Multimorbidity: clinical assessment and management

NICE National Institute for Health and Care Excellence

Consultation on draft guideline – deadline for comments 17.00 on 12/05/2016 **email:** Multimorbidities@nice.org.uk

	Please read the checklist for submitting comments at the end of this form. We cannot accept forms that are not filled in correctly. We would like to hear your views on these questions: 1. Do any recommendations represent a substantial increase in costs, and do you consider that the reasons given in the guideline are sufficient to justify this? 2. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. 3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) See section 3.9 of Developing NICE guidance: how to get involved for suggestions of general points to think about when commenting.
Stakeholder organisation(s) (or your name if you are commenting as an individual):	**Age UK**
Name of commentator (leave blank if you are commenting as an individual):	Tom Gentry

Comment number	**Document** (**full** version, **short** version or the **appendices**)	**Page number** Or **'general'** for comments on the whole document	**Line number** Or **'general'** for comments on the whole document	**Comments** Insert each comment in a new row. Do not paste other tables into this table, because your comments could get lost – type directly into this table.
Example 1	Full	16	45	We are concerned that this recommendation may imply that ……..
Example 2	Full	16	45	Question 1: This recommendation will be a challenging change in practice because ……
Example 3	Full	16	45	Question 2: Our trust has had experience of implementing this approach and would be willing to submit its experiences to the NICE shared learning database. Contact…….
1	Short	5	18-20	We are concerned that the threshold for a tailored approach to care is set at 15 medications. The King's Fund review of

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				the evidence (Polypharmacy and medicines optimisation: Making it safe and sound, King's Fund, 2013) considers people on 10 or more as an "at risk" group as well as those on four to nine in combination with other factors such as being at end of life. The BGS/RCGP/Age UK consensus guideline Fit for Frailty (2014) suggests people on 5 or more medications as being a potential indicator of frailty, a group shown to benefit from a tailored approach to care. Recent work completed by the North West London CLAHRC (unpublished pilot) settled on 6 medications in people over 75 as a prompt for review. We appreciate that some of the risks associated with inappropriate prescribing are picked up elsewhere in the guidance in recommendations on use of STOPP criteria and that the full guidelines outline the specific evidence on adverse events and unplanned admissions. However, we believe this is too narrow a specification of harm considering impact on quality of life and risk of falls in older people (which may be underestimated in the published literature) and sends the wrong message on what is a strong indicator for a tailored approach to care. We think the upper threshold should be ten.
2	Short	5	25	Reviewing medication should happen routinely for people living with long-term condition/s. However, it is particularly important that it happens when someone moves from one caring 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, with clear communication between secondary and primary care settings and this should be reflected in this guidance.
3	Short	6	7-15	The language used describing tools for identifying frailty suggest 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 complaint such as arthritis. The tools described provide strong indicators of frailty but should not be used as a diagnostic tool, as the language implies. 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.
4	Short	7-8		The section titled *Establishing patient preferences, values and priorities* should open the recommendations on *Delivering a tailored approach to care*. These should always be the starting point on discussing and planning a person-centred approach to care, particularly when someone is living with multiple conditions and/or frailty. Our experience from running integrated care programmes around the country demonstrates that having non/minimally-medical conversations before discussing treatment options enables care staff to support planning that is relevant to people and enables them to work towards goals that are important to them. This will additionally mean the role of non-health services, such as activities run by the voluntary sector, can be more easily incorporated into a person's pathway of care. Presenting this step at the beginning of the section would send an important message to the people implementation these recommendations.
5	Short	9	26-29	This recommendation speaks to the significant communications ask throughout these guidelines. Discussing preferences and goals, regardless of the severity or prognosis of your condition/s, can be a distressing and worrying

				process, particularly where this may include conversations about end of life. Many of the recommendations describe very positive steps in working towards shared goals, but they do not sit comfortably with the experience many older people have with care professionals. In research we published with Ipsos MORI (Understanding the lives of people living with frailty, 2014) one participant described a medication she was repeatedly prescribed despite telling her GP it did not work for her. Others we spoke to (Frailty: Language and Perceptions, Britain Thinks/Age UK/BGS,2015) described no effort being taken to engage them in decisions, describing how they would just do what the doctor told them. These speak to big gaps in how we would want care professionals to communicate with older people about their care, impacting on how involved they feel in decisions. Professionals must be trained and supported to communicate sensitively and productively with patients, grounded in the principles of shared decision-making and working to achieve this should be included as a recommendation.
6	Short	General		The guideline does not make sufficient reference to the non-clinical interventions that could support people to manage their health and wellbeing. This includes the role of health services to maintain links with providers of relevant services. For example, the voluntary and community sector (VCS) provide a wide range of services highly valued by older people that support them to stay active and engaged in their community as well as providing practical support. Specific programmes provided by the VCS can also work as a vital link between older people and health services to ensure care targeted at people living with multimorbidity is joined up and holistic. In our integrated care programmes, for example, we support people to express what it most important to them and the challenges they may be having. These “guided conversations” happen in people’s homes with trained Age UK staff and result in care planning that is then fed back into their care team, better targeting the subsequent interventions. This further allows individuals to better identify the services that are right for them, whether NHS services or the many VCS services in their area. Such approaches should be considered in implementing these recommendations.
7	Database of treatment	General		The database of treatment is a useful tool that may have some application in standardising care professional understanding of the respective risks and benefits of certain treatments. However, we have some concerns that by aligning it to a multimorbidity guideline, it risks entrenching existing approaches that focus on single conditions. It does not appear to have the functionality to assess combined risk of treatment (which we accept reflects the absence of robust evidence) beyond displaying multiple conditions’ treatments beside each other. A value judgment could see one drug recommended over another simply on the basis of relative risk between treatments rather than reflecting the goals and preferences of the patient. We do not believe, therefore that this could be used in a patient-doctor consultation, for example, or in planning a person’s care, though it could have some utility in informing and upskilling prescribers in evaluating risks/benefits. We further believe that reducing the amounts of harmful polypharmacy and older people on potentially inappropriate prescriptions (PIPs), particularly in those regularly admitted to hospital, are a higher priorities than promoting a tool to evaluate relative risk.

Insert extra rows as needed

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Checklist for submitting comments

- Use this comment form and submit it as a Word document (not a PDF).
- Include page and line number (not section number) of the text each comment is about.
- Combine all comments from your organisation into 1 response. We cannot accept more than 1 response from each organisation.
- Do not paste other tables into this table – type directly into the table.
- Underline and highlight any confidential information or other material that you do not wish to be made public.
- Do not include medical information about yourself or another person from which you or the person could be identified.
- Spell out any abbreviations you use
- For copyright reasons, comment forms do not include attachments such as research articles, letters or leaflets (for copyright reasons). We return comments forms that have attachments without reading them. The stakeholder may resubmit the form without attachments, but it must be received by the deadline.

You can see any guidance that we have produced on topics related to this guideline by checking NICE Pathways.

Note: We reserve the right to summarise and edit comments received during consultations, or not to publish them at all, if we consider the comments are too long, or publication would be unlawful or otherwise inappropriate.

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