NICE National Institute for Health and Care Excellence

NICE quality standard

Social care for older people with multiple long-term conditions

Quality standard

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Contents

This standard is based on NG22.

This standard should be read in conjunction with QS123, QS120, QS117, QS85, QS50, QS136, QS137, QS153, QS164, QS171 and QS173.

Introduction

This quality standard covers the planning and delivery of coordinated, person-centred social care and support for older people with multiple long-term conditions. The quality standard is focused on people aged over 65 as this is the largest group of people affected by multiple long-term conditions. It includes older people living in their own homes, in specialist settings or in care homes, and those who receive support with funding for their social care and those who do not. For more information see the social care for older people with multiple long-term conditions topic overview.

NICE quality standards focus on aspects of health and social care that are commissioned locally. Areas of national policy, such as funding for social care, are therefore not covered by this quality standard.

Why this quality standard is needed

Older people with multiple long-term conditions are likely to have a wide range of care needs as a result of their conditions. Those with social care needs may need support with personal care and other practical assistance.

The prevalence of long-term conditions is strongly linked to ageing; in England a quarter of people over 60 have multiple (more than 1) long-term conditions. The number of people with multiple long-term conditions in England is rising, and is projected to be 2.9 million by 2018, an increase from 1.9 million in 2008 (Long term conditions compendium of information third edition Department of Health).

A 2012 King's Fund report on Long term conditions and mental health suggests that depression is 7 times higher in people with 2 or more long-term conditions. In addition, the National Development Team for inclusion report A long time coming part 1 indicates that symptoms of depression can often go untreated and affect the abilities of older people to manage their own conditions.

People with long-term conditions account for around 50% of all GP appointments, 64% of all outpatient appointments and 70% of all inpatient bed days. Older people with long-term conditions

are at a higher risk of needing admission to hospital, sometimes for health problems that could be managed at home. Overall, a significant proportion (70%) of government health and social care spending is attributed to the care of older people with long-term conditions, and the costs per individual increase with the number of conditions the person has (Long term conditions compendium of information third edition Department of Health).

In 2014/15, 603,000 people aged over 65 used long-term social care support funded by local authorities (Community care statistics, social services activity, England – 2014–15 NHS Digital) with total local authority spending on social services for older people of £6.8 billion (Personal social services: expenditure and unit costs, England – 2014–15, final release NHS Digital). Although the number of older people in the population is rising, the number receiving publicly funded social care is falling.

Older people may not know what social care support they are entitled to or what their funding options are. This may lead to their needs being left unmet because they are not claiming support. Options for people who pay for their own care and individual budget holders can be complicated and people may not know how to fund residential care if their conditions worsen.

Despite recent policy focusing on integrated health and social care services, some people are still treated as a collection of conditions or symptoms, rather than as a whole person, and there can be poor coordination of care. There is significant variability in the commissioning and provision of health and social care for older people in England. Although good practice on integrating health and social care is beginning to emerge from local areas that have developed new approaches to transforming services, considerable variability remains.

This quality standard has been developed in the context of important legal changes affecting people with social care needs. The Care Act 2014 establishes new provisions as well as updating existing ones, bringing together relevant policy and guidance that may have a significant impact on this group.

The quality standard is expected to contribute to improvements in the following outcomes:

- social care-related quality of life
- health-related quality of life
- involvement in decision-making
- safety of people using services

- hospital admissions
- residential care admissions
- older people being supported to live where they wish
- service user and carer satisfaction.

How this quality standard supports delivery of outcome frameworks

NICE quality standards are a concise set of prioritised statements designed to drive measurable improvements in the 3 dimensions of quality – safety, experience and effectiveness of care – for a particular area of health or care. They are derived from high-quality guidance, such as that from NICE or other sources accredited by NICE. This quality standard, in conjunction with the guidance on which it is based, should contribute to the improvements outlined in the following 3 outcomes frameworks published by the Department of Health:

- Adult social care outcomes framework 2015–16
- NHS outcomes framework 2016–17
- Public health outcomes framework 2016–19.

Tables 1–3 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 Adult social care outcomes framework 2015–16

Domain	Overarching and outcome measures

1 Enhancing quality of life for people with care and support needs	*Overarching measure* 1A Social care-related quality of life** *Outcome measures* **People manage their own support as much as they wish, so they are in control of what, how and when support is delivered to match their needs** 1B Proportion of people who use services who have control over their daily life **Carers can balance their caring roles and maintain their desired quality of life** 1D Carer-reported quality of life** **People are able to find employment when they want, maintain a family and social life and contribute to community life, and avoid loneliness or isolation** 1I Proportion of people who use services and their carers, who reported that they had as much social contact as they would like
2 Delaying and reducing the need for care and support	*Overarching measure* 2A Permanent admissions to residential and nursing care homes, per 100,000 population *Outcome measures* **Everybody has the opportunity to have the best health and wellbeing throughout their life, and can access support and information to help them manage their care needs** **When people develop care needs, the support they receive takes place in the most appropriate setting and enables them to regain their independence** *Placeholder 2F Dementia – a measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life***

3 Ensuring that people have a positive experience of care and support	*Overarching measure* **People who use social care and their carers are satisfied with their experience of care and support services** 3A Overall satisfaction of people who use services with their care and support 3B Overall satisfaction of carers with social services *Placeholder 3E The effectiveness of integrated care* *Outcome measures* **Carers feel that they are respected as equal partners throughout the care process** 3C The proportion of carers who report that they have been included or consulted in discussions about the person they care for **People know what choices are available to them locally, what they are entitled to, and who to contact when they need help** 3D The proportion of people who use services and carers who find it easy to find information about support **People, including those involved in making decisions on social care, respect the dignity of the individual and ensure support is sensitive to the circumstances of each individual** This information can be taken from the Adult Social Care Survey and used for analysis at the local level.

4 Safeguarding adults whose circumstances make them vulnerable and protecting from avoidable harm	*Overarching measure* 4A The proportion of people who use services who feel safe** *Outcome measures* **Everyone enjoys physical safety and feels secure** **People are protected as far as possible from avoidable harm, disease and injuries** **People are supported to plan ahead and have the freedom to manage risks the way that they wish** 4B The proportion of people who use services who say that those services have made them feel safe and secure
Alignment with NHS Outcomes Framework and/or Public Health Outcomes Framework * Indicator is shared ** Indicator is complementary Indicators in italics in development	

Table 2 NHS outcomes framework 2016–17

Domain	Overarching indicators and improvement areas

2 Enhancing quality of life for people with long-term conditions	*Overarching indicator* 2 Health-related quality of life for people with long-term conditions** *Improvement areas* **Ensuring people feel supported to manage their condition** 2.1 Proportion of people feeling supported to manage their condition **Reducing time spent in hospital by people with long-term conditions** 2.3 i Unplanned hospitalisation for chronic ambulatory care sensitive conditions **Enhancing quality of life for carers** 2.4 Health-related quality of life for carers** **Enhancing quality of life for people with dementia** 2.6 *ii A measure of the effectiveness of post-diagnosis care in sustaining independence and improving quality of life** ** **Improving quality of life for people with multiple long-term conditions** *2.7 Health-related quality of life for people with three or more long-term conditions***
4 Ensuring that people have a positive experience of care	*Improvement areas* **Improving the experience of care for people at the end of their lives** 4.6 Bereaved carers' views on the quality of care in the last 3 months of life **Improving people's experience of integrated care** *4.9 People's experience of integrated care**
Alignment with Adult Social Care Outcomes Framework and/or Public Health Outcomes Framework * Indicator is shared ** Indicator is complementary Indicators in italics in development	

Table 3 Public health outcomes framework for England, 2016–19

Domain	Objectives and indicators
1 Improving the wider determinants of health	*Objective* Improvements against wider factors that affect health and wellbeing and health inequalities 1.18 Social isolation
2 Health improvement	*Objective* People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities *Indicators* 2.23 Self-reported well-being 2.24 Injuries due to falls in people aged 65 and over
4 Healthcare public health and preventing premature mortality	*Objective* Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities *Indicators* 4.03 Mortality rate from causes considered preventable** 4.13 Health-related quality of life for older people 4.14 Hip fractures in people aged 65 and over 4.15 Excess winter deaths 4.16 Estimated diagnosis rate for people with dementia*
Alignment with Adult Social Care Outcomes Framework and/or NHS Outcomes Framework * Indicator is shared ** Indicator is complementary	

Safety and people's experiences of care

Ensuring that care is safe and that people have a positive experience of care is vital in a high-quality service. It is important to consider these factors when planning and delivering social care and support services relevant to older people with multiple long-term conditions.

Coordinated services

Social care and support services for older people with multiple long-term conditions should be commissioned from and coordinated across all relevant agencies encompassing all of the person's needs and their whole care pathway. A person-centred, integrated approach to providing services across the statutory, private and voluntary sectors is fundamental to delivering high-quality care to older people with multiple long-term conditions.

The Health and Social Care Act 2012 sets out a clear expectation that the care system should consider NICE quality standards in planning and delivering services, as part of a general duty to secure continuous improvement in quality. Commissioners and providers of health and social care should refer to the library of NICE quality standards when designing high-quality services. Other quality standards that should also be considered when choosing, commissioning or providing a high-quality service for older people with multiple long-term conditions are listed in related quality standards.

Training and competencies

The quality standard should be read in the context of national and local guidelines on training and competencies. All health and social care practitioners in statutory, private and voluntary sector organisations who are involved in assessing, caring for and supporting older people with multiple long-term conditions should have sufficient and appropriate training and competencies to deliver the actions and interventions described in the quality standard. Quality statements on staff training and competency are not usually included in quality standards. However, recommendations in the development source on specific types of training for the topic that exceed standard professional training are considered during quality statement development.

Role of families and carers

Quality standards recognise the important role families and carers (such as family members, friends and neighbours) have in supporting older people with multiple long-term conditions. If appropriate, health and social care practitioners should ensure that family members and carers are involved in the decision-making process about all aspects of the older person's care. The support needs of carers should also be recognised, and carers should be offered referral for a carer's assessment in line with the Care Act 2014.

List of quality statements

Statement 1. Older people with multiple long-term conditions having a care and support needs assessment have their physical and mental health needs included.

Statement 2. 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.

Statement 3. Older people with multiple long-term conditions and eligible social care needs have a named care coordinator.

Statement 4. 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.

Statement 5. 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.

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

Quality statement

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

Rationale

Older people with multiple long-term conditions are likely to have complex needs. Having the opportunity to discuss physical and mental health needs when having a care and support needs assessment will ensure that all their health and social care needs are identified and will enable them to access the support they need to improve their quality of life and maintain their independence. Taking into account the person's strengths, needs and preferences, the assessment will enable health and social care practitioners to work together to meet the person's needs.

Quality measures

Structure

Evidence of a locally coordinated approach to ensure that older people with multiple long-term conditions having a care and support needs assessment have their physical and mental health needs included.

Data source: Local data collection.

Process

Proportion of care and support needs assessments for older people with multiple long-term conditions that include physical and mental health needs.

Numerator – the number in the denominator that include physical and mental health needs.

Denominator – the number of care and support needs assessments for older people with multiple long-term conditions.

Data source: Local data collection.

Outcome

Satisfaction among older people with multiple long-term conditions and social care needs that all their health and care needs are identified and understood.

*Data source:*Local data collection.

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.

What the quality statement means for people using services and carers

Older people with more than 1 long-term condition have their physical and mental health needs included when they have a care and support needs assessment. This will help them and their carers (if appropriate) to think about what they can manage for themselves and what they need help with in their day-to-day life.

Source guidance

- Older people with social care needs and multiple long-term conditions (2015) NICE guideline NG22, recommendation 1.1.3

Definitions of terms used in this quality statement

Multiple long-term conditions

A long-term condition is defined as one that generally lasts a year or longer and impacts on a person's life. Examples include arthritis, asthma, cancer, dementia, diabetes, heart disease, mental health conditions, stroke, and hearing and sight loss. Multiple means a person has more than 1 condition. The impact and symptoms of these conditions can fluctuate, and people may or may not need to take medicines for their conditions.

[NICE guideline on older people with social care needs and multiple long-term conditions]

Care and support needs assessment

The process by which a local authority works with a person to identify their needs and the outcomes they would like to achieve to maintain or improve their wellbeing. The local authority's aim is to determine how it should respond to meet the person's needs under the Care Act 2014. It may also be known as a social care needs assessment.

[NICE guideline on older people with social care needs and multiple long-term conditions and expert opinion]

Equality and diversity considerations

People with communication difficulties, or hearing or sight loss should be offered support to enable them to be involved in their care and support needs assessment.

People with limited independence as a result of a physical disability or mental health condition may need additional support, such as an advocate, to enable them to be involved in their care and support needs assessment.

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

Quality statement

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.

Rationale

Discussing available services will enable older people with multiple long-term conditions and social care needs, and their carers, to consider options that could help them to manage their lives, and maintain their independence and quality of life. Having this discussion at a care and support needs assessment will ensure that all older people with multiple long-term conditions and social care needs are informed about the services available, regardless of whether they arrange and pay for all or part of their own care, or their care is supported by the local authority.

Quality measures

Structure

a) Evidence that accessible information is available locally about 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.

Data source: Local data collection.

b) Evidence of local processes to ensure that care and support needs assessments for older people with multiple long-term conditions include discussions about the services that could help, any cost of these services and how they can be paid for.

Data source: Local data collection.

Process

Proportion of care and support needs assessments for older people with multiple long-term conditions that include discussing services that could help, any cost of these services and how they can be paid for.

Numerator – the number in the denominator that include discussing services that could help, any cost of these services and how they can be paid for.

Denominator – the number of care and support needs assessments for older people with multiple long-term conditions.

Data source: Local data collection.

Outcome

Satisfaction among older people with multiple long-term conditions and social care needs with information provided about support and services.

*Data source:*Local data collection.

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.

What the quality statement means for people using services and carers

Older people with more than 1 long-term conditionwho are having a care and support needs assessment discuss available services that could help them, any cost of these services and how they

can be paid for. This will ensure that they, and their carers, know what support is available to help improve their day-to-day life.

Source guidance

- Older people with social care needs and multiple long-term conditions (2015) NICE guideline NG22, recommendation 1.1.3

Definitions of terms used in this quality statement

Multiple long-term conditions

A long-term condition is defined as one that generally lasts a year or longer and impacts on a person's life. Examples include arthritis, asthma, cancer, dementia, diabetes, heart disease, mental health conditions, stroke, and hearing and sight loss. Multiple means a person has more than 1 condition. The impact and symptoms of these conditions can fluctuate, and people may or may not need to take medicines for their conditions.

[NICE guideline on older people with social care needs and multiple long-term conditions]

Care and support needs assessment

The process by which a local authority works with a person to identify their needs and the outcomes they would like to achieve to maintain or improve their wellbeing. The local authority's aim is to determine how it should respond to meet the person's needs under the Care Act 2014. It may also be known as a social care needs assessment.

[NICE guideline on older people with social care needs and multiple long-term conditions and expert opinion]

Discussing services that could help

People who pay for or arrange their own care, as well as those whose care is publicly funded, should have a discussion with their health or social care practitioner about the types of care and support available, and the choice of local providers. It should include:

- how to obtain care and support services
- the costs of different services

- how to obtain independent financial advice about meeting their care and support needs
- the impact of future changes in funding status or ability to pay
- advocacy services
- any telecare options that may support them, including considering whether a demonstration of telecare equipment could help them to make an informed decision about its usefulness
- social activities and opportunities that can help them to maintain their social contacts, and build new contacts if they wish to.

[Adapted from the Care Act 2014 and the NICE guideline on older people with social care needs and multiple long-term conditions, recommendations 1.1.3, 1.1.6, 1.1.7, 1.5.4. 1.5.11, 1.5.19, and 1.6.4]

Equality and diversity considerations

Information provided to people should be in a format that suits their needs and preferences. In particular, practitioners should identify, record and meet the information and communication needs of people who have hearing loss, sight loss or learning disabilities, as set out in NHS England's Accessible Information Standard.

People with communication difficulties or hearing or sight loss should be offered support to enable them to discuss services that could help, the cost of these services and how they can be paid for.

People with limited independence as a result of a physical disability or mental health condition may need additional support, such as an advocate, to enable them to discuss services that could help, the cost of these services and how they can be paid for.

Quality statement 3: Named care coordinator

Quality statement

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

Rationale

Having a named care coordinator can help older people with multiple long-term conditions and eligible social care needs to get the help they need from the health and social care system. The care coordinator plays a lead role in the care planning process, and supports older people to obtain the services they need, when they need them. They also ensure that the older person and their carers have the information they need to manage the older person's conditions and plan for the future.

Quality measures

Structure

a) Evidence of local arrangements to ensure that older people with multiple long-term conditions and eligible social care needs have a named care coordinator.

Data source: Local data collection.

b) Evidence of a locally agreed specification of the role and functions of the care coordinator.

Data source: Local data collection.

Process

Proportion of older people with multiple long-term conditions and eligible social care needs who have a named care coordinator.

Numerator – the number in the denominator who have a named care coordinator.

Denominator – the number of older people with multiple long-term conditions and eligible social care needs.

Data source: Local data collection.

Outcome

Satisfaction among older people with multiple long term conditions and eligible social care needs with support to help them manage their long-term health conditions.

Data source: Local data collection.

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.

What the quality statement means for people using services and carers

Older people with more than 1 long-term conditionwho need social care services should know the name of a person in the team that supports them who is their care coordinator. The care coordinator is the main contact for everyone involved in the older person's care, including their family and carers, and will support them to manage their conditions and live as they choose.

Source guidance

- Older people with social care needs and multiple long-term conditions (2015) NICE guideline NG22, recommendations 1.2.1 and 1.5.12

Definitions of terms used in this quality statement

Multiple long-term conditions

A long-term condition is defined as one that generally lasts a year or longer and impacts on a person's life. Examples include arthritis, asthma, cancer, dementia, diabetes, heart disease, mental health conditions, stroke, and hearing and sight loss. Multiple means a person has more than 1 condition. The impact and symptoms of these conditions can fluctuate, and people may or may not need to take medicines for their conditions.

[NICE guideline on older people with social care needs and multiple long-term conditions]

Eligible social care needs

Local authorities have a duty to meet people's social care needs that fulfil the criteria in the Care Act 2014. When determining a person's eligibility for social care, local authorities must consider 3 conditions:

- **Condition 1:** The adult's needs for care and support arise from or are related to a physical or mental impairment or illness and are not caused by other circumstantial factors.
- **Condition 2:** As a result of the adult's needs, the adult is unable to achieve 2 or more of the following outcomes:
    - managing and maintaining nutrition
    - maintaining personal hygiene
    - managing toilet needs
    - being appropriately clothed
    - being able to make use of the adult's home safely
    - maintaining a habitable home environment
    - developing and maintaining family or other personal relationships
    - accessing and engaging in work, training, education or volunteering
    - making use of necessary facilities or services in the local community, including public transport, and recreational facilities or services

  - carrying out any caring responsibilities the adult has for a child.

- **Condition 3:** As a consequence of being unable to achieve these outcomes, there is, or there is likely to be, a significant impact on the adult's wellbeing.

[The Care and Support (Eligibility Criteria) Regulations 2014]

Named care coordinator

The named care coordinator is the person from among the group of workers providing care and support designated to take a coordinating role. This could be, for example, a social worker, practitioner working for a voluntary or community sector organisation, or lead nurse.

The named care coordinator acts as the first point of contact and takes responsibility for:

- engaging local community health and social care services, including those in the voluntary sector
- ensuring referrals are made and are actioned appropriately
- giving people and their carers information about what to do and who to contact in times of crisis, at any time of day or 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
- ensuring people and their carers have information about their particular conditions, and how to manage them
- knowing how to access specialist knowledge and support about particular health conditions
- involving carers and advocates.

[NICE guideline on older people with social care needs and multiple long-term conditions, glossary and recommendations 1.2.1 and 1.5.12]

Quality statement 4: Care planning

Quality statement

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.

Rationale

A health and social care plan for older people with multiple long-term conditions and eligible social care needs will clarify how their health and social care needs will be met. They should be involved in developing their health and social care plan to ensure it is person-centred and focused on their priorities and outcomes. Ensuring all parties, including the older person, their carers or advocate and care practitioners, agree with and sign the health and social care plan will encourage joint ownership of the plan and confirm agreement with its content. This will help older people and their carers to consider whether the plan meets their needs and will improve their quality of life.

Quality measures

Structure

a) Evidence of local processes to ensure that older people with multiple long-term conditions and eligible social care needs are involved in developing and agreeing their health and social care plan.

Data source: Local data collection.

b) Evidence of local processes to ensure that health and social care plans for older people with multiple long-term conditions and eligible social care needs include how personal priorities and outcomes will be met.

Data source: Local data collection.

Process

a) Proportion of older people with multiple long-term conditions and eligible social care needs with a health and social care plan that includes how their personal priorities and outcomes will be met.

Numerator – the number in the denominator with a health and social care plan that includes how their personal priorities and outcomes will be met.

Denominator – the number of older people with multiple long-term conditions and eligible social care needs.

Data source: Local data collection.

b) Proportion of older people with multiple long-term conditions and eligible social care needs who sign their health and social care plan.

Numerator – the number in the denominator who sign their health and social care plan.

Denominator – the number of older people with multiple long-term conditions and eligible social care needs.

Data source: Local data collection.

Outcome

a) Satisfaction among older people with multiple long-term conditions and eligible social care needs that their health and social care plan reflects their personal priorities and outcomes.

Data source: Local data collection.

b) Health-related quality of life for older people with multiple long-term conditions and eligible social care needs.

Data source: Local data collection. NHS England's GP patient survey includes questions on health-related quality of life.

c) Social care-related quality of life for older people with multiple long-term conditions and eligible social care needs.

Data source: Local data collection. NHS Digital's Personal social services adult social care survey includes questions on social care-related quality of life.

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.

What the quality statement means for people using services and carers

Older people with more than 1 long-term condition who need social care services (and their carers, if appropriate) are involved in planning their health and social care. This is to make sure that their care and support reflects what is important to them. They should agree and sign their personal health and social care plan and be given a copy to keep.

Source guidance

- Older people with social care needs and multiple long-term conditions (2015) NICE guideline NG22, recommendations 1.2.2 and 1.2.3

Definitions of terms used in this quality statement

Multiple long-term conditions

A long-term condition is defined as one that generally lasts a year or longer and impacts on a person's life. Examples include arthritis, asthma, cancer, dementia, diabetes, heart disease, mental

health conditions, stroke, and hearing and sight loss. Multiple means a person has more than 1 condition. The impact and symptoms of these conditions can fluctuate, and people may or may not need to take medicines for their conditions.

[NICE guideline on older people with social care needs and multiple long-term conditions]

Eligible social care needs

Local authorities have a duty to meet people's social care needs that fulfil the criteria in the Care Act 2014. When determining a person's eligibility for social care, local authorities must consider 3 conditions:

- **Condition 1:** The adult's needs for care and support arise from or are related to a physical or mental impairment or illness and are not caused by other circumstantial factors.
- **Condition 2:** As a result of the adult's needs, the adult is unable to achieve 2 or more of the following outcomes:
    - managing and maintaining nutrition
    - maintaining personal hygiene
    - managing toilet needs
    - being appropriately clothed
    - being able to make use of the adult's home safely
    - maintaining a habitable home environment
    - developing and maintaining family or other personal relationships
    - accessing and engaging in work, training, education or volunteering
    - making use of necessary facilities or services in the local community, including public transport, and recreational facilities or services
    - carrying out any caring responsibilities the adult has for a child.
- **Condition 3:** As a consequence of being unable to achieve these outcomes, there is, or there is likely to be, a significant impact on the adult's wellbeing.

[The Care and Support (Eligibility Criteria) Regulations 2014]

Health and social care plan

Health and social care plans should be tailored to each person, giving them choice and control, and recognising the inter-related nature of multiple long-term conditions. When developing or reviewing a care plan, the person should be offered 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 care needs
- identify health problems, including continence needs and chronic pain and skin integrity, and the support needed to minimise their impact
- include any requirements for managing medicines, for example, the importance of dosage and timing, and the implications of non-adherence
- 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 contact relevant support services
- include leisure and social activities outside and inside the home
- address mobility and transport needs, adaptations to the home and any support needed to use them.

[NICE guideline on older people with social care needs and multiple long-term conditions, recommendations 1.2.5 and 1.2.7]

Equality and diversity considerations

People with communication difficulties or hearing or sight loss should be offered support to enable them to be involved in developing and agreeing their health and social care plan. The plan should be provided in a format that suits their needs and preferences and meets the requirements set out in NHS England's Accessible Information Standard.

People with limited independence as a result of a physical disability or mental health condition may need additional support, such as an advocate, to support them to be involved in developing and agreeing their health and social care plan.

Quality statement 5: Review of health and social care plan

Quality statement

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.

Rationale

An older person's health and social care plan should be reviewed at least once a year, and whenever there is a change in circumstances, to check that it is still meeting the person's needs. It is important to recognise that multiple long-term conditions are associated with changing needs over time, which in turn may have an impact on the needs of carers. Reflecting these changes in the health and care plan will help to ensure the needs of older people with multiple long-term conditions continue to be met, so that they can remain independent for as long as possible.

Quality measures

Structure

Evidence of local arrangements to ensure that health and social care plans for older people with multiple long-term conditions and eligible social care needs are reviewed at least once a year.

Data source: Local data collection.

Process

Proportion of older people with multiple long-term conditions and eligible social care needs who had a review of their health and social care plan within the past 12 months.

Numerator – the number in the denominator who had a review of their health and social care plan within the past 12 months.

Denominator – the number of older people with multiple long-term conditions and eligible social care needs with a health and social care plan for more than 12 months.

Data source: Local data collection. NHS Digital's Adult social care short- and long-term support (SALT) return collects data on the number of people receiving support for more than 12 months who had a review of their care needs during the year.

Outcome

a) Confidence among older people with multiple long-term conditions and eligible social care needs that they can self-manage their conditions.

Data source: Local data collection.

b) Health-related quality of life for older people with multiple long-term conditions and eligible social care needs.

Data source: Local data collection. NHS England's GP patient survey includes questions on health-related quality of life.

c) Social care-related quality of life for older people with multiple long-term conditions and eligible social care needs.

Data source: Local data collection. NHS Digital's Personal social services adult social care survey includes questions on social care-related quality of life.

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.

What the quality statement means for people using services and carers

Older people with more than 1 long-term conditionwho need social care services should have their health and social care plan updated at least once a year, whenever their circumstances change, and at other times if they wish. If appropriate, carers should be involved in discussing whether the health and social care plan needs to change.

Source guidance

- Older people with social care needs and multiple long-term conditions (2015) NICE guideline NG22, recommendation 1.2.4

Definitions of terms used in this quality statement

Multiple long-term conditions

A long-term condition is defined as one that generally lasts a year or longer and impacts on a person's life. Examples include arthritis, asthma, cancer, dementia, diabetes, heart disease, mental health conditions, stroke, and hearing and sight loss. Multiple means a person has more than 1 condition. The impact and symptoms of these conditions can fluctuate, and people may or may not need to take medicines for their conditions.

[NICE guideline on older people with social care needs and multiple long-term conditions]

Eligible social care needs

Local authorities have a duty to meet people's social care needs that fulfil the criteria in the Care Act 2014. When determining a person's eligibility for social care, local authorities must consider 3 conditions:

- **Condition 1:** The adult's needs for care and support arise from or are related to a physical or mental impairment or illness and are not caused by other circumstantial factors.
- **Condition 2:** As a result of the adult's needs, the adult is unable to achieve 2 or more of the following outcomes:
    - managing and maintaining nutrition
    - maintaining personal hygiene

  - managing toilet needs
  - being appropriately clothed
  - being able to make use of the adult's home safely
  - maintaining a habitable home environment
  - developing and maintaining family or other personal relationships
  - accessing and engaging in work, training, education or volunteering
  - making use of necessary facilities or services in the local community, including public transport, and recreational facilities or services
  - carrying out any caring responsibilities the adult has for a child.

- **Condition 3:** As a consequence of being unable to achieve these outcomes, there is, or there is likely to be, a significant impact on the adult's wellbeing.

[The Care and Support (Eligibility Criteria) Regulations 2014]

Health and social care plan

Health and social care plans should be tailored to each person, giving them choice and control and recognising the inter-related nature of multiple long-term conditions. When developing or reviewing a care plan, the person should be offered 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 care needs
- identify health problems, including continence needs and chronic pain and skin integrity, and the support needed to minimise their impact
- include any requirements for managing medicines, for example, the importance of dosage and timing, and the implications of non-adherence
- 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 contact relevant support services

- include leisure and social activities outside and inside the home
- address mobility and transport needs, adaptations to the home and any support needed to use them.

[NICE guideline on older people with social care needs and multiple long-term conditions, recommendations 1.2.5 and 1.2.7]

Equality and diversity considerations

People with communication difficulties or hearing or sight loss should be offered support to enable them to be involved in reviewing their health and social care plan. Their health and social care plan should be provided in a format that suits their needs and preferences and meets the requirements set out in NHS England's Accessible Information Standard.

People with limited independence as a result of a physical disability or mental health problem may need additional support, such as an advocate, to support them to be involved in reviewing their health and social care plan.

People with deteriorating conditions and those who are likely to be approaching the end of their life may need their health and social care plan to be reviewed more often.

Using the quality standard

Quality measures

The quality measures accompanying the quality statements aim to improve the structure, process and outcomes of care in areas identified as needing quality improvement. They are not a new set of targets or mandatory indicators for performance management.

We have indicated if current national indicators exist that could be used to measure the quality statements. If there is no national indicator that could be used to measure a quality statement, the quality measure should form the basis for audit criteria developed and used locally.

See how to use quality standards for more information, including advice on using quality measures.

Levels of achievement

Expected levels of achievement for quality measures are not specified. Quality standards are intended to drive up the quality of care, and so achievement levels of 100% should be aspired to (or 0% if the quality statement states that something should not be done). However, NICE recognises that this may not always be appropriate in practice, taking account of safety, choice and professional judgement, and therefore desired levels of achievement should be defined locally.

NICE's quality standard service improvement template helps providers to make an initial assessment of their service compared with a selection of quality statements. It includes assessing current practice, recording an action plan and monitoring quality improvement. This tool is updated monthly to include new quality standards.

Using other national guidance and policy documents

Other national guidance and current policy documents have been referenced during the development of this quality standard. It is important that the quality standard is considered alongside the documents listed in development sources.

Diversity, equality and language

During the development of this quality standard, equality issues have been considered and equality assessments are available.

Good communication between health and social care practitioners and older people with multiple long-term conditions and social care needs is essential. Treatment, care and support, and the information given about it, should be culturally appropriate. It should also be accessible to people with additional needs such as physical, sensory or learning disabilities, and to people who do not speak or read English. Older people with multiple long-term conditions and social care needs should have access to an interpreter or advocate if needed.

Commissioners and providers should aim to achieve the quality standard in their local context, in light of their duties to have due regard to the need to eliminate unlawful discrimination, advance equality of opportunity and foster good relations. Nothing in this quality standard should be interpreted in a way that would be inconsistent with compliance with those duties.

Development sources

Further explanation of the methodology used can be found in the quality standards process guide.

Evidence sources

The documents below contain recommendations from NICE guidance or other NICE-accredited recommendations that were used by the quality standards advisory committee to develop the quality standard statements and measures.

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

Policy context

It is important that the quality standard is considered alongside current policy documents, including:

- Department of Health (2014) Better care for people with 2 or more long term conditions
- Department of Health (2014) Care Act 2014
- Department of Health (2014) Care and support statutory guidance
- Department of Health (2014) Carers strategy: the second national action plan 2014–2016
- NHS England (2014) Safe, compassionate care for frail older people using an integrated care pathway: practical guidance for commissioners, providers and nursing, medical and allied health professional leaders
- Department of Health (2013) Integrated care: our shared commitment

Definitions and data sources for the quality measures

- NHS Digital (2016) Short- and long-term support (SALT) data collection
- NHS Digital (2015) Personal social services adult social care survey 2014–2015
- NHS England (2015) GP patient survey

- Older people with social care needs and multiple long-term conditions (2015) NICE guideline NG22
- Home care: delivering personal care and practical support to older people living in their own homes (2015) NICE guideline NG21

Related NICE quality standards

Published

- Home care for older people (2016) NICE quality standard 123
- Medicines optimisation (2016) NICE quality standard 120
- Preventing excess winter deaths and illness associated with cold homes (2016) NICE quality standard 117
- Medicines management in care homes (2015) NICE quality standard 85
- Mental wellbeing of older people in care homes (2013) NICE quality standard 50

In development

- Mental wellbeing and independence for older people Publication expected December 2016
- Multimorbidity Publication expected June 2017
- Transition between inpatient mental health settings and community and care homes Publication expected August 2017

Future quality standards

This quality standard has been developed in the context of all quality standards referred to NICE, including the following topics scheduled for future development:

- Care and support of older people with learning disabilities
- Medicines management: managing the use of medicines in community settings for people receiving social care
- Regaining independence (reablement): short term interventions to help people regain independence
- Service user and carer experience of social care

The full list of quality standard topics referred to NICE is available from the quality standards topic library on the NICE website.

Quality standards advisory committee and NICE project team

Quality standards advisory committee

This quality standard has been developed by quality standards advisory committee 3. Membership of this committee is as follows:

Mr Ben Anderson
Consultant in Public Health, Public Health England

Ms Lauren Aylott
Lay member

Ms Deryn Bishop
Public Health Behaviour Change Specialist, Solihull Public Health Department

Jan Dawson
Registered Dietitian

Dr Matthew Fay
GP, Westcliffe Medical Practice, Shipley, West Yorkshire

Dr Malcolm Fisk
Senior Research Fellow, Centre for Computing and Social Responsibility, De Montford University, Leicester

Ms Margaret Goose
Lay member

Dr Ulrike Harrower
Consultant in Public Health Medicine, NHS Somerset

Dr Madhavan Krishnaswamy
Consultant Clinical Oncologist, Southend University Hospital NHS Trust

Mrs Geeta Kumar
Clinical Director, Women's Services (East) Betsi Cadwaladr University Health Board

Mrs Rhian Last
Education Lead, Education for Health, Leeds

Mr Keith Lowe
Head of Quality Support, Home Instead Senior Care (UK) Ltd

Dr Hugh McIntyre (Chair)
Consultant Physician, East Sussex Healthcare Trust

Ms Ann Nevinson
Lay member

Professor Gillian Parker
Professor of Social Policy Research, Social Policy Research Unit, University of York

Mr David Pugh
Independent Consultant, Gloucestershire County Council

Dr Karen Ritchie
Head of Knowledge and Information, Health Improvement Scotland

Dr Eve Scott
Head of Safety and Risk, The Christie NHS Foundation Trust, Manchester

Mr Martin Siddorn
Commissioning Manager, Swindon Borough Council

Dr Susannah Solaiman
GP and Clinical Lead for Integrated Care, Harford Health Centre, NHS Tower Hamlets Clinical Commissioning Group

Dr Jim Stephenson
Consultant Medical Microbiologist, Epsom and St Helier University Hospitals NHS Trust

Mr Darryl Thompson
Registered Nurse (Mental Health), South West Yorkshire Partnership NHS Foundation Trust

Mrs Julia Thompson
Health Improvement Principal, Sheffield City Council

The following specialist members joined the committee to develop this quality standard:

Ms Julie Blake
Independent consultant in occupational therapy, Solihull

Mr Derry Kelleher
Social worker (retired); member, Norfolk Healthwatch

Mr Manoj Mistry
Lay member

Ms Teresa Morris
Social worker, Bolton Clinical Commissioning Group

Dr Peter Sims
GP (retired); Clinical Advisor, Royal College of GPs

Mrs Ann Workman
Director for local delivery, Adult Operations, Essex County Council

NICE project team

Mark Minchin
Associate Director

Michael Mellors
Social Care Adviser

Rachel Neary-Jones
Programme Manager

Craig Grime
Technical Adviser

Melanie Carr
Technical Analyst

Anneka Patel
Project Manager

Christina Barnes
Coordinator

About this quality standard

NICE quality standards describe high-priority areas for quality improvement in a defined care or service area. Each standard consists of a prioritised set of specific, concise and measurable statements. NICE quality standards draw on existing NICE or NICE-accredited guidance that provides an underpinning, comprehensive set of recommendations, and are designed to support the measurement of improvement.

The methods and processes for developing NICE quality standards are described in the quality standards process guide.

This quality standard will be incorporated into the NICE pathway on social care for older people with multiple long-term conditions.

NICE produces guidance, standards and information on commissioning and providing high-quality healthcare, social care, and public health services. We have agreements to provide certain NICE services to Wales, Scotland and Northern Ireland. Decisions on how NICE guidance and other products apply in those countries are made by ministers in the Welsh government, Scottish government, and Northern Ireland Executive. NICE guidance or other products may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

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Endorsing organisation

This quality standard has been endorsed by Department of Health and Social Care, as required by the Health and Social Care Act (2012)

Supporting organisations

Many organisations share NICE's commitment to quality improvement using evidence-based guidance. The following supporting organisations have recognised the benefit of the quality standard in improving care for patients, carers, service users and members of the public. They have agreed to work with NICE to ensure that those commissioning or providing services are made aware of and encouraged to use the quality standard.

- Chartered Society of Physiotherapy

- Royal College of General Practitioners
- Royal College of Nursing
- Royal College of Occupational Therapists
- Royal College of Physicians