, or an informed local authority, but that does not necessarily follow them.

In their new area, issues can often arise from a limited knowledge of what they are entitled to or where to look for support. This combination of isolation from social connections and support networks and unfamiliarity with local and tailored systems, can create a particular vulnerability that mainstream social care is not currently designed to identify nor address.

Wales, with its regional Armed Forces Liaison Officers, was mentioned by interest-holders as a strong model from which other nations can learn. A Welsh Government-commissioned evaluation (WLGA), as reported by the Welsh Local Government Association, found that the AFLO roles had “brought about substantial benefits to the delivery of covenant commitments in Wales¹⁵. While the evaluation itself has not yet been published, wider evidence from WLGA and Welsh Government materials shows that the AFLO model operates through strong partnership working and accessible, community-based support tailored to local needs.

4. Short-Term Funding Is Undermining Long-Term Care

Specialist providers for the Armed Forces community - many of which are charities - often fill gaps in meeting need that statutory services are unable to meet to the same standard. However, many organisations operate

exclusively on short-term grants, often of one to two years, that make it difficult to recruit and retain specialist staff, plan for future demand, or demonstrate long-term impact to commissioners¹⁶.

An interest-holder representing a specialist veteran care home provider described contract rates of approximately £1,000 per week against actual delivery costs of £2,000 per week, requiring £10 million in annual fundraising to remain viable.

Interest-holders were clear that “Short-term funding undermines continuity - by the time we recruit and train staff, funding ends.” Shifting to multi-year commissioning for specialist Armed Forces community social care providers is essential to protect the workforce, sustain relationships with veteran communities, and enable services to plan and deliver strategically rather than simply survive cycle to cycle.

5. Invisible Families

Despite the clear obligations of the Armed Forces Covenant to include families, specialist social care provision for the Armed Forces community remains predominantly focused on veterans, with family members, particularly unpaid carers and bereaved relatives, often overlooked or underserved. The Armed Forces Covenant identifies the considerable sacrifice and contribution of families of serving personnel, veterans, and the bereaved community, yet in practice, specialist provision, commissioning decisions, and Covenant implementation tend to centre on the veteran rather than the family unit.

RBL’s 2021 research on unpaid carers in the Armed Forces community found that two in five carers had received no support in the previous two years, and 71% reported that caring had a negative impact on their mental health¹⁷.

“Unpaid carers, often women, face self-neglect whilst caring. When the carer dies, we get crisis referrals - the veteran’s condition is unchanged but the informal support is gone.” - Care professional.

A person-centred approach to social care for the Armed Forces community must therefore recognise and support the whole family unit. Carers, spouses/partners, children and other family members, and bereaved relatives are not peripheral to this agenda, they are central to it.

14. Walker, D., Kirby, S. & Gribble, R. (2020), Living in Our Shoes: Understanding the Needs of UK Armed Forces Families, Ministry of Defence; Armed Forces Covenant Fund Trust (2024), Serving Families: On the Move programme 2025–26.

15. Welsh Local Government Association (2026). Written evidence submitted to the UK Parliament on the Armed Forces Covenant in Wales: <https://committees.parliament.uk/writtenevidence/135287/html/>

16. Skills for Care (2025), The State of the Adult Social Care Sector and Workforce in England.

17. Royal British Legion (2021), Unpaid Carers in the Armed Forces Community.

6. No Reliable Data, No Reliable Care

Standard care management systems in use across the UK have no consistent field to record Armed Forces status. The Veteran Friendly Framework (VFF) offers a model of what effective identification can achieve¹⁸. Care homes accredited under the VFF are supported to ask about and record residents' Armed Forces background, enabling staff to tailor care to their specific needs and histories. Wider adoption of this identification approach across local authority and wider care provider care management systems could transform the sector's ability to plan and commission appropriately. Without this, local authorities and other social care providers cannot identify who in their population is a member of the Armed Forces community, are unable to effectively track service use, measure outcomes, or commission appropriately to target need. As one participant said:

“No Armed Forces community field in off-the-shelf systems - back-door workarounds cost time, money, training.” - Local authority participant.

The Office for Veterans' Affairs (OVA) announced the programme VALOUR in 2025 to coordinate veteran support nationally and locally, with proposed extension to the wider Armed Forces community at a later stage¹⁹. The provision of extensive funding and collaboration tools has the potential to facilitate widespread best practice, enabling the delivery of tailored support to meet localised need. VALOUR also has the potential to resource practical action to drive the implementation of the Covenant Duty, particularly as further policy areas come into scope, including social care.

However, engagement with a variety of interest-holders demonstrated concerns with VALOUR proposals and implementation. This includes the risk of creating parallel bureaucracy signalling that any new data infrastructure must be built with and around existing systems. Without reliable, consistent identification of Armed Forces community status across care management systems, local authorities and other providers will remain unable to plan, commission, or evaluate services appropriately.

7. Identity Barriers

A recurring theme across engagement was how closely those receiving care identified with their role in the Armed Forces community, and the perceived accessibility of support. For example, interest-holders reported that many people who have served do not identify with the term 'veteran':

“I am not a veteran, I just used to be in the Army”.

This has practical consequences as services labelled 'for veterans' may not be accessed by those who do not recognise that label as applying to them. Interest-holders also noted a tendency to frame veteran need through a PTSD-focussed lens, which can both stigmatise and exclude those whose needs are not mental health related. It is essential that, whilst support explicitly focused on the Armed Forces community is readily available, those providing care services across both Armed Forces and civilian settings are also informed about the unique needs and profile of Armed Forces community members who require social care, so that support is accessible regardless of how an individual chooses to identify.



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18. Care City. (2025). Veteran Friendly Framework: Final Evaluation Report (July 2025). Care City. Available at: <https://www.carecity.org/wp-content/uploads/2025/10/VFF-Final-Evaluation-Report-July-2025.pdf>.

19. Ministry of Defence & Office for Veterans' Affairs (2025). VALOUR: information and next steps. GOV.UK. Available at: <https://www.gov.uk/guidance/valour-information-and-next-steps>

Our Five Calls for Change

The evidence points to five areas where targeted, achievable action would make the greatest difference to the largest number of people. Each recommendation has a clear ask, directed at a specific decision-maker, founded in participant engagement and evidence of gaps in need.

Recommendation 1: RBL calls on the UK Government and devolved governments to provide clear and appropriate resource and training, focused on social care, within Armed Forces Covenant Duty implementation.

The Armed Forces Bill 2026 will extend the Covenant's statutory 'due regard' duty to include social care. RBL calls on the UK Government and devolved governments to publish operational guidance with worked examples of what adequate Covenant compliance looks like within social care.

This could cover needs assessments, commissioning decisions, service design and cross-border coordination. Guidance must reflect devolved legislative contexts and communities, and not rely on materials focused on England alone²⁰.

Local authorities and NHS bodies, and the social care sector must also be supported to implement Covenant extension principles ahead of the statutory duty taking full effect, building a body of good practice that can inform national implementation. Appropriate and sustainable resource must be made available to drive tangible change across social care providers and enhance their ability to effectively support the Armed Forces community. Existing tools such as the Veteran Friendly Framework provide a proven model for building care home staff awareness and capability in meeting Armed Forces community need and should be embedded within Covenant Duty training and implementation guidance.

Recommendation 2: RBL calls on the UK Government, Scottish Government, Welsh Government, and Northern Ireland Executive to collaborate on cross-border portability protocols to maintain tailored care for the Armed Forces community.

These protocols must establish clear mechanisms for the timely transfer of care assessments, including positions on waiting lists, as well as the protection of medication regimes.

Recommendation 3: RBL calls on local authorities, NHS bodies, and the Armed Forces Covenant Fund Trust to roll out multi-year commissioning for specialist providers.

RBL calls on local authorities, national bodies including the relevant NHS systems and the Armed Forces Covenant Fund Trust to move to three-to-five-year commissioning contracts, and to ensure that fee rates within those contracts reflect the genuine cost of specialist care delivery. Single-year or shorter-term funding cycles make it impossible to retain skilled staff, build trust with veteran communities, or develop services strategically. Multi-year commissioning would enable organisations to retain experienced and specialist staff, invest in service development, and build lasting relationships with veteran and Armed Forces communities.

Commissioning guidance should make clear that lowest-cost tendering in specialist care creates false economy, reducing capacity and quality rather than improving value for money. RBL recognises that short-term and inadequate funding is a challenge across the whole social care sector.

²⁰ See Appendix

Recommendation 4: RBL calls for mandated Armed Forces Identifiers in Care Management Systems Across All UK Nations.

RBL calls on the UK Government’s Department of Health and Social Care to mandate an Armed Forces community identifier in all care management system procurement in England; on the Scottish Government to do the same across Scotland’s 31 Health and Social Care Partnerships; on the Welsh Government to require it across all 22 local authority care systems; and on the Northern Ireland Executive to mandate it across the six Health and Social Care Trusts.

A joint four-nations data standards working group spanning health and social care should develop shared technical specifications for Armed Forces community data recording, transfer, and aggregation so that when families move between nations, their information can follow them. This should be pursued alongside wider interoperability standards. Existing frameworks such as the Minimum Operational Data Standard (MODS) - an England wide standard for Care Quality Commission registered adult social care providers - and care management systems that already incorporate Armed Forces community fields, demonstrate that mandating these identifiers is technically achievable. Implementation guidance should specify a minimum data set for Armed Forces community recording, promote consistent coding practices across health, GP, social services, and social care systems, and explicitly seek to avoid duplication of data collection across those systems.

Recommendation 5: RBL calls for reform of mandatory Disabled Facilities Grants to remove the Military Compensation Penalty.

Restrictive means testing policies for DFGs directly contradict the Covenant principle that service in the Armed Forces should not create disadvantage and this process fails to provide any special provision for those who are injured or bereaved and, by definition, have given the most. RBL calls on the UK Government to fully disregard military compensation payments in DFG means-testing, bringing grant policy into line with Covenant obligations and ensuring veterans are not penalised for injuries sustained in service.



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The Roadmap for Change

Delivering on these recommendations requires action at different timescales, across all UK nations, and from multiple agencies simultaneously. The roadmap* below sets out what needs to happen and when. It is structured in three phases and reflects the interconnected nature of the challenges.



* For full, unabridged roadmap details, please refer to the following pages.

Recommendation 1: RBL calls on the UK Government and devolved governments to provide clear and appropriate resource and training, focused on social care, within Armed Forces Covenant Duty implementation.

This recommendation will be undertaken primarily by UK Government; devolved governments; Ministry of Defence; Department of Health and Social Care (DHSC); equivalent devolved health and social care departments; local authorities; social care providers; NHS England; Integrated Care Boards (Phase 2); Armed Forces charities.

0 - 12 Months

As part of Statutory Guidance to be issued alongside the extended Armed Forces Covenant Duty, the MOD must ensure evidence-based and thorough direction on social care is included. This must consist of worked examples covering needs assessment, commissioning, service design and cross-border coordination, reflecting devolved legislative contexts.

1 - 3 Years

Establish a baseline and good understanding of practice to inform the evaluation and measurement of the social care Covenant extension over the next three years. Integrate Armed Forces community social care as a standing indicator in Covenant annual reporting.

3+ Years

Review Covenant Duty implementation across social care, strengthen where compliance remains nominal. Recognition of the legal duty and Armed Forces community, alongside actions for improvement based on Covenant evaluation, should be included within social care strategy.

Impact

Social care services, regardless of whether they cater solely to the Armed Forces community or not, are equipped to deliver tailored support, from a position of understanding the implications of service, and common service-related conditions, and effectively meet need. Existing tools such as the Veteran Friendly Framework provide a proven model for building care home staff awareness and capability in meeting Armed Forces community need, and should be embedded within Covenant Duty training and implementation guidance.

Recommendation 2: RBL calls on the UK Government, Scottish Government, Welsh Government, and Northern Ireland Executive to collaborate on cross-border portability protocols to maintain tailored care for the Armed Forces community.

This recommendation will be undertaken jointly by the UK Government; Scottish Government; Welsh Government; Northern Ireland Executive; local authorities; health and social care bodies; Armed Forces charities.

0 - 12 Months

Pilot portable assessment summaries in areas with high Armed Forces community mobility.

1 - 3 Years

Develop formal cross-border portability protocols through UK-nations collaboration, covering assessment transfer, waiting list continuity and medication regimes.

3+ Years

Legislate for a national portability framework establishing a legal obligation for receiving authorities to honour portable assessments.

Impact

Armed Forces community members experience seamless continuity of care when moving around the UK, with assessments, waiting list positions, and care plans recognised irrespective of location. This ensures their care is not disrupted by mobility linked to Service life, reduces delays, and enables social care systems to respond consistently and appropriately to their needs.



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Recommendation 3: RBL calls on local authorities, NHS bodies, and the Armed Forces Covenant Fund Trust to roll out multi-year commissioning for specialist providers.

This recommendation will be undertaken by social care funding bodies; statutory commissioners across the UK; specialist providers; Armed Forces charities.

0 - 12 Months

Establish examples where this works well and documenting the direct tangible impact on the community to evidence why it's important.

1 - 3 Years

Ensure that strategic commissioning frameworks, with means for robust evaluation, position the Armed Forces community as a distinct cohort, taking into account projected population change.

3+ Years

Actively monitor provider sustainability and joint funding pools between statutory commissioners and the Armed Forces Covenant Fund Trust.

Impact

Specialist providers supporting the Armed Forces community have stable, predictable funding that enables them to plan services, retain skilled staff, and meet emerging needs effectively. Multi-year commissioning strengthens the sustainability of the sector, ensuring that individuals with service-related conditions can access high-quality, tailored support wherever they live, without disruption due to annual funding cycles. RBL recognises that short-term and inadequate funding is a challenge across the whole social care sector.



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Recommendation 4: RBL calls for mandated Armed Forces Identifiers in Care Management Systems Across All UK Nations.

This recommendation will be undertaken by the UK Government; devolved governments; digital bodies; local authorities; social care providers; system suppliers; Ministry of Defence (including Programme CORTISONE).

0 - 12 Months

Develop agreed Armed Forces community identifiers, building on the existing harmonised standard for identifying veterans. Mandate Armed Forces community identifiers in all new care management system procurement across all four nations, with funding to retrofit existing systems.

1 - 3 Years

Monitor implementation of mandated Armed Forces community identifiers and develop protocols enabling data transfer between systems when Armed Forces community members move. Programme CORTISONE, the MOD project to digitise military health records and integrate them into NHS systems for the first time is a significant step that will benefit all service leavers. It is important the MOD continue to roll out and implement this project promptly.

3+ Years

Develop a population-level monitoring dashboard giving commissioners frequent, consistent reporting to agreed common standards on Armed Forces community demographics, service use, and unmet need among those not yet in receipt of support, underpinned by a dedicated Armed Forces community social care research capability. Whilst there is potential for this to be developed as part of wider initiatives seeking to collate and analyse data about the Armed Forces community, including through VALOUR, it is essential that this is regularly reviewed through a social care lens, ensuring data is utilised meaningfully to meet evolving Armed Forces community need.

Impact

Mandating Armed Forces identifiers across care management systems will facilitate a consistent, reliable understanding of where Armed Forces community members are within the social care system, enabling earlier identification of need among those already accessing health and social care, and more tailored support. Population-level data reported frequently and accurately will allow services to track trends, address unmet need, and ensure that care planning and resource allocation genuinely reflect the experiences and requirements of the Armed Forces community across the UK. Implementation guidance should specify a minimum data set for Armed Forces community recording, promote consistent coding practices across health, GP, social services, and social care systems, and explicitly seek to avoid duplication of data collection across those systems.

Recommendation 5: RBL calls for reform of mandatory Disabled Facilities Grants to Remove the Military Compensation Penalties.

This recommendation will be undertaken by the UK Government; local authority housing teams; local authority adaptation teams; occupational therapists; social care practitioners; Armed Forces charities.

0 - 12 Months

Commit through the ongoing DFG reform to fully disregarding military compensation in means-testing, and issue interim guidance to local authorities on discretionary adaptation funding in the meantime.

1 - 3 Years

Legislate for the full disregard of military compensation in DFG means-testing through amendment to the Housing Grants, Construction and Regeneration Act 1996 and update guidance accordingly. Integrate information about Armed Forces community need into materials pertaining to DFG assessment.

3+ Years

Co-produced guidance on the Armed Forces community, for occupational therapists, would ensure they are equipped to recognise service-related need, understand how military compensation interacts with Disabled Facilities Grants, and make appropriate referrals to specialist Armed Forces support.

Impact

Reforming Disabled Facilities Grants to disregard military compensation will ensure that injured serving personnel and veterans are no longer penalised when seeking essential home adaptations, enabling faster, fairer access to safe and appropriate housing. Clear guidance will improve the accuracy of assessments, reduce delays, and ensure that the Armed Forces community receives adaptations that genuinely support independence, rehabilitation, and long-term wellbeing.



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Each devolved nation will need to adapt this roadmap to its own legislative and structural context. England must leverage Integrated Care Boards (ICBs) whilst protecting social care's voice within NHS-dominated structures, a particular concern given the planned abolition of NHS England and its integration into DHSC, alongside major restructuring of ICBs. Whilst this restructuring risks disruption to systems still bedding in, it also presents an opportunity to place social care on a stronger footing within an integrated DHSC structure. Scotland must address the challenges of rural access²¹. Wales should build on its Liaison Officer model and develop Wales-specific practice guidance, which engagement participants noted is currently absent. Northern Ireland should capitalise on its integrated Health and Social Care Trust structure and consider a pathway to statutory Covenant duty adoption.

The evidence presented here points to a system that, despite good intentions, is not consistently meeting the needs of those who have served and their families. The barriers are well understood, the solutions are achievable, and the legislative conditions are more favourable than they have been for some time. Progress will require coordinated action across governments, commissioners, and providers - the roadmap above sets out a practical path forward.

21. Nuffield Trust (2023), *Adult social care in the four countries of the UK*, Explainer Series; Dodsworth & Oung (2023), 'Who organises and funds social care?', Nuffield Trust.

Appendix

- **Social Care Recommendations for Scotland**
- **Social Care Recommendations for England**
- **Social Care Recommendations for Northern Ireland**

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