Multimorbidity

Consultation on draft NICE Quality Standard (QS10023)

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The National Institute for Health and Care Excellence (NICE) is currently developing a Quality Standard on the assessment, prioritisation and management of healthcare for all adults living with multimorbidity. In the context of this statement, multimorbidity is defined as a state where a person is living with two or more long-term health conditions, at least one of which is physical. This Quality Standard is due to be published in June 2017 and as part of the development process, stakeholders have been invited to comment on the draft (available online here). Age UK welcomes this Quality Standard as a positive contribution to supporting older people's health and wellbeing, many of whom live with multiple long-term conditions.

Key points and recommendations

Age UK's detailed comments can be seen in the NICE proforma below. Key points from our response include:

- Recognising the importance of the third sector in identification and subsequent support of people living with multiple long-term conditions.
- Acknowledging the complex relationship between multimorbidity and frailty in the lives of many older people and stressing the importance of comprehensive, whole-person approaches to needs assessments.
- Reiterating the need for person-centred discussion between patients and healthcare professionals around goals, values and priorities to inform treatment options.
- Welcoming the emphasis of the Quality Standard on medicines optimisation and making suggestions about how 'inappropriate polypharmacy' can be addressed.
- Highlighting the need for the involvement of family and carers alongside patients when producing care plans.

Age UK's comments

Comment number	Section	Statement number	Comments
1	General		Age UK welcomes this Quality Standard on multimorbidity as a valuable contribution to improving the care and outcomes of older people living with multiple long-term conditions. Multimorbidity and the increasingly complex health conditions that older people are living with are among the most important issues facing our health and social care system.

2	Statement 1 (What the quality statement means)	1	We are concerned the quality standard doesn't adequately recognise the role that third sector organisations can play in the lives of people living with multimorbidity. In our report '*Untapped Potential: Bringing the voluntary sector's strengths to health and care transformation*' published by the Richmond Group of Charities (of which Age UK is a member), we outlined the case for the third sector in providing care and support services. The third sector represents a trusted and active presence embedded in many local communities with great reach and flexibility. In particular, charities are generally well-placed to support the identification of older people living with multimorbidity in the community. They can also provide a space where people feel able to share their views and manage their long-term conditions, within a package of integrated and coordinated care. For example, Age UK's Personalised Integrated Care programme has shown how adopting person-centred design principles can improve wellbeing and resilience in people living with multiple long-term conditions. Through our programme, we support people to express important values, goals and challenges in their lives. These "guided conversations" result in a collaborative care planning based on shared-decision making between an older person and our Age UK staff. This is then fed back into the care team, to help refine care plans. This allows individuals to better identify the services that are right for them. The effectiveness of this approach is well-documented. The average mental wellbeing of an older person involved in our programme increased by 2.24 points on the Short Warwick-Edinburgh Mental Wellbeing Scale from 21.66 to 23.91. This increase moves the average of the assessed cohort (n=932 people) significantly above the England mean of 23.61. Reductions in pressure on local health and social care systems have also been reported and 8 out of the 9 of our Integrated Care programme pilot sites have been recommissioned. We feel including voluntary sector partners in care-coordination, in leading roles as appropriate, would be beneficial for many people living with multimorbidity and help improve their health and wellbeing.
3	Statement 1 (What the quality statement means)	1	Within this statement, there may also need to be a greater acknowledgement of the role of the community pharmacist in identifying and managing multiple long term conditions, as outlined in a recent report by The Royal Pharmaceutical Society- *'Frontline pharmacists: Making a difference for people with long term conditions.'* Community pharmacists are highly accessible and well placed to identify multimorbidity either through their direct contact with a person or through dispensing habits. In some places, the infrastructure for sharing information gained in the pharmacy with a person's GP and other primary care professionals is underdeveloped and may need to be enhanced.
4	Statement 1 (General)	1	Regarding Question 2 on page 3, how data is currently shared across the NHS and care services can sometimes lead to difficulty in keeping those involved in a person's care aware of changing circumstances such as the development of new health conditions. This can be prominent between primary care providers and hospitals. In identifying multimorbidity and developing an appropriate person-centred response, the lines of communication must be effective between different groups and current structures may not facilitate this.

5	Statement 1 (Definitions)	1	We welcome the recommendation for using primary care electronic health records to identify markers of increased treatment burden, particularly around medications. With regards to question 4 on page 3, it is unclear at present what the tools and protocols for identifying inappropriate polypharmacy and other treatment burdens from electronic records would be. Sample tools as given for assessing frailty in later statements would be a useful addition here.
6	Statements 1 (Definitions)	1	Following on from the above, we recommend the term 'polypharmacy' is defined within this statement. For many people living with multimorbidity, taking multiple medications is a necessary part of their treatment and can improve their quality of life. If optimised properly, a state of 'appropriate' polypharmacy may be the most effective way of managing their conditions. A clear definition of what polypharmacy is and how taking too many medications can lead to unanticipated adverse effects if not optimised properly would be welcome here.
7	Statement 1 (General)	1	Age UK believes that service providers should not only identify multimorbidity but should also aim to segment and understand the needs and care requirements of people living with multiple long-term conditions. We believe that pertinent data, best practice and a consensus of approaches between organisations should be captured in Joint Strategic Needs Assessments and Joint Health and Wellbeing strategies. This supports later commissioning and accountability.
8	Statement 2 (Definitions)	2	We believe it would be useful to define frailty in this statement as there is still a lack of awareness and understanding of what it entails. Age UK understands frailty to be a distinctive state of health related to the ageing process where the body's inbuilt reserves are eroded and people become increasingly vulnerable to physical and emotional setbacks. We would consider frailty to be one of several long-term conditions that a person may be living with. However, we would caution healthcare professionals when working with this statement against using a medical definition of frailty with their patients. In our collaborative work with the British Geriatric Society and Britain Thinks entitled '*Frailty: Language and Perceptions'* we recommend avoiding using the term 'frailty' or any other all-encompassing term altogether. Using 'frailty' with older people was found to elicit strong negative reactions due to an association with a loss of independence and end of life. The work instead found that people prefer to frame their needs in more 'everyday' terms, e.g. as not recovering as well when they get ill or struggling with some daily tasks. We therefore recommend that healthcare professionals use specific examples of living with frailty in order to foster positive and supportive conversations with patients and drive self-identification when performing their assessments.

9	Statement 2 (Process)	2	We feel the language used when describing tools for identifying frailty suggests a more definitive relationship with the presence of frailty than the evidence shows. For example, the gait speed test could be simply indicative of an underlying musculoskeletal condition such as arthritis. The tools described provide strong indicators of frailty but should not be used as a diagnostic tool, as the language in the quality statement implies. Likewise, it is not clear in this quality statement how other conditions, factors, and the general cumulative effect of multimorbidity will impact on the outcomes of these tests, which should be taken into account. Assessment and care planning for frailty should happen through comprehensive geriatric assessment (CGA) or similar multi-disciplinary approach with the tools listed here acting as one form of identifying people that are likely to benefit from these approaches. This could help to ensure that all underlying issues and conditions are fully identified in a person who may be living with frailty so as to develop a holistic response to their needs, looking at both the medical and non-medical.
10	Statement 3 (General)	3	With regard to question 5 on page 3, we believe that keeping the two separate statements represents the best format. We see these two statements as touching upon two related but different ideas: 1. Promoting informed and person-centred medicines optimisation. 2. Promoting broader discussion between healthcare practitioners and patients around social/lifestyle goals, values and plans. This would encompass the non-medical aspects of their care and social prescribing. Statements 3 and 5 overlap in scope but we feel consolidating them may diminish their impact and reiterating them separately is more powerful.
11	Statement 3 (Rationale)	3	Age UK believes that chronic pain, pain management and comfort are key considerations in many people's goals and priorities around their care so should be explicitly addressed in this statement. We would welcome a sentence inserted after *'….side effects because they value the benefits offered by the treatment'* that would read along the lines of the following: *'Discussion with patients around their acceptable levels of pain and what pain management might mean for their overall treatment should be an important consideration'.*
12	Statement 3 (What the quality statement means)	3	We recommend highlighting here the ability of the types of conversations suggested by this statement in signposting to other types of emotional, physical, social and psychological support. People living with multimorbidity often have greater needs in these areas and it is important to ensure every opportunity is taken to make people aware of the support available to them.
13	Statement 4 (What the quality statement means)	4	Regarding Question 4 on page 3, we would be concerned about the capacity of healthcare professionals to coordinate the care of many different people, each with complex, long-term needs. Following on from the previous points, we would argue that collaboration with the third sector around care-navigator/coordinator roles would be beneficial in this area for many local healthcare economies.

14	Statement 4 (What the quality statement means)	4	We also feel that others involved in the care of a person with multiple conditions (such as carers) should be included briefly in this section of Statement 4 and their (central) role in care plans clarified. We recommend an amendment such as that outlined below: ***'Adults with 2 or more long-term conditions** and, with consent, their carers are involved in an overall discussion with their GP or practice nurse about deciding who is responsible for coordinating their care. This should make sure that everyone is clear about this and is happy with the decision'.*
15	Statement 5 (Quality statement and rationale)	5	We believe the addition of a quality statement on medicines optimisation is welcome, however we fear this quality standard may be missing an important point by not promoting the routine implementation of medication reviews and only looking at aspects that involve stopping/changing a medication. First of all, as highlighted in previous comments, this quality standard should overall be clearer about what polypharmacy entails, be it appropriate or inappropriate polypharmacy. It should also make clear that this particular quality statement is about addressing inappropriate polypharmacy, outlining why this is a particular issue for people living with multiple conditions in the 'rationale' for example. Secondly, it should also make recommendations to encourage healthcare professionals to undertake medication reviews on a regular basis, be it as part of this statement (as suggested below), or through a separate quality statement, as we know this is not routinely happening at the moment. Changing needs or developing side effects/adverse events must be recognised and addressed promptly through ongoing review processes. It is particularly important that it happens when someone moves from one care setting to another, for example when they are discharged from hospital. We are often told that people are discharged without sufficient information on how, when or for what duration people should take new medications at discharge or indeed whether new prescriptions following an admission are replacing or complementing existing treatments. Professionals should use such transitions as a prompt to review and discuss medications, including what they entail and whether they align with the patient's aims and aspirations, with clear communication between secondary and primary care settings and this should be reflected in this guidance. As such, we would recommend amending the quality statement so that it reads as: *"Adults have a regular review of their medicines and other treatments for multimorbidity and discuss their treatment regimens, including whether treatments can be stopped or changed".*
16	Statement 5 (Rationale)	5	The rationale at present suggests that *'Optimising treatments according to individual preferences can reduce adverse events and improve quality of life'*. We recommend that in the same vein, it is also made clear that discontinuing a medication isn't (and shouldn't be) about cost savings or patients knowingly being offered substandard care. As such, and building on the comments above, it should be about the patient's health and wellbeing along with the goals and aspirations they have set out as part of the care planning process.

17	Statement 5 (What the quality statement means)	5	More clarification in this quality statement would be useful as to who is providing the medication reviews. For example, community pharmacists offer medication review as well through two services (the New Medicines Service and the Medicines Use Review) already included in the Community Pharmacy Contractual Framework with NHS England. We recommend this is referenced in the Statement.
18	Statement 5 (What the quality statement means)	5	Age UK also believes that *'The aim of this [treatment review] is to improve the person's quality of life'* may not be specific enough although we welcome the acknowledgment that this should be the primary goal of a review. The effect of reducing inappropriate treatments can also greatly improve the lives of carers, family and others involved in a person's care and we would recommend this is included alongside. In light of this, we would recommend the wording *'The aim of this is to improve the quality of life and outcomes for the person, their family and their carers.'*