NICE National Institute for Health and Care Excellence

NICE Pathways

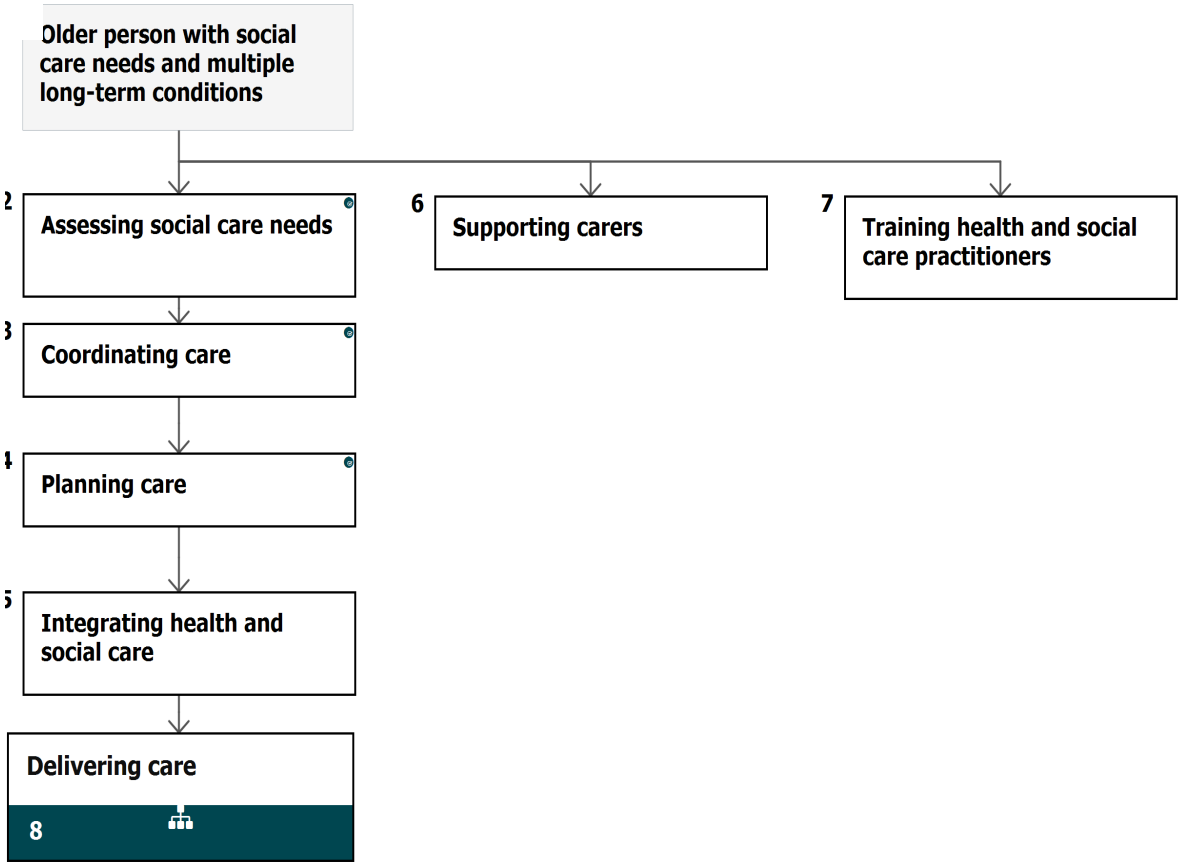
Social care for older people with multiple long-term conditions overview

NICE Pathways bring together all NICE guidance, quality standards and other NICE information on a specific topic.

NICE Pathways are interactive and designed to be used online. They are updated regularly as new NICE guidance is published. To view the latest version of this pathway see:

http://pathways.nice.org.uk/pathways/social-care-for-older-people-with-multiple-long-term-conditions
Pathway last updated: 31 July 2017

This document contains a single pathway diagram and uses numbering to link the boxes to the associated recommendations.



1 Older person with social care needs and multiple long-term conditions

No additional information

2 Assessing social care needs

Health and social care practitioners should consider referring older people with multiple long-term conditions to the local authority for a needs assessment as soon as it is identified that they may need social care and support.

Consider referral for a specialist clinical assessment by a geriatrician or old-age psychiatrist to guide social care planning for older people with social care needs and multiple long-term conditions:

- whose social care needs are likely to increase to the point where they are assessed as having a significant impact on the person's wellbeing
- who may need to go into a nursing or care home.

When planning and undertaking assessments for older people with social care needs and multiple long-term conditions, health and social care practitioners should:

- always involve the person and, if appropriate, their carer
- take into account the person's strengths, needs and preferences
- involve the relevant practitioners to address all of the person's needs, including their medical, psychological, emotional, social, personal, sexual, spiritual and cultural needs; sight, hearing and communication needs; and accommodation and environmental care needs
- ensure that if a person and their carer cannot attend an assessment meeting, they have the opportunity to be involved in another way, for example in a separate meeting or through an advocate (this is in addition to the statutory requirements placed on local authorities in relation to advocacy provision, set out in the Care Act 2014)
- give people information about the services available to them, their cost and how they can be paid for.

Recognise that many carers of older people with social care needs and multiple long-term conditions will also need support. If the person's carer has specific social care needs of their own, refer them to the local authority for a needs assessment in their own right.

Recognise that many older people with social care needs and multiple long-term conditions are also carers, but may not see themselves as such. Ask the person if they have caring responsibilities and, if so, ensure they are offered a carer's assessment.

The health or social care practitioner leading the assessment should discuss with the person any telecare options that may support them so that they can make informed choices about their usefulness to help them manage their conditions, as well as other potential benefits, risks and costs.

The lead practitioner should consider, in discussion with the person, whether a demonstration of telecare equipment would help them to make an informed decision about it.

See what NICE says on home care for older people.

Quality standards

The following quality statements are relevant to this part of the interactive flowchart.

1. Including physical and mental health needs in a care and support needs assessment

2. Discussing services that could help at a care and support needs assessment

3 Coordinating care

Ensure that older people with social care needs and multiple long-term conditions have a single, named care coordinator who acts as their first point of contact. Working within local arrangements, the named care coordinator should:

- play a lead role in the assessment process
- liaise and work with all health and social care services, including those provided by the voluntary and community sector
- ensure referrals are made and are actioned appropriately.

Offer the person the opportunity to:

- be involved in planning their care and support
- have a summary of their life story included in their care plan
- prioritise the support they need, recognising that people want to do different things with their lives at different times, and that the way that people's long-term conditions affect them can change over time.

Ensure the person, their carers or advocate and the care practitioners jointly own the care plan, sign it to indicate they agree with it and are given a copy.

Quality standards

The following quality statement is relevant to this part of the interactive flowchart.

3. Named care coordinator

4 Planning care

Ensure care plans are tailored to each person, giving them choice and control and recognising the inter-related nature of multiple long-term conditions. Offer the person the opportunity to:

- address a range of needs including medical, psychological, emotional, social, personal, sexual, spiritual and cultural needs, sight, hearing and communication needs and environmental care needs
- address palliative and end-of-life needs
- identify health problems, including continence needs and chronic pain and skin integrity, if appropriate, and the support needed to minimise their impact
- identify the help they need to look after their own care and support, manage their conditions, take part in preferred activities, hobbies and interests, and make contact with relevant support services (see also delivering care)
- include leisure and social activities outside and inside the home, mobility and transport needs, adaptations to the home and any support needed to use them.

Discuss managing medicines with each person and their carer as part of care planning.

Write any requirements about managing medicines into the care plan including:

- the purpose of, and information on, medicines
- the importance of dosage and timing and implications of non-adherence
- details of who to contact in the case of any concerns.

See what NICE says on medicines optimisation and managing medicines in care homes.

Develop care plans in collaboration with GPs and representatives from other agencies that will be providing support to the person in the care planning process.

With the person's agreement, involve their carers or advocate in the planning process. Recognise that carers are important partners in supporting older people with social care needs and multiple long-term conditions.

Ensure older people with social care needs and multiple long-term conditions are supported to make use of personal budgets, continuing healthcare budgets, individual service funds and direct payments (where they wish to) by:

- giving them and their carers information about different funding mechanisms they could use to manage the budget available to them, and any impact these may have on their carer
- supporting them to try out different mechanisms for managing their budget
- offering information, advice and support to people who pay for or arrange their own care, as well as to those whose care is publicly funded
- offering information about benefits entitlement
- ensuring that carers' needs are taken fully into account.

Ensure that care plans enable older people with social care needs and multiple long-term conditions to participate in different aspects of daily life, as appropriate, including:

- self-care
- taking medicines
- learning
- volunteering
- maintaining a home
- financial management
- employment
- socialising with friends
- hobbies and interests.

Ensure that care plans include ordinary activities outside the home (whether that is a care home or the person's own home), for example shopping or visiting public spaces. Include activities that:

- reduce isolation because this can be particularly acute for older people with social care needs and multiple long-term conditions (see preventing social isolation)
- build people's confidence by involving them in their wider community, as well as with family and friends.

Review and update care plans regularly and at least annually (in line with the Care Act 2014) to recognise the changing needs associated with multiple long-term conditions. Record the results of the review in the care plan, along with any changes made.

See what NICE says on excess winter deaths and illnesses associated with cold homes.

Quality standards

The following quality statements are relevant to this part of the interactive flowchart.

4. Care planning

5. Review of health and social care plan

5 Integrating health and social care

Build into service specifications and contracts the need:

- to direct older people with social care needs and multiple long-term conditions to different services as needed
- for seamless referrals between practitioners, including the appropriate sharing of information
- to make links with appropriate professionals, for example geriatricians in acute care settings.

Ensure there is community-based multidisciplinary support for older people with social care needs and multiple long-term conditions, recognising the progressive nature of many conditions. The health and social care practitioners involved in the team might include, for example, a community pharmacist, physiotherapist or occupational therapist, a mental health social worker or psychiatrist, and a community-based services liaison worker.

Health and social care practitioners should inform the named care coordinator if the person has needs that they cannot meet.

Named care coordinators should record any needs the person has that health and social care practitioners cannot meet. Discuss and agree a plan of action to address these needs with the person and their carer.

See what NICE says on multimorbidity and patient experience.

6 Supporting carers

In line with the Care Act 2014 local authorities must offer carers an individual assessment of their needs. Ensure this assessment:

- recognises the complex nature of multiple long-term conditions and their impact on people's wellbeing
- takes into account carers' views about services that could help them maintain their caring role and live the life they choose
- involves cross-checking any assumptions the person has made about the support their carer will provide.

Check what impact the carer's assessment is likely to have on the person's care plan.

Support carers to explore the possible benefits of personal budgets and direct payments, and how they might be used for themselves and for the person they care for. Offer the carer help to administer their budget so that their ability to support the person's care or their own health problems are not undermined by anxiety about managing the process.

Consider helping carers access support services and interventions, such as carer breaks.

7 Training health and social care practitioners

Those responsible for contracting and providing care services should ensure health and social care practitioners caring for older people with social care needs and multiple long-term conditions are assessed as having the necessary training and competencies in managing medicines.

See what NICE has says on medicines optimisation.

Ensure health and social care practitioners are able to recognise, consider the impact of, and respond to:

- common conditions, such as dementia, hearing and sight loss, **and**
- common care needs, such as nutrition, hydration, chronic pain, falls and skin integrity, **and**
- common support needs, such as dealing with bereavement and end-of-life, **and**
- deterioration in someone's health or circumstances.

Make provision for more specialist support to be available to people who need it – for example, in response to complex long-term health conditions – either by training practitioners directly involved in supporting people, or by ensuring partnerships are in place with specialist organisations.

See what NICE says on:

- early identification of dementia
- indications for nutrition support
- preventing falls in older people
- preventing pressure ulcers in adults.

8 Delivering care

See Social care for older people with multiple long-term conditions / Delivering social care for older people with multiple long-term conditions

Glossary

Named care coordinator

one of the people from among the group of workers providing care and support designated to take a coordinating role, for example, a social worker, practitioner working for a voluntary or community sector organisation, or lead nurse

Named care coordinators

the people from among the group of workers providing care and support designated to take a coordinating role, for example, social workers, practitioners working for voluntary or community sector organisations, or lead nurses

Sources

Older people with social care needs and multiple long-term conditions (2015) NICE guideline NG22

Your responsibility

The guidance in this pathway represents the view of NICE, which was arrived at after careful consideration of the evidence available. Those working in the NHS, local authorities, the wider public, voluntary and community sectors and the private sector should take it into account when carrying out their professional, managerial or voluntary duties. Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way which would be inconsistent with compliance with those duties.

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