

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

Quality standard

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# Contents

Quality statements .....	5
Quality statement 1: Including physical and mental health needs in a care and support needs assessment.....	6
Quality statement.....	6
Rationale .....	6
Quality measures.....	6
What the quality statement means for different audiences.....	7
Source guidance.....	8
Definitions of terms used in this quality statement .....	8
Equality and diversity considerations .....	8
Quality statement 2: Discussing services that could help at a care and support needs assessment .....	10
Quality statement.....	10
Rationale .....	10
Quality measures.....	10
What the quality statement means for different audiences.....	11
Source guidance.....	12
Definitions of terms used in this quality statement .....	12
Equality and diversity considerations .....	13
Quality statement 3: Named care coordinator .....	15
Quality statement.....	15
Rationale .....	15
Quality measures.....	15
What the quality statement means for different audiences.....	16
Source guidance.....	17
Definitions of terms used in this quality statement .....	17
Quality statement 4: Care planning .....	20

Quality statement.....	20
Rationale .....	20
Quality measures.....	20
What the quality statement means for different audiences.....	22
Source guidance.....	23
Definitions of terms used in this quality statement .....	23
Equality and diversity considerations .....	25
Quality statement 5: Review of health and social care plan .....	26
Quality statement.....	26
Rationale .....	26
Quality measures.....	26
What the quality statement means for different audiences.....	28
Source guidance.....	28
Definitions of terms used in this quality statement .....	28
Equality and diversity considerations .....	30
About this quality standard .....	32
Diversity, equality and language.....	32

This standard is based on NG22.

This standard should be read in conjunction with QS123, QS120, QS117, QS85, QS50, QS136, QS137, QS153, QS164, QS171, QS173 and QS184.

## 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

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

## 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 different audiences

**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 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.

**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. NICE guideline NG22 (2015), 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's 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's 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

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

## 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 different audiences

**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) 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.

**Older people with more than 1 long-term condition who 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. NICE guideline NG22 (2015), 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's 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's](#)

[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 [NICE's 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

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

### 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 different audiences

**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) 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.

**Older people with more than 1 long-term condition who 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. NICE guideline NG22 (2015), 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's 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's 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

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

## 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 different audiences

**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) 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.

**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. NICE guideline NG22 (2015), 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's 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's 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

The following measures can be used to assess the quality of care or service provision specified in the statement. They are examples of how the statement can be measured, and can be adapted and used flexibly.

## 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 different audiences

**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 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.

**Older people with more than 1 long-term condition who 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. NICE guideline NG22 (2015), 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's 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's 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.

## 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.

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, this may not always be appropriate in practice. Taking account of safety, shared decision-making, choice and professional judgement, desired levels of achievement should be defined locally.

Information about [how NICE quality standards are developed](#) is available from the NICE website.

See our [webpage on quality standards advisory committees](#) for details about our standing committees. Information about the topic experts invited to join the standing members is available from the [webpage for this quality standard](#).

NICE has produced a [quality standard service improvement template](#) to help providers make an initial assessment of their service compared with a selection of quality statements. This tool is updated monthly to include new quality standards.

NICE guidance and quality standards apply in England and Wales. Decisions on how they apply in Scotland and Northern Ireland are made by the Scottish government and Northern Ireland Executive. NICE quality standards may include references to organisations or people responsible for commissioning or providing care that may be relevant only to England.

## Diversity, equality and language

Equality issues were considered during development and [equality assessments for this quality standard](#) are available. Any specific issues identified during development of the

quality statements are highlighted in each statement.

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.

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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 \(RCGP\)](#)
- [Royal College of Nursing \(RCN\)](#)
- [Royal College of Occupational Therapists \(RCOT\)](#)
- [Royal College of Physicians \(RCP\)](#)