

Social care of older people with complex care needs and multiple long-term conditions

Short version

Draft for consultation, June 2015

If you wish to comment on this version of the guideline, please be aware that all the supporting information and evidence is contained in the full version.

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Introduction

A long-term condition is one that cannot be cured but can be managed with the use of medicines or other therapies. Long-term conditions may also be known as 'chronic conditions' and 'life limiting conditions'.

The prevalence of long-term conditions is strongly linked to ageing and the number of people with multiple long-term conditions in England is projected to rise to 2.9 million by 2018 ([Long term conditions compendium of information third edition](#) Department of Health). Prevention, delaying onset and slowing the progression of long-term conditions are all important outcomes for older people. Other important outcomes include quality of life and positive experience related to independence, choice, dignity and control.

Despite recent policy focusing on integrated health and social care services, some people are still being treated as a collection of conditions or symptoms, rather than as a whole person ([The mandate: a mandate from the government to the NHS Commissioning Board: April 2013 to March 2015](#) Department of Health). People with multiple long-term conditions want joined-up, coordinated services but often find they are hard to access and fragmented ([Integrated care and support: our shared commitment](#) Department of Health). Poor mental health can be associated with both social isolation and poor physical health, and can go unnoticed. The issue of delivering integrated support to people with long-term conditions who live in nursing and care homes has also been neglected ([A quest for quality in care homes](#) British Geriatrics Society; [Health care in care homes](#) Care Quality Commission).

The Department of Health asked NICE to develop an evidence-based guideline to help address these issues (see the [scope](#)). The guideline was developed by a Guideline Committee following a detailed review of the evidence. The guideline focuses on older people with multiple long-term conditions and their carers. It does not cover younger adults (although many of the recommendations may also be relevant to younger adults). This is because the largest group of people affected by multiple long-term conditions is older people and because older people can experience inequalities in terms

of resource allocation which is in the context of decreasing resources available to them overall ([Older people's vision for long term care](#) Joseph Rowntree Foundation, [What is social care, and how can health services better integrate with it?](#) British Medical Association).

This guideline considers how person-centred social care and support for older people with multiple long-term conditions should be planned and delivered. It addresses how those responsible for commissioning, managing and providing care for people with multiple long-term conditions should work together to deliver safe, high-quality services that promote independence, choice and control.

This guideline has been developed in the context of a complex and rapidly evolving landscape of guidance and legislation, most notably the [Care Act 2014](#). While the Care Act and other legislation describe what organisations must do, this guideline is focused on 'what works' in terms of how to fulfil those duties, and deliver support to older people with complex care needs and multiple long-term conditions.

Person-centred care

This guideline assumes that the practitioners using it will read it alongside the [Care Act 2014](#) and other relevant legislation and guidance. It is also written to reflect the rights and responsibilities that people and practitioners have as set out in the [NHS Constitution for England](#).

Care and support should take into account individual needs and preferences. People should have the opportunity to make informed decisions about their care, in partnership with health and social care practitioners. Practitioners should recognise that each person is an individual, with their own needs, wishes and priorities. They should treat everyone they care for with dignity, respect and sensitivity.

If someone does not have capacity to make decisions, health and social care practitioners should follow the [code of practice that accompanies the Mental Capacity Act](#) and the supplementary [code of practice on deprivation of liberty safeguards](#).

If the person using the service agrees, families and carers should have the opportunity to be involved in decisions about care and support. Families and carers should also be given the information and support they need in their own right.

Recommendation wording

The Guideline Committee makes recommendations based on an evaluation of the evidence, taking into account the quality of the evidence and cost effectiveness.

In general, recommendations that an action 'must' or 'must not' be taken are usually included only if there is a legal duty (for example, to comply with [the Care Act](#) or health and safety regulations), or if the consequences of not following it could be extremely serious or life threatening.

Recommendations for actions that should (or should not) be taken use directive language such as 'agree', 'offer', 'assess', 'record' and 'ensure'.

Recommendations for which the quality of the evidence is poorer, or where there is a closer balance between benefits and risks, use 'consider'.

1 Recommendations

The guideline is based on the best available evidence. The [full guideline](#) **[hyperlink to be added for final publication]** gives details of the methods and the evidence used to develop the guideline.

1.1 *Identifying and assessing social care needs*

Older people with multiple long-term conditions

1.1.1 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.

1.1.2 Consider referral for a one-time assessment by a geriatrician or old-age psychiatrist to guide social care planning for older people with multiple long-term conditions:

- whose social care needs are likely to increase to the point where they are assessed as 'substantial' or 'critical'
- who may need to go into a nursing or care home.

All older people, including those with multiple long-term conditions

1.1.3 When planning and undertaking assessments, health and social care practitioners should:

- always involve the person and their carer (if appropriate)
- take into account the person's strengths, needs and preferences
- involve all relevant practitioners, to address all of the person's needs (including emotional, psychological, social, personal, sensory, communication and environmental care needs, as well as health 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 via an advocate

- give people information about the options for services available to them, the cost of services and how they can be paid for.

1.1.4 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.

1.1.5 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 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 manage their conditions, 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*

Named care coordinator

Older people with multiple long-term conditions

1.2.1 Ensure that older people with multiple long-term conditions have a single, named care coordinator who acts as their first point of contact. The named care coordinator should:

- be involved in the assessment process
- liaise and work with all health and social care services, including those provided by the voluntary and community sector.

- 1.2.2 Ensure care plans are tailored to the individual and focused on ensuring the person has choice and control. Offer the person the opportunity to:
- have a range of needs addressed (including emotional, psychological, social, personal, sensory, communication and environmental care needs, as well as health needs)
 - be supported to minimise the impact of health problems, including continence needs, if appropriate
 - identify how they can be helped to manage their own care and support, which may include information and support to manage their condition/s, taking part in their preferred activities, hobbies and interests (see also section 1.5)
 - ensure that care plans cover leisure and social activities outside and inside the home, mobility and transport needs, adaptations to the home and any support needed to use them.
- 1.2.3 Discuss medicines management as part of care planning.
- 1.2.4 Write any medicines management requirements into the care plan including:
- The purpose of, and information on, medicines
 - The importance of timing and implications of non-adherence.¹
- For more information on medicines management see the NICE guideline on [Medicines optimisation](#).
- 1.2.5 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 This recommendation is taken from NICE's draft [home care](#) guideline.

1.2.6 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 multiple long-term conditions.

1.2.7 Ensure older people with 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 the different mechanisms they can use to manage the budget available to them, including information about any impact different funding mechanisms may have on carers
- 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 those whose care is publicly funded
- ensuring that carers' needs are taken fully into account.

All older people, including those with multiple long-term conditions

1.2.8 Named care coordinators should offer the older 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, to recognise that people want to do different things with their lives at different times (see also section 1.5).

1.2.9 Ensure that care plans enable people 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.

1.2.10 Ensure that care plans include ordinary activities outside the home (whether that is a care home or the person's own home) that reduce isolation, for example, shopping or visiting public gardens and build confidence by being involved in their wider community, as well as with family and friends (see also section 1.6).

1.2.11 Named care coordinators should ensure the person, their carers or advocate and the care practitioners jointly own the care plan and sign it to indicate they agree with it.

1.2.12 Named care coordinators should review and update care plans regularly to reflect changing needs, and at least annually (in line with [the Care Act](#)). Record the results of the review in the care plan, along with any changes made.

1.3 *Supporting carers*

All older people, including those with multiple long-term conditions

1.3.1 In line with [the Care Act](#) local authorities must offer carers an individual assessment of their needs. Ensure this assessment:

- 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.

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

- 1.3.3 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. Help them to administer their budget, so that their ability to support the person's care is not undermined by anxiety about managing the process.
- 1.3.4 Consider helping carers access support services and interventions, such as carer breaks.

1.4 *Integrating health and social care planning*

Older people with multiple long-term conditions

- 1.4.1 Commissioners should build into service specifications and contracts the need:
- to direct older people with multiple long-term conditions to different services
 - for seamless referrals between practitioners.
- 1.4.2 Make provision for community-based multidisciplinary support for older people with multiple long-term conditions. The health and social care practitioners involved in the team might include, for example, a community pharmacist, physical or occupational therapist, a mental health social worker or psychiatrist, and a community-based services liaison.
- 1.4.3 Health and social care practitioners should inform the named care coordinator if the person has needs that they cannot meet.
- 1.4.4 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.

1.5 *Delivering care*

Older people with multiple long-term conditions

Care in care homes

These recommendations for care home providers are about ensuring that care and support addresses the specific needs of older people with multiple long-term conditions in care homes.

- 1.5.1 Identify ways to address particular nutritional and hydration requirements and ensure people have a choice of things to eat and drink and varied snacks throughout the day (including outside regular meal times).
- 1.5.2 Identify how the care home environment and layout can encourage social interaction, activity and peer support.
- 1.5.3 Ensure people are physically comfortable, for example, by allowing them control over the heating in their rooms.
- 1.5.4 Encourage social contact and provide opportunities for education and entertainment by:
 - making it easier for people to communicate and interact with others, for example reducing background noise, providing face-to-face contact with other people, using accessible signage and lighting
 - using a range of technologies such as IT platforms and wifi, hearing loops and TV listeners
 - involving the wider community in the life of the care home through befriending schemes and intergenerational projects.

When providing care for older people with long-term conditions, care home providers should:

- 1.5.5 Make publicly available information about:

- tariffs for self-funded and publicly-funded care
- what residents are entitled to and whether this could change if their funding status or ability to pay changes.

1.5.6 Make available a statement for each person using their services about what their funding pays for.

1.5.7 Build links with local communities, and encourage interaction between residents and local people of all ages and backgrounds.

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

Needs and preferences

1.5.9 Health and social care practitioners should offer older people with 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 cafes, walking groups and specialist support groups, exercise and dance.

Self management and support

1.5.10 Health and social care practitioners should review recorded information about medicines and therapies regularly and follow up any issues related to medicines management. This includes making sure information on changes to medicine is made available to relevant agencies.

1.5.11 Social care practitioners should contact the person's healthcare practitioners with any concerns about prescribed medicines.

1.5.12 Social care practitioners should tell the named care coordinator if any prescribed medicines are affecting the person's wellbeing. This could include known side effects or reluctance to take medicines.

1.5.13 Health and social care providers should recognise incontinence as a symptom and ensure people have access to diagnosis and

treatment. This should include meeting with a specialist continence nurse.

- 1.5.14 Health and social care providers should give information and advice about continence to older people. Make a range of continence products available, paying full attention to people's dignity and respect.
- 1.5.15 Give people information about how your service can help them manage their lives. This should be given:
- at the first point of contact and when new problems or issues arise
 - in different formats which should be accessible (including through interpreters).
- 1.5.16 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.

All older people, including those with multiple long-term conditions

Provision of information

- 1.5.17 Named care coordinators should review information needs regularly, recognising that people may not take in information when they receive a new diagnosis.
- 1.5.18 Consider continuing to offer information and support to people and their family members or carers even if they have declined it previously.

Continuity of care

- 1.5.19 Named care coordinators should take responsibility for:
- giving older people and their carers information about what to do and who to contact in times of crisis, at any time of day and night

- ensuring an effective response in times of crisis
- ensuring there is continuity of care with familiar workers, so that wherever possible, personal care and support is carried out by workers known to the person and their family and carers
- engaging local community health and social care services, including those in the voluntary sector
- ensuring older people and their carers have information about their particular condition, and how to manage it
- knowing where to access specialist knowledge and support, about particular health conditions
- involving carers and advocates.

1.6 *Preventing social isolation*

All older people, including those with multiple long-term conditions

- 1.6.1 Health and social care practitioners should support older people with multiple long-term conditions to maintain links with their friends, family and community, and identify if people are lonely or isolated.
- 1.6.2 Named care coordinators and advocates should 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.
- 1.6.3 Health and social care practitioners should give advice and information about social activities and opportunities that can help people have more diverse social contacts.
- 1.6.4 Commissioners should consider funding and collaborating with community enterprises and services to help people to remain active in the home and engaged in the community, including when people are in care homes.

- 1.6.5 Voluntary and community sector providers should consider collaborating with local authorities to develop new ways to help people to remain active and engaged in their communities, including when people are in care homes.

1.7 *Training health and social care practitioners*

Older people with multiple long-term conditions

- 1.7.1 Commissioners and providers should ensure health and social care practitioners caring for people with multiple long-term conditions have the necessary training and are assessed as competent in medicines management.
- 1.7.2 Ensure health and social care practitioners are able to recognise:
- common conditions, such as dementia and sensory loss, and
 - common care needs, such as nutrition, hydration and skin integrity, and
 - common support needs, such as dealing with bereavement and end-of-life, and
 - deterioration in someone's health or circumstances².

² This recommendation is taken from NICE's draft [home care](#) guideline.

2 Implementation: getting started

NICE has worked with the Guideline Committee to identify areas in this draft guideline that may have a significant impact on practice and could be difficult to implement.

Older people with multiple long-term conditions and their carers should have choice and control over all aspects of their lives, and support should be person-centred to enable this. The principles of choice, control and person-centred care have been fundamental to good social care for many years but as individual experience continues to be variable, they remain crucial areas to emphasise. This means that the most important and challenging areas of the draft guideline to implement will be:

- Empowering older people and carers to choose and manage their own support (for example, recommendations 1.1.3, 1.2.2 and 1.2.7)
- Empowering and valuing practitioners so they can deliver person-centred care (for example, recommendations 1.2.1, 1.5.17 and 1.7.2)
- Integrating different care and support options so that coherent, person-centred care is possible (for example, recommendations 1.2.1, 1.4.1 and 1.4.2).

More information on each of these areas is provided below.

How stakeholders can help us

During consultation we want you to let us know whether you agree with the three areas identified. If not, which other aspects of the guideline will have a greater impact, or be more of a challenge to implement?

Please also send us suggestions about how implementation challenges could be addressed. You could, for example, share examples of good practice, or provide educational materials or other resources that you have found useful. This information will be used to write an implementation section for the final guideline.

Please use the comments form to send us your feedback.

Challenges for implementation

Empowering older people and carers to choose and manage their own support

Care coordinators will need to look for ways to support the person's choice of care, activities, hobbies and relationships, and to share information and knowledge that can help. This will call for a change of culture that enables practitioners to offer a proactive service with a focus on anticipating future and ongoing needs, and a more flexible approach to care planning. (Related to recommendations 1.1.3, 1.2.2 and 1.2.7).

Empowering and valuing practitioners so they can deliver person-centred care

Taking a coordinated approach that looks at 'the whole person' rather than addressing separate conditions is complex. This means managers will need to recognise and support the important role health and social care practitioners have. Care coordinators may need help to improve their knowledge of local services and how to work with them to prevent people falling between services. Health and social care practitioners may need training and support in recognising common conditions, care and support needs, and in empowering older people and their carers. (Related to recommendations 1.2.1, 1.5.17 and 1.7.2).

Integration of different care and support options to enable person-centred care

Older people with multiple long-term conditions need everyone involved in their care to work together to deliver joined-up services. Staff need to be supported by systems and structures that help them do this. Through service specification, commissioners have a key role in enabling people to work across traditional service boundaries and professional specialisms. (Related to recommendations 1.2.1, 1.4.1 and 1.4.2).

3 Research recommendations

The Guideline Committee has made the following recommendations for research, based on its review of evidence, to improve care for people in the future and improve NICE guidance. The Guideline Committee's full set of research recommendations is detailed in the [full guideline](#).

3.1 *Older people's experiences*

What is the lived experience of older people with multiple long-term conditions?

Why this is important

While there was some evidence on the experiences of older people with multiple long-term conditions, there were gaps in relation to people's experience of:

- the effect of interactions between multiple conditions on each other, and on the person, over time
- the impact of living with multiple conditions on people's independence, activities, participation and communication as their conditions progress
- the impact of living with multiple conditions at different stages of a person's life
- the priorities, meanings and preferences of people living with multiple conditions.

3.2 *Service delivery models*

Which models of service delivery are effective and cost-effective for older people with multiple long-term conditions?

Why this is important

There was a lack of evidence about different models of support provision for older people with multiple long-term conditions. There is a need, therefore, for robust evaluations of different approaches, for example, studies which compare:

- models led by different practitioners
- different team structures
- the components and configurations of models
- the barriers and facilitators to implementation of models.

3.3 *Reablement*

What is the impact of reablement interventions on outcomes for older people with multiple long-term conditions?

Why this is important

There is a need to determine the impact of reablement interventions on this particular group of older people. The Committee noted the particular importance of identifying whether reablement interventions or approaches have any preventative effects such as keeping people out of hospital or preventing their condition worsening.

3.4 *Supporting people in care homes to stay active*

What is the most effective and cost-effective way of supporting older people with multiple long-term conditions in care homes to live as independently as possible?

Why this is important

There is a need for robust evaluation of different interventions for supporting older people with long-term conditions in care homes. The Committee thought it particularly important to ensure that future studies evaluate how people living in care homes can best be supported to participate in social and leisure activities, given that views data, Committee members' experiences and expert witness testimonies indicated that people living in care homes can feel particularly isolated and unable to take part in activities of their choice.

3.5 *Developing a 'risk positive' approach in care homes*

What is the effectiveness and acceptability of different strategies to enable positive risk-taking in care homes?

Why this is important

The Committee noted that people take informed risks as part of normal everyday life, but for older people who need support, their ability to take these risks can be limited. Helping older people exercise choice and control, therefore, relies on a 'risk positive' approach. They identified a gap in the literature about what works well in care homes in this respect and suggested future studies could usefully include:

- a systematic review of the literature on perceptions of and approaches to risk-taking in care homes
- organisational, operational and individual-level approaches to risk-taking in care homes
- the views and experiences of people using care home services and their carers
- the barriers and facilitators to risk-positive approaches in care homes.

4 Other information

4.1 *Scope and how this guideline was developed*

NICE guidelines are developed in accordance with a [scope](#) that defines what the guideline will and will not cover.

How this guideline was developed

NICE commissioned the NICE Collaborating Centre for Social Care to develop this guideline. The Centre established a Guideline Committee (see section 5), which reviewed the evidence and developed the recommendations.

When this guideline was started, we used the methods and processes described in the [Social Care Guidance Manual](#) (2013). From January 2015 we used the methods and processes in [Developing NICE Guidelines: The Manual](#) (2014).

5 The Guideline Committee, NICE Collaborating Centre and NICE project team, and declarations of interests

5.1 Guideline Committee

Belinda Black

Chief Executive, Sheffcare, Sheffield

Beth Britton

Carer

Gillian Crosby

Director, Centre for Policy on Ageing, London

Jeremiah Kelleher

Former Local Authority Manager and former Social Worker (now retired), Norfolk County Council, Norfolk

Ann MacFarlane

Person using services

Kevin Minier

Carer

Lelly Oboh

Consultant Pharmacist, Care of Older People, Guy's and St Thomas' NHS Foundation Trust, NHS Community Health Services and NHS Specialist Pharmacy Services, London

Deborah Read

Social Worker, Nottinghamshire County Council, Nottinghamshire

Janet Reynolds

Principal Caseworker (adults), Leeds City Council Adult Social Care, Leeds, and Practice Learning Tutor, University of Bradford, Bradford

Diana Robinson

Person using services and a carer

Karin Tancock

Professional Adviser for Older People and Long Term Conditions, College of Occupational Therapists, London

Philippa Thompson

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Bernard Walker (Chair)

Independent Consultant in Social Care, Health and Management, Liverpool

Maggie Winchcombe

Director, Years Ahead Ltd, Middlesex

Chris Wood

Senior Research and Policy Officer, Action on Hearing Loss, London

Ann Workman

Assistant Director Adult Social Care, Darlington Borough Council, Darlington, County Durham

NICE Collaborating Centre for Social Care technical team

A technical team at the NICE Collaborating Centre for Social Care was responsible for this guideline throughout its development. It prepared information for the Guideline Committee, drafted the guideline and responded to consultation comments.

Amanda Edwards

Deputy Chief Executive, Social Care Institute for Excellence and Director, NICE Collaborating Centre for Social Care

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5.2 NICE social care team

Nicola Bent

Programme Director, Health and Social Care Quality Programme

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| | | | |
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| | group that reports to Kingston's Adult Safeguarding Partnership Board), Better Services Better Value: Member for South West Commissioning Group. | | |
| Belinda Black | Received a grant from the European Research Council to undertake a 3 year project that commenced in February 2015 looking at how technology can be used to support people with cognitive problems and dementia. | Personal non-pecuniary interest | None |
| Bernard Walker | Occasional consultancy work for local authorities and other bodies in the social care field, Associate Research in Practice for Adults, provides advice to HSA Global (Health Care Consultancy) on integration of Local Government with NHS. | Personal pecuniary interest | None |
| Bernard Walker | Chair of the Professional Assembly and the Adults Faculty at the College of Social Work. | Non-personal pecuniary interest | None |
| Beth Anderson | Sister and sister's partner are consultant neurologists for Newcastle Hospitals NHS Foundation Trust and are both shareholders in Rubrum, a company developing eHealth solutions for long-term conditions. | Personal family interest | None |
| Beth Britton | Freelance consultant on learning disability/Dementia and Ageing with MacIntyre, involved in work with UK Gov G8 Dementia Summit, NHS IQ (Commitment for Carers), National Council for Palliative Care (Dementia and End of Life, Guideposts Trust (Dementia Awareness), Age UK Brent (Dementia and Ageing), Crossroads Care, Sensory Plus, Gracewell Healthcare, Swan Advocacy (Dementia and Advocacy), NHS/BMA 'Timely Diagnosis of Dementia', GB Care Shows, Care Show Bournemouth, GE Healthcare, NHS Expo, CQC | Personal pecuniary interest | None |

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| | and Royal College of Psychiatry Memory Services National Accreditation Programme (Memory Service Peer Review), Local Gov Digital Dept, Bucks New University, Royal College of Nursing, Royal College of General Practitioners, Age UK and Carewatch, member on Standing Commission on Carers. | | |
| Beth Britton | Member of Dementia Post Diagnosis Support Working Group (Dept of Health); Dementia Friends - Dementia Friends Champion; CQC - Member Adult Social Care Co-Production Group; Dementia Action Alliance- Member of the DAA and support the Carers' Call to Action; BRACE - Ambassador; Alzheimer's Society – Volunteer, Public Health England; National Mental Health Intelligence Network; Dementia Expert Reference Group. | Personal non-pecuniary interest | None |
| Diana Robinson | Has a small shareholding in Reckitt Benckiser and indivior (yields less than £1,000 pa), Patient and Public Involvement work - the following may pay expenses and/or honoraria for meetings, workshops or conference attendance; and for reviewing research proposals, National Institute for Health Research, Programme Grants for Applied Research funding panel; occasional lay peer reviews; National Cancer Research Institute; National Cancer Intelligence Network; NICE UK Database of Uncertainties of Effects Treatments Steering Group; Health Research Authority; University of Leeds (IMPACCT study and Leeds Clinical Research Facility Executive); Care Quality Commission;, NHS England; Health Quality Improvement Partnership - | Personal pecuniary interest | None |

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| | Service User Network; National Institute for Cardiovascular Outcomes Research; involvement coach for Cancer Research UK;), Royal College of Radiologists; Academic Committee and Lay Network; Royal College of Physicians; Care of the Dying Adult and Lower Back Pain Guidance Development Groups; British Heart Foundation | | |
| Diana Robinson | Sister-in-law works for University College London as Credit Control Manager | Personal family interest | None |
| Janet Reynolds | Works part-time with Bradford University and also with a voluntary organisation supporting services with direct payments. | Personal pecuniary interest | None |
| Jeremiah Kelleher | Undertaking paid work with Healthwatch Norfolk which involves visiting a care home as part of a project to examine service for older people with dementia. It is strictly local and project will report in 2014. | Personal non-pecuniary interest | None |
| Karin Tancock | Works part time for the College of Occupational Therapists as the Professional Affairs Officer for Older People. | Personal pecuniary interest | None |
| Maggie Winchombe | Contracted to Southwark to deliver Trusted Assessor training programmes to staff. | Personal non-pecuniary interest | None |
| Philippa Thompson | Works at Independent Lives and Kate Mercer Training (KMT) has been contracted to write the assessment, support planning, personal budget and direct payment parts of the new training materials for advocacy under the Care Act 2014. KMT is providing this service for the Department of Health, which is funding the development of the materials. | Non-personal pecuniary interest | None |
| Philippa Thompson | Member of the English steering committee of the Campaign for a Fair Society. | Personal non-pecuniary interest | None |