NICE National Institute for Health and Care Excellence

Appendix B1: Stakeholder consultation comments table

2019 surveillance of Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence (2009)

Consultation dates: 23 January 2019 to 5 February 2019

Do you agree with the proposal to not to update the guideline?			
Stakeholder	**Overall response**	**Comments**	**NICE response**
East Lancashire Hospitals NHS Trust	No	Since CG76 guidance was issued new services have been introduced into community pharmacy in NHSE that are specifically aimed at improving medicines adherence (New Medicine Service and targeted Medicines Use Reviews). It would seem amiss to make no mention of these; and I think ICE should be encouraging health professionals to refer patients into these services, and for community pharmacists to actively seek out eligible patients In the section relating to Supporting Adherence, I think there should be some thought given to the pharmacy systems that pharmacies use (hospital and community) being able to provide printed reminder sheets and/or	Thank you for your comment. The New Medicines Service and Medicines Use Reviews are services agreed by NHS Employers and the Pharmaceutical Services Negotiating Committee and funded by NHS England. These services are consistent with current NICE guidance on medicines adherence and medicines optimisation. Because the availability of such services will vary locally and could change over time, we think that altering the guideline to refer specifically to such services is not needed and the advice could become out of date. NICE also has a guideline on promoting health and wellbeing through community pharmacies, which aims to

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		medicines administration record charts. Most community systems will do the latter, but most hospital systems don't; and I'd hazard neither will provide simple reminder charts. With regards to reminder charts they should include the Indication for a particular medicine. This would need engagement with Systems Suppliers In the section detailing Communication between healthcare professionals, it should be stipulated that reasons for starting *and* changing medicines are passed on (currently the guidance only stipulates reasons for cessation). Again Systems Suppliers could have a role here ensuring their systems facilitate this transfer of care information; and (perhaps?) mandate the capture of this in prescribing, pharmacy and GP systems so the information is overtly captured at prescribing and viewable whenever needed. Too often nobody can tell or know (including patients and other prescribers) why someone is prescribed a particular medicine.	encourage more people to use community pharmacies by integrating them within existing health and care pathways and ensuring they offer standard services and a consistent approach. The guideline on medicines adherence has recommendations on providing information to patients, which should be tailored to the patient's needs. As implementation of recommendations should be undertaken locally to meet requirements of local populations and services, it is not appropriate to address the capabilities of individual pharmacy systems. In terms of communications between healthcare professionals and transfer of care, the guideline on medicines optimisation has recommendations on medicines-related communication systems when patients move from one care setting to another. Overall, there is no need to update the guideline to cover these issues at this time.
Ferrer Internacional S.A.	No	After ten years of the last version and as new evidences have arised, a new update of the guideline would be pertinent	Thank you for your comment.
University of East Anglia	No	At the University of East Anglia we have undertaken a programme of research regarding medicines adherence that is not recognised in the existing guidance and nor had it been identified in the surveillance monitoring – it was an NIHR funded HTA. The randomised controlled trial of multi-compartment compliance aids compared with	Thank you for your comment. We will add the studies by Bhattacharya et al. (2016) and Brown et al. (2017) to the summary of evidence. The systematic review component of this work by Bhattacharya et al. (2016) noted: 'Of the eight studies, four suggested improved

		standard care concluded ""**Do not initiate medication organisation devices without prior detailed medication review and vigilant monitoring"** which was a rapid response arising from this work and published in the British Medical Journal in 2014. The full report is provided in "The feasibility of determining the effectiveness and cost-effectiveness of medication organisation devices compared with usual care for older people in a community setting: systematic review, stakeholder focus groups and feasibility randomised controlled trial." NIHR Journals Library; 2016 Jul. (Health Technology Assessment, No. 20.50.) The IMAB-Q which is a tool to support patients and practitioners in working together to identify and prioritise patient's barriers to medication adherence was validated in over 600 patients presenting to community pharmacies. The findings of this study are available from the Pharmacy Research UK website: https://pharmacyresearchuk.org/wp-content/uploads/2017/01/IMAB-Q-validation-and-feasibility-testing-full-report.pdf This report has also not been identified in the surveillance monitoring.	adherence in the MOD [multicompartment medicines device] group. Owing to overall heterogeneity, a meta-analysis was not possible.' The inconsistency of the evidence base is broadly similar to the inconsistent evidence available when developing the recommendations in the guideline. The guideline committee noted: 'For patients who have practical problems in managing complex regimes or who may be forgetful these devices may have a value. The GDG considered that many individuals develop their own strategies and that the evidence on these devices was not strong enough to make recommendations for widespread use.' Therefore, the recommendation on such devices was restrictive: Because evidence supporting interventions to increase adherence is inconclusive, only use interventions to overcome practical problems associated with non-adherence if a specific need is identified. Target the intervention to the need. Interventions might include: • suggesting that patients record their medicine-taking • encouraging patients to monitor their condition • simplifying the dosing regimen • using alternative packaging for the medicine • using a multi-compartment medicines system. The randomised controlled trial component of Bhattacharya et al. (2016) was described as a feasibility study. It had 4 arms: weekly medication organisation device; monthly medication organisation device; weekly usual packaging; monthly usual packaging. Overall 29 participants were included (7–8 people per arm).

			The authors concluded 'Medication organisation device provision to unintentionally non-adherent older people may cause medication-related adverse events'. The adherence rates in all arms were high (95–97%) and did not differ between groups. The occurrence of 5 adverse events in people using medication organisation devices is concerning, particularly because of the small sample size and short duration of the study (3 weeks). For all people with adverse events, the authors concluded 'It is a possibility that study participation improved medication adherence…' However, for 2 of these patients the reported data show that their adherence was lower during the study than before the intervention, which contradicts the authors' conclusion. Additionally, there is a logical mismatch in the findings that the multi-compartment medicines systems did not affect adherence, yet did cause adherence-related adverse events. Overall, this study does not provide sufficient evidence to update the guideline at this time, but underlines the need for further research in this area. The study by Brown et al. (2017) included people prescribed medicines for prevention of cardiovascular disease. As part of the research process the tool was reduced from 30 questions to 10. These questions address issues noted in the guideline on medicines adherence. Additionally, the sample was noted to be generally 'generally high adherers'. Further work to determine whether this tool is effective for identifying people who currently do not adhere to their medicines or are at risk of reducing their adherence is needed.

Royal College of Paediatrics and Child Health medicines committee	Yes	Not relevant to our population.	Thank you for your comment.
Anaphylaxis Campaign	No	As a member of the Prescription Charge Coalition, Anaphylaxis Campaign do not agree that the guideline should not be updated. This is particularly in reference to "1.2.10 Ask patients if prescriptions charges are a problem for them. If they are, consider possible options to reduce costs." We believe that the guideline should be more specific in outlining the need for clinicians to ensure that patients are aware of the current exemptions criteria, prescription prepayment certificate and NHS low income scheme when they are prescribed medication. This is vital to ensure patients who are eligible for these benefits can take advantage of them. Often there is confusion around exemptions on prescription charges. This is due to the prescription charges exemptions list. The list was created in 1968 and has only been updated once since (in 2009 to add patients with cancer). Condition progression and medical care has changed vastly in this period, outdating the original list.	Thank you for your comment. We have looked at the papers that you referred to: • Hex et al. (2018) Economic evaluation of the benefits of extending free prescriptions to people with long-term conditions • Prescription Charges Coalition. (2017). Still paying the price • Gilmore, I. (2009). Prescription Charges Review: The Gilmore Report However, decisions about prescription charges are made by the Department of Health and Social Care. We expect healthcare professionals to be aware of relevant exemptions available for their patients and direct patients to further information on exemptions. No update to the recommendation on asking about prescription charges is necessary at this time.

		Evidence has found that adherence is reduced due to the implementation of prescription charges for those living with a long-term condition. A recent report by the York Health Economics Consortium found that in just Parkinson's and Inflammatory Bowel Disease (IBD) a £20.8million saving would be made by the NHS due to a decrease in hospital admissions because of better medicines adherence. The York Health Economics Consortium found that if prescription charges for people with a long-term condition were scrapped there would be: 11.4% less hospital admissions for people with Parkinson's 9% less A&E visits for people with Parkinson's 7,149 less flares for people with IBD 3,887 less GP visits for people with Crohn's Further evidence on the correlation between improved adherence and the scrapping of prescription charges can be found in the following pieces of work: York Health Economic Consortium. (2018). Economic evaluation of the benefits of extending free prescriptions to people with long-term conditions. Prescription Charges Coalition. (2017). Still paying the price Gilmore, I. (2009). Prescription Charges Review: The Gilmore Report	

Primary Immunodeficiency UK	No	As a member of the Prescription Charges Coalition we do not agree that the guideline should not be updated. Reference to "1.2.10 Ask patients if prescriptions charges are a problem for them. If they are, consider possible options to reduce costs.": Prescription charges place a high financial burden on people affected by chronic life-long conditions such primary immunodeficiency (genetic conditions that affect the immune system). These charges impede adherence especially for affected young people. The guideline should be more specific in outlining the need for medical professionals to support patients through awareness of the current exemptions criteria, prescription prepayment certificate and NHS low income schemes. This will help ensure patients who are eligible for these benefits can take advantage of them. Evidence has found that adherence is reduced due to the implementation of prescription charges for those living with a long-term condition. The exemption list on prescription charges needs updating. The list was created in 1968 and has only been updated once for inclusion of cancer drugs. Evidence on the link between improved adherence and the scrapping of prescription charges can be found in the following pieces of work: *Prescription Charges Coalition*. (2017). Still paying the price	Thank you for your comment. Please see our response to the comment on prescription charges above.

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		Gilmore, I. (2009). Prescription Charges Review: The Gilmore Report	
Parkinson's UK	No	As Co-Chairs of the Prescription Charges Coalition, Parkinson's UK do not agree that the guideline should not be updated. This is particularly in reference to "1.2.10 Ask patients if prescriptions charges are a problem for them. If they are, consider possible options to reduce costs." We believe that the guideline should be more specific in outlining the need for clinicians to ensure that patients are aware of the current exemptions criteria, prescription prepayment certificate and NHS low income scheme when they are prescribed medication. This is vital to ensure patients who are eligible for these benefits can take advantage of them. Often there is confusion around exemptions on prescription charges. This is due to the prescription charges exemptions list. The list was created in 1968 and has only been updated once since (in 2009 to add patients with cancer). Condition progression and medical care has changed vastly in this period, outdating the original list. Evidence has found that adherence is reduced due to the implementation of prescription charges for those living with a long-term condition.	Thank you for your comment. Please see our response to the comment on prescription charges above.

		A recent report by the York Health Economics Consortium found that in just Parkinson's and Inflammatory Bowel Disease (IBD) a £20.8million saving would be made by the NHS due to a decrease in hospital admissions because of better medicines adherence. The York Health Economics Consortium found that if prescription charges for people with a long-term condition were scrapped there would be: 11.4% less hospital admissions for people with Parkinson's 9% less A&E visits for people with Parkinson's 7,149 less flares for people with IBD 3,887 less GP visits for people with Crohn's Further evidence on the correlation between improved adherence and the scrapping of prescription charges can be found in the following pieces of work: *York Health Economic Consortium*. (2018). Economic evaluation of the benefits of extending free prescriptions to people with long-term conditions. *Prescription Charges Coalition*. (2017). Still paying the price *Gilmore, I*. (2009). Prescription Charges Review: The Gilmore Report	
Royal College of Physicians		We have liaised with our Joint Specialty Committee for Clinical Pharmacology and Therapeutics and agree that it is	Thank you for your comment.

		not necessary to update these two guidelines at the present time.	
Kidney Care Uk	No	We do not agree with the recommendation not to update the guideline. In section 1.2.10 there is specific reference to asking the patient whether 'prescriptions charges are a problem for them. If they are, consider possible options to reduce costs.' There is evidence of patients finding the cost of prescriptions a barrier to adherence, especially those with multi-morbidities. We believe that the guideline should be more specific in outlining the need for clinicians to ensure that patients are aware of the current exemptions criteria, prescription prepayment certificate and NHS low income scheme when they are prescribed medication. This is vital to ensure patients who are eligible for these benefits can take advantage of them. Often there is confusion around exemptions on prescription charges. This is due to the prescription charges exemptions list. The list was created in 1968 and has only been updated once since (in 2009 to add patients with cancer). Condition progression and medical care has changed greatly in this period, outdating the original list.	Thank you for your comment. Please see our response to the comment on prescription charges above.

		Evidence has found that adherence is reduced due to the implementation of prescription charges for those living with a long-term condition.	
Royal College of Nursing	Yes	No comments provided	Thank you for your response.
Children's Liver Disease Foundation	No	As members of the Prescription Charges Coalition, Children's Liver Disease Foundation do not agree that the guideline should not be updated. This is particularly in reference to "1.2.10 Ask patients if prescriptions charges are a problem for them. If they are, consider possible options to reduce costs." We believe that the guideline should be more specific in outlining the need for clinicians to ensure that patients are aware of the current exemptions criteria, prescription prepayment certificate and NHS low income scheme when they are prescribed medication. This is vital to ensure patients who are eligible for these benefits can take advantage of them. Often there is confusion around exemptions on prescription charges. This is due to the prescription charges exemptions list. The list was created in 1968 and has only been updated once since (in 2009 to add patients with cancer). Condition progression and medical care has changed vastly in this period, outdating the original list.	Thank you for your comment. Please see our response to the comment on prescription charges above.

		Evidence has found that adherence is reduced due to the implementation of prescription charges for those living with a long-term condition. Evidence on the correlation between improved adherence and the scrapping of prescription charges can be found in the following pieces of work: York Health Economic Consortium. (2018). Economic evaluation of the benefits of extending free prescriptions to people with long-term conditions. Prescription Charges Coalition. (2017). Still paying the price Gilmore, I. (2009). Prescription Charges Review: The Gilmore Report Research by the Prescription Charges Coalition has demonstrated that prescription charges are a major barrier to people taking their medicines effectively, leading them to severely compromise their health. This is particularly relevant to young people with liver disease as the introduction of prescription charges comes at a time when they are transferring from paediatric to adult services. Children's Liver Disease Foundation (CLDF) is the only UK charity dedicated to fighting all childhood liver diseases. We do this by providing information to families and to health professionals, emotional support to young people with liver disease and their families, funds for research and a voice for all affected. For further information go to childliverdisease.org	

AbbVie	Yes	AbbVie agree with the indication from topic experts, that the recommendations remain valid and the principles underlying the recommendations remain unchanged. Therefore AbbVie support NICE's decision to not update the medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence guidelines. AbbVie support the aim of the guidelines: to ensure that a person's decision to use a medicine is an informed choice. It was noted in the surveillance document that topic experts indicated that the recommendations were durable, but they may not be well implemented across the system. Though no information was identified to suggest that an update could influence barriers to implementation. NICE should consider exploring this further, and reviewing whether healthcare professionals (who prescribe, dispense or review medicines or who have a role in making decisions about medicines with patients) are using these guidelines in practice, and that patients are being involved in decisions to use a medicine. NICE should also consider reviewing how these guidelines are made known to healthcare professionals, and how to encourage better implementation across the system. For example, the associated tools and resources page on the NICE website could be reviewed, and more up-to-date, relevant, materials added.	Thank you for your comment and your support for the surveillance decision not to update this guideline. The surveillance review documents and decision will be published on the NICE website and will confirm that the guideline recommendations are still current. However, if any new evidence becomes available, the guideline will be reviewed before its next scheduled surveillance review. In terms of supporting implementation of the guideline, we produce a range of resources for putting guidance into practice. See the tools and resources page for the guideline on medicines adherence for full details. For example, NICE has published shared learning examples of how NICE guidance and standards on medicine management have been put into practice in the NHS, local authorities, voluntary sector and a range of other organisations.

		NICE should also ensure that their decision to not update the guidelines, and the reasons behind this decision, are well communicated, so is not perceived by the system as a de-prioritisation of the guidelines. In the surveillance document, feedback suggested there has been progress in aspects of care covered by the guidelines, including shared decision making. AbbVie welcomes the development of NICE's Shared Decision Making guideline. Shared Decision Making is something we support given the opportunities it affords to ensure that care and treatment are based on the needs and preferences of patients and carers. We look forward to responding to the consultation on the draft scope, and welcome the opportunity to work with NICE to develop the guideline, as appropriate.	
Sickle Cell Society	No	As a member of the Prescription Charges Coalition, we do not agree that the guideline should not be updated. This is particularly in reference to "1.2.10 Ask patients if prescriptions charges are a problem for them. If they are, consider possible options to reduce costs." We believe that the guideline should be more specific in outlining the need for clinicians to ensure that patients are aware of the current exemptions criteria, prescription prepayment certificate and NHS low income scheme when they are prescribed medication. This is vital to ensure patients who are eligible for these benefits can take advantage of them.	Thank you for your comment. Please see our response to the comment on prescription charges above.

		Often there is confusion around exemptions on prescription charges. This is due to the prescription charges exemptions list. The list was created in 1968 and has only been updated once since (in 2009 to add patients with cancer). Condition progression and medical care has changed vastly in this period, outdating the original list. Evidence has found that adherence is reduced due to the implementation of prescription charges for those living with a long-term condition. A recent report by the York Health Economics Consortium found that in just Parkinson's and Inflammatory Bowel Disease (IBD) a £20.8million saving would be made by the NHS due to a decrease in hospital admissions because of better medicines adherence. The York Health Economics Consortium found that if prescription charges for people with a long-term condition were scrapped there would be: 11.4% less hospital admissions for people with Parkinson's 9% less A&E visits for people with Parkinson's 7,149 less flares for people with IBD 3,887 less GP visits for people with Crohn's Further evidence on the correlation between improved adherence and the scrapping of prescription charges can be found in the following pieces of work:	

		York Health Economic Consortium. (2018). Economic evaluation of the benefits of extending free prescriptions to people with long-term conditions. Prescription Charges Coalition. (2017). Still paying the price Gilmore, I. (2009). Prescription Charges Review: The Gilmore Report	
National Rheumatoid Arthritis Society	No	As Co-Chairs of the Prescription Charges Coalition, the National Rheumatoid Arthritis Society does not agree that the guideline should not be updated. This is particularly in reference to "1.2.10 Ask patients if prescriptions charges are a problem for them. If they are, consider possible options to reduce costs." We believe that the guideline should be more specific in outlining the need for clinicians to ensure that patients are aware of the current exemptions criteria, prescription prepayment certificate and NHS low income scheme when they are prescribed medication. This is vital to ensure patients who are eligible for these benefits can take advantage of them. Often there is confusion around exemptions on prescription charges. This is due to the prescription charges exemptions list. The list was created in 1968 and has only been updated once since (in 2009 to add patients with cancer). Condition progression and medical care has changed vastly in this period, outdating the original list.	Thank you for your comment. Please see our response to the comment on prescription charges above.

		Evidence has found that adherence is reduced due to the implementation of prescription charges for those living with a long-term condition. A recent report by the York Health Economics Consortium found that in just Parkinson's and Inflammatory Bowel Disease (IBD) a £20.8million saving would be made by the NHS due to a decrease in hospital admissions because of better medicines adherence. The York Health Economics Consortium found that if prescription charges for people with a long-term condition were scrapped there would be: 11.4% less hospital admissions for people with Parkinson's 9% less A&E visits for people with Parkinson's 7,149 less flares for people with IBD 3,887 less GP visits for people with Crohn's Further evidence on the correlation between improved adherence and the scrapping of prescription charges can be found in the following pieces of work: York Health Economic Consortium. (2018). Economic evaluation of the benefits of extending free prescriptions to people with long-term conditions. Prescription Charges Coalition. (2017). Still paying the price Gilmore, I. (2009). Prescription Charges Review: The Gilmore Report	
British Society for Heart Failure	Yes	We think it is reasonable for NICE not to update these guidelines.	Thank you for your comment.

Crohn's and Colitis UK	No	As Co-Chairs of the Prescription Charges Coalition, Crohn's and Colitis UK do not agree with the proposal not to update the guideline. Our concern is based on the impact of prescription charges on medicines adherence for people with inflammatory bowel disease and other long-term conditions, on which there is more recent evidence that should be taken into consideration. In the current guideline, this is acknowledged but not adequately addressed in "1.2.10 Ask patients if prescriptions charges are a problem for them. If they are, consider possible options to reduce costs." We believe that the guideline should be more specific in outlining the need for clinicians to ensure that patients are aware of the current exemption criteria, prescription prepayment certificate and NHS low income scheme when they are prescribed medication. This is vital to ensure patients who are eligible for these can take advantage of them, yet our research shows that it often takes a number of years before patients become aware of them and many find out through friends and family rather than through the clinicians who are supporting their treatment and care. This is compounded by the medical exemption list, which was created in 1968 and has only been updated once since (in 2009 to add patients with cancer). Condition progression and medical care has changed vastly in this period, outdating the original list.	Thank you for your comment. Please see our response to the comment on prescription charges above.

		Evidence has found that adherence is reduced due to the implementation of prescription charges for those living with a long-term condition. A recent report by the York Health Economics Consortium found that in just Parkinson's and Inflammatory Bowel Disease (IBD) a £20.8million saving would be made by the NHS due to a decrease in hospital admissions because of better medicines adherence. The York Health Economics Consortium found that if prescription charges for people with a long-term condition were scrapped there would be: 11.4% less hospital admissions for people with Parkinson's 9% less A&E visits for people with Parkinson's 7,149 less flares for people with IBD 3,887 less GP visits for people with Crohn's Further evidence on the correlation between improved adherence and the scrapping of prescription charges can be found in the following pieces of work: York Health Economic Consortium. (2018). Economic evaluation of the benefits of extending free prescriptions to people with long-term conditions. Prescription Charges Coalition. (2017). Still paying the price Gilmore, I. (2009). Prescription Charges Review: The Gilmore Report	

Northumbria Healthcare NHS Foundation Trust	Yes	There is much going on in the area of medicines optimisation, therefore a refresh in a year or two would seem to be more appropriate. It would be appropriate to merge NG5 and CG76	Thank you for your comment. The surveillance review confirms that the guideline recommendations are still current. However, if any new evidence becomes available, the guideline will be reviewed before its next scheduled surveillance review. And, as noted in the surveillance report, if the guidelines need updating we will also consider merging them.
Norfolk and Norwich University Hospital Foundation Trust on behalf of the Medicines Optimisation Group East Anglia (MOG_EA)	No	No comments provided	Thank you for your response.
North West Boroughs Healthcare NHS Foundation Trust	Yes	Supported by published evidence.	Thank you for your comment.

Do you have any comments on areas excluded from the scope of the guideline?

Stakeholder	Overall response	Comments	NICE response
East Lancashire Hospitals NHS Trust	No	No comments provided	Thank you for your response.

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Quality and leadership – NICE	No	No comments provided	Thank you for your response.
Ferrer Internacional S.A.	No	But an update of the guideline would be appreciated by doctors and the public	Thank you for your comment. As noted in the surveillance report, the evidence does not suggest a need to update at this time and topic experts advised us that the recommendations remained valid.
University of East Anglia	No	No comments provided	Thank you for your response.
Royal College of Paediatrics and Child Health medicines committee	Yes	However, there is no discussion around compliance in young people which is an important topic, particularly in those with chronic illness starting in childhood for example diabetes, asthma, epilepsy etc. There is no other guidance for this and some of the areas covered within this guidance also covers young people.	Thank you for your comment. Although the scope of the guideline excluded children and young people, it noted: 'However, the guideline recommendations may be considered for a child or young person who is deemed competent to express a view on their prescription.'
Anaphylaxis Campaign	No	No comments provided	Thank you for your response.
Primary Immunodeficiency UK	No	No comments provided	Thank you for your response.
Parkinson's UK	No	No comments provided	Thank you for your response.
Royal College of Physicians	Not answered	No comments provided	Thank you for your response.

Kidney Care Uk	No	No comments provided	Thank you for your response.
Royal College of Nursing	No	No comments provided	Thank you for your response.
Children's Liver Disease Foundation	No	No comments provided	Thank you for your response.
AbbVie	No	No comments provided	Thank you for your response.
Sickle Cell Society	No	No comments provided	Thank you for your response.
National Rheumatoid Arthritis Society	No	No comments provided	Thank you for your response.
British Society for Heart Failure	No	No comments provided	Thank you for your response.
Crohn's and Colitis UK	No	No comments provided	Thank you for your response.
Northumbria Healthcare NHS Foundation Trust	No	No comments provided	Thank you for your response.
Norfolk and Norwich University Hospital Foundation Trust on behalf of the Medicines	Yes	We are delighted to see that you are consulting on a decision regarding whether to update either or both of the following guidelines:	Thank you for your response. In the guideline on medicines optimisation, recommendation 1.4.1 notes 'Consider carrying out a structured medication review for

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Optimisation Group East Anglia (MOG_EA)		Medicines optimisation: the safe and effective use of medicines to enable the best possible outcome for patients NG5 Medicines adherence: involving patients in decisions about prescribed medicines and supporting adherence CG76. We strongly believe that both sets of guidelines require updating. With respect to NG5 there is burgeoning evidence for the need to implement deprescribing in a more proactive manner. Research within our local trusts has identified that deprescribing is largely reactive and that large numbers of potentially inappropriate medicines are still prescribed when patients are discharged from hospital. Similarly we know that those medicines were prescribed prior to admission and therefore the problem frequently originates from primary care. Deprescribing of a proactive nature is not just confined to polypharmacy but any patient starting any long term therapy. Evidence suggests that risks for many chronic disease medications can eventually outweigh benefits and that the concept of discontinuation needs discussing with patients in a more routine manner. Consideration of the deprescribing evidence base now requires inclusion within the medicines optimisation guideline. We are also aware of research in Norfolk which demonstrated that starting patients on compliance devices can be potentially dangerous if their dosages have been previously tailored on unidentified non-adherence. The same problems of dose related side effects can occur when	some groups of people when a clear purpose for the review has been identified. These groups may include: • adults, children and young people taking multiple medicines (polypharmacy) • adults, children and young people with chronic or long-term conditions • older people.' Deprescribing may be the result of a medicines review, rather than the focus of a review. We identified new evidence that medicines management interventions such as medicines review and clinical decision support systems can improve outcomes such as reducing prescription of potentially inappropriate medicines. However, this evidence did not indicate that deprescribing outside the context of a structures medicines review would be suitable for specific drugs, drugs classes or indications. We will continue to consider any emerging evidence in this area. If new evidence emerges we will consider its impact on the guideline on medicines adherence and any relevant disease-specific guidelines. The research from Norfolk that you mention appears to refer to the study by Bhattacharya et al. (2016). Please see the response above that addressed this study in detail. Overall, the evidence on multicompartment medicines devices appears to be inconsistent and thus is insufficient to trigger an update of the guideline at this time.

		individuals transfer from their own home to a care home environment whereby they are now given all medicines and doses. To date the focus of guidelines has been on improving adherence assuming that this will always lead to positive outcomes. The guidelines require review to incorporate a more balanced approach to any activities designed to improve patient adherence in those individuals who have been identified as potentially non-adherent. Kind regards On behalf of MOG_EA	
North West Boroughs Healthcare NHS Foundation Trust	No	No comments provided	Thank you for your response.

Do you have any comments on equalities issues?

Stakeholder	Overall response	Comments	NICE response
East Lancashire Hospitals NHS Trust	No	No comments provided	Thank you for your response.
Ferrer Internacional S.A.	Yes	Concerning **1.2 Supporting adherence, Interventions to increase adherence** it should be mentioned/considered in 1.2.8. (an additional bullet)	Thank you for your response. We have assessed the evidence provided on 'polypills' and note that they should not be added to the summary of evidence:

		a polypill for several patients/diseases could be an easy, simple and efficient tool to increase adherence. This is based on the following arguments In 2000, the WHO (1) recommended the development of fixed-dose combinations to increase adherence to medications. In 2007, the WHO discussed the value of a polypill for the prevention of CV disease (2). In 2016 and 2017, the European Society of Cardiology guidelines (3, 4) have openly and strongly advocated for the use of a polypill to increase adherence for the prevention of CVD. The polypill concept for CVD was reviewed and supported at "The Lancet" (5) in March 2017 with two review papers and an editorial "….the availability and use of an affordable polypill would be welcome to help achieve the WHO target of cutting the number of deaths from non-communicable diseases by 25% by 2025". Finally, polypill would be a cost-effective intervention for secondary prevention of the cardiovascular disease from the UK perspective, and for every 1,000 patients treated with a polypill vs monocomponents, 37 non-fatal CV events and 10 CV deaths are estimated to be avoided in 10 years (6). (1) WHO medicines strategy: framework for action in essential drugs and medicines policy 2000–2003. Geneva, World Health Organization, 2000.	• These documents were published before the start date for evidence considered in this surveillance (1 July 2016). – WHO medicines strategy: framework for action in essential drugs and medicines policy 2000–2003 – Prevention of cardiovascular disease: Guideline for assessment and management of cardiovascular risk (2007) – Cost-effectiveness and public health benefit of secondary cardiovascular disease prevention from improved adherence using a polypill in the UK (2015) • Surveillance does not consider guidelines produced by other organisations. Additionally, these guidelines are more relevant to related topic-specific guidelines, such as Cardiovascular disease: risk assessment and reduction, including lipid modification. NICE clinical guideline (CG181) – European Guidelines on cardiovascular disease prevention in clinical practice (2016) – 2017 ESC Guidelines for the management of acute myocardial infarction in patients presenting with ST-segment elevation • The Lancet series of articles on polypills are review articles but do not meet the criteria for systematic reviews, so are not eligible for inclusion in surveillance. The guideline on medicines adherence recommends simplifying the dosing regimen as an option for improving adherence. We consider this recommendation to include 'polypills' if the prescriber considers an available product to be appropriate for the patient. Therefore,

		(2) WHO. Prevention of cardiovascular disease: Guideline for assessment and management of cardiovascular risk. World Health Organization, August 2007. (3) European Guidelines on cardiovascular disease prevention in clinical practice. Atherosclerosis. September 2016. (4) 2017 ESC Guidelines for the management of acute myocardial infarction in patients presenting with ST-segment elevation. European Heart Journal (2017), 1–66 (5) http://www.thelancet.com/series/polypills (6) Becerra V. et al. Cost-effectiveness and public health benefit of secondary cardiovascular disease prevention from improved adherence using a polypill in the UK. BMJ Open. 2015 May 9;5(5): e007111.	NICE's guidelines on medicines adherence and medicines optimisation are consistent with the evidence on polypills.
University of East Anglia	No	No comments provided	Thank you for your response.
Royal College of Paediatrics and Child Health medicines committee	Yes	See above re young people	Thank you for your comment. Please see the response to the previous comment on young people above.
Anaphylaxis Campaign	No	No comments provided	Thank you for your response.
Primary Immunodeficiency UK	No	No comments provided	Thank you for your response.

Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its officers or advisory committees

Parkinson's UK	No	No comments provided	Thank you for your response.
Royal College of Physicians	Not answered	No comments provided	Thank you for your response.
Kidney Care Uk		For kidney patients there is an inequity between those who receive their medications free of charge if they are on dialysis but have to pay if they have a transplant.	Please see our response to the comment on prescription charges above.
Royal College of Nursing	No	No comments provided	Thank you for your response.
Children's Liver Disease Foundation	No	No comments provided	Thank you for your response.
AbbVie	No	No comments provided	Thank you for your response.
Sickle Cell Society	No	No comments provided	Thank you for your response.
National Rheumatoid Arthritis Society	No	No comments provided	Thank you for your response.
British Society for Heart Failure	No	No comments provided	Thank you for your response.
Crohn's and Colitis UK	No	No comments provided	Thank you for your response.

Northumbria Healthcare NHS Foundation Trust	No	No comments provided	Thank you for your response.
Norfolk and Norwich University Hospital Foundation Trust on behalf of the Medicines Optimisation Group East Anglia (MOG_EA)	No	No comments provided	Thank you for your response.
North West Boroughs Healthcare NHS Foundation Trust	No	No comments provided	Thank you for your response.