The BASW / DHSC Capability Statement for Social Work with Older People

NICE recommendations and quality statements

- **What the BASW Capability Statement CPD means for social work with older people**:

Understanding and appreciation of social work with older people
Ability to work confidently and capably with older people, seeking specialist input as needed.
Contribution to local and national learning, education, research and learning.
Co-production of policy, practice and education.
Awareness of issues relating to dementia, mental health, hospital social work, learning disabilities, end of life and palliative care.

Guideline
NG22 Older people with social care needs and multiple long-term conditions, published November 2015
Key recommendations
1.1.3 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[1] • give people information about the services available to them, their cost and how they can be paid for.
1.1.5 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.

Telecare to support older people with social care needs and multiple long-term conditions

1.1.6 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.

1.1.7 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.

1.2 Care Planning

1.2.1 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.

Planning care collaboratively

1.2.5 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 section 1.5)
- 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.

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

1.2.7 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[3]
- details of who to contact in the case of any concerns.

  For more information on managing medicines see the NICE guidelines on medicines optimisation and managing medicines in care homes.

1.2.8 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.

1.2.9 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.

1.2.10 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.

1.2.11 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.

1.2.12 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 section 1.6)
- build people's confidence by involving them in their wider community, as well as with family and friends.

1.5 Delivering care

Providing support and information

1.5.1 Health and social care providers should ensure that care is person-centred and that the person is supported in a way that is respectful and promotes dignity and trust.

1.5.2 Named care coordinators should review people's information needs regularly, recognising that people with existing conditions may not take in information when they receive a new diagnosis.

1.5.3 Consider continuing to offer information and support to people and their carers even if they have declined it previously, recognising that long-term conditions can be changeable or progressive, and people's information needs may change.

1.5.4 Inform people about, and direct them to, advocacy services.

1.5.5 Health and social care practitioners should offer older people with social care needs and multiple long-term conditions:

- opportunities to interact with other people with similar conditions
- help to access one-to-one or group support, social media and other activities, such as dementia cafés, walking groups and specialist support groups, exercise and dance.

1.6 Preventing social isolation

1.6.2 Health and social care practitioners should support older people with social care needs and multiple long-term conditions to maintain links with their friends, family and community, and identify if people are lonely or isolated.

1.6.3 Named care coordinators and advocates should provide information to help people who are going to live in a care home to choose the right care home for them, for example one where they have friends or links with the community already.

1.6.4 Health and social care practitioners should give people advice and information about social activities and opportunities that can help them maintain their social contacts, and build new contacts if they wish to.

Quality Standard

QS132 Social care for older people with multiple long-term conditions, published September 2016

Quality Statement

Quality statement 1: Including physical and mental health needs in a care and support needs assessment

Older people with multiple long-term conditions having a care and support needs assessment have their physical and mental health needs included.

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers (such as local authorities, general practices, and community care providers) ensure that arrangements are in place for relevant health and social care practitioners to contribute to care and support needs assessments for older people with multiple long-term conditions, and that the assessment includes the person's physical and mental health needs.

Health and social care practitioners (such as social workers, occupational therapists, GPs, geriatricians, district nurses and mental health nurses) contribute to care and support needs assessments for older people with multiple long-term conditions, ensuring that their physical and mental health needs are included.

Commissioners (such as local authorities, clinical commissioning groups and NHS England) ensure that systems are in place for providers to work together so that physical and mental health needs are included when care and support needs assessments are carried out for older people with multiple long-term conditions.

Quality statement 2: Discussing services that could help at a care and support needs assessment

Older people with multiple long-term conditions having a care and support needs assessment discuss services that could help, any cost of these services and how they can be paid for.

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers (such as local authorities and community care providers) ensure that processes are in place to ensure that older people with multiple long-term conditions who have a care and support needs assessment discuss services that could help, any cost of these services and how they can be paid for.

Health and social care practitioners (such as social workers and occupational therapists) have a discussion with older people with multiple long-term conditions who have a care and support needs assessment about services that could help, any cost of these services and how they can be paid for.

Commissioners (such as local authorities and clinical commissioning groups) ensure that up-to-date, accessible information is available about local services that could help older people with multiple long-term conditions and social care needs, any cost of these services and how they can be paid for. Commissioners specify that their providers ensure that older people with multiple long-term conditions have the opportunity to discuss services that could help when they have a care and support needs assessment.

Quality statement 3: Named care coordinator

Older people with multiple long-term conditions and eligible social care needs have a named care coordinator.

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers (such as local authorities, general practices and community care providers) ensure that older people with multiple long-term conditions and eligible social care needs have a named care coordinator. Providers ensure that staff working with an older person support the role of their care coordinator by contributing to care planning, sharing information about the person and agreeing joint working arrangements.

Health and social care practitioners (such as district nurses, social workers, occupational therapists, GPs and voluntary sector practitioners) ensure that they know who the care coordinator is for an older person with multiple long-term conditions and eligible social care needs, and share information with them. If they are assigned as the

care coordinator, they ensure that they carry out the role in accordance with the locally agreed specification.

Commissioners (such as local authorities and clinical commissioning groups) ensure that there is local agreement on the role and responsibilities of a care coordinator, and that all health and social care staff support the care coordinator by contributing to care planning, sharing information and agreeing joint working arrangements.

Quality statement 4: Care planning

Older people with multiple long-term conditions and eligible social care needs have an agreed health and social care plan that includes how their personal priorities and outcomes will be met.

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers (such as local authorities, general practices, community health and care providers and secondary care) ensure that processes are in place for older people with multiple long-term conditions and eligible social care needs to be involved in developing a health and social care plan that includes how their personal priorities and outcomes will be met. Providers ensure that the health and social care plan is agreed and signed by all parties, and that the person is given a copy.

Health and social care practitioners (such as social workers, GPs, district nurses, geriatricians and mental health nurses) involve older people with multiple long-term conditions and eligible social care needs in developing a health and social care plan that includes how their personal priorities and outcomes will be met. Practitioners ensure that the health and social care plan is agreed and signed by all parties, and that the person is given a copy.

Commissioners (such as local authorities, and clinical commissioning groups) commission services that ensure older people with multiple long-term conditions and eligible social care needs are involved in developing health and social care plans that includes how personal priorities and outcomes will be met. This includes ensuring that health and social care plans are agreed and signed by all parties, and that the person is given a copy.

Quality statement 5: Review of health and social care plan

Older people with multiple long-term conditions and eligible social care needs have a review of their health and social care plan at least once a year.

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers (such as local authorities, general practices, community care providers and secondary care) ensure that older people with multiple long-term conditions and

eligible social care needs have a review of their health and social care plan at least once a year. The frequency of reviews will depend on individual circumstances and should be agreed with the person.

Health and social care practitioners (such as social workers, GPs, community nurses, geriatricians, occupational therapists, physiotherapists and mental health nurses) carry out a review of the health and social care plan for older people with multiple long-term conditions and eligible social care needs at least once a year. Practitioners should agree the frequency of reviews with the person.

Commissioners (such as local authorities, clinical commissioning groups and NHS England) commission services that carry out a review of the health and social care plan for older people with multiple long-term conditions and eligible social care needs at least once a year.

Guideline
NG32 Older people: independence and mental wellbeing, published December 2015
Key recommendations

1.5 Identifying those most at risk of a decline in their independence and mental wellbeing

1.5.1 Make service providers and others aware of the effect that poor mental wellbeing and lack of independence can have on an older person's mental and physical health and their social interactions.

1.5.2 Ensure staff in contact with older people are aware of the importance of maintaining and improving their independence and mental wellbeing.

1.5.3 Ensure staff in contact with older people can identify those most at risk of a decline in their independence and mental wellbeing (see implementation section). This includes being aware that certain life events or circumstances are more likely to increase the risk of decline. For example, older people whose partner has died in the past 2 years are at risk. Others at risk includes those who:

- are carers
- live alone and have little opportunity to socialise
- have recently separated or divorced
- have recently retired (particularly if involuntary)
- were unemployed in later life
- have a low income
- have recently experienced or developed a health problem (whether or not it led to admission to hospital)
- have had to give up driving
- have an age-related disability
- are aged 80 or older.

1.5.4 Ensure staff in contact with older people give those most at risk information on activities that might help them (see sections 1.2–1.4).

Quality Standard

QS50 Mental wellbeing of older people in care homes, published December 2013

Quality Statement

Quality statement 1: Participation in meaningful activity Older people in care homes are offered opportunities during their day to participate in meaningful activity that promotes their health and mental wellbeing.

What the quality statement means for organisations providing care, social care, health and public health practitioners, local authorities and other commissioning services

Organisations providing care ensure that opportunities for activity are available and that staff are trained to offer spontaneous and planned opportunities for older people in care homes to participate in activity that is meaningful to them and that promotes their health and mental wellbeing.

Social care, health and public health practitioners ensure that they offer older people in care homes opportunities during their day to participate in spontaneous and planned activity that is meaningful to them and that promotes their health and mental wellbeing.

Local authorities and other commissioning services ensure that they commission services from providers that can produce evidence of activities that are undertaken within the care home and can demonstrate that staff are trained to offer spontaneous and planned opportunities for older people in care homes to participate in activity that is meaningful to them.

Quality statement 2: Personal identity Older people in care homes are enabled to maintain and develop their personal identity.

What the quality statement means for organisations providing care, social care, health and public health practitioners, local authorities and other commissioning services

Organisations providing care work to embed a culture built on dignity and choice in care homes and ensure that staff are trained to work in partnership with older people in care homes in order to enable them to maintain and develop their personal identity.

Social care, health and public health practitioners work with older people in care homes to tailor support and opportunities to their needs and preferences, with the aim of maintaining and developing their personal identity.

Local authorities and other commissioning services ensure that they commission services from providers that can produce evidence of the actions they have taken to embed a culture of dignity and choice, and that staff are trained to work in partnership with older people in care homes in order to enable them to maintain and develop their personal identity.

Quality statement 3: Recognition of mental health conditions Older people in care homes have the symptoms and signs of mental health conditions recognised and recorded as part of their care plan.

What the quality statement means for organisations providing care, social care, health and public health practitioners, local authorities and other commissioning services

Organisations providing care ensure that staff are trained to be alert to the symptoms and signs of mental health conditions in older people in care homes and to record them in a care plan.

Social care, health and public health practitioners look for symptoms and signs of mental health conditions and record them in the older person's care plan.

Local authorities and other commissioning services commission services from providers that can produce evidence of protocols for training staff to be alert to the symptoms and signs of mental health conditions in older people in care homes and to record them in a care plan.

Quality statement 4: Recognition of sensory impairment Older people in care homes who have specific needs arising from sensory impairment have these recognised and recorded as part of their care plan.

What the quality statement means for organisations providing care, social care, health and public health practitioners, local authorities and other commissioning services

Organisations providing care ensure that staff are trained to be alert to specific needs arising from sensory impairment in older people in care homes and to record them in a care plan.

Social care, health and public health practitioners are alert to and recognise specific needs arising from sensory impairment in older people in care homes and record them in their care plan.

Local authorities and other commissioning services commission services from providers that can produce evidence of protocols for training staff to be alert to specific needs arising from sensory impairment in older people in care homes and to record them in a care plan.

Quality statement 4: Recognition of sensory impairment Older people in care homes who have specific needs arising from sensory impairment have these recognised and recorded as part of their care plan.

What the quality statement means for organisations providing care, social care, health and public health practitioners, local authorities and other commissioning services

Organisations providing care ensure that staff are trained to be alert to specific needs arising from sensory impairment in older people in care homes and to record them in a care plan.

Social care, health and public health practitioners are alert to and recognise specific needs arising from sensory impairment in older people in care homes and record them in their care plan.

Local authorities and other commissioning services commission services from providers that can produce evidence of protocols for training staff to be alert to specific needs arising from sensory impairment in older people in care homes and to record them in a care plan.

Quality statement 5: Recognition of physical problems Older people in care homes have the symptoms and signs of physical problems recognised and recorded as part of their care plan.

What the quality statement means for organisations providing care, social care, health and public health practitioners, local authorities and other commissioning services

Organisations providing care ensure that staff are trained to be alert to symptoms and signs of physical problems in older people in care homes and to record them in a care plan.

Social care, health and public health practitioners look for symptoms and signs of physical problems in older people in care homes and record them in their care plan.

Local authorities and other commissioning services commission services from providers that can produce evidence of protocols for training staff to be alert to the symptoms and signs of physical problems in older people in care homes and to record them in care plans.

Quality statement 6: Access to healthcare services Older people in care homes have access to the full range of healthcare services when they need them.

What the quality statement means for organisations providing care, social care, health and public health practitioners, local authorities and other commissioning services

Organisations providing care ensure that they work in partnership with healthcare organisations to implement effective arrangements for access to primary, secondary, specialist and mental health services for older people in care homes.

Social care, health and public health practitioners facilitate access to primary, secondary, specialist and mental health services for older people in care homes by referring the person to the required service when they need it.

Local authorities and other commissioning services commission services from providers that can produce evidence of arrangements with local healthcare organisations which facilitate access to primary, secondary, specialist and mental health services for older people in care homes.

Guideline
NG27 Transition between inpatient hospital settings and community or care home settings for adults with social care needs, published December 2015
Key recommendation

Communication and information sharing

1.1.4 Ensure that the person, their carers and all health and social care practitioners involved in someone's move between hospital and home are in regular contact with each other. This is to ensure the transition is coordinated and all arrangements are in place. For more on medicines-related communication and medicines reconciliation during transitions, see sections 1.2 and 1.3 in NICE's guideline on medicines optimisation and section 1.3 in NICE's guideline on managing medicines in care homes.

Discharge planning: key principles

1.5.10 Ensure continuity of care for people being transferred from hospital, particularly older people who may be confused or who have dementia. For more information on continuity of care see the recommendations in section 1.4 of NICE's guideline on patient experience in adult NHS services.

1.5.11 Ensure that people do not have to make decisions about long-term residential or nursing care while they are in crisis.

1.5.12 Ensure that any pressure to make beds available does not result in unplanned and uncoordinated hospital discharges.

Discharge planning

1.5.14 The discharge coordinator should work with the hospital- and community-based multidisciplinary teams and the person receiving care to develop and agree a discharge plan.

1.5.15 The discharge coordinator should ensure that the discharge plan takes account of the person's social and emotional wellbeing, as well as the practicalities of daily living. Include:

- details about the person's condition
- information about the person's medicines
- contact information after discharge
- arrangements for continuing social care support
- arrangements for continuing health support
- details of other useful community and voluntary services.

Quality Standard

QS136 Transition between inpatient hospital settings and community or care home settings for adults with social care needs, published December 2016

Quality Statement

Quality statement 1: Information sharing on admission Adults with social care needs who are admitted to hospital have existing care plans shared with the admitting team.

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers (such as hospitals, GPs, community services and local authorities) ensure that systems are in place to transfer existing care plans for adults with social care needs to the admitting team when they are admitted to hospital. This may include the use of Summary Care Records, hospital passports or other profiles containing important information about the person's needs and wishes.

Health and social care practitioners (such as care home managers, GPs and social workers) ensure that they share existing care plans with the admitting team when they arrange a hospital admission for adults with social care needs.

Commissioners (clinical commissioning groups, local authorities and NHS England) ensure that they commission services in which adults with social care needs have existing care plans shared with the admitting team when they are admitted to hospital. This may include the use of Summary Care Records, hospital passports or other profiles containing important information about the person's needs and wishes.

Quality statement 3: Coordinated discharge Adults with social care needs who are in hospital have a named discharge coordinator.

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers (hospitals) ensure that systems are in place so that adults with social care needs have a named discharge coordinator.

Health and social care practitioners (for example, members of the hospital-based multidisciplinary team) ensure that they involve the discharge coordinator in all decisions about discharge planning for adults with social care needs.

Commissioners (clinical commissioning groups) ensure that they commission services that provide a named discharge coordinator for adults with social care needs.

Quality statement 4: Discharge plans Adults with social care needs are given a copy of their agreed discharge plan before leaving hospital.

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers (hospitals) ensure that systems are in place for adults with social care needs to be given a copy of their agreed discharge plan before they leave hospital.

Health and social care practitioners (discharge coordinators and members of the hospital- and community-based multidisciplinary teams) ensure that they give a copy of the agreed discharge plan to adults with social care needs before they leave hospital.

Commissioners (clinical commissioning groups) ensure that they commission services in which adults with social care needs are given a copy of their agreed discharge plan before leaving hospital. This supports NHS England's Seven day services clinical standards, standard 1.

Quality statement 5: Involving carers in discharge planning Adults with social care needs have family or carers involved in discharge planning if they are providing support after discharge.

What the quality statement means for service providers, health and social care practitioners, and commissioners

Service providers (hospitals) ensure that systems are in place to enable adults with social care needs to have family or carers involved in discharge planning if they are providing support after discharge.

Health and social care practitioners (such as discharge coordinators and members of the hospital-based multidisciplinary team) ensure that adults with social care needs have family or carers involved in discharge planning if they are providing support after discharge.

Commissioners (clinical commissioning groups) ensure that they commission services in which adults with social care needs have family or carers involved in discharge planning if they are providing support after discharge. This supports NHS England's Seven day services clinical standards, standard 1.

Quality Standard
QS13 End of life care for adults, published 2011, updated 2017
Quality Statement
Quality statement 2: Communication and information People approaching the end of life and their families and carers are communicated with, and offered information, in an accessible and sensitive way in response to their needs and preferences.

What the quality statement means for each audience

Service providers ensure that systems are in place to communicate with, and offer information to, people approaching the end of life and their families and carers, in an accessible and sensitive way, in response to their needs and preferences.

Health and social care workers communicate with, and offer information to, people approaching the end of life and their families and carers, in an accessible and sensitive way, in response to their needs and preferences.

Commissioners ensure they commission services with systems in place to communicate with, and offer information to, people approaching the end of life and their families and carers, in an accessible and sensitive way, in response to their needs and preferences.

People approaching the end of life and their families and carers are communicated with and offered information in a sensitive way, at a time when it is helpful and with respect for their needs and preferences.

Quality statement 3: Assessment, care planning and review People approaching the end of life are offered comprehensive holistic assessments in response to their changing needs and preferences, with the opportunity to discuss, develop and review a personalised care plan for current and future support and treatment.

What the quality statement means for each audience

Service providers ensure that systems are in place to ensure comprehensive holistic assessments are carried out with people identified as approaching the end of life, in response to their changing needs and preferences, with the opportunity to discuss, develop and review a personalised care plan for current and future support and treatment.

Health and social care professionals offer or contribute to comprehensive holistic assessments with people identified as approaching the end of life, in response to their changing needs and preferences, including giving them the opportunity to discuss, develop and review a personalised care plan for current and future support and treatment.

Commissioners ensure they commission services that carry out comprehensive holistic assessments with people identified as approaching the end of life, in response to their changing needs and preferences, which include the opportunity to discuss, develop and review a personalised care plan for current and future support and treatment.

People approaching the end of life are offered full assessments to ensure they are getting the best care and support for their circumstances. During these assessments, they have the opportunity to discuss their needs (for example, physical, psychological, social,

spiritual and cultural needs) and preferences. This includes the opportunity to develop and review a care plan detailing their preferences for current and future support and treatment.

Quality statement 4: Holistic support – physical and psychological People approaching the end of life have their physical and specific psychological needs safely, effectively and appropriately met at any time of day or night, including access to medicines and equipment.

What the quality statement means for each audience

Service providers ensure that services are available and systems are in place to meet the physical and specific psychological needs of people approaching the end of life, including access to medicines and equipment, in a safe, effective and appropriate way at any time of day or night.

Health and social care professionals manage physical and specific psychological symptoms in people approaching the end of life, including provision of medicines and equipment, in a safe, effective and appropriate way at any time of day or night. This may include contacting specialists for advice.

Commissioners ensure they commission generalist and specialist services that are able to meet the physical and specific psychological needs of people approaching the end of life, including access to medicines and equipment, in a safe, effective and appropriate way at any time of day or night.

People approaching the end of life receive treatment and care to manage their physical and psychological needs, which may be at any time of day and night.

Quality statement 5: Holistic support – social, practical and emotional People approaching the end of life are offered timely personalised support for their social, practical and emotional needs, which is appropriate to their preferences, and maximises independence and social participation for as long as possible.

What the quality statement means for each audience

Service providers ensure that systems are in place to provide timely personalised support to people approaching the end of life for their social, practical and emotional needs. Support should be appropriate to their preferences, and maximise independence and social participation for as long as possible.

Health and social care workers follow local policies and procedures and signpost to relevant national or local services, to ensure that people approaching the end of life are offered timely personalised support for their social, practical and emotional needs. Support

should be appropriate to their preferences, and maximise independence and social participation for as long as possible.

Commissioners ensure they commission services that provide timely personalised support to people approaching the end of life for their social, practical and emotional needs. Support should be appropriate to their preferences, and maximise independence and social participation for as long as possible.

People approaching the end of life are offered social, practical and emotional support tailored to their needs and at the right time to help them feel supported, retain their independence and do things they enjoy for as long as possible.

Quality statement 6: Holistic support – spiritual and religious People approaching the end of life are offered spiritual and religious support appropriate to their needs and preferences.

What the quality statement means for each audience

Service providers ensure that systems are in place to offer, facilitate and provide (including sign-posting and referral) spiritual and religious support to people approaching the end of life that is appropriate to the person's needs and preferences.

Health and social care workers offer, facilitate and provide (including sign-posting and referral) spiritual and religious support to people approaching the end of life that is appropriate to the person's needs and preferences.

Commissioners ensure they commission services with adequate provision for offering, facilitating and providing (including sign-posting and referral) spiritual and religious support to people approaching the end of life that is appropriate to person's needs and preferences.

People approaching the end of life are offered spiritual and/or religious support appropriate to their needs and preferences.

Quality statement 7: Holistic support – families and carers Families and carers of people approaching the end of life are offered comprehensive holistic assessments in response to their changing needs and preferences, and holistic support appropriate to their current needs and preferences.

What the quality statement means for each audience

Service providers ensure that systems are in place to offer families and carers of people approaching the end of life comprehensive holistic assessments in response to their

changing needs and preferences, and holistic support appropriate to their current needs and preferences.

Health and social care professionals offer families and carers of people approaching the end of life comprehensive holistic assessments in response to their changing needs and preferences, and holistic support appropriate to their current needs and preferences.

Commissioners ensure they commission services that offer comprehensive holistic assessments in response to their changing needs and preferences, and holistic support appropriate to their current needs and preferences.

Families and carers of people approaching the end of life have their own needs fully assessed as appropriate for their changing needs and preferences, and are offered support to help them cope

Quality statement 8: Coordinated care People approaching the end of life receive consistent care that is coordinated effectively across all relevant settings and services at any time of day or night, and delivered by practitioners who are aware of the person's current medical condition, care plan and preferences.

What the quality statement means for each audience

Service providers ensure that systems (such as those for information sharing) are in place, to provide consistent care at all times of day and night to people approaching the end of life, that is coordinated effectively across all relevant settings and services and delivered by practitioners who are aware of the person's current medical condition, care plan and preferences.

Health and social care professionals provide consistent care for people approaching the end of life at all times of day or night that is coordinated effectively across all relevant settings and services. They follow local policies and procedures for information sharing so that care is delivered by practitioners who are aware of the person's current medical condition, care plan and preferences.

Commissioners ensure they commission services with appropriate systems in place (including those for information sharing) to ensure that people approaching the end of life receive consistent care at all times of day and night, that is coordinated effectively across all relevant settings and services and that is delivered by practitioners who are aware of their current medical condition, care plan and preferences.

People approaching the end of life receive care whenever they need it (day or night) that is consistent, smoothly coordinated and delivered by staff who are aware of their medical condition, care plan and preferences.

Quality statement 9: Urgent care People approaching the end of life who experience a crisis at any time of day or night receive prompt, safe and effective urgent care appropriate to their needs and preferences.

What the quality statement means for each audience

Service providers ensure that systems are in place to provide people approaching the end of life who experience a crisis at any time of day or night, with prompt, safe and effective urgent care, appropriate to the person's needs and preferences.

Health and social care professionals respond appropriately to crises experienced by people approaching the end of life, at any time of day or night, by providing prompt, safe and effective urgent care, appropriate to the person's needs and preferences.

Commissioners ensure they commission urgent care services that provide people approaching the end of life who experience a crisis at any time of day or night, with prompt, safe and effective urgent care, appropriate to the person's needs and preferences.

People approaching the end of life who experience a crisis at any time of day or night receive prompt, safe and effective urgent care that takes into account their needs and preferences.

Quality statement 10: Specialist palliative care People approaching the end of life who may benefit from specialist palliative care, are offered this care in a timely way appropriate to their needs and preferences, at any time of day or night.

What the quality statement means for each audience

Service providers ensure that systems are in place (such as shift patterns and on-call rotas), to provide timely specialist palliative care and advice at any time of day and night for people approaching the end of life who may benefit from specialist input. Care should be appropriate to the person's needs and preferences.

Health and social care professionals provide timely specialist palliative care and advice at any time of day or night for people approaching the end of life who may benefit from it, or know who to contact for specialist palliative care and advice. Care should be appropriate to the person's needs and preferences.

Commissioners ensure they commission specialist palliative care services with sufficient provision and capacity to provide timely specialist palliative care and advice at any time of day and night for people approaching the end of life who may benefit from specialist input. Care should be appropriate to their needs and preferences.

People approaching the end of life are offered specialist palliative care if their usual care team are unable to relieve their symptoms adequately. It is offered at the right time for them and is appropriate to their needs and preferences at any time of day or night.

Quality statement 14: Care after death – bereavement support People closely affected by a death are communicated with in a sensitive way and are offered immediate and ongoing bereavement, emotional and spiritual support appropriate to their needs and preferences.

What the quality statement means for each audience

Service providers ensure that systems are in place for people closely affected by a death that include sensitive communication and provision for immediate and ongoing bereavement, emotional and spiritual support appropriate to their needs and preferences.

Health and social care workers communicate sensitively with people closely affected by a death and offer them immediate and ongoing bereavement, emotional and spiritual support appropriate to their needs and preferences.

Commissioners ensure they commission services for people closely affected by a death that include sensitive communication and provision for immediate and ongoing bereavement, emotional and spiritual support appropriate to their needs and preferences.

People closely affected by a death are communicated with in a sensitive way and offered bereavement, emotional and spiritual support appropriate to their needs and preferences. This may include information about practical arrangements and local support services, supportive conversations with staff, and in some cases referral for counselling or more specialist support.

Guideline
NG96 Care and support of people growing older with learning disabilities, published April 2018
Key recommendation
1.1.2 Ensure that care and support for people with learning disabilities is tailored to their needs, strengths and preferences and is not determined solely by their age or learning disability. 1.1.4 Recognise that people with learning disabilities may be carers, but may not see themselves as such. Ask the person if they have caring responsibilities and, if so, offer them a carer's assessment to meet their needs[1]. [This recommendation is adapted from the NICE guideline on older people with social care needs and multiple long-term conditions.]

1.1.7 Social care and primary care practitioners should regularly review the communication needs of people with learning disabilities as they grow older to find out if they have changed. This should usually be when:

- other needs are being assessed, for example, during general health and dental checks
- there is reason to believe their communication needs may have changed.

1.1.12 Find out and prioritise the needs and preferences of the person. Ensure these are not overshadowed by the decisions or preferences of others, including when the person lacks capacity.

1.3.5 Practitioners carrying out assessments of care and support needs should help people to think about what they want from life as they age. This should include:

- asking people how they would like to spend their time and with whom, and enabling them to explore personal and sexual relationships
- encouraging them to develop support networks and to build and maintain links with friends and family and with community groups – these might include social, cultural and faith-based groups.

1.4.5 Health and social care practitioners should work with the person and those most involved in their support to agree a plan for the future. Help them to make decisions before a crisis point or life-changing event is reached (for example, the death of a parent or a move to new housing).

1.7.3 Managers in health and social care services should ensure that all staff working with people with learning disabilities have skills and knowledge in:

- communication methods, including non-verbal communication
- building good relationships with people with learning disabilities and making them feel at ease
- the physical, mental health and sensory needs of older people with learning disabilities, related to both their age and disability
- the application of the Mental Capacity Act 2005
- safeguarding issues, including how to report concerns and keep people safe
- common health conditions to which people with learning disabilities are predisposed, for example, the earlier onset of dementia

- assessing people's changing needs as they grow older, and not assuming that any new problems are due to their learning disability when they could be symptoms of other conditions or difficulties (diagnostic overshadowing)
- the main causes of early death in people with learning disabilities.

There are also recommendations which may be helpful to inform social workers knowledge regarding annual health checks, hospital discharge, the relationship between dementia and learning disabilities, end of life care and staff training.

Guideline
NG97 Dementia: assessment, management and support for people living with dementia and their carers, published June 2018
Key recommendation

1.3 Care coordination

1.3.2 Named professionals should:

- arrange an initial assessment of the person's needs, which should be face to face if possible
- provide information about available services and how to access them
- involve the person's family members or carers (as appropriate) in support and decision-making
- give special consideration to the views of people who do not have capacity to make decisions about their care, in line with the principles of the Mental Capacity Act 2005
- ensure that people are aware of their rights to and the availability of local advocacy services, and if appropriate to the immediate situation an independent mental capacity advocate
- develop a care and support plan, and:
    - agree and review it with the involvement of the person, their family members or carers (as appropriate) and relevant professionals
    - specify in the plan when and how often it will be reviewed
    - evaluate and record progress towards the objectives at each review
    - ensure it covers the management of any comorbidities
    - provide a copy of the plan to the person and their family members or carers (as appropriate).

1.11 Supporting carers

1.11.4 Advise carers about their right to the following and how to get them:

- a formal assessment of their own needs (known as a 'Carer's Assessment'), including their physical and mental health
- an assessment of their need for short breaks and other respite care.

1.12 Moving to different care settings

1.12.1 For guidance on managing transition between care settings for people living with dementia, see:

- the NICE guideline on transition between inpatient hospital settings and community or care home settings for adults with social care needs
- the NICE guideline on transition between inpatient mental health settings and community or care home settings
- section 1.2 of the NICE guideline on medicines optimisation.

  Follow the principles in these guidelines for transitions between other settings (for example from home to a care home or respite care).

1.12.2 Review the person's needs and wishes (including any care and support plans and advance care and support plans) after every transition.

1.13 Staff training and education

1.13.6 Health and social care professionals advising people living with dementia (including professionals involved in diagnosis) should be trained in starting and holding difficult and emotionally challenging conversations.

Quality Standard
QS10079, Dementia (update), expected to publish June 2019