

# NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

## SCOPE

### 1 **Guideline title**

Multimorbidity: the assessment, prioritisation and management of care for people with commonly occurring multimorbidity

#### 1.1 **Short title**

Multimorbidity: assessment and management

### 2 **The remit**

NHS England has asked NICE: to develop a clinical guideline on the following topic: Multimorbidity: Assessment, prioritisation and management of care for people with commonly occurring multimorbidity.

### 3 **Need for the guideline**

#### 3.1 **Epidemiology**

- a) Multimorbidity in its broadest sense has been defined as the combination of 1 chronic disease with at least 1 other disease (acute or chronic) or biopsychosocial (biological, psychological or social) factor (associated or not) or somatic (related to or affected by the body) risk factor. It is often defined more simply as the co-existence of 2 or more long term conditions. Generalist and multiagency care is particularly relevant to people with multimorbidity, while specialist care is usually organised around care for a single condition. Multimorbidity increases markedly with age, but it is also found in younger people, especially in socially deprived areas where the co-existence of physical and mental health problems is particularly common. Multimorbidity is associated with poor quality of life, disability, psychological

problems and increased mortality. Multimorbidity is also associated with increased frequency of health service use including emergency hospital admission, adverse drug events, polypharmacy, duplicate testing and poor care co-ordination. Polypharmacy is often significantly driven by the introduction of multiple drugs intended to prevent future morbidity and mortality, but the case for using such drugs weakens as life expectancy reduces. The absolute difference made by each additional drug may also reduce when people are taking multiple preventative medicines.

- b) Some conditions are commonly found together because one can be caused by the other (for example, diabetes can cause chronic kidney disease) or because they share an aetiology, (for example, smoking is an important cause of both lung cancer and coronary heart disease). Other conditions such as pain and depression are not known to share an aetiology, but are common comorbidities of many conditions. The implications of multimorbidity for healthcare are highly variable depending on which conditions an individual has. For some people, a single condition such as a potentially fatal cancer may be dominant, at least for a time. Groups of conditions which have closely related or concordant treatment, such as diabetes, hypertension and angina pose fewer problems of co-ordination than groups where treatment is discordant, such as people who experience both physical and mental health conditions.
- c) Management of care in some people with multimorbidity may be difficult because of limited access to healthcare or because most care is received from a specialist service which does not address all of their needs. These include people who are homeless and those who are usually cared for by services focusing on a particular morbidity (for example, people with learning difficulties or people with severe mental illness who may not have their physical health needs addressed, or people with chronic physical health problems

who may not have their mental health needs identified and effectively managed).

- d) NICE guidelines have already been developed for the management of many individual diseases and conditions. The aim of this guideline is to inform patient and clinical decision-making and models of care for people with multimorbidity who would benefit from a tailored approach. The guideline will not develop recommendations on management of individual conditions or on organisation of care for individual conditions.

### **3.2 Current practice**

Clinical care is largely informed by evidence and guidelines for single systems or diseases. Current clinical practice is increasingly specialist, with healthcare professionals often basing treatment decisions on relatively narrow aspects of an individual's health problems. Issues associated with multimorbidity, such as polypharmacy and related adverse events, are considered in some settings, such as general practice and services caring for older people. However, there is a lack of information to guide decisions about multiple medicine use, including information on the effect of stopping some treatments and information comparing the benefits of different drug combinations when managing patients with multimorbidity.

## **4 The guideline**

The guideline development process is described in detail on the NICE website (see section 6, 'Further information').

This scope defines what the guideline will (and will not) examine, and what the guideline developers will consider. The scope is based on the referral from NHS England. The areas that will be addressed by the guideline are described in the following sections.

## **4.1 Population**

### **4.1.1 Groups that will be covered**

- a) Adults (18 years and over) with multimorbidity.

### **4.1.2 Groups that will not be covered:**

- a) Children and young people under 18 years.
- b) People who only have multiple mental health problems and no physical health problems.
- c) People with a single long-term condition.

## **4.2 Setting**

- a) All settings in which NHS care is delivered.

## **4.3 Management**

### **4.3.1 Key issues that will be covered**

- a) Identifying people with multimorbidity who need a tailored approach to healthcare. The guideline will consider both individual indicators and multi-variable prediction tools for identifying people who most need a tailored approach, using the following as potential indicators for risk stratification, for example:
  - taking large numbers of prescribed drugs
  - having unplanned hospital admissions
- b) Principles for assessing and prioritising health care interventions for individuals with multimorbidity, including the values and preferences of the individual
- c) Assessing methods for estimating life expectancy, evaluating frailty and assessing burden of treatment.
- d) Ranking absolute risks and benefits of interventions for prevention or improving prognosis of common morbidity (for example,

treatments to improve glucose and blood pressure control, statins, angiotensin-converting enzyme [ACE] inhibitors, drugs for osteoporosis).

- d) Effects of stopping common drug treatments.
- e) Strategies for managing healthcare for people with multimorbidity
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  - strategies to improve continuity of care e.g. case management, care plans, named healthcare professionals
  - format of consultations with healthcare professionals
  - models of multi-professional healthcare (for example co-ordinated care for common patterns of co-morbidity such as joint clinics across specialties)
  - self-management and expert patient programmes.
- f) Barriers to optimising healthcare for people with multimorbidity.

#### **4.3.2 Clinical issues that will not be covered**

- a) Symptomatic treatment.
- b) The management and organisation of healthcare for individual conditions
- c) End of life care

#### **4.4 Main outcomes**

- a) Services and interventions will be evaluated based on outcomes defined by the guideline development group. Examples could include:
  - health-related quality of life (for example, EQ-5D)
  - mortality
  - patient and carer experience of care

- continuity of care
- healthcare utilisation, for example:
  - unplanned hospital admissions
  - length of hospital stay
  - number of primary care appointments.

## **4.5 Review questions**

Review questions guide a systematic review of the literature. They address only the key issues covered in the scope, and usually relate to interventions, diagnosis, prognosis, service delivery or patient experience. Please note that these review questions are draft versions and will be finalised with the Guideline Development Group.

### **4.5.1 Population identification**

- a) What indicators or tools identify people who need a tailored approach to the care of their multimorbidity?

### **4.5.2 Assessment and prioritisation**

- a) What principles are important for assessing and prioritising healthcare interventions for people with multimorbidity?
- b) What is the clinical and cost-effectiveness of tools used to elicit patient and carer preferences about treatments?
- c) What is the clinical and cost effectiveness of using prognostic indices or tools for estimating life expectancy or evaluating frailty to support decisions on prioritising or stopping treatment?
- d) What is the clinical and cost effectiveness of tools to estimate burden of treatment?
- e) How might data from condition-specific guidance best be used and presented to inform a ranking of treatments based on absolute risk and benefit and time to achieve benefits?
- f) What are the effects of stopping common drug treatments?

### **4.5.3 Management of care**

- a) What is the clinical and cost effectiveness of strategies to improve continuity of healthcare, for example care plans, case management and named health professionals to improve outcomes for people with multimorbidity?
- b) What format(s) of consultations with healthcare professionals improve outcomes for people with multimorbidity?
- c) What models of multi-professional care improve outcomes for people with multimorbidity?
- d) What is the clinical and cost effectiveness of self-management and expert patient programmes in improving outcomes for people with multimorbidity?

### **4.5.4 Barriers to management in people with multimorbidity**

- a) What are the barriers that prevent healthcare professionals from stopping preventative treatments?
- b) What are barriers to healthcare professionals optimising care for people with multimorbidity?

## **4.6 *Economic aspects***

Developers will take into account both clinical and cost effectiveness when making recommendations involving a choice between alternative interventions. A review of the economic evidence will be conducted and analyses will be carried out as appropriate. In particular, the management of care for people with multimorbidity is likely to be a high priority in terms of health economic analysis.

In cost effectiveness analyses the preferred unit of effectiveness is the quality-adjusted life year (QALY), and the costs considered will usually be only from an NHS and personal social services (PSS) perspective. Further detail on the methods can be found in 'The guidelines manual'.

## **4.7 Status**

### **4.7.1 Scope**

This is the final scope.

### **4.7.2 Timing**

The development of guideline recommendations will begin in November 2014.

## **5 Related NICE guidance**

### **5.1 Published guidance**

- Psychosis with co-existing substance misuse. NICE clinical guideline 120 (2011).
- Depression in adults with a chronic physical health problem. NICE clinical guideline 91 (2009).
- Medicines Adherence: involving patients in decisions about prescribed medicines and supporting adherence. NICE clinical guideline 76 (2009).

### **5.2 Guidance under development**

NICE is currently developing the following related guidance (details available from the NICE website):

- Medicines optimisation. NICE clinical guideline. Publication expected March 2015.
- Social care of older people with multiple long-term conditions. NICE social care guidance. Publication expected October 2015.
- Transition between inpatient hospital settings and community or care home settings for adults with social care needs. NICE social care guidance. Publication expected November 2015.
- Older people: independence and mental wellbeing. NICE public health guidance. Publication expected November 2015.
- Dual diagnosis: meeting people's wider health and social care needs when they have a severe mental illness and misuse substances. NICE public health guidance. Publication expected September 2016



- Multimorbidities: system integration to meet population needs. NICE public health guidance. Publication date to be confirmed.
- Care of the dying adult. NICE clinical guideline. Publication date to be confirmed.

## **6 Further information**

Information on the guideline development process is provided in the following documents, available from the NICE website:

- How NICE clinical guidelines are developed: an overview for stakeholders the public and the NHS: 5th edition
- The guidelines manual.

Information on the progress of the guideline will also be available from the NICE website.