Multimorbidity: clinical assessment and management

Consultation on draft guideline - Stakeholder comments table
31/03/16 to 12/05/16

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Stakeholder	Document	Page No	Line No	Comments Please insert each new comment in a new row	Developer's response Please respond to each comment
Action on Hearing Loss	Short version	General		Action on Hearing Loss welcomes the opportunity to provide comments on the 'The Multimorbidity: Clinical Assessment and Management draft guidance. Hearing loss is a long-term condition affecting over 11 million people in the UK – one in six of the population. As our society ages this number is set to grow and by 2035 there will be more than 15.6million people with hearing loss in the UK. Hearing loss is the most widespread long-term condition among older people, experienced by almost three quarters (71%) of all people over 70 years. 1 Hearing loss has significant personal and social costs and leads to high levels of social isolation and consequent mental ill health, and research shows it can increase the risk and impact of other long-term conditions such as depression and dementia. Many people with hearing loss are likely to have one or more other long-term conditions, and unaddressed hearing loss will cause issues for the management of other conditions, including problems with communication with health and care professionals. In turn, effective diagnosis and management of hearing loss can minimise these impacts on peoples' lives, improving their quality of life, independence, and their ability to deal with any other long-term conditions.	Thank you for your comment and for contributing to the consultation process.

[1] Action on Hearing Loss (2015) Hearing matters. Available at: www.actiononhearingloss.org.uk/hearingmatters

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				Our recently released evidence-based report 'Hearing Matters- Why Urgent Action is needed on deafness, tinnitus and Hearing loss across the UK2 along with our Joining Up report 3 showed how large cost savings and improvements to quality of life could be achieved from better provision, assessment and management of health and social care services to people who have hearing loss and additional other long-term conditions. Research has also identified particularly high levels of communication difficulties and major issues accessing health care, high risks of misdiagnosis and increased waits for treatments for profoundly deaf British Sign Language (BSL) users in mainstream care. As they age and develop other long-term conditions, BSL users need culturally sensitive provision of care and particular interventions to ensure they can communicate independently and are not excluded. These include the proper provision of communication support such as BSL interpreters, and access to specialist diagnostic tools – interventions that are not usually available in mainstream care but which are essential for this group.	

[2] Action on Hearing Loss (2015) Hearing matters. Available at: www.actiononhearingloss.org.uk/hearingmatters

[3] Action on Hearing Loss (2013) Joining Up. Available at: www.actiononhearingloss.org.uk/joiningup

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				As the largest UK charity working for people with hearing loss and deafness, including researching, campaigning and providing services, Action on Hearing Loss would like to offer our expertise and support in developing this guidance on Multi morbidity: Clinical Assessment and Management, in order to improve standards for people with hearing loss and other long-term conditions across the UK.	
Action on Hearing Loss	Short version	General		Hearing loss is the most widespread long-term condition among older people, experienced by almost three quarters (71%) of all people over 70 years, and it can lead to communication difficulties, causing increased risk of problems with the management of other long-term conditions such as depression and dementia, diabetes, Parkinson's and mobility issues. Sight loss also has significant impacts on a person's quality of life and independence. Its prevalence also increases with age and it is very common in older people, affecting half of all people aged 90 and over. Given the prevalence and impact of hearing loss and sight loss, we feel that the guidance should include sensory loss throughout document as well as physical and mental health conditions.	Thank you for your comment. Following stakeholder comment the GDG have added a recommendation at the start of the guideline to indicate that sensory impairments should be considered as longterm conditions.
Action on Hearing Loss	Short versi	3	18	Point 3 should read 'they have both long term physical, sensory and mental health conditions" As hearing loss is will be 2030 be in the top 10 UK disease burdens above hearing	Thank you for your comment. We have amended the guideline to clarify our definition of multimorbidity to include adults with symptom complexes which are not currently

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	on			diabetes and cataracts , and is the most widespread long term condition in those of the age of 70 in the UK4	classified as diseases, such as sensory impairment of various kinds, including hearing loss.
Action on Hearing Loss	Short version	4	2-13	When offering a tailored approach to care, provide the person with multimorbidity with an individualised management plan which focuses on: Should include the following in point 4. The line should read 'how the person's health conditions, sensory impairments and their treatments interact and how this affects their quality of life' Research has shown that those with addressed hearing loss have better quality of life outcomes, better social engagement, mental and physical health than those with unaddressed hearing loss.5 Adult Hearing Screening- Can we afford to wait any longer? Ear Foundation and Action on Hearing Loss 2016	Thank you for your comment. The GDG have added a recommendation at the start of the guideline to indicate that sensory impairments should be considered as longterm conditions. This should ensure that consideration of sensory impairments in included when agreeing a management plan.
Action on Hearing Loss		5	7-12	Promote the opportunistic screening of known co-morbidities during routine care; so that they can be acknowledged and dealt with. Screening for hearing loss would help ameliorate the stigma and the perception that it is an inevitable consequence of ageing and would help ensure both individuals and the medical profession deal with the significant and unmet health and communication needs of this group. Adult Hearing Screening- Can we afford to wait any longer? Ear Foundation and Action on Hearing Loss 2016	Thank you for your comment. Within the scope of this guideline it was not possible to evaluate the clinical and cost-effectiveness of screening programmes to identify undiagnosed comorbid conditions. The GDG agrees that this may be an interesting area for future research to investigate.
Action on Hearing	Shor	6	5-15	Hearing Loss is strongly associated with falls and maintaining	Thank you for this information. The guideline is not

[4] Mathers, Loncar (2005) Updated projections of global mortality and burden of disease, 2002-2030:data sources, methods and results. Evidence and Information for Policy World Health Organization
[5] Ear Foundation (2016) and Action on Hearing Loss: Adult Hearing Screening- Can we afford to wait any longer?

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Loss	t version			gait and balance. Research shows a 3 fold increase in the risk of falls even if the hearing loss is only mild in nature http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3518403/. Any assessment of frailty should acknowledge the effect that hearing loss has on falls. It increases falls and hence frailty, due to the increase in cognitive load and decreased spatial awareness that can occur with hearing loss; fewer cognitive resources are available to help with maintaining balance and gait	addressing causes of frailty but wishes to improve recognition of frailty among healthcare professionals and empower them to consider it when seeing patients.
Action on Hearing Loss	Short version	7	9-13	Consider the communication needs of those who have hearing loss or deafness. BSL users are often unable to access 'accessible information' that would allow them to tailor their health care, and therefore actively participate in their care. Interpreters are often not available for appoints and written documents are often in language that maybe inaccessible to some BSL users. www.actiononhearingloss.org.uk/Hearing Matters	Thank you for your comment the communication needs of those who have hearing loss or deafness. NICE guideline on Patient Experience (CG138) includes general recommendations on communication and information needs.
Action on Hearing Loss	Short version	7	26-28	The statement should read in the 2nd sentence 'Include a discussion of mental health/sensory impairments and how these issues can burden and affect their wellbeing'	Thank you for your comment. The GDG agrees that sensory impairments can affect wellbeing, however the purpose of these recommendations was not to give an exhaustive list of all conditions that can impact upon wellbeing. The GDG have included sensory impairment in the list of example condition categories that can constitute multimorbidity.
Action on Hearing Loss	Short version	8	1-9	Establish a treatment burden- Include in the discussion any effects of the non-treatment of sensory issues on their day to day health and mental health. Research has shown that hearing loss at least doubles the risk of developing depression and increases the risk of anxiety; and that hearing loss doubles the risk of dementia.	Thank you for your comment. The GDG agree that sensory loss may affect treatment burden, however the purpose of these recommendations was not to give an exhaustive list of all conditions that affect treatment burden. The GDG have included sensory impairment in the list of example condition categories that can constitute multimorbidity.

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				www.actiononhearingloss.org.uk/Hearing Matters	
Action on Hearing Loss	Short version	9	5-8	Hearing loss and deafness impacts on communication. The communication needs of individuals should be considered on a case by case basis when relaying information about care, medication and treatments. Some Profoundly Deaf people use BSL as their first language and will require an interpreter to help gain a proper diagnosis and inform the person about their care.	Thank you for your comment. The GDG agree that hearing loss and deafness impacts on communication. The GDG have included sensory impairment in the list of example condition categories that can constitute multimorbidity. Recommendations about communication and formats required for communication are included in the NICE guideline on Patient Experience (CG138).
Action on Hearing Loss	Short version	10	10-18	Individual Management plan should include inclusion of assessment, diagnosis and management of hearing loss where applicable, which should also include information about preferred or best communication needs and strategies, such as BSL for example.	Thank you for your comment. The GDG agree that consideration of any sensory loss is important for individual management plans. The GDG have included sensory impairment in the list of example condition categories that can constitute multimorbidity.
Action on Hearing Loss	Short version	10	20-24	Comprehensive assessment of older people with complex needs in hospital should include sensory assessments as well as discussed early, these impact on frailty and can affect the diagnosis of other co-morbidities; either through the inability to comprehend information or in the case of dementia lead to possible misdiagnosis or a worsened prognosis. Our Joining UP report Joining Up estimated that up 28 million could be saved by properly managing hearing loss in people with hearing loss, and thus delaying admission into residential care.	Thank you for your comment. The GDG agree that sensory assessment is an important component of a comprehensive/holistic assessment. This guideline does not specify within the recommendations the precise components of a comprehensive assessment although functional impairments such as sensory loss are included in the definition used for our search for evidence.
Age UK	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 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)	Thank you for your comment. The GDG agree that people on 10 or more drugs or 4 to 9 drugs with other risk factors may be at risk. The review of evidence did not find any strong evidence supporting precise cut-offs in terms sensitivity and specificity for predicting adverse events. However in general greater numbers of medications were associated with higher levels of risks. The GDG felt this represented a strong

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				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.	indication to consider those taking 15 or more drugs as at high risk and a weaker, but still genuine, indication to consider those taking 10 or more drugs as at risk. The GDG were also aware of the need to consider workload. This assessment is reflected in the language of the recommendations, which still advises readers to consider using an approach to care that takes account of multimorbidity in the population taking 10 or more drugs or less than 10 but who are for some reason at particular risk of adverse events. These recommendations are not meant to restrict the population in whom this approach could be used, but to help identify those for whom it is most likely to be beneficial.
Age UK	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 complemeting 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.	Thank you for your comment. These issues are included in other NICE guidance such as Medicines Adherence (CG76) and Medicines Optimisation (NG5)guidelines.
Age UK	Shor	6	7-15	The language used describing tools for identifying frailty	Thank you for your comment. The GDG considered that

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	t			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.	clinical judgement was required in choice of method of assessment and interpretation of that assessment. The tools recommended for identifying frailty in people with multimorbidity have been chosen as evidence demonstrated that they are accurate at identifying frailty as compared to established gold standard methods. However, the GDG agree that the assessments in the recommendation cannot be used to provide a formal diagnosis of frailty, for which a gold standard method of assessment should rather be used. Rather the GDG believe that these assessments should be used to highlight if a person with multimorbidity may be vulnerable and may require additional assessment.
Age UK	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	Thank you for your comment. The GDG has considered your suggestion. The recommendations have been re-ordered, and the terms used in the guideline have been amended. The section on how to identify people who may benefit from an approach to care that takes account of multimorbidity, has been moved and now comes immediately after 'taking account of multimorbidity in tailoring the approach to care'. The GDG considers the revised order best for clarity. The order is not meant to be prescriptive.

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				of the section would send an important message to the people implementation these recommendations.	
Age UK	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.	Thank you for your comment. The GDG recognise that healthcare professionals may require training and support to improve communication with patients.
Age UK	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	Thank you for your comment. During scoping of the guideline non-clinical interventions to support health and well-being for people with multimorbidity was not prioritised. The GDG acknowledge that these are important and that support for

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				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.	people to engage in their treatments is also to be welcomed.
Age UK	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	Thank you for your comment. The GDG acknowledges that the tool is limited by available data and does not allow consideration of combined risks of treatment. Thank you for your response that the tool is not appropriate for use in a consultation and may be more appropriate for education of practitioners. The GDG agrees that the tool is not a substitute for other review and the optimisation of medicines. NICE has developed guidance specifically on Managing medicines in care homes (SC1).

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				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.	
Alzheimer's Society	Short	General	General	There are 850,000 people in the UK living with dementia; 42,000 of whom are under the age of 65. Alzheimer's Society knows that these numbers are increasing. As our recent report for the APPG on dementia (which can be found here) found; 7 in 10 people living with dementia are also living with another medical condition. A study has shown the most common conditions for people living with dementia: • 41 per cent have high blood pressure • 32 per cent have depression • 27 per cent have heart disease • 18 per cent have had a stroke or transient ischemic attack (mini stroke) • 13 per cent have diabetes (Barnett et al, 2012). These conditions not only affect a person's quality of life but also have huge implications for the treatment and management of their dementia. Research by the International Longevity Centre – UK (ILC) found that people with dementia	Thank you for your comment. The guideline will not be making comprehensive recommendations for the care of people with dementia as NICE are currently updating the guideline on dementia and the scope includes multimorbidity that may need to treated differently because of dementia.

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				are less likely to have cases of depression, diabetes or urinary tract infections diagnosed, and those that do are less likely to receive the same help to manage and treat these comorbidities. This can lead to people's dementia worsening more quickly, which in turn leads to greater health and social care costs. The ILC – UK estimate the cost for mismanagement of dementia and these three conditions alone is at least £994.4 million annually. (ILC – UK, 2016) The financial cost, as well as the impact on a person with dementia, of living with multi-morbidities highlights the need to make reference to people living with dementia throughout these guidelines.	
Alzheimer's Society	Short	3	11-21	This section makes reference to 'frailty and falls' which is experienced by people with dementia owing to the symptoms of the condition, however a specific reference to dementia in this section would be beneficial. This would encourage health professionals to understand the specific needs of a person with dementia and recognise the need for a tailored approach. Our recent APPG on dementia heard an example from a gentleman living with dementia who told us: 'Dementia is seen by almost everyone as just a memory problem, so it is not common knowledge that day-to-day tasks become more tiring – physically as well as mentally. Simple things like getting up in the morning or walking down the road shopping can seem like a mountain to climb. You become more and more	Thank you for your comment. The guideline will not be making comprehensive recommendations for the care of people with dementia as NICE are currently updating the guideline on dementia and the scope includes multimorbidity that may need to be treated differently because of dementia.

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				fatigued to the point you're exhausted before you even start the day... The brain starts to not send those important messages to the body to move, so it becomes harder; the muscles waste, you put on weight because you cannot exercise which then becomes a vicious circle you cannot break. This breaks down the body's strength and immune system. I have cardiac arrhythmia and angina which of course only worsens the condition as the blood flow alters and causes TIA, Transient ischaemic attacks, commonly known as mini-strokes. This then affects the dementia.' Professionals must be able to recognise the symptoms of dementia and how they can impact on a person's day to day life before considering how their other conditions may affect them.	
Alzheimer's Society		4	22-24	When medicines interact negatively, it can exacerbate someone's dementia or another health condition. For example, our recent APPG on dementia inquiry heard many instances of people's medication for other conditions having a negative impact on their dementia. We heard from a man with dementia whose anticholinergic medication for his bladder problems made his dementia worse, making him confused, drowsy and more likely to fall. It was decided that this put him at a greater risk than not taking it at all and consequently he came off the	Thank you for your comment. The GDG agrees on the importance of recognising when medicines may be causing problems such as confusion. NICE are currently updating guidance on Dementia and this includes specific consideration of treatment of co-morbidities and how they should be considered when treating people with Dementia. The GDG recognises that it can be difficult to make these decisions and that clinical judgement is required. The

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				medication. We also heard from clinicians who told us that they are routinely forced to make difficult decisions about frail elderly people with multiple morbidities medication; something they currently do without comprehensive guidance such as a NICE guideline. The more medication someone is taking, the more complicated the decision and the bigger potential risks of mismanagement. Clinicians also have to ensure someone is supported and able to take their treatment – something that can be more difficult as a consequence of someone's dementia. Pharmacists have an important role to play in medication management as they may see an individual more often than their GP, for example when collecting repeat prescriptions. This guideline should highlight the need for strengthening the links between community pharmacists and primary care.	guideline committee hope that this guideline will support healthcare professionals to consider the risks and benefits of starting or continuing medicines that people are taking. This guidance should be used alongside other NICE guidance relevant to prescribing medication, including the Medicines Optimisation guideline (NG5). The guideline is directed to all healthcare professionals who see people with multimorbidity and that includes community pharmacists. We have clarified this in the 'Context' section of the short guideline and the introduction to the Full guideline. The importance of communication between all those involved in prescribing and dispensing medicines is included in other NICE guidance for example Medicines Optimisation guideline (NG5) and Medicines Adherence guideline (CG76)
Alzheimer's Society		11	10-13	When someone develops a long-term condition, such as diabetes or dementia, they are placed on a GP's register for that condition. If they have multiple conditions, they will be on each respective condition's register. GPs are required to routinely review each condition, and will call people in for separate reviews of each one. This is despite many of the reviews sharing similar elements e.g. taking someone's blood pressure or weight. The APPG on dementia inquiry heard the story of a woman in a care home who received four letters inviting her to separate appointments for each of her conditions. It was not only a logistical nightmare for her and	Thank you for your comment. The GDG agrees that condition-specific care that does not seek to address a person's needs across all of their conditions may be unhelpful for people with multimorbidity. This guideline has recommended the use of an approach to care that takes account of multimorbidity which takes into account all of their conditions and treatments, as well as their values and preferences. This should include regular review of their medications. The evidence reviews did not find convincing evidence for

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				the care home, but also indicative of a lack of proper oversight of health and wellbeing and lack of care co-ordination. To ensure people have an integrated care plan and their care is properly co-ordinated, every individual living with dementia and comorbidities should have a minimum of one holistic review of their care and support per year. This review should look at all of their conditions, how their various medications interact with one another and any decisions should be made in consultation with the person with dementia and their carer (if appropriate).	any model of care and the guideline is therefore unable to recommend a specific model of care to overcome the problems you describe. The GDG are aware of ongoing research in this area which will hopefully be able to inform models of care. In addition NICE are currently updating guideline on Dementia and this specifically includes consideration of treatment of other conditions.
Arthritis Research UK	Full			This response covers the following areas: • Overview • Musculoskeletal conditions • Multimorbidity • Musculoskeletal conditions and multimorbidity -Impact on quality of life -Case study -Health and social care system -Society and economy • Our recommendations	Thank you for your comment.
Arthritis Research UK	Full	General	General	Musculoskeletal conditions are a common component of multimorbidity. Both musculoskeletal problems and multimorbidity are more common in the elderly, and with an ageing population, the number of people living with musculoskeletal ill health and multimorbidities in the UK is set	Thank you for your comment and for this information. NICE has developed a range of guidelines on musculoskeletal conditions. Further details are available on their website at the following link: https://www.nice.org.uk/guidance/conditions-and-

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				to rise.	diseases/musculoskeletal-conditions.
Arthritis Research UK	Full	General	General	However, multimoribidity is not only associated with ageing. Owing to the demographic of the population, there are more people under 65 years of age with multimorbiditiy than over this age.6 This means that people will be living with multimorbidities for large parts of their life. We therefore need to identity, assess and manage care and treatment for patients with multimorbidites whatever their stage of life.	Thank you for your comment. The recommendations in the guideline apply to adults of any age with multimorbidity unless specified.
Arthritis Research UK	Full	General	General	Around 10 million people live with the devastating pain of a musculoskeletal condition across the UK. Painful musculoskeletal conditions are now the largest single cause of years lived with disability (YLDs) and the third-largest cause of disability adjusted life years (DALYs).7	Thank you for this information,
Arthritis Research UK	Full	General	General	Large numbers of people live with musculoskeletal conditions: • Each year 1 in 5 of the general population consults a GP about a musculoskeletal condition.8 • 400,000 people live with rheumatoid arthritis.9 • 8.75 million people have sought treatment for	Thank you for this information. .

6 Barnett K et al. (2012). Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. Lancet 380 (2012): 37-43.

7 Murray C J et al. (2013). UK Health Performance: Findings of the Global Burden of Disease Study 2010. Lancet 381(9871): 997-1020.
8 Arthritis Research UK National Primary Care Centre, Keele University (2009), Musculoskeletal Matters.
9 Arthritis Research UK (2013) Osteoarthritis in general practice

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				osteoarthritis, the common form of arthritis, across the UK (this constitutes a third of all people over 45 years of age)10. • Around 9 million people in England have chronic or persistent back pain; of which 5.5 million experience severe back pain.11 • Each year 89,000 people across the UK fracture their hip.12	
Arthritis Research UK	Full	General	General	The main symptoms of musculoskeletal conditions are pain, joint stiffness and limitations of movement. These symptoms often fluctuate over time and can have a marked impact on quality of life.	Thank you for this information.
Arthritis Research UK	Full	General	General	Many people develop more than two long-term conditions simultaneously without the conditions being causally linked. These conditions can be referred to as multimorbidities. • 15 million people in England have a long term condition but the number living with more than one long-term condition is predicted to increase13. • The number of people living with more than one long term condition is increasing.	Thank you for your comment. We include reference to these facts in the Full guideline.

10 Arthritis Research UK (2013) Osteoarthritis in general practice
11 Arthritis Research UK (2015). The musculoskeletal calculator.
12 National Osteoporosis Society (2011). A fragile future: 25th anniversary report
13 Department of Health (2012) Long Term Conditions Compendium of Information: Third Edition

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				• 78% of GP consultations are for people with multimorbidities14. • Multimorbidity is more common in the elderly, although the overall number of people living with multimorbidities is greater in those under 65.15 • In the most deprived areas, multimorbidity can develop 10-15 years before it does in more affluent areas.16	
Arthritis Research UK	Full	General	General	Arthritis Research UK will publish a policy report 'musculoskeletal conditions and multimorbodities' in autumn 2016	Thank you for this information. .
Arthritis Research UK	Full	General	General	Musculoskeletal conditions, such as arthritis, are a major component of multimorbidity, with major impact on quality of life for those affected, often needing substantial input from health and care services: • Painful conditions are one of the ten most common comorbidities in primary care17. • Four out of five people with osteoarthritis have at least one other long term condition such as hypertension, cardiovascular disease or depression.18 • Two thirds of people with osteoarthritis report	Thank you for this information.

14 Salisbury C et al (2011) Epidemiology and impact of multimoribidity in primary care a retrospective cohort study Br J Gen Pract 1:61: e12-21
15 Barnett Opus Cit.
16 Barnett Opus Cit.
17 Guthrie, Bruce, Payne, Katherine, Alderson, Phil, McMurdo, Marion E T, Mercer, Stewart W. "Adapting clinical guidelines to take account of multimorbidity". BMJ (2012);345:e6341
18 Breedveld F et al. (2004). Osteoarthritis: the impact of a serious disease, Rheumatology 43:1, 14-18.

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				symptoms of depression when their pain is at its worst.19 • One in six people with rheumatoid arthritis has major depression.20	
Arthritis Research UK	Full	General	General	NICE clinical guideline CG146 Osteoporosis: assessing the risk of fragility fracture (Aug 2012) states that 'Residents in care homes have a high risk of fragility fractures. Reasons for this include age and fragility with multimorbidities.' We note that the draft multimorbidity guideline considers stopping common drug treatments osteoporosis and it is important that this is not seen as blanket guidance but the decision is made on a case by case basis as some people may continue to benefit from longer treatment.	Thank you for your comment. The GDG have reviewed the recommendation following stakeholder comment and clarified the intention of the recommendation. The recommendation asks clinicians to inform the person the evidence of no continued benefit on average after three years of use. The group considers this consistent with the aim of encouraging patients to participate in decision making related to their care. .
Arthritis Research UK	Full	General	General	Living with multimorbidities has an impact on a person's quality of life; but if they also have a painful musculoskeletal condition they will report a far lower quality of life.	Thank you for your comment. Specific consideration of Musculoskeletal conditions is outside the remit of this guideline, which instead looks at the more general assessment and management of multimorbidity. However, the guideline includes recommendations that encourage clinicians to establish disease and treatment burden of the individual and the group would consider all populations with musculoskeletal conditions to be covered by these recommendations.

19 Arthritis Care (2010). Arthritis Hurts: the hidden pain of arthritis
20 Matcham F et al. (2013). The prevalence of depression in rheumatoid arthritis: a systematic review and meta-analysis. Rheumatology (Oxford) 52(12):2136-2148

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Arthritis Research UK	Full	General	General	Data from the January – March 2014 wave of the GP Patient Survey were analysed to understand the burden, quality of life and other issues impacting on people over 45 years of age living with a musculoskeletal condition (arthritis, back pain) and other long term conditions (diabetes, heart problem, lung problem, mental health and cancer in the last five years).	Thank you for this information
Arthritis Research UK	Full	General	General	Figures from the GP Patient Survey21 show that those with arthritis or back pain as one of their long term conditions, have a poorer quality of life (a score of 0.71) than those who have any long term conditions other than a musculoskeletal one (a score of 0.79), using the EQ-5D assessment tool. The presence of arthritis or back pain as a long term condition contributes to a significantly lower quality of life score.	Thank you for this information. Following stakeholder comment the GDG added a recommendation to clinicians to consider the presence of pain. Please see recommendation 1.6.5 in the NICE version, which states: Be alert to the possibility of: • depression and anxiety (consider identifying, assessing and managing these conditions in line with the NICE guideline on common mental health disorders) • chronic pain and the need to assess this and the adequacy of pain management

21 https://gp-patient.co.uk/surveys-and-reports#july-2014

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				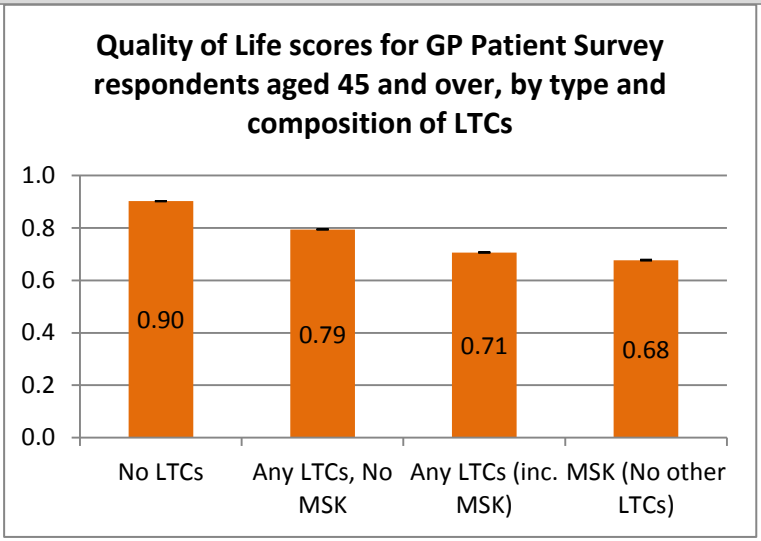	
Arthritis Research UK	Full	General	General	Pain is one of the main symptoms of a musculoskeletal condition. There is a reciprocal relationship between living in pain and depression: pain makes everyday tasks and life uncomfortable, and thus impacts on a person's ability to be active and independent. This in turn can lead to depression as a person's world becomes smaller because their health does not allow them to participate in activities that were once commonplace.	Thank you for your comment. Specific consideration of Musculoskeletal conditions is outside the remit of this guideline, which instead looks at the more general assessment and management of multimorbidity. However, the group has drafted recommendations that encourage clinicians to establish disease and treatment burden of the person with multimorbidity and the group would consider all populations with musculoskeletal conditions to be covered by these recommendations. Following stakeholder comment the GDG have added a recommendation to ensure the presence

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					of pain is explored. Please see recommendation 1.6.5 in the NICE version, which states: Be alert to the possibility of: • depression and anxiety (consider identifying, assessing and managing these conditions in line with the NICE guideline on common mental health disorders) • chronic pain and the need to assess this and the adequacy of pain management
Arthritis Research UK	Full	General	General	Depression is an established co-morbidity of rheumatoid arthritis22and one in six people with rheumatoid arthritis has major depression23. The presence of depression alongside rheumatoid arthritis can also lead to a person's pain and overall disability being worst.24	Thank you for your comment. The recommendations encourage clinicians to consider people with both long term mental health and physical conditions as individuals who will benefit from an approach to care that takes account of multimorbidity. The guideline includes recommendation to be alert to the presence of depression and anxiety.
Arthritis Research UK	Full	General	General	The NICE guideline on depression CG90 (2009) recognises the inter-dependency and reciprocal relationship between pain and depression: 'A chronic physical health problem can both cause and exacerbate depression: pain, functional impairment and disability associated with chronic physical health problems can greatly increase the risk of depression in people with physical illness, and depression can also exacerbate the pain	Thank you for your comment. The recommendations encourage clinicians to consider people with both long term mental health and physical conditions as individuals who might benefit from an approach to care that takes account of multimorbidity. This issue is also highlighted in the 'treatment burden' section of the guideline.

22 Michaud K, 'Co-morbidities in rheumatoid arthritis', Clinical Rheumatology, 2007; 21, 885-906
23 Matcham F et al. (2013). The prevalence of depression in rheumatoid arthritis: a systematic review and meta-analysis. Rheumatology (Oxford) 52(12):2136-2148.
24 Sheehy C et al. (2006). Depression in rheumatoid arthritis – underscoring the problem. Rheumatology (Oxford) 45(11):1325-1327.

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				and distress associated with physical illnesses and adversely affect outcomes, including shortening life expectancy'.	
Arthritis Research UK	Full	General	General	The draft multimorbidity guideline advises clinicians to 'be alert to possible depression and anxiety and consider assessing for these conditions and managing them in line with the NICE guidance on common mental health disorders.' It is important for healthcare professionals to also 'be alert to the presence of pain; take into consideration pain and the relationship it has with depression and anxiety.	Thank you for your comment. The recommendations have been amended and clinicians are now encouraged to be alert to the possibility of chronic pain and the need to assess this and also assess the adequacy of treatment. Please see recommendation 1.6.5 in the NICE version, which states: Be alert to the possibility of: • depression and anxiety (consider identifying, assessing and managing these conditions in line with the NICE guideline on common mental health disorders) • chronic pain and the need to assess this and the adequacy of pain management
Arthritis Research UK	Full	General	General	Relevant NICE clinical guidelines such as osteoarthritis do recognise the importance of healthcare professionals establishing the presence of 'comorbidities' and undertaking a holistic assessment of a person's needs which encompasses social, work, pain, attitudes to exercise and their support network25.	Thank you for this information. The guideline committee agree that NICE guidance in single long-term conditions do recognise the presence of co-morbidities and multimorbidity and did not want to repeat those areas in this general guideline. . .
Arthritis Research UK	Full	General	General	In summary, as we know there is a strong link between chronic physical pain and depression. It is important that pain is	Thank you for your comment and for participating in the consultation process.

25 NICE. (2014). Osteoarthritis: care and management in adults

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				identified as a multimorbidity that exacerbates other health conditions. Single disease guidelines, should seek to highlight the need for a holistic assessment of a person's needs including the existing of other long term conditions. In addition, it is also important that patients with multiple conditions have a single, coordinator of their care to assist with self-management and advise on the interactions between health conditions and also any risks of treatments conflicting.	The group's intention is that recommendations which detail the principles of an approach to care that takes account of multimorbidity would support identifying people whose quality of life have been impacted by pain and depression. Clinicians have been encouraged in the guideline to deliver an approach to care that takes account of multimorbidity, which supports reducing treatment burden and optimising care. The development of an individualised management plan is also recommended and discussions on this includes information on who is responsible for the coordination of care.
Arthritis Research UK	Full	General	General	Musculoskeletal conditions are mainly long term conditions causing pain and disability. Around 20% of the general population consult their GP about a musculoskeletal problem like arthritis each year. That amounts to over 100,000 consultations a day, the majority of which are for osteoarthritis and back pain, accounting for a substantial attendance and demand for resource in primary care26.	Thank you for this information.
Arthritis Research UK	Full	General	General	Care planning is an approach that people with long term conditions can use to manage their health and wellbeing. By taking a holistic approach and empowering people to self–manage, care planning can help to address the growing healthcare challenge of supporting people with long term	Thank you for this information.

26 Hippisley-Cox, J. (2009), Trends in Consultation Rates in General Practice 1995/6 to 2008/9: Analysis of the QResearch database, NHS Information Centre for Health and Social Care: ref for 100,000 stats).

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				conditions, including the increasing proportion of people with multi-morbidities.27	
Arthritis Research UK	Full	General	General	Care planning can be used to support self–management of musculoskeletal conditions with fluctuating symptoms, as well as helping to prevent the recurrence of some forms of musculoskeletal conditions. However, only around 12% of people with a musculoskeletal condition say they have a written care plan28.	Thank you for this information. Specific consideration of Musculoskeletal conditions is outside the remit of this guideline, which instead looks at the more general assessment and management of multimorbidity
Arthritis Research UK	Full	General	General	There is a challenge in ensuring that the benefits of standardised processes and financial incentives can be achieved alongside care that considers the individual priorities and needs of people with multimorbidity. In general practice, there can be tension between the need for compliance with disease specific guidelines, and a culture which fosters and enables opportunities for holistic aspects of care for people with multimorbidity to be discussed.	Thank you for your comment. The guideline committee hope that this guideline will allow for a more holistic approach to care of people with multimorbidity.
Arthritis Research UK	Full	General	General	Musculoskeletal health is a data poor area. There is a need for greater granularity in data collection relating to the incidence, prevalence and geographical distribution of musculoskeletal conditions in the UK, as well as the health status of people with such conditions. General practice has provided a lead in electronic record-keeping and coding of disease, but more	Thank you for your comment.

27 Arthritis Research UK (2014). Care planning and musculoskeletal health.
28 Ibid

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				could be done to improve coding – especially for musculoskeletal problems - to identify population need and understand the outcomes of health interventions.	
Arthritis Research UK	Full	General	General	We note that the multimorbidity guideline is reviewing whether 'polypharmacy is associated with a greater risk of admission to care facility amongst people with multimorbidity.' We also note that the draft guideline recommend clinicians use 'a tailored approach to care for people of any age with multimorbidity who are prescribed 15 or more regular medicines' and clinicians consider 'a tailored approach to care for people of any age with multimorbidity who are i.) prescribed 10 to 14 regular medicines ii.) Are prescribed fewer than 10 regular medicines but are at particular risk of adverse events'.	Thank you for your comment.
Arthritis Research UK	Full	General	General	In summary, current healthcare systems are rarely well configured to address the challenges of multimorbidity, including musculoskeletal conditions as treatment is often disease focused rather than looking at the holistic needs of a patient. This often results in challenges for both a holistic approach and with coordination within the health system. Professional bodies must ensure that healthcare professionals involved in care planning have relevant training, including in musculoskeletal core skills. Healthcare professionals should ask about musculoskeletal pain during care planning where appropriate, should consider how the person's function, mobility and wider health and wellbeing are affected, and should understand interventions to enable people to improve their musculoskeletal health.	Thank you for your comment and case study. This guideline concerns the identification and management of people with multimorbidity, which necessarily includes people with a variety of long-term conditions, including musculoskeletal problems. Within the scope of this guideline, it is not possible to make comprehensive recommendations specifically for the care of people with musculoskeletal conditions but the guideline committee consider that the recommendations should help to establish disease burden and thereby improve wellbeing. Following stakeholder comment attention to the presence of pain has also been added. Please see recommendation 1.6.5 in the NICE version, which

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				Case study: Jack, 65 years old. "If I did it yesterday I can do it today. If I did it today I can do it tomorrow." This is Jack's attitude in the face of his gruelling two hour morning routine to get up and mobile each day. What motivates Jack through his routine, consisting of physio exercises, multiple medications and personal care are a set of short, medium and long term goals. Jack's short-term goals include nights out with friends. His longer term goals involve studying and going abroad: these goals provide a daily aspiration for Jack to improve his mobility and stability. Jack was diagnosed with asthma at 5 months old; at the age of 65 he is now managing a number of conditions including osteoarthritis, carpal tunnel syndrome, a colostomy bag as the result of surgery for colon cancer, an underactive thyroid, diabetes, cataracts, an enlarged prostate and problems with his gall bladder. Jack has a high level of motivation when managing his many conditions, but his quality of life is affected by conditions related to his mobility and independence: "It's the arthritis, the carpal tunnel and the bladder control…they're the things that really affect my quality of life". Jack's relationship with the health system began when he was five months old, and he has become an expert in self-management. "I've been self-managing my asthma for fifty odd years". But he thinks the current system simply does not support people as much as it could. Jack emphasised the lack	states: Be alert to the possibility of: • depression and anxiety (consider identifying, assessing and managing these conditions in line with the NICE guideline on common mental health disorders) • chronic pain and the need to assess this and the adequacy of pain management The guideline includes research recommendation on organisation of care to inform models of care where care is configured to needs of patient rather than disease focussed. Training of healthcare professionals is outside the scope of the guideline.

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				of coordination within the system. Over the previous month Jack had thirteen medical appointments. He finds this time consuming and waring even in retirement, and appreciates it must be extremely difficult for people who also have to work. This lack of coordination also extends to managing medication. "I've got four pages of repeat prescriptions, of about seventeen different items, the trouble is they all get out of sync…so I'm in and out of the GPs ordering repeat prescriptions and picking stuff up from the pharmacy virtually every week." Jack says it would help if there were a single person who had an overview of all his conditions that he could go to for help and advice. "The only thing you do need with self-management is someone to approach, you know if you do have a problem". Jack already experiences this with his stoma nurse (for his colostomy) who he can't praise highly enough, but he would like to have a similar figure with knowledge across all his conditions. Being able to build strong ongoing relationships with health care professionals, such as physiotherapists, is also important to Jack because they can understand and support him to self-manage.	
Arthritis Research UK	Full	General	General	People in more deprived areas are much more likely to report arthritis than people in equivalent age groups who live in less deprived areas. The prevalence of arthritis in those aged 45-64 (people who are of working age) is more than double in the most deprived areas (21.5%) compared the least deprived	Thank you for this information.

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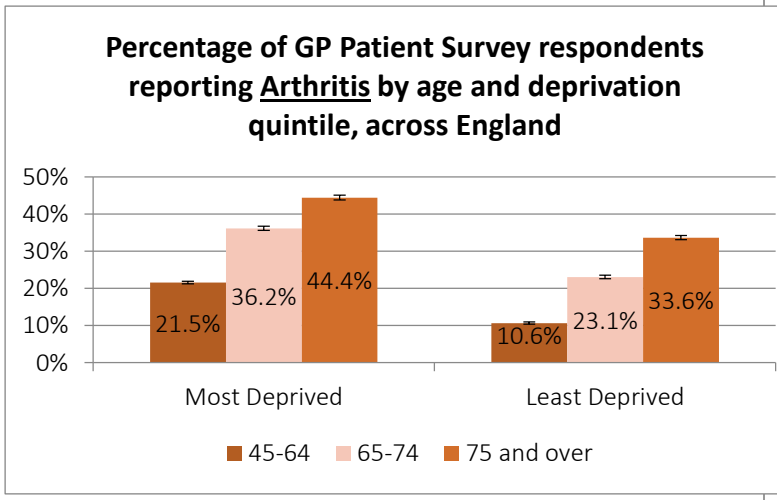
				areas (10.6%)29.  	
Arthritis Research UK	Full	General	General	The pain and fatigue musculoskeletal conditions cause often makes working life hard. People who find standing and walking painful can have difficulty travelling to work and may have to stop doing physically demanding roles. Only two-thirds (59.7%) of people with a musculoskeletal condition of working age are in work. This compares poorly with other chronic long-	Thank you for this information.

[29] https://gp-patient.co.uk/surveys-and-reports#july-2014

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				term conditions and is substantially lower than for those without any health problems or disability (73.5 %).30	
Arthritis Research UK	Full	General	General	This in turn can have a detrimental impact on an individual's self-esteem and mental health. The relationship between physical and mental health is considered by many to be bi-directional – i.e. the two conditions influence each other.31	Thank you for your comment. This guideline contains recommendations on the assessment of mental health and of how disease and treatment burden may impact on the mental health and wellbeing of people with multimorbidity. Please see the section on 'Establishing disease and treatment burden' in the NICE version of the guideline. Recommendation 1.6.3 states: Establish disease burden by talking to people about how their health problems affect their day-to-day life. Include a discussion of: • mental health • how disease burden affects their wellbeing • how their health problems interact and how this affects quality of life.
Arthritis Research UK	Full	General	General	Musculoskeletal and mental health are common co-morbidities. Over 32% of working-age people with musculoskeletal disorders have co-morbid depression. People with a mental health problem alongside a musculoskeletal problem are less likely to be in work.32	Thank you for this information.

30 Department of Work and Pensions (Feb 2015). Labour Force Survey analysis of disabled people by region and main health problem.
31 McGee R et al (Sep 2010). Exploring the connection between physical and mental health conditions.
32 Bevan S (2015). Data taken from the Work Foundation's analysis of the Health Survey for England, 2015. Presentation to the symposium

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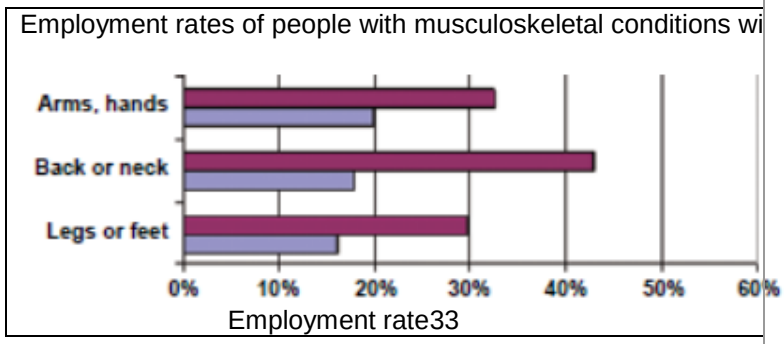
Arthritis Research UK	Full	General	General	Amongst the working age population, the highest proportion of people living with a musculoskeletal condition also have a mental health condition. Both of these conditions are responsible for the greatest number of working days lost.  	Thank you for this information.
Arthritis Research UK	Full	General	General	We recommend that the *identification, assessment and management of musculoskeletal conditions* as a major multimorbidity are recognised in NICE's multimorbidity guidelines.	Thank you for your comment. We have added text to the section 'Terms used in this guideline' to indicate that multimorbidity includes a wide range of conditions including pain.
Arthritis Research UK	Full	General	General	We recommend that NICE's multimorbidity guideline clearly indicates that healthcare professionals should a) '*Be alert*' to	Thank you for your comment. The GDG agree and have added a recommendation in line with your suggestion.

33 McGee Opus Cit.

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				the presence of pain and b) that if pain is identified then it should be *'assessed and managed'* in relation to the relevant NICE guidelines. (This would provide parity with how **depression** is approached in the NICE multimorbidity draft guideline.)	Please see recommendation 1.6.5 which states: Be alert to the possibility of: • depression and anxiety (consider identifying, assessing and managing these conditions in line with the NICE guideline on common mental health disorders) • chronic pain and the need to assess this and the adequacy of pain management
Arthritis Research UK	Full	General	General	The NICE multimorbidity guideline should signpost to those disease specific guidelines it has already issued which recommend healthcare professional to be aware of comorbidites (e.g. **Osteoarthritis:** care and management in adults (CG177) and **Rheumatoid arthritis** the management of rheumatoid arthritis in adults (CG79)).	Thank you for your comment. The multimorbidity guideline will be available on the NICE website with other NICE guidance. The guideline committee consider that the multimorbidity guideline is potentially relevant to many people who have conditions that are covered by NICE guidance even if those guidelines do not make specific reference to co-morbidities. We will work with NICE teams to ensure improved cross referral which will include ensuring disease specific guidance cross-refers to multimorbidity guideline.
Arthritis Research UK	Full	General	General	The Committee use rheumatoid arthritis as an example of those who may benefit from a tailored approach (Figure 3, pg 56, Draft for consultation). The Committee should provide feedback on and include in its guidance, how it wishes healthcare professionals to identify painful conditions such as rheumatoid arthritis	Thank you for your comment. Figure 3 is not suggesting that all people with rheumatoid arthritis require the approach in this guideline, but rheumatoid arthritis is provided as an example of one of multiple conditions that an individual may have that increases need for such an approach.
Arthritis Research UK	Full	General	General	The committee should consider the role that pharmacists should play in the management of multimorbidity and patient awareness around multiple drug prescriptions in coordination	Thank you for your comment. We have clarified in the 'context' section of the short guideline that the recommendations are relevant to all healthcare professionals

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				with other healthcare professionals.	working with people with multimorbidity and that includes pharmacists.
Arthritis Research UK	Full	General	General	Professional bodies must ensure that healthcare professionals involved in care planning have relevant training, including in musculoskeletal core skills.	Thank you for your comment. The GDG agree that clinicians involved in the care of people with multimorbidity should have training relevant to this role but specific recommendations about training are outside the scope of this guideline..
BACD		General		Horridge_et_al-2016-Developmental_Medici Horridge_et_al-2016-Developmental_Medici BACDCommentsEmail.msg Please see attached consultation response on behalf of BACD; with attached literature regarding multi-morbidity in the paediatric population.	Thank you for your comment. During the scoping stage it was felt that the committee could not adequately address the needs of children with multimorbidity within this guideline. Making recommendations for people under 18 years would require a different GDG constitution and reviews of different evidence.
British Academy of Childhood Disability	Full	General	General	There is reference to people across the adult life span; but the majority of the focus is around frailty and the more elderly population. Young people with developmental disorders and disabled young people who have multiple co-morbities should be highlighted as a vulnerable group; especially in early adult life 18-25 years; around transition from paediatric to adult services. There is a need for GP/Primary care physicians to	Thank you for your comment. The scope of the guideline covers the identification and management of adults of all ages with multimorbidity. Unfortunately, the vast majority of evidence identified for the guideline was conducted with an older adult population. Some of the recommendations are therefore limited to older adults, as the GDG were concerned about generalising the evidence available to younger adults

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				become expert in managing this patient population; or for the development of secondary care physicians to support care into adult life.	with multimorbidity. However, where it was possible to generalise, they have done so. NICE have developed specific guidance on transition 'Transition from children's to adults' services for young people using health or social care services' [NG43]
British Academy of Childhood Disability	Full	General	General	There is no discussion of safeguarding issues in this vulnerable population; or of assessment of capacity.	Thank you for your comment. All NICE guidelines include an introductory paragraph on patient centred care which makes explicit reference to capacity and the Mental Capacity Act.
British Academy of Childhood Disability	Full	General	General	We note guideline clarifies that this only applies to those aged 18 years and above; we would like to understand why children and young people have been omitted, as they experience multi-morbidity too, as evidenced data work produced by clinical colleagues in BACD: please see papers attached.	Thank you for your comment. During the scoping stage it was felt that the committee could not adequately address the needs of younger people with multimorbidity within this guideline. Making recommendations for people under 18 years requires a different GDG constitution and reviews of different evidence.
British Infection Association	Full			The BIA is content with this document. Thank you.	Thank you for your comment and for participating in the consultation process.
British Kidney Patient Association	Short	5	9	We would recommend that medication be reviewed on an annual basis, as well as during routine care, with a view to understanding the patient's polypharmacy burden. If a patient is receiving drugs from both primary and secondary care then this should be done in conjunction with both prescribers. When a patient leaves hospital care must be taken to ensure that drugs which may have been suspended (or started) during the hospital stay or acute period are restarted (or stopped) in a timely manner.	Thank you for your comment. Recommendation on regular review and on medicines reconciliation can be found in NICE guideline on Medicines Adherence (CG76) and NICE guideline on medicines optimisation (NG5).

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British Kidney Patient Association	Short	24	5	A recent study in Northern Ireland showed that the average kidney patient has 19 tablets a day, which covers 4-10 different medications. We would suggest that even at the lower end of types of medication, the sheer numbers of tablets requires great care and a tailored approach/explanation to patients to encourage them to understand what the drugs are for. We recommend that volume as well as type of medication should be considered in this guideline.	Thank you for your comment. The GDG agree that the volume of actual tablets and medicines taken by a person contribute to a need for an approach to care that takes account of multimorbidity. However the evidence identified in the review focuses on the number of prescriptions, therefore there is only evidence that the number of prescribed medicines (and not the total volume of tablets) are associated with adverse outcomes. The GDG therefore believes it is appropriate for the recommendation to relate specifically to prescribed medicines. In reality the GDG are aware that there are some people who will be taking many tablets even in the lower numbers of prescriptions, hence the wording of the following recommendations to consider an approach to care that takes account of multimorbidity, for some groups prescribed less than 10 medications.
British Kidney Patient Association	Short	10	9	We would like to know why the plan is referred to as a 'management' plan rather than a 'care' plan – on the face of it 'care' plan seems more appropriate.	Thank you for your comment. The GDG chose to use the tem individualised management plan as the emphasis is on clinical aspects of care, in particular decisions around reducing treatment burden. The GDG were aware that care plan has a specific meaning in social services and is often used to cover a wider range of patient related issues. .
British Kidney Patient Association	Short	10	18	Where the guideline states that copies of a plan should be passed to the person, we suggest that copies of it should be shared between secondary care, the community, a care home, family and carers as appropriate (with permission).	Thank you for your comment. The wording of the recommendation has been changed in line with your suggestion.
British Kidney Patient Association	Full	14	42	We appreciate the mention of acute kidney injury and its risks. We have developed information resources for people at risk of AKI, or people who have had an episode of AKI. These have been produced with patients, the Royal College of GPs and	Thank you for your comment and this information.

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				the NHS England 'Think Kidneys' campaign and we suggest that they are signposted to support the multi-morbidity guidelines. http://www.britishkidney-pa.co.uk/images/stories/patient_information_leaflets/AKI_Leaflet-_How_to_keep_your_Kidneys_Safe.pdf http://www.britishkidney-pa.co.uk/images/stories/patient_information_leaflets/AKI_leaflet.pdf	
British Kidney Patient Association	General			All people with late stage chronic kidney disease will be asked to take many tablets, regardless of age – and this includes children and young people. This younger group should not be omitted from annual or regular medication reviews, and they and their families will need much support to maintain the demanding regimes and varying times at which they are meant to have their medications.	Thank you for your comment. During the scoping stage it was felt that the committee could not adequately address the needs of younger people with multimorbidity within this guideline. Making recommendations for people under 18 years requires a different GDG constitution and reviews of different evidence.
British Kidney Patient Association	General			It should also be noted that some medications (such as immunosuppressants) have to be taken either x hours before or after food, while others have to be taken with food. Tailored advice on multiple medications must include this sort of information – and be made as easy as possible.	Thank you for your comment. The GDG agree that the formulation and schedule for taking medication may contribute to treatment burden in people with multimorbidity. In addition to the items suggested in the recommendation for the assessment of treatment burden, the GDG believe that clinicians should use their own professional experience to add to these discussions, which may include consideration of the formulation of their medications. These issues are more specifically covered in the NICE guideline on Medicines Adherence(CG76).
British Kidney Patient Association	General			Anyone who has chronic kidney disease is at risk of Acute Kidney Injury, as is someone who has had an episode of AKI and this should be noted in tailored assessments.	Thank you for your comment. This guideline concerns the identification and management of people with multimorbidities, which necessarily includes people with a variety of long-term conditions, including chronic kidney

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					disease. Within the scope of this guideline, it is not possible to make comprehensive recommendations or comment on specific risks for people with chronic kidney disease. NICE has previously published guidance specifically on the care of people with chronic kidney disease.
British Medical Association	full	general	general	We welcome the efforts NICE to address this important problem. One of the main difficulties GPs have with NICE guidance is to apply recommendations from a single-disease model to their patients, the majority of whom have more than one long term condition, problems with polypharmacy, differing expectations and priorities for care, and sometimes limited life expectancy. We would hope that this document will empower GPs to individualise their patient's care around those areas which have maximum impact on quality of life, prognosis, and always in line with their patient's wishes.	Thank you for your comment.
British Medical Association	full	general	general	While practices are remunerated on the basis of qof scores, or evaluated on the basis of GP metrics, this reinforces the need for a mechanism of exception reporting to be maintained, and not in itself be taken as a measure of (inverse) quality of care.	Thank you for your comment.
British Medical Association	full	general	general	We feel that the form of this guidance, written as it is in the 'language of NICE' is unhelpful and obscures rather than helps its core message. We would strongly recommend that this is released as a more literary 'position paper' as its main method of communication, with the guideline being released as a subsidiary document to justify the comments in the main document. This will ensure wider dissemination of the main messages.	Thank you for your comment. We have worked to improve the guideline with NICE following stakeholder comments and have included some of your suggestions in our re-wording. However, NICE has a remit to write evidence based guidelines for clinical practice rather than position papers.
British Medical	short	3	13	Delete 'consider' and replace with 'apply'	Thank you for your comment.

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Association					'Consider' in the context of NICE recommendations, reflects the strength of the evidence and indicates that the GDG could not make a strong recommendation based on the evidence because the balance between benefits and harms was not definitive.
British Medical Association	short	5	19,23,24	We recommend removing the precise numbers which cannot be based on science, and rephrase along the lines of 'prioritise this approach on those taking the most medicines, or those at highest risk through other factors.'	Thank you for your comment. The GDG considered that polypharmacy can be a significant problem and wanted to provide some guidance to doctors other than a non-specific comment. The GDG noted that the evidence demonstrated that people taking 15 or more drugs may be at significantly higher risk of unplanned hospital admissions and agreed via consensus that they may also be at increased risk of mortality. On this basis the GDG agreed that people taking 15 or more drugs would benefit from an approach to care that takes account of multimorbidity and this can be considered on the basis of the number of drugs alone, independent of other risk factors.
British Medical Association	-	-	-	-	-
British Medical Association	short	6	5	Please add a reference to 'those who appear frail based on the general clinical assessment of an experienced clinician'	Thank you for your comment. The GDG considered that the simple performance measures included were adequate to cover this.
British Medical Association	short	6	20	Please add a reference to 'those who appear frail based on the general clinical assessment of an experienced clinician'	Thank you for your comment. The group has considered your suggestion and believe that the general clinical assessment of an experience clinician would emerge when using the recommended tools.
British Medical Association	short	7	1	The precise figures for frailty are nonsensical for a condition with no firm diagnostic features, and so affected by psychosocial factors. Please consider rephrasing this.	Thank you for your comment. The figures specified in the recommendation have been chosen as evidence demonstrated that they are accurate in identifying frailty as

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					compared to established gold standard methods of identifying frailty. However, the GDG agree that the assessments in the recommendation cannot be used to provide a formal diagnosis of frailty, for which a gold standard method of assessment should rather be used. Rather the GDG believe that these assessments should be used to highlight if a person with multimorbidity may be vulnerable and may require additional assessment. For this purpose, thresholds can be useful as a guide for clinicians in practice. This is discussed in the LETR (p. 225). However, for the PASE recommendation we have reconsidered the recommendation and the figures have been rounded up for ease of use.
British Thoracic Society (comments endorsed by the Royal College of Physicians)	Short	Section 1.3/1.8 10		The concept of "tailored" therapy seems not to carry any real meaning at least as defined here. The definition in 1.8 would apply to anybody with a long term condition or indeed any patient interacting with a healthcare system, "taking account of a person's individual needs, preferences…etc." The principles in section 1.3 are also seem generic and this seems a missed opportunity to focus on specific concerns for this population. Perhaps this should be shorter and make it more explicit that this is simply good LTC management not something "different". In essence this is patient-centres care which we should all be striving to deliver.	Thank you for your comment. The GDG recognise that the approach in the guideline may be appropriate for many people with long term conditions.
British Thoracic Society (comments endorsed by the Royal College of Physicians)	Short	11		Points 6, 7 and 8 stress a variety of difference medicines but unfortunately fail to mention inhalers. Given that COPD / asthma are very common co-morbidities many patients will be taking several inhalers. The document should explicitly say that not only should a pharmacy / medicine review take place	Thank you for your comment. Inhalers have been added to this list.

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				but the inhaler technique should be checked at every opportunity (as per NICE guidance).	
British Thoracic Society (comments endorsed by the Royal College of Physicians)	Short	13, 14-17		Context: p13 14-17. The two clusters are better thought of as (1) a cluster of multi-morbidity occurring in older people as they age because of an accumulation of long term conditions and (2) of multimorbidity in younger people arising through intense exposure to risk factors (smoking, poor diet, immobility, adverse early life environment) strongly associated with social deprivation. The co-occurrence of mental and physical conditions occurs throughout the life-course.	Thank you for your comment and your views on how multimorbidity might be conceptualised. The GDG were not aware of any evidence to support your causal hypothesis and were concerned about generalisations when individualisation of management might be most important. The GDG do agree that it can be important to ensure that younger people are given appropriate preventative treatment and that the approach to treatment should ensure that the assessment included consideration of treatments that should be started as well as treatments that should be stopped.
British Thoracic Society (comments endorsed by the Royal College of Physicians)	Short	7		Although there is a comment made about mental health disorders and assessing these where indicated the prevalence of anxiety and depression in people with multi-morbidity is huge. For example up to 50% of people with COPD will experience these issues. A more active approach than screening is required if someone thinks they are depressed - specific questions should be asked during interviews to identify the nature of an individual's mood, especially given recent published evidence that mental state is a major factor for admission / re-admission.	Thank you for your comment. The GDG agree that if case finding does suggest a person is depressed than appropriate assessment and management is required. This is included in NICE guidance on common mental health disorders which is referenced in recommendation 1.6.5
British Thoracic Society (comments endorsed by the Royal College of Physicians)	Short	3		There should be explicit reference to smoking as one of the major drivers of multimorbidity, smoking cessation as the most effective treatment for many major long term conditions and health inequality and the need for it to be embedded in pathways of care, especially in mental health.	Thank you for your comment. While the GDG agree that there are a number of important areas for consideration in care of people with multimorbidity, within the scope of this guideline, the modification of specific risk factors associated with multimorbidity was not identified as a priority for review.

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British Thoracic Society (comments endorsed by the Royal College of Physicians)	Short	13		The document correctly stresses the importance of medication and polypharmacy and so specific reference to use of devices (esp inhalers) would be welcome.	Thank you for your comment. We have added inhalers to the list of examples of medicines.
British Thoracic Society (comments endorsed by the Royal College of Physicians)	Short	Section 1.5		Since a major concern is the unnecessary use of long term preventative medicine in people with a short life-expectancy would it be worth including the "surprise" question around section 1.5?	Thank you for your comment. The 'surprise question' is discussed in the Full guideline in section 7.6.5. The GDG did not want to specifically identify people in the last year of life as they considered that specific issues are relevant to that group. The focus of the guideline was on people with multimorbidity, some of whom may benefit from starting preventative treatment.
British Thoracic Society (comments endorsed by the Royal College of Physicians)	Short	18		Section 3 page 18: People with multiple conditions that synergistically increase risk have higher event rates. Giving a BP lowering medication to a frail patient which causes dizziness and then a fall is of course a bad outcome but the document acknowledges that there is no evidence to be stopping these medications in people with a poor prognosis who are not symptomatic as a matter of general policy.	Thank you for your comment. This research recommendation is about ways of predicting life expectancy.
British Thoracic Society (comments endorsed by the Royal College of Physicians)	Short	General		Regarding research questions - as mentioned in point 1 the failure to adequately treat multiple conditions in people with multimorbidity is at least as big a problem as the use of preventative medicines if not larger. We don't know what would happen if we stop preventative medicine in the frail elderly but we do know that not giving beta blockers to COPD patients post MI is killing them – research into how to address	Thank you for your comment. The GDG agree that may people with multimorbidity may require appropriate treatments to be started. Condition specific issues are outside the scope of this guideline.

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				this is needed.	
British Thoracic Society (comments endorsed by the Royal College of Physicians)	Short	General		The issue of multi-morbidity seems to be framed in a largely negative way. This which may arise from a focus on avoiding polypharmacy in frail elderly patients. However, a problem of equal importance for multi-morbidity is the under-diagnosis of co-occurring conditions and their systematic undertreatment An obvious example of underdiagnoses is the failure to identify COPD in people with cardiac disease (and vice versa) and the systematic underuse of effective secondary prevention strategies in COPD patients who have heart disease, in particular beta blockers.	Thank you for your comment. The GDG agree that undertreatment can be a significant problem and have included recommendations to remind healthcare professionals that a review may highlight treatments that should be started as well as treatments that should be stopped. The assessment for common co-morbidities is outside the scope of the guideline.
British Thoracic Society (comments endorsed by the Royal College of Physicians)	Short	General		Explicit reference should be made to the fact that parity of esteem for mental illness requires a focus on the physical health problems of people with mental health problems. This is again largely an issue of undertreatment.	Thank you for your comment. We recognise that people who have severe and enduring mental illness should be screened and assessed (for example, for cardiovascular disease) but people with only mental health problems are not included in this guideline population.
Compassion in Dying	Full	General	General	Compassion in Dying is a national charity working to inform and empower people to exercise their rights and choices around their treatment and care. We do this by: • providing information and support over our freephone Information Line; • supplying free Advance Decision to Refuse Treatment (ADRT) forms and publications which inform people how they can plan ahead for the end of their lives;	Thank you for your comment. This guideline is intended to cover the identification and management of people with multimorbidity, and therefore it is not possible to make a recommendation on the care of people with single conditions. The GDG agrees that tailoring care to an individual is appropriate for people who do not have multimorbidity. This guideline does not replace the recommendations on the care of people with single conditions in other NICE guidance, which include consideration of individualised care.

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				• delivering one-to-one support to older people through our outreach service, My Life, My Decision; • running information sessions and training for professionals, community groups and volunteers on a range of end-of-life topics, including accredited Continuing Professional Development (CPD) modules; and • conducting and reviewing research into end-of-life issues to inform policy makers and promote patient-centred care. We welcome this guidance, in particular the recommendations on engaging with patient preferences and developing a care plan to reflect those preferences. However, we have a number of reservations about the wording of specific sections and omissions of critical information regarding how a person can plan ahead for their care in a legally binding way. While it may fall outside the remit of this consultation, we strongly believe that everybody receiving care would benefit from a 'tailored approach', not just people who have multiple conditions. We hope that the emphasis on providing a tailored approach for people with multimorbidities in this guidance does not imply that people with individual diseases and conditions should not also receive a tailored approach.	
Compassion in Dying	Full	12	26 - 27	We do not consider 'provide the person with multimorbidity with an individualised management plan' to be appropriate wording for what this recommendation is trying to achieve.	Thank you for your comment. This recommendation has been amended and now reads as follows: When offering an approach to care that takes account of multimorbidity, focus

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				Firstly, a plan which incorporates the points outlined in lines 28 to 36 should be referred to as a care plan not a management plan, as it is clearly not intended to focus solely on how the person's care is managed, but also covers the person's preferences, values and care needs in general. Secondly, it is not appropriate to recommend that such a plan be 'provided' to the person. Plans need to be created in a process that involves the person and while we would hope many clinicians would instinctively do this, we worry that the use of 'provide' may be misunderstood as meaning that this collaborative process is not crucial to creating a plan. We would recommend using language which demonstrates the need to involve the person themselves. Indeed this is reflected on line 8, p.13, which encourages clinicians to 'develop' a plan 'with the person' – we consider this to be much more appropriate, when considered with our comments in the previous paragraph, and recommend that the guidance consistently uses this language throughout. Comment 5 expands more on our concerns regarding recommendation 31.	on: • how the person's health conditions and their treatments interact and how this affects quality of life • the person's individual needs, preferences for treatments, health priorities, lifestyle and goals • the benefits and risks of following recommendations from guidance on single health conditions • improving quality of life by reducing treatment burden, adverse events, and unplanned care • improving coordination of care across services. Additionally, we have changed the wording to 'share' copies of management plan with the person.
Compassion in Dying	Full	14	37	We do not believe that the purpose of providing a tailored approach should be framed as simply a way to reduce treatment burden and optimise care. While these are inevitable benefits of such an approach, the primary purpose of person centred care should always be that the person themselves receives the care that is right for them, as an individual. As it is	Thank you for your comment. We have changed the wording to emphasise the aim of improving quality of life as follows: Discuss with the person that the purpose of the approach to care is to improve quality of life'. This might include reducing treatment burden and optimising care and support by identifying:

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				currently worded, there is scope to misinterpret the intent behind the approach to be purely outcome based. Indeed justification for the inclusion of a tailored approach in the guidance Patient experience in adult NHS services: improving the experience of care for people using adult NHS services is 'Patients wish to be seen as an individual within the healthcare system'. We feel the current wording may detract from achieving this.	•ways of maximising benefit from existing treatments, •treatments that could be stopped because of limited benefit, •treatments and follow-up arrangements with a high burden, •medicines with a higher risk of adverse events (for example, falls, gastrointestinal bleeding, acute kidney injury), •non-pharmacological treatments as possible alternatives to some medicines •alternative arrangements for follow-up to coordinate or optimise the number of appointments.
Compassion in Dying	Full	15	20 - 25	It is critical that patient preferences, values and priorities are established, and we welcome the inclusion of the wording 'at the first point of contact' as these discussions should commence as early as possible. However, we strongly urge the guidance committee to include reference in the guidance to the tools that are available for people to plan for their treatment and care in a legally binding way, such as advance decisions to refuse treatment. The effect of this would be two-fold: 1. It would prevent care plans being created which are in conflict with existing, and legally binding, expressions of wishes around refusal of treatment; and 2. It would provide an opportunity for people to explore whether they do actually want to record their treatment preferences in a legally binding way. For similar reasons we recommend that this section of the guidance encourage clinicians to explore whether the person	Thank you for your comment. The GDG recognise that although multimorbidity is particularly prevalent as people get older this guideline does not address issues around end of life. The GDG have added 'advance care planning' to the recommendations in relation to future plans (recommendation 7). However they considered that more detailed reference for example to Lasting Powers of Attorney for Health and Welfare and do not resuscitate instructions were outside the scope of this guideline.

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				has a Lasting Power of Attorney for Health and Welfare. Again, if the person has then at this point the clinician can ensure the person understands what this means and how this may interact with their care plan. If the person hasn't then this would be an opportunity for them to explore whether they would want to legally appoint somebody to make decisions on their behalf, rather than that person just 'being involved' in decisions about their care. The priority of the tailored approach must be to ensure the person themselves has all the necessary information to decide how they want to be cared for.	
Compassion in Dying	Full	16	28 - 37	The terminology used is inconsistent in this section, are clinicians being asked to 'develop an individualised care plan' or 'provide the person with a management plan'? We recommend the term care plan be used, which better reflects the nature of the information that should be included (treatment preferences, values and priorities etc.). While we acknowledge that the wording of the guidance on line 31 is open ('which could include:'), we would still recommend an additional bullet point in this section along the lines of 'and anything else which the person considers important to them'. This is to prevent the process of creating a care plan becoming a checklist for clinicians, as opposed to an opportunity to explore with the person exactly what they want from their care.	Thank you for your comment. The wording the GDG preferred was individualised management plan to avoid confusion with how terms are used elsewhere. Your suggestion of 'other areas the person considers important to them' has been added to the recommendation.

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Croydon CCG	Full	183	16	Recommendation 9 includes those who are at particular risk of adverse events. Although tools like STOPP:START are mentioned it would be useful to have more detail in this recommendation about how these people might be identified	Thank you for your comment. This recommendation refers to how the number of medications a person is taking may be used to identify people who may be at risk of adverse events. The use of risk tools that identify for example risk of unplanned admission and methods of identifying frailty are suggested as methods of identifying people. The wording of the recommendations has been altered to clarify this. Please see recommendations 1.3.2 and 1.3.3 which state (respectively): • Consider using a validated tool such as eFI, PEONY or QAdmissions, if available in primary care electronic health records, to identify adults with multimorbidity who are at risk of adverse events such as unplanned hospital admission or admission to care homes. • Consider using primary care electronic health records to identify markers of increased treatment burden such as number of regular medicines a person is prescribed.
Croydon CCG	Full	General		Those people who have dementia will have particular risks when it comes to treating co-morbidities including the risk of over/under dosing of medicines as well as the increased risk of side effects that are particularly detrimental to them e.g. confusion. Given the number of people suffering from dementia and that 70% of them will have another condition, it would be good to have more detail included in the guidelines. In addition throughout most of the document it refers only to discussions with the person but where someone lacks capacity	Thank you for your comment. NICE is currently updating the guideline on dementia and so the Multimorbidity guideline will not be making comprehensive recommendations in this area. The scope of the update includes the management of multimorbidities that require different treatment because of the person's dementia .

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				this will not be appropriate. Reference should therefore be made to best interest discussions, involving family members, carers, power of attorney etc.	
Croydon CCG	Full	16	24	This mentions starting medicines that a person might benefit from but doesn't emphasise the need to review the benefit against risks of increasing pill burden/polypharmacy.	Thank you for your comment. The GDG reviewed the recommendations and considered that overall the emphasis on reducing treatment burden provided adequate overall guidance without repeating the need to consider treatment burden specifically here.
Croydon CCG	Full	16	27	As mentioned above this should also include overall benefit of starting a medicine or treatment as well as continuing. There could be a link here to NNT/NNH and the database.	Thank you for your comment. Adding further data on NNH would be useful however we were limited by the data available in previous guidelines, which contained limited information on harms of treatment. The GDG believe that this is a consequence of clinical trials containing limited information about adverse events.
Croydon CCG	Full	16	30	By only mentioning osteoporosis it implies that this is the main disease area where stopping treatment should be considered. There appears to be little mention of the symptomatic treatments that may be no longer required because of changes in activity/mobility e.g. if angina related to exercise is no longer a problem a nitrate might be stopped, or if asthma triggered by exercise is no longer a risk the beta-agonist might be stopped.	Thank you for your comment. The GDG consider that the continuation of symptomatic treatments is covered in recommendation 1.6.17. which now states: After a discussion of disease and treatment burden and the person's, personal goals, values and priorities, develop and agree an individualised management plan with the person. Agree what will be recorded and what actions will be taken. These could include: • starting, stopping or changing medicines and non-pharmacological treatments • prioritising healthcare appointments • anticipating possible changes to health and wellbeing • assigning responsibility for coordination of care and

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					ensuring this is communicated to other healthcare professionals and services • other areas the person considers important to them • arranging a follow-up and review of decisions made. Share copies of the management plan in an accessible format with the person and (with the person's permission) other people involved in care (including healthcare professionals, a partner, family members and/or carers).
Croydon CCG	Full	16	31	When a person is frail their needs are likely to change rapidly. A reminder of this may be useful	Thank you for your comment. While there is overlap between frailty and multimorbidity the care of people with frailty is beyond the scope of the guideline.
Croydon CCG		General		Any increase in costs/resources should be off-set by savings in drug costs, wasted medicines and hospitalisation	Thank you for your comment.
Croydon CCG		General		Developing and maintaining an individualised care plan will be difficult to achieve because of the time factor involved whilst the services are currently over-stretched	Thank you for your comment. The GDG did not consider that agreeing a plan with the person with multimorbidity would result necessarily results in additional resource costs. The aim is to inform the content and quality of current reviews and discussions and tailor these more specifically to the needs of people with multimorbidity. Review of medicines and treatments is considered a core part of the delivery of medical care and already part of the role of healthcare practitioners. It can be spread over several consultations. The GDG considered that in many cases the delivery of an approach to care that takes account of multimorbidity could be carried out as part of usual medical practice when providing and reviewing care for people with multimorbidity.

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Department of Health	Full	General	General	We are concerned that the draft guideline has missed an opportunity to highlight the needs of people with learning disability who have a shorter life expectancy and are less likely to have their physical and mental health managed well. The evidence is that men with learning disabilities die on average 13 years sooner than men in the general population. Women with learning disabilities die on average 20 years sooner than women in the general population. Overall, 22% of people with learning disabilities are under 50 when they die. One of the recommendations of the Confidential Inquiry into Premature deaths Of people with Learning Disability (CIPOLD) was that NICE guidelines should take account of multi-morbidity. The findings of that report have of course been given further weight by the recent Mazars report on Southern Health. There were a number of exchanges with NICE about taking forward that recommendation some time back, and we believe the proposed guideline on multi-morbidity was at least a part of the answer. Here is a link to the exec. summary of CIPOLD, for reference: http://www.bris.ac.uk/media-library/sites/cipold/migrated/documents/finalreportexecsum.pdf	Thank you for your comment. We have added a recommendation at the start of the guideline to highlight that people with learning disabilities are included in the guideline and also clarified in the section 'Terms used in this guideline' that multimorbidity does include ongoing conditions such as learning disability. NICE is currently developing guidance on mental health and learning disability.
Department of Health	Full	General	General	There is much evidence suggesting the needs of people with profound and multiple learning disabilities (PMLD) and complex needs should be specifically addressed. They are among the most disabled and can have impairments of vision,	Thank you for your comment. This guideline concerns the identification and management of people with multimorbidity, which necessarily includes people with a variety of long-term conditions, including learning disabilities. Within the scope of

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				hearing, movement, epilepsy, autism and most cannot walk unaided. They have complex health needs requiring extensive help. They have communication difficulties (they are non-verbal, have limited or few words and symbols). They face particular barriers many of which are set out in Mansell, J (2010) Raising Our Sights: services for adults with profound intellectual disabilities. They are less likely to have access to a personalised approach and are less likely to experience positive outcomes. Harflett, Turner, Brown (2015) The Impact of Personalisation on the lives of the most isolated people within learning disabilities. It would be helpful for the guideline development group to consider and reference this and other evidence, for example, the Lambeth Mencap PMLD project (2010), The Health Equalities Framework Atkinson D, Boulter P, Hebron C, Moulster G (2013), Wade D (2009), Holistic Health Care, What is it and how can we achieve it?	this guideline, it is not possible to make comprehensive recommendations for the care of people with learning disabilities. NICE has previously published guidance on the care of people with learning disabilities and challenging behaviour, and is currently developing guidance on learning disability and mental health.
Department of Health	Full	General	General	The first paragraph in the introduction acknowledges that people living in the most deprived areas have double the rate of multi-morbidity in middle age than those living in the most affluent areas (p.18). This clearly identifies the need for a targeted approach to address health inequalities in multi-morbidity. The guideline as a whole could be strengthened by ensuring it gives due consideration to health inequalities across a range of dimensions, for example, those from lower socio-economic groups, vulnerable groups such as homeless people or ethnic minorities.	Thank you for your comment. People from lower Socio Economic groups who often develop multimorbidity at a younger age were identified as a key equalities area for this guideline. The group considered all recommendations to cover this subgroup and in particular that the inclusion of opportunistic methods of identifying people with multimorbidity as well as methods using medical records increased the ability to identify people who might benefit. The GDG also use the recommendations to indicate that the process of review may require medicines to be started as well as stopped and that undertreatment is also a potential issue. Please see the section in the NICE guideline, entitled:

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					Reviewing medicines and other treatments, and recommendations 1.6.9 to 1.6.16.
Department of Health	Full	81	16	Section 6.1 is about the barriers to optimising care for patients with multi-morbidity. It is good to see that the guideline acknowledges that financial resources may limit access to medication for people with multi-morbidity (page 87) and that people in deprived areas may prioritise other concerns (paying bills) over engaging in health related behaviours (page 89). In order to help professionals identify and address these barriers, which are disproportionately experienced by those from more deprived areas, it may be helpful to give some examples of barriers faced by those from deprived areas and how health professionals can address this. Similarly, while the population assessed on page81 includes adults with multi-morbidity, their family/carers, and healthcare professionals who treat patients with multi-morbidity, it may also be helpful here to include the views of healthcare professionals who practice in more deprived areas or who have experience of working with vulnerable groups.	Thank you for your comment. As part of the evidence review investigating the factors that may act as barriers to optimising care for people with multimorbidity, the GDG were particularly interested in finding evidence that was conducted with populations from deprived and/or at risk backgrounds, including evidence based on qualitative interviews and focus groups with healthcare professionals who practice in deprived areas. The evidence that was identified within this group has been highlighted in the review, as you note. However there was unfortunately very limited evidence for this population identified for the review, and the GDG did not believe that there was sufficient information to inform a recommendation on how health professionals should address barriers that are specific to this group.
Department of Health	Full	General	General	As NHS England have a health inequalities legal duty to have regard to the need to reduce health inequalities it would be helpful for this to be referenced appropriately in the guideline.	Thank you for your comment. We have added this fact to the introduction to the Full guideline.
Department of Health	Full	General	General	On page 89 the guideline acknowledges that multi-morbidity is more common in less affluent areas. It then goes on to encourage health professionals to view the patient individualistically and holistically – ensuring consideration of the wider social circumstances. These are two very important	Thank you for your comment. The socio-economic determinants of health inequality and associated multimorbidity are beyond the scope of this clinical guideline. People from lower socio economic groups were identified as a key group in equalities assessment for this guideline and

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				points and although we are pleased to see them reflected on page 89, they are not reflected throughout the whole document and the guideline says little about how health professionals might take account of the wider social environment which has influenced such higher multi-morbidity in making their assessments and developing tailored care plans. The guideline would benefit from a more overt consideration of health inequalities in the development and treatment of multi-morbidity.	the GDG discussed the relevance of all recommendations to this subgroup. As you indicate the GDG consider that viewing the patient holistically should allow attention to the individual patient circumstances. NICE has provided advice on health inequality and population health [LGB4].
Department of Health	Full	General	General	There is a concern from a health inequalities perspective that the tools used to identify those at risk of multi-morbidity overlooks vulnerable groups who would not have been captured in the literature reviewed, for example, homeless people, vulnerable migrants, Gypsies/Travellers, and sex workers.	Thank you for your comment. The GDG note that vulnerable groups such as those you list are likely not to be included in studies. This may be particularly true for those studies that recruit from primary care databases, since people in these population groups may be less likely to be registered with a GP. Those risk tools that identify people with multimorbidity at risk of adverse outcomes on the basis of primary care records may therefore be less likely to identify people in these groups who are at risk. However the guideline also recommends opportunistic identification of people who may benefit and the GDG believe that clinicians should take into consideration any factors including socio-economic status and membership in vulnerable groups that are not captured elsewhere. Please see recommendation 1.3.1 in the NICE version, which states: Identify adults who may benefit from an approach to care that takes account of multimorbidity (as outlined in section 1.5):

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					• opportunistically during routine care • proactively using electronic health records. Use the criteria in recommendation 1.2.1 to guide this.
Editors	Short	3	1.1.2	We suggest that the second sentence is edited to avoid repetition. 'Discuss this with the patient alongside their preferences for care and treatment.'	Thank you for your comment. We have edited the recommendation as suggested in your comment. Please see recommendation 1.1.3 which states: Think carefully about the risks and benefits, for people with multimorbidity, of individual treatments recommended in guidance for single health conditions. Discuss this with the patient alongside their preferences for care and treatment.
Editors	Short	3	1.2.1	We understand why you want to emphasise that the whole age range is covered, but the guideline doesn't apply to under 18s. We suggest that this recommendation is reworded 'Consider a tailored approach to care for adults of any age with multimorbidity if any of the following apply: (bullet points)'	Thank you for your comment. We have edited the recommendation as suggested in your comment. Please see recommendation 1.2.1 which states: Consider an approach to care that takes account of multimorbidity if the person's requests it or if any of the following apply: • they find it difficult to manage their treatments or day-to-day activities • they receive care and support from multiple services and need additional services • they have both long-term physical and mental health conditions • they have frailty (see section 1.4) or falls • they frequently seek unplanned or emergency care (see also recommendation 1.3.2)

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					• they are prescribed multiple regular medicines (see section 1.3).
Editors	Short	4	1.3	It was agreed at the editorial meeting that this whole section would be better after the sections on how to identify people who may benefit from a tailored approach to care. That is, after the section 'How to identify people who may benefit from a tailored approach to care' and the section 'How to assess frailty' and before the section 'Delivering a tailored approach to care'. This order is being adopted for the NICE pathway.	Thank you for your comment. We have edited the order of the recommendation as suggested in your comment. This section now starts at numbering: 1.5.
Editors	Short	4	1.3.1	At the editorial meeting, overlap between this recommendation and the recommendation below (1.3.2) was discussed. If the purpose of 1.3.1 is to cover principles and 1.3.2 to set out steps to follow when delivering a tailored approach to care, 1.3.1 could be reworded as follows 'When offering a tailored approach to care, focus on (bullet points):....' Individualised care is indicated by the individual bullet points and the management plan is mentioned in detail in the next recommendation so the information isn't needed in 1.3.1	Thank you for your comment. Thank you for your comment. This recommendation has been edited as suggested in your comment. It is now numbered: 1.5.1 as the recommendations have also been reordered.
Editors	Short	4	1.3.1	We suggest that 'guidelines' is changed to 'guidance' for consistency with recommendation 1.1.2	Thank you for your comment. This has edited as suggested in your comment. The ordering of the recommendation has also been amended and this recommendation is numbered: 1.5.1.
Editors	Short	4	1.3.2	We suggest that the stem of the recommendation is reworded for consistency with the heading for section 1.6 'Follow these steps when delivering a tailored approach to care.....Can we shorten the first bullet point 'Explain the purpose of a tailored approach to care...'	Thank you for your comment. We have amended the recommendation as suggested in your comment. Please note the recommendations have also been renumbered and this item can be found at: 1.5.2.

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Editors	Short	5	1.4.3	We suggest that 'people of any age' is changed to 'adults of any age' because the guideline doesn't cover under 18s.	Thank you for your comment. The recommendation has been amended as suggested in your comment. Please note, the recommendations have been re-ordered and this item is numbered: 1.3.3.
Editors	Short	5	1.4.4	We suggest that 'people of any age' is changed to 'adults of any age' because the guideline doesn't apply to under 18s.	Thank you for your comment. The recommendation has been amended as suggested in your comment. Please note, the recommendations have been re-ordered and this item is numbered: 1.3.4.
Editors	Short	6, 7	1.5.2 to 1.5.5	Should these recommendations use 'adults with multimorbidity' rather than 'people with multimorbidity'?	Thank you for your comment. Thank you these recommendations have been amended as suggested in your comment.
Editors	Short	7	Line 14	This sub-heading sounds like a recommendation. We suggest that this is brought in line with the other sub-headings in this section. 'Explaining the purpose of a tailored approach to care'	Thank you for your comment. The heading has been edited as suggested, but please note that the recommendations have been re-ordered. This item can be found in section 1.6.
Editors	Short	8	1.6.6	We don't include recommendations from the patient experience guideline in other guidelines. We have already referred to the patient experience in recommendation 1.6.1. Please delete recommendation 1.6.6.	Thank you for your comment. We have received feedback from the NICE editors that an exception will be made to this rule.
Editors	Short	8	1.6.7	We suggest that 'values' is added to the stem of the recommendation to match the sub-heading and the wording in recommendation 1.3.2	Thank you for your comment. The recommendation has been amended as suggested in your comment.
Editors	Short	9	1.6.9	We suggest that this is reworded to shorten and clarify that the information is in the database 'When reviewing medicines and other treatments, use the database of treatment effects to find information on medicines for conditions that the person has.'	Thank you for your comment. The recommendation has been amended as suggested in your comment.

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Editors	Short	10	1.6.15	We suggest that 'values' is added to this recommendation as well as 1.6.7. '...what is important to them in terms of personal goals, values and priorities.....'	Thank you for your comment. The recommendation has been amended as suggested in your comment.
Editors	Short	10	1.6.17	We suggest that the stem of the recommendation includes 'personal goals'.' After a discussion of disease and treatment burden and the person's personal goals, values and priorities.....actions to take. These could include.....'	Thank you for your comment. The recommendation has been amended as suggested in your comment.
Health & Social Care Information Centre	Full	general	general	Re Question 3 above (What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.)): Reference to the availability and encouraging use of the Summary Care Record (SCR) to its full potential would be appropriate in this guidance. Background: Over 55 million people in England now have an SCR and it is available for authorised healthcare staff to use when delivering direct care to a patient away from their registered GP practice. As at April 2016 5 million SCRs had been used to better inform care. Currently over 73,000 SRCs are viewed every week (equating to 3.8 million per year) and this number is rising steadily. As a minimum SCRs contain information about medications, any known allergies and adverse reactions from a patient's GP record. Enhanced functionality to allow SCRs to be enriched with a set of additional information from the GP record (including significant medical history, anticipatory care information and patients' specific care needs) with the explicit	Thank you for your comment. The information you have provided in your comment will assist the NICE resource team with finalising the guideline. This has helped the team to consider the areas which will have the biggest impact on practice and the areas that will be the most challenging to implement. The GDG believe that services should ensure that relevant health information about a person with multimorbidity should be shared between all of the clinicians involved in their care, and have made a recommendation about this. The GDG agree that shared medical records, which may be facilitated by initiatives such as the Summary Care Record, may help to facilitate this process. We have added a reference to this in section 6.3.4.

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				consent of the patient has now been enabled across 99% of GP practices. Once a patient's record has been enriched it will be accessible by all healthcare staff that access the SCR with no developments required at the viewing side. Relevant formal approved endorsements of the SCR: "The ability to create richer Summary Care Records provides an excellent opportunity to share additional information such as care plans, and we strongly encourage primary care teams to consider processes to seek the required consent from those patients that would benefit most." Professor Jonathan Benger, NHS England Director for Urgent Care "Continuity of information is a vital contributor to continuity of care and better outcomes. The ability to enrich Summary Care Records beyond medications, allergies and bad reactions mean that more and more relevant information from the GP practice will be potentially available wherever a patient is receiving treatment in the NHS. This will improve safe, effective care and contribute to a positive experience for patients." Dr Martin McShane, NHS England Director for Long Term Conditions 'When treating older patients, the Summary Care Record, enriched with additional information gathered during the process of Comprehensive Geriatric Assessment, or as part of the proactive care processes within the primary and community care setting, can be used to support decisions from the beginning of any new episode of care. This will increase	

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				the likelihood that complex conditions are accurately recognised and more appropriate treatment plans put in place. This will contribute to safer, more effective and efficient care for older people across the urgent care system, potentially avoiding the need for hospital admission or helping facilitate earlier and safer discharge' The British Geriatrics Society More information about the SCR is available at www.hscic.gov.uk/scr More details about how the SCR can be enriched and what additional information from the GP record it will then contain is available at http://systems.hscic.gov.uk/scr/gppractices/additional In summary: People with multimorbidity are particularly likely to benefit from having their SCR enriched with additional information, supporting safer, more effective and efficient person centred care, and improving the patient experience of care. The SCR is a nationwide data sharing solution, available now and has been identified as one of the key national systems that provide the 'electronic glue' i described in the Five Year Forward View. i NHS (2014), Five Year Forward View (p 31). Available from: http://www.england.nhs.uk/wp-content/uploads/2014/10/5yfv-web.pdf See also the Foreword of the National Information Board Propsectus: September 2015	

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				https://www.gov.uk/government/publications/national-information-board-nib-interim-report-2015/national-information-board-prospectus-september-2015	
Health & Social Care Information Centre	Full	13	26	Please consider specifically referring to the Summary Care Record, as well as "primary care electronic health records"	Thank you for your comment. The GDG has considered your suggestion but were not aware that the Summary Care Record (SCR) could be searched in the way primary care electronic records can and have therefore not added SCR to the recommendation.
Health & Social Care Information Centre	Full	123	27	Table 7.2.6 Please consider specifically referring to the Summary Care Record, as well as "primary care electronic health records"	Thank you for your comment. The use of primary care electronic records is in specific relation to how clinicians may identify people who may be at risk of adverse events using the number of medications that they are taking. The GDG were not aware that the Summary Care Record can be used in this way.
Individual	Short	4	9	This is the only reference I can find to the interaction of the health conditions themselves and I feel that this issue has not been given due weight in these guidelines. Obviously treatment interactions are important and it is good to see this issue thoroughly addressed in these guidelines. As a patient with multi-morbidities, however, I find that little consideration is given to the interactions of the health conditions themselves and the associated effect on symptoms. I have spoken to other patients with multi-morbidities and they have had the same experience. If the patient raises the subject of a symptom which is not normally associated with condition A, there is a tendency for the specialist consultant just to say 'oh, that's probably due to condition B' and show no further interest.	Thank you for your comment. The GDG acknowledges the issues you raise and hope that recommendations on establishing disease and treatment burden highlights the importance of talking to people about how their health problems affect their day to day lives. The GDG recognises the difficulties for patients who may have symptoms which do not fit easily into specified clinical diagnoses but this area is outside the scope of this guidance.

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				Meanwhile GPs are so overloaded that they tend to refer any complex issues back to the consultants so they don't get addressed. The problem of interpreting multiple symptoms also leads to delays in diagnosis and to misdiagnosis. Another important and associated issue which is not addressed in these guidelines is the inclination of many doctors to leap to the conclusion that patients who have multiple symptoms (which do not fit the clinical picture of a specific pathology) must therefore have a somatised condition. I refer you to this NHS web page as an example of this unfortunate perspective which I fear is prevalent: https://www.nbt.nhs.uk/clinicians/services-referral/neuropsychiatry-clinicians/management-somatoform-disorders As you will see, the advice given on this official NHS site is to keep such patients away from other doctors, to persuade them to dismiss any new symptoms as also somatic, and to develop a 'therapeutic alliance' with a close relative to enforce the doctor's perspective. This imposition of the (often erroneous) doctor's perspective upon the patient (often enlisting close relatives to overrule the patient) seems to be the antithesis of NICE's declared intention (as described on Prof Haslam's blog) of putting patients 'in the driving seat'. It leads to misdiagnosis and/or late diagnosis of multi morbidities and also of rare diseases as described in the recent Rare Disease UK report: http://www.raredisease.org.uk/documents/patient-experiences-2015.pdf I believe that this issue needs to be urgently addressed, not least because it also leads to the	

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				misallocation of valuable mental health resources.	
Individual	SHORT	General	General	I am concerned that this is a medical model and does not appear to take into account the social interventions that are important for the prevention and treatment of multimorbidities and of ageing. For example, the need to get out and socialise, the opportunities for people in care homes to take part in meaningful activity. The need for adequate appropriate transport. The possibilities of social interaction through technology.	Thank you for your comment. The guideline includes people of all ages with multimorbidity. While multimorbidity increases with age, there are significant issues for younger people with multimorbiditiy. The guideline does not address prevention of multimorbidity and ageing.
Individual	short	6	7	Speed alone is not always an indicator of frailty	Thank you for your comment. The GDG discussed your comment but considered that clinical judgement is required in application of any assessment tool which is why a range of tools are included.
Keele University	Full	General	General	This is an impressively wide-ranging document, which has considered a vast amount of published material, and which has come up with many useful and practical recommendations. As this is not condition specific – this is quite different from other guidance with a broad evidence based. Readers felt the document would benefit from a summary introduction to the epidemiology of the problem (two or more conditions are the norm for example, rather than the extreme), with a clear statement about the different issues that this raises for public health and organisation-level policy decisions on the one hand and for personal patient-level decisions on the other.	Thank you for your comment. GDG discussion about definitions of multimorbidity is discussed in chapter 5. The guideline is a clinical guideline directed to clinical care rather than to public health or policy decisions.

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Keele University	Full	General	General	Readers felt that at times the full document was repetitious. A clear statement about the exact aims of the document would help and readers felt a restructuring could improve operationalisation and usability of the document – e.g. what is multi-morbidity; creating an individualised care plan; policy; service models that could support policy; definition of what is tailored care; how to identify those most suited to tailored care. For example feedback from colleagues within the unit queried whether tailored care applied to those at risk of admission to hospital/care facility or of risk of death.	Thank you for your comment. The Full document provides an account of the review questions, the evidence assessed and GDG discussion. The aim is to be both comprehensive and transparent. The guideline is organised around the areas identified at the scoping phase of the guideline as important areas to review. The GDG acknowledge that because many of the areas in this guideline inter-relate, there is a significant amount of cross referencing and hence potential repetition. The recommendations are directed to adults with multimorbidity who may benefit from this approach and includes those at risk of admission to hospital/care facility or of risk of death but is not confined to them.
Keele University	Full	General	General	Many of the suggestions/recommendations are very reasonably couched in the language of individual patient-sharing decisions. However much of the evidence concerns prognostic tools/models and predictions of future outcomes. The predictive value and usefulness of these for the management of an individual in real-time clinical consultations looks to be very low. However, for a commissioning organisation or a public health committee or a whole primary care organisation, the use of such tools/models might be reasonable as a way of driving policy change and organising care (e.g. Hemingway H, Croft P, Perel P, Hayden JA, Abrams K, Timmis A, Briggs A, Udumyan R, Moons KG, Steyerberg EW, Roberts I, Schroter S, Altman DG, Riley RD; PROGRESS Group. Prognosis research strategy (PROGRESS) 1: a framework for researching clinical outcomes. BMJ. 2013 Feb	Thank you for your comment. The GDG agree that it might be reasonable to investigate whether prognostic tools, such as those recommended in this guideline, may have utility in guiding health policy and service-level health initiatives. Within the scope of this guideline, it was not possible to evaluate the clinical and cost-effectiveness of using prognostic tools in this capacity.

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				5;346:e5595. doi: 10.1136/bmj.e5595) . For example a drive to reduce polypharmacy in a primary care organisation might usefully target a group deemed at severe incapacity and with a high risk of unplanned hospital admission, even if this is not a comprehensive or cast-iron way to locate all such individuals (given the poor prognostic performance of many of the tools/models reviewed). All the material underpinning this issue is there in the guidelines, but the guidelines would benefit from a clear conceptual statement about 'policy' versus 'individual care' and the different roles of tools/models for each purpose.	
Keele University	Full	General|	General	GP colleagues highlighted the various initiatives that also impact on this Guideline – for example NHSE DES for Primary care – highlighting the 2% most frail patients; local enhanced schemes for managing frail patients. They highlighted that patients have multiple care plans that do not carry over from one organisation to another – in fact within one organisation there can be multiple care plans. Colleagues felt it would be helpful for the guideline to suggest a 'lead' for a care plan that is carried across care pathways/departments/services.	Thank you for your comment. The GDG agrees that it is important that an individualised management plan for a person with multimorbidity should incorporate consideration of all of a person's conditions and should be shared between all health professionals involved in their care. The GDG have made a recommendation (1.6.17) that someone involved in the care of the person with multimorbidity should assume responsibility for coordinating care and communicating the individualised management plan to other health professionals and services.
Keele University	Full	12		Barriers to optimising care – this doesn't seem an appropriate heading for this section – along with our comments regarding a potential restructuring, this heading could be: Creating an individualised care plan	Thank you for your comment. We have removed the heading as suggested, it has been edited to: 'Creating an individualised care plan'.
Keele University	Full	13	19	Example of repetition of approach on page 12 (line 14) point 3	Thank you for your comment. The group considers that the

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				– this repetition then slightly undermines the value of these statements	first recommendation describes the person who may benefit from an approach to care that takes account of multimorbidity. The second recommendation is about how to identify those people.
Keele University	Full	13	26	Point 7 – recommends tools, which could be put on page 12 point 3	Thank you for your comment. Recommendation '3' is describing the population who may particularly benefit from an approach to care that takes account of multimorbidity and recommendation '7' is about methods of identifying these people using electronic records in primary care. It is not appropriate therefore to move information. As a results of the changes made following stakeholder consultation the relevant recommendations number are now '5' and '8'and '9'. '
Keele University	Full	13	32	It was felt that the recommendation threshold of 15 medications was well explained but noted an additional reference that could be considered. Payne RA, Abel GA, Avery AJ, Mercer SW, Roland MO. Is polypharmacy always hazardous? A retrospective cohort analysis using linked electronic health records from primary and secondary care. Br J Clin Pharm. 2014; 77(6):1073-82 – which suggests polypharmacy is less risky in presence of multimorbidity. This would further support the use of threshold for polypharmacy being 15 drugs rather than 5. GP colleagues highlighted the issue of medications being 'stopped' during a hospital admission with no view on the long term consequence of this for the individual (eg anti-depressants). However we wondered whether high risk drug combinations	Thank you for your comment and for your suggested evidence. One of these papers (Payne et al. 2014) was excluded from the review as it did not meet the inclusion criteria as specified in the review protocol. The GDG do not consider there to be a causal relationship between polypharmacy and adverse outcomes in people with multimorbidity, and are aware that the association between polypharmacy and adverse outcomes reduces when multimorbidity status is considered. Rather, the GDG believed that polypharmacy could be used as a useful marker of adverse outcomes, as it is easy to measure in clinical practice. Within the scope of this guideline, it was not possible to look for evidence that evaluates the association between specific

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				should be highlighted here under polypharmacy as there is evidence that particular combinations are associated with increased admissions. Howard RL, Avery AJ, Howard PD, Partridge M. Investigation into the reasons for preventable drug related admissions to a medical admissions unit: observational study. Qual Saf Health care. 2003; 12: 280-5. Pirmohamed M, James S, Meakin S, Green C, Scott AK, Walley TJ, Farrar K, Park BK, Breckenridge AM. Adverse drug reactions as cause of admission to hospital: prospective analysis of 18 820 patients. BMJ. 2004; 329:15-9. Chen YF, Avery AJ, Neil KE, Johnson C, Dewey ME, Stockley IH. Incidence and possible causes of prescribing potentially hazardous/contraindicated drug combinations in general practice. Drug Safety. 2005;28(1):67-80. Howard RL, Avery AJ, Slavenburg S, Royal S, Pipe G. Lucassen P, Pirmohamed M. Which drugs cause preventable admissions to hospital? A systematic review. Br J Clin Pharm. 2006; 63(2):136-47. Leendertse AJ, Egberts ACG, Stoker LJ, van den Bemt PMLA. Frequency of and risk factors for preventable medication-related hospital admissions in the Netherlands. Arch Intern Med. 2008;168(17):1890-6.	drugs and drug combinations and adverse outcomes. As a consequence it is not possible to make a recommendation on the consideration of specific drug combinations. Further guidance on the management of medication can be found in existing NICE guidance (Medicines Optimisation NG5).
Keele University	Full	14	12	Point 12 – made us wonder why the age category was highlighted – since the recommendation is the same for those over and under 65 years of age with frailty & multi-morbidity. Within primary care settings the recommendations could also be quite difficult to implement eg assessing gait speed.	Thank you for your comment. The GDG were aware that some clinicians may not be aware that frailty may be experienced by adults of all ages, and not only older adults. The GDG believed that is important that clinicians also assess for the presence of frailty in younger adults, and

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					therefore chose to include a separate recommendation to highlight this. The evidence for use of frailty assessment is largely from populations of older adults without validation in younger people so the recommendations for people less than 65 years are 'consider' recommendations. The GDG considered the feasibility of the tools to perform in primary care settings when making their recommendation, and chose to recommend several tools so clinicians could choose one that was feasible in their practice.
Keele University	Full	15	4	Treatment burden – readers wondered whether risk of falls should be highlighted in this section as this appears to be omitted	Thank you for your comment. The items included in this list concern factors that may commonly be associated with treatment burden, as identified from evidence that has evaluated methods of assessing treatment burden. The GDG agree that the consideration of falls risk is important when considering a tailored support to care, and have noted this elsewhere in the recommendations.
Keele University	Full	15	30	Readers felt "e.g Stroke" was not required	Thank you for your comment. The GDG has considered your suggestions and considered that an example can be helpful and have not changed the wording of the recommendation.
Keele University	Full	15	39	Points 23-26 seem to repeat each other and readers felt there was a need only for 2 statements – one to assess risk/benefits of medications and one to assess stopping some of these.	Thank you for your comment. The GDG have considered your suggestion and believe that the two separate recommendations are required. The first, asks clinicians to use the database of treatment effects find out the effectiveness and duration of treatments and to consider the populations included in treatment trials when reviewing medicines and other treatments. The second recommendation, encourages clinicians to engage with the patient to determine the benefits or harms caused by treatments being used.

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Keele University	Full	16	24	Picking out osteoporosis seems to suggest to the reader this is the only medication stoppage to be considered	Thank you for your comment. For this guideline we sought evidence on the outcomes associated with stopping several commonly prescribed preventative medications. However, the GDG did not believe that there was sufficient evidence to make a recommendation to consider stopping the other medications that were considered (statins and anti-hypertensive medications). The GDG have written recommendations that clinicians may wish to stop other medications that a person with multimorbidity is receiving, after discussion with the person. The GDG have also written a research recommendation for further research to evaluate outcomes following stopping other commonly used preventative medications.
Keele University	Full	16	36	This section for developing an individualised care plan felt a bit thin – and developing this further could help to prevent an unexpected admission. Suggested additions could include: disease monitoring, use of AHPS to improve functioning, nutritional status and support, consideration of end of life care (given these are irreversible LTC), contact of other family members,	Thank you for your comment. This section is not intended to cover detail of a comprehensive care plan but management specific to multimorbiditiy the detail of which is outlined in earlier sections.
Keele University	Full	16	40	This section would fit better in individualised care plan section	Thank you for your comment. The evidence reviews did not find evidence to support recommendations of comprehensive assessments similar to CGA for all people with multimorbidity. This recommendation is therefore for a subgroup of people with multimorbidity which is why it is in a different section.
Keele University	Full	20	33	Suggest a slight reordering of the relevant NICE guidelines so	Thank you for your comment. As all guidelines are

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				that the most relevant are listed first	considered relevant we have instead reordered the guidelines alphabetically for easy use.
Keele University	Full	30	9	Methods state literature reviews are excluded as evidence– readers queried whether this applied just to quantitative data, as 2 literature reviews appear to have been included in the qualitative element.	Thank you for your comment. Systematic literature reviews may be included as evidence in quantitative reviews if they match the review protocol and conduct adequate assessment of the internal validity of the included studies. In this guideline, no systematic reviews were identified that sufficiently matched the review protocols for any of the quantitative reviews. This was not the case for one of the qualitative reviews in this guideline, where 2 systematic reviews were identified that did match the review protocol.
Keele University	Full	46	3	Indirectness is defined twice – so this is repeated – could one be removed (e.g. p 41 line 30)	Thank you for your comment. We have edited this section..
Keele University	Full	53	11	Whilst the guideline is recommended for people with more than 1 condition that affects their daily living, in practice this could be difficult to identify – readers wondered whether recommendations could be made so that practitioners have advice on how effects on functioning could be assessed in everyday consultations and recorded.	Thank you for your comment. The GDG wished to move away from a culture of using specific tools for patient assessment unless these tools are well validated and shown to be useful. Rather they were keen to empower healthcare professionals to use clinical judgement and discussion with patients about disease and treatment burden.
Keele University	Full	53	32	Recommendation 1 – this seems to fit better with an introduction to the guideline rather than a recommendation in its own right	Thank you for your comment. The GDG considered it important to include this as a recommendation as recommendations will often be seen on NICE website and elsewhere without reference to other parts of the guideline. This information is included in the introductory text for the full guideline and within the context section of the NICE Version.
Keele University	Full	59	1	Section 6 Clinical Evidence – whilst it is recognised that the GDG are seeking to ensure that all existing advice/guidelines from other organisations was considered, this seems to be a	Thank you for your comment. The GDG agree that it was important to consider the experiences and views of people with multimorbidity when developing this guideline. Within the

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				top down approach and raises queries as to the level of individual/patient engagement in the development of these priority areas.	review you mention, we prioritised the inclusion of published guidance where people with multimorbidity were included in the development of recommendations (p. 59, line 14-15). Furthermore, we included consideration of whether people with multimorbidity were involved in the development of the guidance as a quality criteria when assessing the quality of guidance included (p.44-45).
Keele University	Full	99		Issue around access times to appointments and length of appointments, planned reviews etc. is hidden in this section yet is important for service provision and would sit well within a section on recommendations for services	Thank you for your comment. The GDG agree that access and delivery of healthcare consultations is an important consideration for people with multimorbidity, and searched for evidence on the clinical and cost-effectiveness of service level interventions to address this. However, little evidence was available to inform a recommendation for clinical practice, and so the GDG chose to prioritise a research recommendation for research in this area.
National Osteoporosis Society	Full	General		We feel the tailored approach to care within this guidance is welcome.	Thank you for your comment and for participating in the consultation process.
National Osteoporosis Society	Short	6	1	The document describes how to assess for frailty but does not mention any positive preventive health measures that could be of benefit for this group. We feel more could be done within the guideline to keep people well through targeted prevention measures, including measures to reduce falls and fractures risk.	Thank you for your comment. The GDG acknowledge the overlap between frailty and multimorbidity. The group recommends assessment of frailty as a way to identify people who may benefit from an approach to care that takes account of multimorbidity. The prevention and management of frailty is however outside the scope of the guideline.
National Osteoporosis Society	Short	8	20	Falls and fractures is an example of adverse outcomes which we would welcome being included in the list to talk to patients about.	Thank you for your comment. The GDG reviewed the recommendation and preferred not to add further examples but agree that other issues may be relevant such as falls and

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					fractures. .
National Osteoporosis Society	Full	16	25	We are deeply concerned that this recommendation will result in bisphosphonate treatment being withdrawn from all patients after 3 years of treatment without consideration of their risk of fracture at that point, and without appropriate protocols to ensure that they are reviewed after a defined time period. This is not in the interests of patients at high risk of fractures; it does not reflect the evidence for treatment: nor does it reflect clinical practice of osteoporosis specialists. We firmly believe that this is the wrong approach and puts patients at risk. We urge NICE to revise the recommendation and instead focus on the need for ongoing review of fracture risk factors in people with multimorbidities.	Thank you for your comment. The GDG has considered your suggestion and the recommendation has been edited and, now reads as follows: Tell a person who has been taking bisphosphonate for osteoporosis for at least 3 years that there is no consistent evidence of: • further benefit from continuing bisphosphonate for another3 years • harms from stopping bisphosphonate after 3 years of treatment. Discuss stopping bisphosphonate after 3 years and include patient choice, fracture risk and life expectancy in the discussion.
National Osteoporosis Society	Full	16	25	Alendronate should be reviewed after 5 years of use. With regard to stopping bisphosphonate treatment, we refute the statement that there is 'no consistent evidence of further benefit after 3 years of treatment'. While most placebo-controlled trials were limited to 3 years, some have showed fracture reduction benefits beyond 3 years of treatment. The clinical fracture arm of the Fracture Intervention trial of alendronate was 4.2 years duration on average and showed a reduction in vertebral fractures (Cummings 1998). The extension of the VERT trial of risedronate was placebo-controlled and was of 5 years duration and showed a reduction in vertebral fractures	Thank you for your comment. With regards to the publications you identify, the two trials are both looking at an original randomisation of a population to start bisphosphonates or placebo. The GDG considered that the gold standard evidence for this question was from trials that randomised those already on bisphosphonates to stop or continue. The continued benefit seen at 5 years (Sorenson) or 4.2 years (Cummings) cannot be attributed specifically to continuing the medication for that time, it is entirely plausible that the benefit comes from the first 3 years of treatment or less. The guideline (Compston) and commentary (Black) assess similar evidence to that considered by the GDG. All three groups note there is uncertainty around stopping. However the GDG reached its conclusion taking into account

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				(Sorensen 2003). These papers seem not to have been considered in the preparation of this recommendation. A less dogmatic statement would be 'that there is no consistent evidence of further benefit after 5 years of treatment'. This revision is in keeping with the NOGG guidelines for the UK (Compston 2013) and other authorities (Black 2012). Cummings SR, Black DM, Thompson DE, Applegate WB, Barrett-Connor E, Musliner TA, et al. Effect of alendronate on risk of fracture in women with low bone density but without vertebral fractures: results from the Fracture Intervention Trial. JAMA. 1998;280(24):2077-82. Sorensen OH, Crawford GM, Mulder H, Hosking DJ, Gennari C, Mellstrom D, et al. Long-term efficacy of risedronate: a 5-year placebo-controlled clinical experience. Bone. 2003;32(2):120-6. Compston J, Bowring C, Cooper A, Cooper C, Davies C, Francis R, et al. Diagnosis and management of osteoporosis in postmenopausal women and older men in the UK: National Osteoporosis Guideline Group (NOGG) update 2013. Maturitas. 2013;75(4):392-6. Black DM, Bauer DC, Schwartz AV, Cummings SR, Rosen CJ. Continuing bisphosphonate treatment for osteoporosis--for whom and for how long? The New England Journal of	all available trials of stopping versus continuing. The wording of the recommendation has been edited to highlight some of the uncertainty and now reads as follows: Tell a person who has been taking bisphosphonate for osteoporosis for at least 3 years that there is no consistent evidence of: • further benefit from continuing bisphosphonate for another3 years • harms from stopping bisphosphonate after 3 years of treatment. Discuss stopping bisphosphonate after 3 years and include patient choice, fracture risk and life expectancy in the discussion.

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				Medicine. 2012;366(22):2051-3.	
National Osteoporosis Society	Full	16	25	Zoledronate should be reviewed after 3 years of use. Where a patient is being treated with zoledronic acid, we agree that treatment should be reviewed after 3 years.	Thank you for your comment.
National Osteoporosis Society	Full	16	25	The guideline states 'Discuss stopping bisphosphonate after 3 years' but gives no guidance how to assess whether this is clinically appropriate. We are concerned that, in practice, all patients will be removed from bisphosphonates after 3 years of treatment regardless of their current fracture risk.	Thank you for your comment. Following stakeholder comment the recommendations has been changed to include consideration of fracture risk. The recommendation now reads as follows: Tell a person who has been taking bisphosphonate for osteoporosis for at least 3 years that there is no consistent evidence of: • further benefit from continuing bisphosphonate for another3 years • harms from stopping bisphosphonate after 3 years of treatment. Discuss stopping bisphosphonate after 3 years and include patient choice, fracture risk and life expectancy in the discussion.
National Osteoporosis Society	Full	16	25	Where a patient is at high risk of vertebral fracture (has low BMD or already has vertebral fracture/s) alendronate should be continued for a further 5 years, or zoledronate for a further 3 years, without a break in treatment. There is evidence that patients who have been on alendronate for 4-5 years benefit from a further 5-year treatment course (as	Thank you for your comment. This review did not seek to include evidence for the benefit of bisphosphonate treatment following extended use. Rather we searched for evidence that evaluated the effects of stopping bisphosphonate treatment after >1 year of treatment, which included data from the two studies you have highlighted. This data did not demonstrate consistent evidence that stopping

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				compared to placebo) in that their risk of vertebral fracture is reduced (Black 2006). Further, the HORIZON extension study that showed a reduction in morphometric vertebral fractures in women treated with zoledronate for 6 compared to those treated for 3 years with zoledronate and 3 years placebo (Black 2012). Thus, in a patient with a particularly high risk of vertebral fracture (where their T-score is less than -2.5 or they have already had a vertebral fracture) then it is appropriate to recommend a 10-year course, or a 6-year course of zoledronate. Black DM, Schwartz AV, Ensrud KE, Cauley JA, Levis S, Quandt SA, et al. Effects of continuing or stopping alendronate after 5 years of treatment: the Fracture Intervention Trial Long-term Extension (FLEX): a randomized trial. JAMA. 2006;296(24):2927-38. Black DM, Reid IR, Boonen S, Bucci-Rechtweg C, Cauley JA, Cosman F et al. The effect of 3 versus 6 years of zoledronic acid treatment of osteoporosis: a randomized extension to the HORIZON-Pivotal Fracture Trial (PFT). J Bone Miner Res. 2012 Feb;27(2):243-54 Drug holidays are discussed in SIGN guidelines on osteoporosis and the prevention of fragility fractures. It recommends: "Alendronic acid may be continued for up to 10 years in postmenopausal women with osteoporosis, especially those that are at high risk of vertebral fracture".	bisphosphonates following 3 years' of treatment was associated with clinical harm. On the basis of the evidence included in the review, the GDG believe that it is appropriate to make a recommendation that clinicians consider stopping bisphosphonate treatment following this time. However, since the GDG acknowledge that the likely harms of stopping treatment may vary depending on the person's fracture risk, they have made a recommendation to stop treatment should be made while taking into consideration the likelihood that a person will experience benefit from continuing treatment and the risk of harms following stopping treatment. We have changed the recommendation to highlight this, which now reads as follows: Tell a person who has been taking bisphosphonate for osteoporosis for at least 3 years that there is no consistent evidence of: • further benefit from continuing bisphosphonate for another3 years • harms from stopping bisphosphonate after 3 years of treatment. Discuss stopping bisphosphonate after 3 years and include patient choice, fracture risk and life expectancy in the discussion.

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National Osteoporosis Society	Full	16	25	Where a patient requires a pause in treatment, this should last for 2-3 years before reassessment. Appropriate recall protocols will ensure that the need to resume treatment is reviewed after a defined period. While it will be appropriate for some patients to pause bisphosphonate treatment for 2-3 years, this should always be viewed as temporary. In the FLEX trial, the BMD of the total hip was back to baseline at the end of the 5 years on placebo and so it is likely the fracture risk would be as great as it was when the treatment was first started (Black 2006). Additionally, age is a very strong independent risk factor for fracture, so fracture risk in untreated patients will increase with age. The draft recommendation does not make this clear. We are concerned that, in practice, all patients will be removed from bisphosphonates after 3 years without appropriate recall protocols to ensure patients are reviewed after a defined period. Black DM, Schwartz AV, Ensrud KE, Cauley JA, Levis S, Quandt SA, et al. Effects of continuing or stopping alendronate after 5 years of treatment: the Fracture Intervention Trial Long-term Extension (FLEX): a randomized trial. JAMA. 2006;296(24):2927-38.	Thank you for your comment about recall protocols. The evidence included in the review demonstrated that in people who have been receiving bisphosphonate treatment for 3 years or more, there was no consistent evidence that stopping treatment for up to 3 years was associated with clinical harm. The GDG therefore do not agree that routine use of recall protocols is necessary within this timeframe. However, the GDG agree that clinicians will wish to review the decision to stop bisphosphonate treatment if they believe that a person's circumstances have changed; for example, if a clinician believes that a person's risk of fracture has increased. We have added a comment in the LETR to note this. Following stakeholder comment the recommendations has been changed to include consideration of fracture risk. The recommendation now reads as follows: : Tell a person who has been taking bisphosphonate for osteoporosis for at least 3 years that there is no consistent evidence of: • further benefit from continuing bisphosphonate for another3 years • harms from stopping bisphosphonate after 3 years of treatment. Discuss stopping bisphosphonate after 3 years and include patient choice, fracture risk and life expectancy in the discussion.
National	Full	16	25	Where a pause in treatment is appropriate, the reasons will be	Thank you for your comment. The GDG agree that proper

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Osteoporosis Society				discussed with the patient and they will understand when their need to resume treatment will be reviewed. The National Osteoporosis Society provides an enquiries service which regularly hears from people in distress who have had osteoporosis treatments withdrawn. Patients may become concerned if they do not understand the reason for pausing treatment when previously the need for this has been pressed upon them. Poor understanding may also make them reluctant to engage with future reviews and to later comply with treatments that they may no longer see as necessary. Sufficient time must be allowed when reviewing any treatment to ensure that patients receive the information and support they need.	discussion with the patient about treatments is required. Following stakeholder comment the recommendation has been edited and, now reads as follows: Tell a person who has been taking bisphosphonate for osteoporosis for at least 3 years that there is no consistent evidence of: • further benefit from continuing bisphosphonate for another3 years • harms from stopping bisphosphonate after 3 years of treatment. Discuss stopping bisphosphonate after 3 years and include patient choice, fracture risk and life expectancy in the discussion.
National Osteoporosis Society	Full	262	10	The document states that this study shows benefit of stopping bisphosphonates with respect to time to clinical vertebral fracture. It does not appear to correspond to any of the studies in the Table 107 and is not mentioned in the appendices. We are not aware of this paper so cannot comment on its validity. A reference should be added for this source.	Thank you for your comment. This evidence statement is related to the second row in Table 108 and is taken from the Black 2012 study included in this review. We apologise that this data was missing from the clinical evidence table in the appendix, and have now added this.
National Voices	Full	general	general	National Voices welcomes the recognition that people with multiple health conditions need a 'tailored approach' to their care, treatment and support. Our comments will be on the following general themes.	Thank you for your comment. The GDG agree that many people will benefit from a tailored approach to care and have amended the wording of the recommendations to reflect that we are specifically referring to an approach that takes account of. However this guideline is intended to cover the

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				First, very many people using health and other services will benefit from a tailored approach, not only those with recognisable 'multimorbidities'. This has been posited since Wagner developed the chronic care model for all people with long term conditions (a model which was tailored for the NHS in 2003). It has continued to inform policy and practice in England, for example with the policy aim that every person with a long term condition should have a care plan, access to their records, and support to build their knowledge, skills and confidence to manage successfully (see the first Mandate to NHS England). There is a risk in the guideline assuming that the tailored approach is only for a select sub-group of those with multiple ltcs: that is, that health services will see this as an 'unusual' or limited population who can be diverted to segmented services, without challenging existing care models. This would exacerbate a tendency seen, for example, in the current GP contract with its assumption that care planning is only for the '2% most vulnerable' elderly patients; and in the Right Care programme's emphasis on driving better implementation of single condition pathway medicine except for a small proportion of 'complex' patients. Mainstream care will remain incentivised around single condition guidelines and pathways and many people with single long term conditions, or less complex multimorbidities, will be unable to benefit from proven tailored approaches such as those currently being explored by the Realising the value programme. Conversely, the NHS Five Year Forward View insists on a transformed relationship with	identification and management of people with multimorbidity, and therefore it is not possible to make a recommendation on the care of people with single conditions. This guideline does not replace the recommendations on the care of people with single conditions in other NICE guidance, which also include consideration of individualised care as does the patient Experience guideline (CG138). Thank you for your comments about the recommendations about implementing a tailored approach to people with multimorbidity. The GDG agree that care for people with multimorbidity should be informed by the person's values and preferences, and this guideline includes recommendations that clinicians should seek to discuss these with the person when considering a change in management. Please see the following recommendations in the 'delivering an approach to care that takes account of multimorbidity; *Recommendation 1.6.7 under sub section: 'establishing patient goals, values and priorities' *Recommendation 1.6.15 under sub section: 'reviewing medicines and other treatments'. *****Recommendation 1.6.17 under subsection: 'agreeing the individualised management plan.

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				'people and communities' that empowers people to take better control of their health and care, and which is further expressed in the Six Principles embedded in the NHS Planning Guidance, including that care should be 'person centred: personalised, coordinated and empowering'. Second, the 'tailored approach' described in the draft guideline has limitations which it is hoped that the guideline committee can address and overcome in the further phase of guideline development. These relate to the need firmly to root the approach in personalised care and support planning, as a process that can assist and enable the person and their carer(s) to identify their own priorities and preferences for their care, support and treatment; and subsequently to draw upon the range of known, evidenced person centred and often community based interventions that can then support people to achieve self-identified goals. These include, for example, support for self management (including through self management education), health coaching, peer support, social prescribing, asset based community development approaches and other interventions described in an extensive literature. In our specific comments National Voices will suggest places in the guideline where these could be described and specified. More generally we advise changing 'tailored' to 'personalised' throughout. This would support the personalisation approach of adult social care and its continued spread and development in healthcare. Third, while the guideline is well informed by certain kinds of	Within this guideline, we sought evidence to evaluate the clinical and cost-effectiveness of self-management interventions to improve outcomes for people with multimorbidity, including the effectiveness of expert patient programmes. The evidence identified did not demonstrate consistent benefit of these programmes for people with multimorbidity. However, the GDG believed that further research that evaluates alternative forms of these interventions may inform future practice. Following stakeholder comments the GDG reviewed the terminology used in the guideline. The GDG considered that the term 'personalised' is currently used in relation to 'personalised medicine' and preferred to continue to use the terms 'tailored' and 'individualised' as these have a clear meaning. Thank you for comment about the importance of considering qualitative evidence from people with multimorbidity, their

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				evidence, we believe it would also benefit from hearing qualitative evidence from people attempting to manage multiple conditions, and who can provide experiential testimony of the likely value and effectiveness of the approaches described in the guideline.	families and carers in the development of this guideline. The GDG agree, and recommendations within this guideline are informed by a qualitative evidence review exploring the beliefs and experiences of care as experienced by people with multimorbidity and their carers.
National Voices	Full	12	14	'Consider a personalised approach for any person who may benefit, including those with any long term condition. Mandate a personalised approach for any person with multimorbidity where any of the following apply:'	Thank you for your comment. The GDG agree that the approach outlined may be appropriate for people without multimorbidity. This guideline is intended to cover the identification and management of people with multimorbidity, and therefore it is not possible to make a recommendation on the care of people with single conditions. This guideline does not replace the recommendations on the care of people with single conditions in other NICE guidance, which include consideration of individualised care or the approach outlines in the Patient Experience guideline (CG138). The guideline is unable to mandate an approach due to the quality of evidence available.
National Voices	Full	12	17	Replace 'care' with 'care and support'. Support services may well be non-statutory and it is important to take these into account when assessing a person's whole package of care. 'Care and support' is recognised terminology in adult social care.	Thank you for your comment. The GDG has considered your suggestion and preferred to leave the wording as 'care' and intend this to be interpreted in its broadest sense. 'Care and support' is more commonly used in social service planning.
National Voices	Full	12	24	'Principles of a personalised approach'	Thank you for your comment. The group has changed the terminology in the guideline to 'an approach to care that takes account of multimorbidity'. There were initial concerns about specific meanings attributed to term 'personalised' such as 'personalised medicine' and in the context of social

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					care plans in how those are funded. What is meant by 'an approach to care that takes account of multimorbidity' is included in 'terms used in this guideline'.
National Voices	Full	12 and 12	26 39	In these lines delete the word 'multimorbidity'. These principles and barriers apply to any person who may benefit from a personalised approach, including but not only those with multimorbidity	Thank you for your comment. The GDG agree that the approach outlines may be appropriate for people without multimorbidity. This guideline is intended to cover the identification and management of people with multimorbidity, and therefore it is not possible to make a recommendation on the care of people with single conditions. This guideline does not replace the recommendations on the care of people with single conditions in other NICE guidance, which include consideration of individualised care or the approach outlines in the Patient Experience guideline (CG138).
National Voices	Full	12	26	National Voices rejects the formulation used here: 'provide the person with an individualised management plan'. We refer to the guideline committee to definitions of personalised care and support planning in the statutory guidance to local authorities on the Care Act 2014; the NHS England handbook for care and support planning; and National Voices' guide to care and support planning. In addition there are first person statements on what care planning should be which help form the core of the 'narrative' for person centred coordinated care that was adopted as the single definition of the goals of integrated care across the national health and social care system in May 2013 (see 'Integrated Care: Our Shared Commitment', DH 2013). These all emphasise that it is not 'being provided with a plan' that creates better outcomes for the person: it is the process of care planning. This process should be a partnership process,	Thank you for your comment. Following stakeholder consultation the wording of this recommendation has been altered to say that any written plan should be shared with the person. Thank you for the reference to the Cochrane Review Coulter A et al (2015). This review was identified. in our literature search, however it was excluded as it did not meet the review protocol. Specifically, studies included in the review were not conducted specifically with a population with multimorbidity.

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				making use of two kinds of expertise – that of the person, with their knowledge of their lives, circumstances, sources of support, preferences, values and capacities, together with the way that conditions impact on their lives; and that of the care system with its knowledge of medical and clinical factors and treatments, effective interventions, and sources of care and support. The aim of the process is to enable the person to identify the things that matter most to them in managing their life and condition(s), and then to identify the most appropriate range of care, support and treatment to enable them to succeed. The evidence that this approach can lead to beneficial health outcomes is documented in a Cochrane review: Coulter A et al. Personalised care planning for adults with chronic or long-term health conditions. Cochrane Database of Systematic Reviews 2015, Issue 3, Art. No.: CD010523. DOI: 10.1002/14651858.CD010523.pub2.This review defines personalised care planning as an anticipatory (forward-looking), negotiated discussion or series of discussions between a patient and a health professional (perhaps with other professional or family members present) to clarify goals, options and preferences and develop an agreed plan of action based on this mutual understanding. The review summarised evidence from 19 RCTs and concluded that personalised care planning is a promising approach that offers the potential to provide effective help to patients, leading to better health outcomes. We do not understand why this evidence was not included in the draft guideline.	

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				The health service currently provides people with 'care plans' and 'management plans' which they do not own, often not knowing they have one, not being involved in drawing them up, and not able to amend them as circumstances change. This fundamental misunderstanding of care planning must be corrected.	
National Voices	Full	13	3	We would prefer the formulation: 'Enable the person to identify and establish their values, preferences and priorities'	Thank you for your comment. The group has considered your suggestion, but agrees that the original draft of the recommendation is clear. Detail on what is involved is further elaborated in later recommendations.
National Voices	Full	13	8	See comments on care planning in p12 line 36 above. Change 'individualised management plan' to 'personalised care and support plan'.	Thank you for your comment. The GDG considered your suggestion but did not agree that using terms 'personalised' or care and support' were appropriate as these have specific meanings primarily in social care.
National Voices	Full	13	15	Insert: identifying patient's needs for ongoing support	Thank you for your comment. The group has considered your suggestion, preferred not to include the need for ongoing support and to maintain the emphasis on clinical aspects of multimorbidity.
National Voices	Full	13	16	Insert: documenting the plan and sharing it with the patient	Thank you for your comment. This is covered in recommendation 35 in the full guideline, which encourages health care professionals to share copies of the management plan in an accessible format with the person and (with the person's permission) other people involved in care (including healthcare professionals, a partner, family members and/or carers).
National Voices	Full	13	19	Identifying people with single or multiple conditions who might benefit from a personalised approach only through direct contact or through their electronic care records is not	Thank you for your comment. The GDG agree that using risk tools based on primary healthcare data and/or identifying people opportunistically during routine care may fail to

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				adequate. We would prefer to see reference to applying the principles of population health management using various data sources to identify people in the relevant population. We would also like to see reference to proactive research to ensure that people who are not registered on GP lists, or who are registered but have barriers to accessing the GP – in other words, those at risk of exclusion from health care – are identified.	identify some people with multimorbidity who may benefit from multimorbidity approach, but are not registered with healthcare services. Within the scope of this guideline it was not possible to also evaluate the effectiveness of using various data sources to identify people who are not registered on GP lists, or who are registered but have barriers to accessing the GP
National Voices	Full	13	32-37	We recommend mandating a personalised approach for all people who are using 10 or more medications, recognising the support that is required to be successful at this self management task (the treatment burden) not just the risk of drug interactions.	Thank you for your comment. The quality of the evidence did not allow the GDG to mandate this approach for all people who are using 10 or more medications. The available evidence is of association between polypharmacy and adverse outcomes without clear evidence of clinical and cost effectiveness of any specific intervention.
National Voices	Full	14 and 14	10 22	We agree with the use of frailty assessment scales but question why only one is specified. We are aware that others are acceptable and have been adopted within the healthcare system.	Thank you for your comment. We sought evidence that evaluated the accuracy of a variety of tools to identify frailty, including simple assessments as well as validated scales. The GDG chose to recommend several options that clinicians may wish to use. The decision on which of these tools was included was based on their accuracy as well as the tools that clinicians believed would be easiest to conduct in routine clinical practice.
National Voices	Full	14	37	National Voices would dispute that 'the purpose of a personalised approach is to find ways of reducing treatment burden and optimising care'. The purpose of a personalised approach is to find the most appropriate ways to support each individual to live well with their condition(s). This should be expressed in the language of the person and in relation to their self identified goals, for example: 'if you want to continue	Thank you for your comment. The recommendation has been amended to emphasis improvement in quality of life and now states: Discuss with the person that the purpose of the approach to care is to improve quality of life'. This might include reducing treatment burden and optimising care and support by identifying: •ways of maximising benefit from existing treatments,

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				gardening we will need to find ways to help you manage your breathlessness'. If this primary purpose is achieved it is likely to reduce the treatment burden and optimise care; but these are secondary purposes. A third is to avoid unnecessary episodes of recourse to urgent and emergency care.	•treatments that could be stopped because of limited benefit, •treatments and follow-up arrangements with a high burden, •medicines with a higher risk of adverse events (for example, falls, gastrointestinal bleeding, acute kidney injury), •non-pharmacological treatments as possible alternatives to some medicines •alternative arrangements for follow-up to coordinate or optimise the number of appointments. The GDG also agrees that the a reduction of recourse to urgent and emergency care would be positive for patients and healthcare professionals.
National Voices	Full	15	2	Also: to help find other non-medical sources of support if required, e.g. community services or peer support	Thank you for your comment. This recommendation is specifically about reducing treatment burden. Information about support groups is already recommended to people in the NICE Patient Experience Guideline (CG138).
National Voices	Full	15	26 to 33	We welcome the outcomes described here as possible personal goals. We would suggest that the guideline also includes 'maintaining/increasing independence' and 'having control over the way I am supported or cared for'.	Thank you for your comment. The GDG has amended the recommendations to include 'maintaining their independence' as suggested. They did not agree that 'having control over the way I am supported or cared for' was a necessary addition.
National Voices	Full	16	22	Add: Share decisions with patients and use evidence-based patient decision aids, where available, to help patients reach informed decisions about their treatment options (see NICE quality standard on Patient Experience in Adult NHS Services)	Thank you for your comment. As you indicate the use of decision aids where these are available is already recommended in NICE patient Experience guideline (CG138). The guideline committee were not aware of any

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					decision aids that address issues of polypharmacy and multimorbidity.
National Voices	Full	16	29 to 37	National Voices would like to see this section revised to take account of non-clinical actions that might better support a person with condition(s) to manage successfully. There is significant evidence on the effectiveness of person centred interventions such as those being studied in the Realising the Value programme (see 'At the Heart of Health: realising the value of people and communities', Nesta, 2016; plus the evidence studied for NICE guideline 44 on community engagement; various evidence reviews for person centred care from the Health Foundation; etc)	Thank you for your comment. Within this guideline we conducted evidence reviews to evaluate the effectiveness of service-level interventions to improve the care of people with multimorbidity, and have made recommendations on the basis of the available evidence. The GDG believe that the care of people with multimorbidity should be person-centred, and have made recommendations about the way in which clinicians can seek to achieve this. Related guidance can be found in the Patient Experience NICE Guideline (CG138).
National Voices	Full	71	1	Personalised care planning as described in our earlier comments has been the subject of a Cochrane Review cited here: Coulter A, Entwistle VA, Eccles A, Ryan S, Shepperd S, Perera R. Personalised care planning for adults with chronic or long-term health conditions. Cochrane Database of Systematic Reviews 2015, Issue 3. Art. No.: CD010523. DOI: 10.1002/14651858.CD010523.pub2. We would ask the guideline committee to consider this review and its recommendations for further research.	Thank you for your comment and suggested reference. We identified this paper during our searches; however it was excluded as it did not match the review protocol. The Cochrane review is not specific to multimorbiditiy.
National Voices	Full	237	2	We propose adding a recommendation as follows: 'Professionals working with people with multiple long term conditions should: a) ensure that they have appropriate skills in the detection and basic management of non severe psychological disorders in people from different cultural backgrounds; and, b) be familiar with appropriate counselling techniques and drug therapy, while arranging prompt referral to specialists of those people in whom psychological difficulties	Thank you for your comment. This guideline included a recommendation to assess for the presence of depression on the basis of evidence identified that indicated that common mental health conditions can be an outcome of treatment burden and that they may act as a barrier to the optimal care of people with multimorbidity. This guideline does not replace recommendations on the identification and management of conditions as specified in single-condition guidelines, and the

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				continue to interfere significantly with wellbeing or self management.' This wording is taken from NICE NG17 Type 1 diabetes but is equally relevant in this context.	specific identification and management of psychological disorders should be conducted in accordance with existing NICE guidance.
National Voices	Full	237	15-17	We propose an amendment to: 'Be alert to possible clinical or subclinical depression and anxiety'. Sub-clinical problems still have an adverse impact on people's ability to self-manage and can escalate if not identified early.	Thank you for your comment. This guideline included a recommendation to assess for the presence of depression on the basis of evidence identified that indicated that common mental health conditions can be an outcome of treatment burden and that they may act as a barrier to the optimal care of people with multimorbidity. The guideline refers to NICE guideline on Common mental health disorders and that the case finding questions recommended in that guidance would alert healthcare professionals to indications of anxiety or mood disorder.
NHS England (Long Term Conditions Team)	Short	8	14-19	Could reference be made to offering support to carers, in line with other NICE guidelines such as dementia and psychosis and schizophrenia?	Thank you for your comment. Carer burden is included in the outcomes when examining evidence in the guideline. The guideline makes reference to ensuring carers are involved in decisions as required but carer support is outside the scope of this guideline.
NHS England (Long Term Conditions Team)	Full	65	Table 17	Is there a typo on p65 in the last sentence of the table "elicit preferences only after the older adult with multi-morbidity"?	Thank you for your comment. This has been edited to read: 'Elicit patient preferences only after the older individual with multimorbidity is sufficiently informed'.
NHS England (Long Term Conditions Team)	Short	10	13-17	Could an extra point be added to this list around personal goals?	Thank you for your comment. Goals is now included in the recommendation.
NHS England (Long Term Conditions Team)	Short	10	13-17	Could a point be added here about the Summary Care Record and/or discussing with the person the option of 'switching on ' the enriched version of the SCR? SCRs provide healthcare	Thank you for your comment. We have added detail about use of the SCR to the Full guideline in section 6.3.4.

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				professionals treating patients in different care settings with faster access to key clinical information and the enriched version can support immediate access in secondary care of care plans and frailty codes. http://systems.hscic.gov.uk/scr	
NHS England (Long Term Conditions Team)	Full	General *(but in particular Pages 53, 102, 188 and 270)*	General	This is a helpful guideline which could be used to support changed approaches to multi-morbidity and personalised care planning for older people and in particular those living with frailty. The extensive evidence reviews, which underlie the guideline, are extremely helpful and comprehensive. Clinicians will find these helpful if presented in an accessible summary format to support their decision making and the advice they provide to patients, carers and families. However because the evidence reviews draw on established research evidence, which is currently of generally low quality, the guidance itself has necessarily remained somewhat non-directive. While providing a general framework for discussion between patients, carers, their families and professionals this may also defeat the objectives of providing patient centred decision making. We would question how in practice this guidance would be used to best effect. In the absence of clear evidence of benefit/harm for the various interventions considered (with the notable exception of bisphosphonates) the choices available remain very much in the hands of clinicians who may feel obliged to direct patient choice. Where incentives remain to prescribe interventions where there is genuine equipoise it is contended that clinicians may err towards continuation.	Thank you for your comment. The evidence reviews will be available on the NICE website but are not usually summarised further. The GDG note that there is a paucity of research conducted specifically with people with multimorbidity, and have specified several research recommendations to address this. The GDG recognise the potential for decisions to be influenced by incentives but hope that this guideline will empower healthcare professionals to consider the relevance of single disease guidelines and recommendations to their patients and to more appropriately consider issues such as treatment burden..

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				We are concerned that the choices which result from tailored care discussions therefore will remain largely in the hands of either clinicians, or partially informed families or carers, or be driven by external factors including other condition specific NICE guidance or incentivisation frameworks. We are also concerned that there are complex associations between multi morbidity and cognitive disorder in older people, which have not been fully reflected in this guidance. See for example: 1) http://onlinelibrary.wiley.com/doi/10.1111/j.1532-5415.2008.02109.x/abstract?userIsAuthenticated=false&deniedAccessCustomisedMessage= 2) http://ageing.oxfordjournals.org/content/early/2011/03/17/ageing.afr010.short 3) http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0084014 We believe this is important for two reasons: 1) It is likely that patients with multiple co-morbidity and significant cognitive disorder could be unable or unwilling to participate in complex discussions about aspects of their physical health conditions. This will add additional complexity to the development of a	Thank you for your comment about the needs of people with multimorbidity and cognitive disorders. All NICE guidelines include an introductory paragraph on patient centred care which makes explicit reference to capacity and the Mental Capacity Act.

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				tailored care plan which could lead to these individuals being excluded altogether from such discussions 2) Where there is genuine uncertainty about the balance of harms/benefits of a given intervention for a patient who lacks capacity to make decisions a series of best interests discussions will be required within statutory frameworks which could be time consuming and potentially burdensome to all participants. We welcome the use of a clear approach to identification but draw attention to the findings of the QAdmissions validation study http://bmjopen.bmj.com/content/3/8/e003482.short which will be familiar to the GDG. It is clearly stated here that further economic evaluation of cost effectiveness of such algorithms in primary care settings is required before they can be recommended for widespread use. We would welcome the views of the GDG about this as this guideline may lead to widespread use of QAdmissions in ways for which it is not validated economically with unanticipated results. We also recognise that the GDG were concerned that the use of QAdmissions may be misinterpreted suggest that this concern could be echoed in the guideline itself. However we are concerned that QAdmissions is based on low quality evidence and is only valid with high specificity in a population at high risk of unplanned hospital admissions. In this group, which are likely to exhibit high frailty indices, tailored care planning may be more properly focused around anticipatory and end of life care planning. We question whether this should	NICE are updating the guideline on Dementia and the scope of that guideline specifically included ethics, consent and advanced care planning as well as management of co-morbidities. Regarding your comment on the QAdmission validation study, no economic evidence was available on the cost effectiveness of QAdmission at the time when the guideline was developed, however the GDG considered the economic implications of recommending the use of health electronic records or risk tools and they are reported in the 'Recommendation and link to evidence' section. The recommendation made asks health care professionals to consider these tools as one way of identifying people with complex multimorbiditiy. It is not a strong recommendation which the GDG agree would not be justified by the lack of economic evidence. Should new economic data be available when this guideline is updated, the recommendation may be reviewed. The guideline scope included how to identify people with complex multimorbidity. The GDG judged that the tools recommended had adequate predictive power to be potentially useful.

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				either be reflected in the guideline itself or whether the guideline should be directed at another segment of the multi-morbidity population (for which QAdmissions is less helpful in identification) if a principle aim of the guideline is to increase the number of life years with reduced intervention burden. We would welcome the GDG views about this. We would also value the views of the GDG on whether targeting a high risk admissions group in this way would be as effective as anticipated given the well documented 'regression to mean' characteristics of this population: http://www.kingsfund.org.uk/sites/files/kf/Case-Management-paper-The-Kings-Fund-Paper-November-2011_0.pdf We welcome the use of frailty assessments to identify people suitable for tailored care planning. We would welcome the views of the GDG about the use of the newly developed electronic frailty index, which is becoming widely available and already in use in some areas in England. We accept that this is not fully evaluated but also note that the tools recommended have comparatively little validation evidence to support their widespread use. The GDG have assumed at multiple points in the development of the guideline that the recommendations for identification and tailored care planning can be undertaken within the context of a short consultation. We would welcome evidence to support these assumptions. Intuitively and in practice structured care	Following stakeholder comment the GDG assessed the use of the electronic frailty index and have added this to the list of tools that might be considered for use. Thank you for your comment about the time needed to conduct an assessment of people with multimorbidity. The GDG discussed this at length. The GDG considered that the recommendations inform the content and approach of consultations with this group of patients. Review of medicines and treatments is a core part of the delivery of medical care and already part of the role of healthcare practitioners. The GDG considered that discussions are likely to be spread over several consultations in primary care and therefore could be carried out as part of usual medical practice when providing and reviewing care for people with multimorbidity. The GDG recognised that current practice is highly variable with many healthcare practitioners already using longer

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				planning is likely to be time consuming and resource intensive if it is to address all of the issues set out in the guideline adequately. Furthermore the benefits assumed by professionals undertaking structured care planning do not consistently translate to benefits 'felt' by patients. See for example: 1) http://cssr.berkeley.edu/pdfs/QALTC_CarePlanDev.pdf 2) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215103/dh_133127.pdf It is our concern that if implemented as intended this guideline may consume considerable professional time, with unanticipated increased workload on primary care professionals, including GPs without translating to the intended benefits for people with multiple comorbidity. Consideration should be given to noting the importance of longer consultations for people with multi-morbidity and the potential that this may be in the longer-term have a net time benefit for health professionals.	consultations or double appointments for people with complex needs. We did search for evidence to evaluate the clinical and cost-effectiveness of alternative formats of health consultations, including longer appointment times. However, no evidence was identified. The GDG have specified a research recommendation for research to evaluate different strategies of organising primary care for people with multimorbidity to further inform this area.
NHS England (Long Term Conditions Team)	Short	8	27	Instead of 'prolonging life' – it should be 'life-prolonging interventions'.	Thank you for your comment. The GDG has considered your suggestion, but opted to retain 'lengthening life' in the list as they think this is clear. Please note, however, there are further edits within this recommendation. It now reads: Encourage people with multimorbidity to clarify what is important to them, including their personal goals, values and priorities. The list of what this may include has also been

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					expanded to add 'maintaining their independence'.
NHS England (Long Term Conditions Team)	Short	10	1.6.17	Suggest adding a final bullet point 'documenting a personalised care plan'	Thank you for your comment. The recommendation now includes agreeing what will be recorded in the plan.
NHS England (Long Term Conditions Team)	Full	General	General	Observation is around the EoL management. Understanding (and managing the consequences of) the relationship between multi morbidity and frailty at different points along frailty trajectories - particularly in advanced frailty transitioning towards end of life care - is an ever increasing challenge for primary care teams. There is still quite a bit of confusion in primary care about the similarities and differences between frailty and multi morbidity, the relationship between the two, and how to manage one in the presence of the other, most particularly towards the end of life. This would be a good opportunity to increase understanding and add some clarity to that debate, I completely support the suggestion of trying to develop some clearer linkage in this area.	Thank you for your comment. The GDG recognise the overlap between frailty and multimorbidity and in this guideline frailty is used as a marker for people who may benefit from an approach to care that takes account of multimorbidity and in whom burden of treatment should be assessed. The recommendations have been revised and include a definition of multimorbidity and this includes symptom complexes such as frailty or chronic pain as examples of what may constitute a long term health condition. Please see recommendation 1.1.1, which states: Be aware that multimorbidity refers to the presence of 2 or more long-term health conditions, which can include: • defined physical and mental health conditions such as diabetes or schizophrenia • ongoing conditions such as learning disability • symptom complexes such as frailty or chronic pain • sensory impairment such as sight or hearing loss • alcohol and substance misuse. The guideline however does not provide comprehensive guidance on management of people with frailty.
NHS England (Long Term Conditions Team)	Full	General	General	The framing of the paper is broadly biomedical and tends to defer to a paternalistic language ('provide patients with a care plan') and clinical outcomes rather than outcomes that matter to individuals. Preferred framing is with personal outcomes,	Thank you for your comment. The GDG agrees that it is important that clinicians agree decisions on care in collaboration with people with multimorbidity following discussions that include consideration of the person's values

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				wellbeing and independence. We are promoting a personalised approach whereby we want our workforce to support people to manage their own health and wellbeing and live independently in their communities.	and preferences, as well as their priorities for the outcomes of treatment. This guideline includes recommendations to this effect. Please see the following recommendations in the 'delivering an approach to care that takes account of multimorbidity' section; *Recommendation 1.6.7 under sub section: 'establishing patient goals, values and priorities' *Recommendation 1.6.15 under sub section: 'reviewing medicines and other treatments'. *Recommendation 1.6.17 under subsection: 'agreeing the individualised management plan. Following stakeholder consultation we have altered the wording to remove any indications of paternalism – for example we have changed 'provide' to 'share' .
NHS England (Long Term Conditions Team)	Full	General	General	Would NICE be able to provide a view on when there will be a revise/review the guideline (if not mentioned already) as there is sparse current evidence but there is a growing focus on multi-morbidity and therefore a rapidly developing area?	Thank you for your comment. Once published, all NICE guidance is regularly checked, and updated in light of new evidence if necessary. Further details on how guidelines are developed can be found at: https://www.nice.org.uk/article/pmg20/chapter/1-Introduction-and-overview#choice-of-guideline-topics
NHS England's South Central Medical Directorate	Short	4	14	From the way the recommendations are worded, section 1.3.2 seems rather at odds with the priority in the 5YFW for the NHS to drive person-centred care. A 'tailored approach' to multi-morbidity should start with the person, and focus primarily on their personal goals and care needs and a discussion of disease management and 'treatment burden' should follow from the person and be facilitated by, rather than led, by the	Thank you for your comment. The GDG reviewed the wording of the recommendation but did not consider that a change to the order of the bullet points was required. The GDG considered that explaining the aims of review to the patient was in most cases a necessary first step to ensure clear understanding between professional and patient of the aims of their discussion. An understanding of disease and

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				clinician.	treatment burden is also helpful when discussing patient's goals and priorities. The GDG however also understood that although there are clear steps in this process, it is not necessarily a linear process and items in the list may need re-visiting as more information is shared.
NHS England's South Central Medical Directorate	Short	4	25	Confusion as to whether the guideline is referring to a 'clinical management plan' for use by clinicians primarily, or a plan of care for the person for their use, and for the reference of carers, family and a range of care providers	Thank you for your comment. The plan relates primarily to clinical management and can be used by person with multimorbidity and shared as appropriate with providers and family and carers. The wording of the recommendation has been changed to clarify this. Please see recommendation 1.6.17 in the NICE version, which states: After a discussion of disease and treatment burden and the person's, personal goals, values and priorities, develop and agree an individualised management plan with the person. Agree what will be recorded and what actions will be taken. These could include: • starting, stopping or changing medicines and non-pharmacological treatments • prioritising healthcare appointments • anticipating possible changes to health and wellbeing • assigning responsibility for coordination of care and ensuring this is communicated to other healthcare professionals and services • other areas the person considers important to them • arranging a follow-up and review of decisions made. Share copies of the management plan in an accessible

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					format with the person and (with the person's permission) other people involved in care (including healthcare professionals, a partner, family members and/or carers).
NHS England's South Central Medical Directorate	Short	5	7-25	As above, a missed opportunity to advocate a person-centred approach. Using National Voices 'I' statements, everyone should have a 'tailored', individualised approach, not just those selected by the means described in this section. It isn't clear how actions described at lines 9 and 11, for example, will support the need for all people with 2 or more LTCs to have an individualised care plan. Suggest everyone with 2 or more LTCs is offered the opportunity to develop a tailored approach to their care.	Thank you for your comment. The guideline is not suggesting that all people with 2 or more long-term conditions need a multimorbidity approach to care and this section is intended to help identify those people who are most likely to benefit from an approach to care that takes account of multimorbidity.
NHS England's South Central Medical Directorate	Short	7	15-20	As above, this describes a clinician-led approach to multi-morbidity management. Conversation should start with the person and their ho pes for their care and quality of life. Benefits and 'burdens' of treatment may be perceived differently by the clinician and the person, and care will be needed throughout the discussion to ensure that the patient is the decision-maker regarding stopping treatments.	Thank you for your comment. The GDG disagree and consider that it is necessary to explain the purpose of a review to the patient to ensure the patient can engage with the process.
NHS England's South Central Medical Directorate	Short	8	1-9	As above, conversation is 'disease' driven rather than led by person's goals and quality of life aspirations.	Thank you for your comment. The GDG has considered your comment and believes the recommendation as originally drafted is clear. There are additional recommendations in the section on delivering an approach to care that takes account of multimorbidity; these recommendations ask healthcare professionals to encourage people with multimorbidity to clarify what is important to them, including their personal goals, values and priorities.

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NHS England's South Central Medical Directorate	Short	8	14-19	Could reference be made to offering support to carers, in line with other NICE guidelines such as dementia and psychosis and schizophrenia?	Thank you for your comment. Carer burden is included in the outcomes when examining evidence in the guideline. The guideline makes reference to ensuring carers are involved in decisions as required but carer support is outside the scope of this guideline
NHS England's South Central Medical Directorate	Short	8	20	This should be the starting point for section 1.6 of the Short Guideline	Thank you for your comment. The GDG considered that providing the context for the discussion was important and therefore that explaining the aims of review is an important first step.
NHS England's South Central Medical Directorate	Short	9-10	4	Section 4 'Reviewing medicines and other treatments' addresses important issues but the checklist could also make the link between number of medicines and the need for outpatient appointments/ ongoing monitoring as these factors are important to people with multi-morbidities especially those who are also frail.	Thank you for your comment. We have added this to the recommendation on assessment of treatment burden.
NHS England's South Central Medical Directorate	Short	10	10	As above, the discussion should start with the person's preferences, values and priorities; is this a 'clinical plan' or a 'care plan'? This section could also mention the potential for those with multi-morbidities to undertake some follow-up / monitoring interventions that they perceive as 'burdensome' in different ways to reduce the burden, eg, telemonitoring, skype appointments, telephone consultations, etc.	Thank you for your comment. The list provided here are examples and not intended to be comprehensive. The plan is primarily a clinical management plan.
NHS England's South Central Medical Directorate	Short	10	13-17	Could an extra point be added to this list around personal goals?	Thank you for your comment. Goals has been added to the stem of the recommendation.
NHS England's South Central Medical Directorate	Short	10	13-17	Could a point be added here about the Summary Care Record and/or discussing with the person the option of 'switching on ' the enriched version of the SCR? SCRs provide healthcare professionals treating patients in different care settings with	Thank you for your comment. We have added detail about use of the SCR to the Full guideline.

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				faster access to key clinical information and the enriched version can support immediate access in secondary care of care plans and frailty codes. http://systems.hscic.gov.uk/scr	
NHS England's South Central Medical Directorate	Short	10	27-28	Clarify how individualised management plan differs from care plans (if it does).	The individualised management plan is primarily concerned with clinical management and healthcare provision. The GDG specifically chose not to use the term 'care plan' because it has a specific meaning in social services and is often used to cover a wider range of patient related issues. .
NHS England's South Central Medical Directorate	Full	General *(but in particular Pages 53, 102, 188 and 270)*	General	This is a helpful guideline which could be used to support changed approaches to multi-morbidity and personalised care planning for older people and in particular those living with frailty. The extensive evidence reviews, which underlie the guideline, are extremely helpful and comprehensive. Clinicians will find these helpful if presented in an accessible summary format to support their decision making and the advice they provide to patients, carers and families. However because the evidence reviews draw on established research evidence, which is currently of generally low quality, the guidance itself has necessarily remained somewhat non-directive. While providing a general framework for discussion between patients, carers, their families and professionals this may also defeat the objectives of providing patient centred decision making. We would question how in practice this guidance would be used to best effect. In the absence of clear evidence of benefit/harm for the various interventions considered (with the notable exception of bisphosphonates) the choices available remain very much in the hands of clinicians who may feel obliged to direct patient choice. Where	Thank you for your comment. The evidence reviews will be available on the NICE website but are not usually summarised further. The GDG note that there is a paucity of research conducted specifically with people with multimorbidity, and have specified several research recommendations to address this. The GDG recognise the potential for decisions to be influenced by incentives but hope that this guideline will empower healthcare professionals to consider the relevance of single disease guidelines and recommendations to their patients and to more appropriately consider issues such as treatment burden..

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				incentives remain to prescribe interventions where there is genuine equipoise it is contended that clinicians may err towards continuation. We are concerned that the choices which result from tailored care discussions therefore will remain largely in the hands of either clinicians, or partially informed families or carers, or be driven by external factors including other condition specific NICE guidance or incentivisation frameworks. We are also concerned that there are complex associations between multi morbidity and cognitive disorder in older people, which have not been fully reflected in this guidance. See for example: 4) http://onlinelibrary.wiley.com/doi/10.1111/j.1532-5415.2008.02109.x/abstract?userIsAuthenticated=false&deniedAccessCustomisedMessage= 5) http://ageing.oxfordjournals.org/content/early/2011/03/17/ageing.afr010.short 6) http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0084014 We believe this is important for two reasons: 3) It is likely that patients with multiple co-morbidity and significant cognitive disorder could be unable or unwilling to participate in complex discussions about aspects of their physical health conditions. This will	Thank you for your comment about the needs of people with multimorbidity and cognitive disorders. All NICE guidelines

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				add additional complexity to the development of a tailored care plan which could lead to these individuals being excluded altogether from such discussions 4) Where there is genuine uncertainty about the balance of harms/benefits of a given intervention for a patient who lacks capacity to make decisions a series of best interests discussions will be required within statutory frameworks which could be time consuming and potentially burdensome to all participants. We welcome the use of a clear approach to identification but draw attention to the findings of the QAdmissions validation study http://bmjopen.bmj.com/content/3/8/e003482.short which will be familiar to the GDG. It is clearly stated here that further economic evaluation of cost effectiveness of such algorithms in primary care settings is required before they can be recommended for widespread use. We would welcome the views of the GDG about this as this guideline may lead to widespread use of QAdmissions in ways for which it is not validated economically with unanticipated results. We also recognise that the GDG were concerned that the use of QAdmissions may be misinterpreted suggest that this concern could be echoed in the guideline itself. However we are concerned that QAdmissions is based on low quality evidence and is only valid with high specificity in a population at high risk of unplanned hospital admissions. In this group, which are likely to exhibit high frailty indices, tailored care planning may be more properly focused around anticipatory	include an introductory paragraph on patient centred care which makes explicit reference to capacity and the Mental Capacity Act. NICE are updating the guideline on Dementia and the scope of that guideline specifically included ethics, consent and advanced care planning as well as management of co-morbidities. Regarding your comment on the QAdmission validation study, no economic evidence was available on the cost effectiveness of QAdmission at the time when the guideline was developed, however the GDG considered the economic implications of recommending the use of health electronic records or risk tools and they are reported in the 'Recommendation and link to evidence' section. The recommendation made asks health care professionals to consider these tools as one way of identifying people with complex multimorbiditiy. It is not a strong recommendation which the GDG agree would not be justified by the lack of economic evidence. Should new economic data be available when this guideline is updated, the recommendation may be reviewed. The guideline scope included how to identify people with complex multimorbidity. The GDG judged that the tools recommended had adequate predictive power to be potentially useful.

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				and end of life care planning. We question whether this should either be reflected in the guideline itself or whether the guideline should be directed at another segment of the multi-morbidity population (for which QAdmissions is less helpful in identification) if a principle aim of the guideline is to increase the number of life years with reduced intervention burden. We would welcome the GDG views about this. We would also value the views of the GDG on whether targeting a high risk admissions group in this way would be as effective as anticipated given the well documented 'regression to mean' characteristics of this population: http://www.kingsfund.org.uk/sites/files/kf/Case-Management-paper-The-Kings-Fund-Paper-November-2011_0.pdf We welcome the use of frailty assessments to identify people suitable for tailored care planning. We would welcome the views of the GDG about the use of the newly developed electronic frailty index, which is becoming widely available and already in use in some areas in England. We accept that this is not fully evaluated but also note that the tools recommended have comparatively little validation evidence to support their widespread use. The GDG have assumed at multiple points in the development of the guideline that the recommendations for identification and tailored care planning can be undertaken within the context of a short consultation. We would welcome evidence to support	Following stakeholder comment the GDG assessed the use of the electronic frailty index and have added this to the list of tools that might be considered for use. Thank you for your comment about the time needed to conduct an assessment of people with multimorbidity. The GDG discussed this at length. The GDG considered that the recommendations inform the content and approach of consultations with this group of patients. Review of medicines and treatments is a core part of the delivery of medical care and already part of the role of healthcare practitioners. The GDG considered that discussions are likely to be spread over several consultations in primary care and therefore could be carried out as part of usual medical practice when providing and reviewing care for people with multimorbidity. The GDG recognised that current practice is highly variable with many healthcare practitioners already using longer consultations or double appointments for people with

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				these assumptions. Intuitively and in practice structured care planning is likely to be time consuming and resource intensive if it is to address all of the issues set out in the guideline adequately. Furthermore the benefits assumed by professionals undertaking structured care planning do not consistently translate to benefits 'felt' by patients. See for example: 3) http://cssr.berkeley.edu/pdfs/QALTC_CarePlanDev.pdf 4) https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/215103/dh_133127.pdf It is our concern that if implemented as intended this guideline may consume considerable professional time, with unanticipated increased workload on primary care professionals, including GPs without translating to the intended benefits for people with multiple comorbidity. Consideration should be given to noting the importance of longer consultations for people with multi-morbidity and the potential that this may be in the longer-term have a net time benefit for health professionals.	complex needs. We did search for evidence to evaluate the clinical and cost-effectiveness of alternative formats of health consultations, including longer appointment times. However, no evidence was identified.
NHS England's South Central Medical Directorate	Short	8	27	Instead of 'prolonging life' – it should be 'life-prolonging interventions'.	Thank you for your comment. The GDG has considered your suggestion, but opted to retain 'lengthening life' in the list as they think this is clear. Please note, however, there are further edits within this recommendation. It now reads:

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					Encourage people with multimorbidity to clarify what is important to them, including their personal goals, values and priorities. The list of what this would include has also been expanded to add 'maintaining their independence'.
NHS England's South Central Medical Directorate	Short	10	1.6.17	Suggest adding a final bullet point 'documenting a personalised care plan'	Thank you for your comment. The recommendation now includes agreeing what will be recorded in the plan.
NHS England's South Central Medical Directorate	Full	General	General	Observation is around the EoL management. Understanding (and managing the consequences of) the relationship between multi morbidity and frailty at different points along frailty trajectories - particularly in advanced frailty transitioning towards end of life care - is an ever increasing challenge for primary care teams. There is still quite a bit of confusion in primary care about the similarities and differences between frailty and multi morbidity, the relationship between the two, and how to manage one in the presence of the other, most particularly towards the end of life. This would be a good opportunity to increase understanding and add some clarity to that debate, I completely support the suggestion of trying to develop some clearer linkage in this area.	Thank you for your comment. The GDG recognise the overlap between frailty and multimorbidity and in this guideline frailty is used as a marker for people who may benefit from an approach to care that takes account of multimorbidity and in whom burden of treatment should be assessed. The recommendations have been revised and include a definition of multimorbidity and this includes symptom complexes such as frailty or chronic pain as examples of what may constitute a long term health condition. The guideline however does not provide comprehensive guidance on management of people with frailty. Please see recommendation 1.1.1 which states: Be aware that multimorbidity refers to the presence of 2 or more long-term health conditions, which can include: • defined physical and mental health conditions such as diabetes or schizophrenia • ongoing conditions such as learning disability • symptom complexes such as frailty or chronic pain • sensory impairment such as sight or hearing loss • alcohol and substance misuse.

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NHS England's South Central Medical Directorate	Full	General	General	The framing of the paper is broadly biomedical and tends to defer to a paternalistic language ('provide patients with a care plan') and clinical outcomes rather than outcomes that matter to individuals. Preferred framing is with personal outcomes, wellbeing and independence. We are promoting a personalised approach whereby we want our workforce to support people to manage their own health and wellbeing and live independently in their communities.	Thank you for your comment. The GDG agree that it is important that clinicians agree decisions on care in collaboration with people with multimorbidity following discussions that include consideration of the person's values and preferences, as well as their priorities for the outcomes of treatment. This guideline includes recommendations to this effect. The wording of the recommendations has been altered following consultation to make the framing less paternalistic. Please see section 1.6 on 'delivering an approach to care that takes account of multimorbidity' and the subsection entitled 'agreeing the individualised management plan'. Specifically, recommendation 1.6.17 now states: After a discussion of disease and treatment burden and the person's, personal goals, values and priorities, develop and agree an individualised management plan with the person. Agree what will be recorded and what actions will be taken. These could include: • starting, stopping or changing medicines and non-pharmacological treatments • prioritising healthcare appointments • anticipating possible changes to health and wellbeing • assigning responsibility for coordination of care and ensuring this is communicated to other healthcare professionals and services

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					• other areas the person considers important to them • arranging a follow-up and review of decisions made. Share copies of the management plan in an accessible format with the person and (with the person's permission) other people involved in care (including healthcare professionals, a partner, family members and/or carers).
NHS England's South Central Medical Directorate	Full	General	General	Would NICE be able to provide a view on when there will be a revise/review the guideline (if not mentioned already) as there is sparse current evidence but there is a growing focus on multi-morbidity and therefore a rapidly developing area?	Thank you for your comment. Once published, all NICE guidance is regularly checked, and updated in light of new evidence if necessary. A formal check of the need to update a guideline is usually undertaken by NICE every 2 years, and is always undertaken at least every 4 years from the date of guideline publication. This seeks to identify recommendations that are no longer current or need to be revised. Further details on how guidelines are developed and updated can be found at: https://www.nice.org.uk/article/pmg20/chapter/1-Introduction-and-overview#choice-of-guideline-topics
NHS England's South Central Medical Directorate	Full	65	Table 17	Is there a typo on p65 in the last sentence of the table "elicit preferences only after the older adult with multi-morbidity"?	Thank you for your comment. This has been edited to read: 'Elicit patient preferences only after the older individual with multimorbidity is sufficiently informed'.
NHS Sheffield CCG	Short	General	general	The guidance is welcome as it will be helpful to HCPs when reviewing patients medicines and supporting joint decision making as patients life expectancy changes.	Thank you for your comment and for participating in the consultation process.
NHS Sheffield CCG	Short	3	18	Should patients with learning disabilities be included here?	Thank you for your comment. We have amended the guideline to clarify our definition of multimorbidity to include adults with learning disabilities.
NHS Sheffield CCG	Short	5	19	It would be useful to have a link to 1.8 to define what is included in medicines. Also to specify inhaler therapies are	Thank you for your comment. We have added the hyperlink as suggested and added inhaler as you suggest..

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				included.	
NHS Sheffield CCG	Short	4	25	Suggest re word individualised management plan to individualised care plan. Management plan has different connotations within our organisation and may lead to confusion. (See also p10 line 9,18 28)	Thank you for your comment. The GDG recognise that there is a general lack of consistency in how terms are used across health care. The GDG considered that individualised management plan most clearly represented their intention.
NHS Sheffield CCG	Short	5	17	Suggest add hyperlinks to explain how to access Q Admissions and PEONY	Thank you for your comment. It is not usual NICE practice to hyperlink to sites over which NICE do not have control.
NHS Sheffield CCG	Short	5	19,23,24	Good that specific numbers are given regarding how many regular medicines patients need to be on to benefit from a tailored approach for review.	Thank you for your comment.
NHS Sheffield CCG	Short	6	14	Suggest add hyperlinks to explain how to access PRISMA-7 questionnaire	Thank you for your comment. NICE does not usually include hyperlinks to sites that are outside NICE control as these may change.
NHS Sheffield CCG	Short	6	29	Starting line 29 to line 5 on page 7. Could these frailty assessment tools also be used in primary care and community settings, to simplify this section on how to assess frailty.	Thank you for your comment. The GDG wished to encourage the consideration of frailty and to provide tools for consideration of frailty in primary and community care settings where frailty may not usually be assessed. For this reason they chose to recommend simpler tests and tools in those settings with more advanced tests in setting where there may be more time and expertise.
NHS Sheffield CCG	Short	7	18	Insert additional parameter – identify change in treatments required in line with new evidence/ guidance	Thank you for your comment. The list provided is a list of examples aimed specifically to reduce treatment burden. Changes in line with new evidence do not necessarily come into this category.
NHS Sheffield CCG	Shor	9	26	It would be helpful to have examples either in the guidance or	Thank you for your comment. We will pass this information to

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	t			in the tools and resources to support implementation	NICE team for consideration for tools and resources to support the guideline.
NHS Sheffield CCG	Short	10	6	Bisphosphonates have been singled out presumably because this is the only one with evidence to support stopping. For clarity, could the reasons be included as to why other groups of drugs for example statins are not given firm recommendations.	Thank you for your comment. The scope for the guideline included reviewing evidence for the effect of stopping drugs. It had been envisaged that given the large number of people taking medicines such as statins and antihypertensives that such evidence would be available. There was however a lack of evidence to make a specific recommendation on stopping statins. This is discussed in the Full guideline.
NHS Sheffield CCG	Short	10	6	There is a risk that prescribers may interpret this section out of context and stop all patients on bisphosphonates after 3 years routinely. This does not appear to be consistent with NICE osteoporosis guidance.	Thank you for your comment. Current NICE guidance recommends the use of bisphosphonates but does not specify the duration of treatment. The GDG agrees that the level of evidence available does not support stopping all people after 3 years of use. However the GDG believes there is sufficient evidence to recommend a discussion over the evidence for the continued use of bisphosphonates beyond 3 years and the choice of stopping treatment. This is not inconsistent with the recommendations to initiate treatment in NICE TAs 160 and 161. The wording of the recommendation has been altered to clarify the GDG's position. Please see recommendation 1.6.16 which states: Tell a person who has been taking bisphosphonate for osteoporosis for at least 3 years that there is no consistent evidence of: • further benefit from continuing bisphosphonate for another3 years • harms from stopping bisphosphonate after 3 years of

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					treatment. Discuss stopping bisphosphonate after 3 years and include patient choice, fracture risk and life expectancy in the discussion.
NHS Sheffield CCG	Short	10	18	The plan needs to be communicated to other care providers, should care be transferred. This is not addressed in the guidance. (shared record preference)	Thank you for your comment. The recommendation has been re-worded following stakeholder consultation to include sharing of the plan as agreed with the patient.
NHS Sheffield CCG	Short	11	12	Reword 'develop a coordinated, integrated plan' to ONE coordinated etc	Thank you for your comment. This wording is taken from the NICE social care guideline Transition between inpatient hospital settings and community or care home settings for adults with social care needs.
NHS Sheffield CCG	Short	11	14	Putting this guideline into practice: Apart from line 15 and 16, this section is generic and applies to any NICE guideline. We question the value of its inclusion in the body of the guideline. We consider that this is a challenging guideline for HCPs to implement and requires a change in routine practice. More specific recommendations on addressing this issue would be welcome.	Thank you for your comment. We have added additional text following consultation.,
NHS Sheffield CCG	Short	13	9	Context: we suggest this section is moved to the beginning of the document and renamed introduction. This would clearly set the scene for the subsequent recommendations.	Thank you for your comment. The short version of the guideline is based on a standard NICE template. We will provide your feedback to NICE.
NHS Sheffield CCG	Database of treatment effec	general	general	This is a very useful resource to aid implementation. However, it mainly includes NNT. Further development to cover more NNH would increase its applicability, particularly when considering stopping medications.	Thank you for your comment. The GDG agrees that more information of NNH would be helpful but there is little evidence available on harms to allow this.

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	ts				
Patient Information Forum	Short	3	13	We are concerned that the wording of this recommendation may lead to some patients not being offered the tailored/personalised support that is outlined in this guideline. Evidence shows benefits of tailored (personalised) approach to all people with multiple long term conditions, and so the guideline should recommend it is an approach/option made available for ALL patients. (Whilst recognising that for the following groups there may increased benefit.)	Thank you for your comment. 'Consider' in the context of NICE recommendations, reflects the strength of the evidence and indicates that the GDG could not make a strong recommendation based on the evidence because the balance between benefits and harms was not definitive. The group has therefore, considered your suggestion but opted to leave the recommendation as originally drafted.
Patient Information Forum	Short	3	15	What measure will be used to assess patient ability to manage day today activities or treatments? Would tools / approaches (that have an evidence base demonstrating effectiveness) be included within the tools and resources section (referred to: page 11, line 15) to support practitioners?	Thank you for your comment. The GDG considered that many healthcare practitioners, particularly those working in primary care could make a qualitative judgement about which of their patients were likely to be appropriate for an approach to care that takes account of multimorbidity. The GDG felt that this was likely to be identified within clinical encounters.
Patient Information Forum	Short	4	3	We do not agree with using the word 'provide' here: the key to this approach is involvement and engagement of the individual (to ensure approach is tailored/personalised), any plan needs be developed with the patient rather than provided too them. There is much evidence about co-creation being key to ensuring 'plans' are appropriate and used (see for example Health Foundation resources on person-centred care).	Thank you for your comment. The recommendation has been reworded following stakeholder suggestions. Please see recommendation 1.5.1 in the NICE version which states: When offering an approach to care that takes account of multimorbidity, focus on: • how the person's health conditions and their treatments interact and how this affects quality of life • the person's individual needs, preferences for treatments, health priorities, lifestyle and goals • the benefits and risks of following recommendations from guidance on single health conditions • improving quality of life by reducing treatment

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					burden, adverse events, and unplanned care • improving coordination of care across services.
Patient Information Forum	Short	4	4	We feel that explicitly referencing these are 'patient identified goals' is important to emphasise that the goals and the plan must be owned by the patient (see National Voices resources on care and support planning).	Thank you for your comment. The GDG considered that later recommendations in the guideline e.g. recommendation 1.6.7 make this clear.
Patient Information Forum	Short	4	2	Plan needs to be created/delivered in an accessible format, see Accessible Information Standard, but also beyond groups covered in the Standard, to include consideration of language and other characteristics, if they are to be effective. Would this be covered in this section?	Thank you for your comment. The recommendation has been amended and healthcare professionals are now encouraged to: share copies of the management plan in an accessible format with the person and (with the person's permission) other people involved in care (including healthcare professionals, a partner, family members and/or carers).
Patient Information Forum	Short	8	13	As above 'patient preference' needs to include a consideration of communication needs, this should be explicitly stated.	Thank you for your comment. This aspect of care is included in the NICE Patient Experience guideline (CG 138).
Patient Information Forum	Short	8	14	This process is a journey, specifying "at the first point of contact" may not be appropriate.	Thank you for your comment. 'Point of contact' has been removed from the recommendation. Please see recommendation 1.6.6 in the NICE version, which states: Clarify with the patient whether and how they would like their partner, family members and/or carers to be involved in key decisions about the management of their conditions. Review this regularly. If the patient agrees, share information with their partner, family members and/or carers. [This recommendation is adapted from the NICE guideline on patient experience in adult NHS services.]

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Patient Information Forum	Short	5	5	Evidence exists around importance of building linking with community based organisations to engage with and reach wider numbers of parents: could this be included as an option here.	Thank you for your comment. The GDG discussed this suggestion but were unclear how it would fit with the recommendations.
Patient Information Forum	Short	7	16	Jargon: 'optimising care' 'reducing treatment burden': please use plain English to express these aims. Would another aim not be around increasing confidence to self manage or self care?	Thank you for your comment. The GDG has discussed your suggestion, but feel that 'optimising care' and 'reducing treatment burden' are clear. At the end of development, other versions of this guideline are created, and this includes the Information for Patients version of the guideline, which explains the recommendations in layman's terms. While the GDG agree that increasing confidence in self-management may be an aim for some people, it is not a specific aim of reducing treatment burden.
Patient Information Forum	Short	10	18	Plans should be created and provided in accessible format informed by patient preference. The owner of this individualised management plan should be the patient not the clinician. A digital version of the plan would enable constant update and review. Also need to ensure that the patient has understood what is being decided and what is contained in the plan. Checking understanding, and addressing poor comprehension when required, is an important step that is missing.	Thank you for your comment. General aspects of communication and information are included in the NICE guideline on Patient Experience (CG138). The recommendation includes agreement with the patient about what is recorded and actions taken is included in the recommendation.
Patient Information Forum	Short	11	3	A tailored approach to care should also take account a patient's communication needs (and those of their	Thank you for your comment. These aspects of care are included in the NICE Patient Experience guideline.

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				carer/families where appropriate).	
Patient Information Forum	Short	9	4	What tools are available to support clinicians in these conversations with patients where health literacy issues mean there experience difficulty understanding the questions asked of them? We would strongly recommend the 'tools and resources' section (referred to: page 11, line 15) links to evidence based tools that can support these conversations.	Thank you for your comment. The guideline did not examine evidence for tools to support conversations with patients with health literacy issues and so cannot provide specific recommendations for these.
Patient Information Forum		General		Health literacy has very serious implications for health inequalities and outcomes as people with low literacy skills are less likely to adopt positive health behaviours, access screening services, understand their disease or disclose additional health problems. It also limits their capacity to prepare for follow-up appointments and self-care. (Manning D & Dickens C (2006) Health literacy: more choice, but do cancer patients have the skills to decide? European Journal of Cancer Care, 15: 448-452)	Thank you for your comment and this information. The GDG acknowledges that poor health literacy has an impact on the extent to which people are active participants in their healthcare. This is true however for all people with poor health literacy and not only people with multimorbiditiy. The focus in the guideline is on face to face discussion and includes steps which the GDG consider will help to improve patient engagement for example eliciting people's views about their conditions and treatments and their values and preferences. This guideline makes explicit reference to the Medicines Adherence (CG76) guideline which includes recommendations for clinicians to consider training in communications to improve their ability to communicate these issues with patients.
Patient Information Forum		General		Study for National Voices assessed the evidence from 85 systematic reviews published since 1998 to summarise the	Thank you for your comment and this information. The guideline committee agree that tailoring information to the

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				best research evidence available about improving information and understanding. This found that one of the single most important things you can do to improve health information initiatives and to increase their impacts is to provide individuals with specific, tailored information and education. (National Voices (2014) Improving information and understanding)	individual is important, and this is reflected in the recommendations, please see recommendations in the sections of the NICE version listed below: • Section 1.5 **Principles of an approach to care that takes account of multimorbidity** • Section 1.6 **Delivering an approach to care that takes account of multimorbidity**
Patient Information Forum		General		Patient Activation Measure: see http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/supporting-people-manage-health-patient-activation-may14.pdf	Thank you for your comment and for this reference. Specific ways of engaging patients in decision-making was beyond the scope of this guideline.
Patient Information Forum		General		Health Literacy Action Plan Scotland: see http://www.gov.scot/resource/0045/00451263.pdf	Thank you for your comment and for this reference. We did not search for evidence to evaluate methods of addressing health literacy in people with multimorbidity, and so would not have included this reference. The GDG acknowledge that it is important that clinicians take into consideration health literacy of people with multimorbidity when discussing treatment, and have highlighted this in the relevant LETR (p. 250),
Patient Information Forum		General		Teachback (a technique for clear communication) Scottish Health Council: see http://www.scottishhealthcouncil.org/patient__public_participation/participation_toolkit/teach-back.aspx#.VzRmbPkrLIU	Thank you for your comment and for this reference. Specific ways of improving information and of engaging patients was beyond the scope of this guideline.
Public Health England (PHE)	Full	General	General	Drug and alcohol misuse and dependence need to be flagged more clearly both as co-morbidities in themselves and also as factors influencing compliance with treatment. Interactions between illicit drugs, alcohol and prescription and over-the-	Thank you for your comment. This guideline concerns the clinical assessment and management of people with multimorbidity, which necessarily includes people with a variety of long-term conditions, including drug and alcohol

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				counter medicines also need to be considered.	dependence. Within the scope of this guideline, it is not possible to make comprehensive recommendations for the care of people with drug and alcohol dependence. NICE has previously published guidance specifically on the care of people with drug and alcohol dependence . We have added a recommendations and a section to' terms used in this guideline' to explain what we mean by multimorbidity and this includes alcohol and substance misuse in this. Please see recommendation 1.1.1 which states: Be aware that multimorbidity refers to the presence of 2 or more long-term health conditions, which can include: • defined physical and mental health conditions such as diabetes or schizophrenia • ongoing conditions such as learning disability • symptom complexes such as frailty or chronic pain • sensory impairment such as sight or hearing loss • alcohol and substance misuse.
Royal College Of General Practitioners	Short	General	General	The RCGP welcomes the opportunity to comment on the draft NICE guideline March 2016. The provision of effective, person centred care to patients with multimorbidity is a key part of creating a modern 21st century NHS and is a challenge in which general practice is very much at the forefront. This was	Thank you for your comment. We agree that there are a number of important areas for consideration in care of people with multimorbidity. This guideline addresses the assessment, prioritisation and management of care but not how specific interventions may have different outcomes in

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				reflected when the RCGP Council adopted the development of measures to incentivise the provision of patient-centred care to those living with multimorbidity as one of its policy and campaigns priorities for 2015/16. Those living with multiple long-term conditions have to manage the burden of their illnesses. Patients often have to change their behaviour as a result of their illnesses and at times have to influence the behaviour of others to fit in with the lifestyle shaped by their conditions and treatment. Where factors such as frailty, manual dexterity, low health literacy and cognitive impairment occur alongside multimorbidity, the burden of illness is greater. The treatment of multiple long-term conditions also involves a great amount of effort and time from patients. Patients and their carers have to collate clinical information on their health and input this into administrative systems, attend appointments and understand their test results, all of which have an effect on quality of life for patients, their families and their carers. They have to navigate through specialised care, where at times specialists don't know what other specialists are doing. Whilst aspects of the current system are set up to maximise clinical outcomes, much of the current system actually makes it difficult for those in primary care to prioritise what matters most to patients and their lifestyle. As a result of the experience of patients with multiple long-term	people with multimorbidity. The GDG agree on problems of disease and treatment burden and sought to address this in the recommendations. Please see recommendations 1.6.3 and 1.6.4 in the NICE version of the guideline, which state: Establish disease burden by talking to people about how their health problems affect their day-to-day life. Include a discussion of: • mental health • how disease burden affects their wellbeing • how their health problems interact and how this affects quality of life. Establish treatment burden by talking to people about how treatments for their health problems affect their day-to-day life. Include in the discussion: • the number and type of healthcare appointments a person has and where these take place • the number and type of medicines a person is taking and how often • any harms from medicines • non-pharmacological treatments such as diets, exercise programmes and psychological treatments • any effects of treatment on their mental health or

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				conditions in the current health system the College welcomes the introduction of NICE's guidelines on multi-morbidity. The College has some general comments on the guidelines which are listed below: Harms of therapy and overtreatment The guideline recognises the potential harms of therapy and the need to be prepared to reduce and stop treatments when the health gain is small and the quality of life may be diminished. The RCGP feels the guidelines could explore in more detail lifestyle interventions, with these being considered before the use of medications in certain cases. This allows health care professionals to play more of a role as a lifestyle dispenser and health coach, encouraging a shift in culture from one of medication focus to that of behavioural change. Deprivation The RCGP feels that the draft guidelines do not acknowledge the role that deprivation can play in the prevalence of multimorbidity. The RCGP feels that there should be more reference to social care and other wider determinants of health, such as housing and social isolation, which all impact on health and wellbeing. There is research which suggests that in deprived areas multimorbidity occurs 10-15 years earlier than in affluent areas. It is important to recognise that multimorbidity is linked to deprivation, not age alone. Terminology	wellbeing. The scope for this guideline included the evaluation of the effectiveness of service-level and self-management

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				The RCGP feels that terms like "tailored care" and "management plans" give the guidelines a paternalistic doctor-centric feel, reading as if the health care professionals would develop the plan rather than it being the product of a collaborative decision making process with the individual. The RCGP recommends terms such as an individualised/personalised care plan as alternatives. As these guidelines begin to embrace person centred coordinated care it would be helpful to reference The Health Foundations four principles of person centred care: - Affording people dignity, compassion and respect; - Offering coordinated care, support and treatment; - Offering personalised care, support and treatment; - Supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life. The RCGP feels that when talking about tailored approaches or individualised/ personalised care plans the document should refer to all patients with multimorbidity, all patients with only one chronic condition, and all patients with acute problems as well, not just to some patients. The implication that it only applies to some patients appears in various paragraphs. The proposed approach in the draft guidance will make it less likely that clinicians will adopt a tailored approach, since it will depend on them remembering to apply it to some patients; whereas if standard practice it will be offered to all.	interventions to improve the care of people with multimorbidity. We agree that there are a number of important areas for consideration in care of people with multimorbidity. However, within the scope of this guideline, we were not able to include evidence evaluating the effectiveness of lifestyle interventions. The GDG are aware of evidence that multimorbidity is more prevalent amongst people from deprived backgrounds; this is noted in the introduction to the guideline. Considering the socioeconomic determinants of multimorbidity is however outside the scope of the guideline. Following stakeholder comment the wording of some of the recommendations has changed to remove any suggestion of paternalism. The GDG preferred to continue with the term individualised management plan as the emphasis in the guideline is on clinical care and terms such as care plan have specific meanings in other setting.

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				Patient Decision The RCGP suggests that it would be valuable to have specific tools for helping with Shared Decision Making (SDM) for those living with multimorbidity and information for patients and carers about how to help with these choices. The RCGP would like to see greater mention in the guidance of how a person's health literacy, activation and capabilities would be assessed and how this could have an impact on the development of any care plans. The value in establishing these, for a health care professional is to support people to become active self managers of their health and wellbeing rather than being seen as a passive recipient of a medical solution. The RCGP also feels it would be of benefit to those in primary care to highlight the importance of continuity of care in patient decision making, and relationship building between patient and doctor. Resources The RCGP feels there is potential for tools and resources to be developed to support adoption of the guidelines in practice. The RCGP and Coalition for Collaborative Care have already developed guidelines on Collaborative Care and Support Planning alongside the House Of Care, which could be referenced as a guide for health professionals.	The GDG agree that the approach may be appropriate for many people with one condition only but there are specific issues for people with complex multimorbidity for whim this guideline is intended. The GDG has made a recommendation which encourages clinicians to include the person with multimorbidity in discussions related to their care and to provide them with copies of any specific management plan that has been agreed. The group has also developed a database of treatment effects, which was also subject to consultation. The use of decision aids where these are available is already recommended in NICE patient Experience guideline (CG138). The guideline committee were not aware of any decision aids that address issues of polypharmacy and multimorbidity. The GDG considered that health literacy is an important issue but that it is not specific to multimorbiditiy. The GDG are aware of evidence that patient activation may impact on the likelihood that people will engage in health behaviour, however this evidence was not considered for this

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				Carers The RCGP feels that there is not enough reference to and consideration of the role of carers. The RCGP has produced a range of resources to support carers, accessible at www.rcgp.org.uk/clinical-and-research/clinical-resources/carers-support.aspx Safeguarding As a significant number of people with multimorbidity may have cognitive impairment the Mental Capacity Act needs to be considered. Safeguarding considerations should also be taken into account as well, including the opportunity to see adults only to check for disability hate crime.	guideline. It was also beyond the scope of this guideline to evaluate methods of assessing for patient activation. The GDG believe that empowering people with multimorbidity in managing their conditions is important, and suggest ways in the LETR for this review how clinicians can seek to empower people with multimorbidity within their consultations. The GDG agree that ensuring continuity of care is important when providing care for people with multimorbidity. Based on evidence that a lack of continuity of care can be a barrier to optimal care for people with multimorbidity, the GDG have made a recommendation that clinicians should agree responsibility for coordinating care, and ensure this is communicated to all clinicians involved in the person's care. Thank you for highlighting these resources that the RCGP has developed. Within the guideline, we sought for evidence that evaluated the effectiveness of models of care, including collaborative care and support planning, to support people with multimorbidity. Within this guideline, we did not find sufficient evidence to support a specific recommendation on the use of any model of care for people with multimorbidity. These documents were also not relevant for inclusion in this review. Therefore we are not able to recommend specific reference to these documents. Patient and carer experience of care is included in the

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					outcomes when evidence was examined. The guideline development group has considered the role of carers when making their recommendations, however specific carer assessment and specific interventions for carers is beyond this guideline's remit. All NICE guidelines include an introductory paragraph on patient centred care which makes explicit reference to capacity and the Mental Capacity Act.
Royal College Of General Practitioners	Short	Question 1	Question 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? Any costs that arise as a result of the guidelines will not be substantial, and any financial implications that do occur are justified. It is important to note that where increases in costs do occur it is likely that this will be counterbalanced by savings elsewhere. The College would also like to highlight that the GP Forward View allocated funding to offer patients with multiple long-term conditions longer consultations, as well as tackling the issues facing general practice such as workforce shortages and unmanageable workload. With regard to financial implications of the guidance, it is likely that many of the recommendations will be realised through longer consultations. For example, understanding a patient's disease and treatment burdens, the establishment and recording of patient preferences, values and priorities, medication reviews and the development of individualised	Thank you for participating in the consultation process and for your view that any costs that arise will not be substantial. The information you have provided in your comment will assist the NICE resource team with considering the areas which will have the biggest impact on practice and the areas that will be the most challenging to implement.

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				management plans will all take additional consultation time. This has potential to increase cost due to sheer number of patients living with multiple long-term conditions in comparison with the current GP workforce. The development of information systems which can identify markers of increased treatment burden or adverse events, by monitoring number of medicines a person is prescribed and the number of unplanned emergency care admissions, and which can help to ensure advanced care planning, will also require funding. Increased costs may also occur as secondary care adapts to improve access to the skills of a medical generalist. This is particularly the case in the care of the elderly, care of children and adults with mental health problems and in diagnostics – such as radiology. The College welcomes the recommendation of a comprehensive assessment of older people with complex needs at the point of admission to hospital; however, this is likely to have financial implications. The College recommends that named care navigators be adopted to prevent patients and carers from having to make numerous trips to appointments, and these too will take time and money to implement. The guidance's recommendations for research are likely to result in an increase in costs. The College welcomes the acknowledgement that current primary care is not structured to prioritise the needs of patients living with multiple long-term conditions and that continued research is needed to provide	

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				alternate ways of caring for this group. Large trials into defined patient groups living with multiple long-term conditions would have particular financial impact, as would trials into community holistic assessment, stopping preventive medicines and predicting life expectancy.	
Royal College Of General Practitioners	Short	Question 2	Question 2	Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. Although an activity GPs do on a daily basis, reviewing medicines and other treatments may be an aspect of the guidelines which is challenging to implement. Whilst GPs are expert medical generalists it is extremely difficult to know how different drugs recommended for individual diseases will interact. Despite the introduction of these guidelines, all other guidelines remain single disease focused. It would be impossible for a guideline to list how different illnesses and medications interact; however, at times GPs can struggle to establish what is best for each patient. This is especially the case where GPs are reviewing medications prescribed in secondary care. Furthermore, a broader view also needs to be developed as to what is included when making judgements about drug effectiveness. Whilst trials may show a drug to be successful, in patients with multi-morbidity there are more factors at play. Where factors such as frailty, deteriorating manual dexterity, low health literacy and cognitive impairment occur alongside multi-morbidity, is the task of medication review is more	Thank you for your comment. The information you have provided in your comment will assist the NICE resource team with finalising the guideline. This will help the team to consider the areas which will have the biggest impact on practice and the areas that will be the most challenging to implement. The GDG agree that reviewing medicines and treatments is a regular part of what GPs do every day and acknowledge that GPs may require additional training to consider all the factors involved. The GDG hope that the guideline will empower GPs to use their judgement as required. The GDG recognise the current challenges facing primary care but agree with your comment 326 that this guidance may any costs would be counterbalanced by savings elsewhere.

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				difficult. GPs may need additional support or training to gain greater knowledge and understanding of medication interactions and their influencing factors. GPs may also need more support in identifying non-pharmalogical treatments that are available to patients. It should also be noted that the impact of physical and mental long term conditions can pose a challenge for those working in general practice and may have implications for the implementation of some aspects of the guidelines. Despite the fact that long-term physical and mental health conditions are common there are few studies that review the effects of physical and mental health morbidity on each other. The stigma around mental health issues is also a challenge when managing multimorbidity. Patients with physical conditions may choose not to disclose their mental health conditions, which can make treating their illnesses difficult for a GP. The guidelines do not highlight the complications that physical and mental health conditions can pose and the how combination could make it difficult for GPs to realise some aspects of the guideline such as establishing patient preferences, values and priorities. From a patient and carers' point of view a lack of resources for patients living with multiple long-term conditions may hinder the adoption of these guidelines. A single disease focus on material for patients and a lack of information to support patients in shared decision making could make it difficult for	

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				patients to easily developed tailored care plans or establish their priorities. Whilst patients may experience treatment burden, they may also struggle to understand why medication is being stopped and may not be able to associate different symptoms with the different medications they take. Whilst the pointers to help put the NICE guidelines into practice are helpful, some practices may struggle to find the time and capacity, or have the skillset, to implement some of these recommendations. For example, in light of current workforce and workload challenges practices may struggle to carry out baseline assessments, consider the data needed to measure improvement and identify a person to champion the guidelines. Lack of time will act as a barrier to realising many aspects of the guidelines that will make most impact. General practice is currently facing a workload and workforce crisis and for the guidelines to be successfully implemented more will need to be done to tackle these challenges to give general practice time to prioritise the care of those living with multiple long-term conditions.	
Royal College Of General Practitioners	Short	Question 3	Question 3	What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) The recent introduction of the GP Forward View is a great step towards tackling some of the barriers facing GPs in England in caring for patients with multiple long-term conditions; however, the benefit of the GP forward view will not be felt overnight.	Thank you for participating in the consultation process. The information you have provided in your comment will assist the NICE resource team with finalising the guideline. Your comments will help the team to consider the areas which will have the biggest impact on practice and the areas that will be the most challenging to implement.

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				Longer consultations Longer consultations would help in addressing some of the challenges discussed. This approach would enable patients with multiple long-term conditions to have more time to discuss their complex conditions with their GP. A study by Mercer et al. (2007) in Scotland found that patients in the most deprived areas had more problems to discuss (especially psychosocial), yet clinical encounter length was generally shorter – at 8.2 minutes on average compared to 8.6 minutes in more affluent areas. Further research in Scotland that looked into the impact of longer consultations in deprived areas found that an increase in consultation length for patients with complex needs to an average of 15 minutes was associated with enhanced levels of patient enablement. The study34 recommends that 15 minute consultations should be standard for patients with multimorbidity, and suggests that more integrated working would free up time to allow this to happen. Interface Better communication at the interface between primary and secondary care could assist in overcoming some of the	

[34] Mercer S, W., Watt, G. C. M. (2007). The Inverse Care Law@ Clinical Primary Care Encounters in Deprived and Affluent Areas of Scotland. Annals of Family Medicine. Available at: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2094031/

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				barriers which could hinder the adoption of NICE's multimorbidity guidelines. As patients transition between primary and secondary care, and different sectors of the healthcare system, information can be lost and healthcare professionals may not be aware of the actions and decisions taken by those from other sectors. The development of improved electronic health record systems have the potential to develop and shape new ways of clinical working at the interface between primary and secondary care. Advanced health record systems could search for previous changes in medication, alert GPs and specialists to potential adverse medical interactions and also calculate risks versus benefits for certain patient interventions35. In addition structured Electronic Date Interchange (EDI) of hospital letters to GPs and GPs to hospital would save both systems having to scan and code documents. At present GP practices have a large bureaucratic burden of scanning and coding records in order to maintain a patient's summary and identify active or past problems. Without this primary care produced summary, primary and secondary care will both be unable to manage patients with multimorbidity effectively. Similarly once a patient is discharged from hospital there is	

[35] Dawes M. (2010). Comorbidity: we need a guideline for each patient not a guideline for each disease. *Family Practice*. Available at: http://www.ncbi.nlm.nih.gov/pubmed/20081211

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				considerable work in primary care for the GPs to reconcile the discharge medication and ensure any discontinued medication is removed from the repeat medication list to prevent confusion and mistakes in medication. Support for medication reviews Those in general practice would benefit from support when prescribing new medicines or completing medication reviews. Technological developments could support doctors when prescribing multiple medications by highlighting potential risks36. Online systems recording numbers to treat, for example, or duration for which medication should to be taken, could ensure that patients have the greatest chance of positive health outcomes. In Scotland, the NHS and the Scottish Government have already developed a decision making tool designed to aid those caring for patients with multiple long-term conditions. The App identifies 7 steps intended to provide a clear structure for the medicine review process. This process is focused on the needs of the patient and encourages communication between doctor and patient to identify non-pharmalogical solutions in addition to medicine related ones. Additional research	

[36] Marengoni A and Onder G. (2015). Guidelines, polypharmacy and drug-drug interactions in patients with multimorbiidty. *British Medical Journal.* Available at: http://www.bmj.com/content/350/bmj.h1059

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				Patients with multiple long-term conditions are often excluded from single disease clinical research, in order to ensure there are no influencing external factors. This method of research aims to understand how to treat an 'average patient'. As a result there is little evidence base for patients with multiple long-term conditions, yet it is often patients with multi-morbidities to whom the findings of this research are applied. As the guidelines suggest, more research is needed to support those in general practice when caring for patients with multiple long-term conditions. More broadly there is a lack of research into the ways in which professional practice can be developed and services designed to provide the most effective care to patients with multi-morbidity. It is fundamental that more research is conducted into meeting the needs of patients with multiple long-term conditions, alongside influencing factors such as socio-economic deprivation, condition severity, frailty and vulnerability37i. In addition better understanding is required of how clinicians and patients use research evidence, and how this feeds into clinical communication, diagnostic options and shared decision making38.	

[37] Smith S, Fortin M, Hudon C, O'Dowd T (2012). Managing patients with multimorbiidty: systematic review of interventions in primary care and community settings. *British Medical Journal.* Available at: http://www.bmj.com/content/345/bmj.e5205
[38] Greenhalgh K., Howick J and Maskrey N. (2014). Evidence based medicine: a movement crisis? *British Medical Journal*. Available at: http://www.bmj.com/content/348/bmj.g3725

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				Furthermore, where research is conducted it is often led by those with vested interests in the study outcomes. The drug and medical services industry plays a large role in clinical trials, and is often responsible for defining an illness and the levels of benefit at which a drug is deemed to be successful39. This makes it difficult for clinicians to establish if an intervention is suitable for an average patient, let alone for patients with multi-morbidity. Drug effectiveness can only be judged in terms of what is effective for the patient, not solely in term of numbers to treat or harm and placing greater emphasis on what is important to patients in research is needed. Training Education needs to move away from the current approach of focusing on single diseases and move towards holistic care, preferably in the patient's own setting and context, with a focus on influencing factors such as frailty. Training should ensure health care professionals recognise that the needs of the patient are the priority and not the illness itself, alongside ensuring that the patient is involved in making shared decisions which enable them to self-manage. Training also needs to address the ageing population and how the role of	

[39] Greenhalgh K., Howick J and Maskrey N. (2014). Evidence based medicine: a movement crisis? *British Medical Journal*. Available at: http://www.bmj.com/content/348/bmj.g3725

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				GPs is increasingly similar to that of a geriatrician. Added to this, trainees need more practice in negotiating management and treatment plans with patients and better understanding of the issues affecting compliance and how to rationalise medication regimens to ensure optimum uptake and reduce over medicalization. Such training should assist in the implementation of NICE's guidance.	
Royal College Of General Practitioners	Short/Full	General	General	One of the most important things to do is to recognise and code these patients as multi-morbid. The RCGP feels the importance of coding is missing from the current version of the guidelines. The RCGP does not agree with the assumption that elderly have to be frail as mentioned in the document. The issues may be different for younger people e.g. a pregnant woman with diabetes and depression.	Thank you for your comment. The GDG consider that not all people who are multimorbid require the approach laid out in this guideline and are therefore unsure whether coding as multi-morbid would be helpful. The guideline does not make the assumption that the elderly have to be frail- the recommendations for assessment of frailty include recommendations for people under 65 years. The GDG agree that the issues may be different for people at different ages and with different combinations of conditions which is why the guideline provide broad principles and approaches.
Royal College Of General Practitioners	Short/Full	General	General	A standard form to document patient's preferences values and priorities would also be of assistance in providing care for patients living with complex needs. Advanced care plans should come in a standard format so that patients, their carers and health and social care professionals can recognise them.	Thank you for your comment. While the GDG agree that standard forms and formats can be useful to identify documentation around patient preference and care plans, specific recommendations on which forms should be used for these purposes was beyond the scope of this guideline. The

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				The introduction of a national patient held record such as this one http://www.pilgrimshospices.org/wp-content/uploads/My-advance-care-plan.pdf or the RCGP North Ireland health care passport http://www.rcgp.org.uk/rcgp-nations/rcgp-northern-ireland/my-healthcare-passport.aspx would also be of benefit to both GPs and patients.	GDG also note that discussion of patient preferences/values need not involve formal documentation.
Royal College Of General Practitioners	Short/Full	General	General	Rare diseases need to be mentioned with signposting for resources for GPs, patients and their carers	Thank you for your comment. The GDG agrees that rare diseases are a component of multimorbidity for some patients. However within the context of this guideline it is not possible to signpost to resources for each category of long term condition.
Royal College Of General Practitioners	Short/Full	General	General	The RCGP welcomes the inclusion of the database of treatment effects and guide as this sort of information is critical in tailoring treatment. However: - It is not immediately obvious that it exists – it should be very prominent - The format is fiddly and non-intuitive – some investment in design would result in greater usage. - The case study in the guide document is a good idea. Some more of these would be helpful – perhaps presented as Powerpoints to use as teaching and dissemination aids. A handful of cases illustrating different dilemmas would be good.	Thank you for your comment. The GDG agrees that the format has limitations. Unfortunately no further resource is available to fund development of a web-based tool or equivalent. However the data is open source and there is potential for the incorporation of the data feeding the tool into more user-friendly formats. The GDG agrees that case studies are useful to explain the intended use of the database and will pass your comments to NICE.
Royal College Of General Practitioners	Short	3	13	This guidance is useful and timely as it ties in with current work on Long Term Conditions. However, it generally lacks detail and guidance on recommendations for its implementation in practices or CCGs. It would be helpful to have examples of the definitions of what diseases are being referred to as multimorbidity. Diabetes or	Thank you for your comment. A recommendation has been added to highlight that multimorbidity refers to the presence of 2 or more long term health conditions and examples of the types of conditions, symptoms and impairments that this includes have been listed.

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				Osteoarthritis may be obvious, but it should also include another disease like Coeliac disease. Inclusion of recommendations for metrics for assessment would mean that people do not need to come up with their own which may not be appropriate or practical.	
Royal College Of General Practitioners	Short	4	14	The RCGP welcomes the list proposed but feels that the following statement should come at the top: 'Establish patient preferences, values and priorities (see recommendations 1.6.6 to 1.6.8).'	Thank you for your comment. The GDG has considered your suggestion but opted to leave the bullet points in the order in which they were originally drafted. The GDG considered that explaining the aims of review to the patient was a necessary first step to ensure clear understanding between professional and patient.
Royal College Of General Practitioners	Short	5	5	It is unclear why this approach is only for some patients. In particular, we have the following specific comments: 1.4.2 GPs are fully aware of which patients are at risk for these two reasons. 1.4.3 Why 15? It would be appropriate to provide some evidence/reason. 1.4.4 The RCGP feels that it may be useful to include also patients who are prescribed fewer than 10 regular medicines. Patients should not be denied the opportunity to take an active role in their care. The RCGP considered that all patients would benefit from, and should receive, a tailored approach to care. Doctors should not therefore identify patients who may benefit from a tailored approach to care. In addition, the RCGP does not see any evidence of analysis of the opportunity cost of differentiating in this way. Identifying	Thank you for your comment. Recommendation 1.4.2 (now numbered 1.3.2 after edits) is about using electronic records to identify these patients. The GDG acknowledge that many of these patients may be known individually to GPs but there are likely to be some who are not and using electronic records ensures these patients can be flagged. The supporting evidence for the recommendation 1.4.3 is in the Full guideline in chapter 7. The GDG agree that people on 10 or more drugs or 4 to 9 drugs with other risk factors may be at risk. The review of evidence did not find any strong evidence supporting precise cut-offs in terms sensitivity and specificity for predicting adverse events. However in general greater numbers of medications were associated with higher levels of risks. The

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				people who may benefit from a tailored approach to care would take 40-60 minutes complete. SPARRA data has been used in Scotland to help health care professionals to prioritise and identify patients with complex care needs who are likely to benefit most from anticipatory health care. The RCGP is aware that this tool has been really controversial and some GPs have found it inaccurate and not useful.	GDG felt this represented a strong indication to consider those taking 15 or more drugs as at high risk and a weaker, but still genuine, indication to consider those taking 10 or more drugs as at risk. This assessment is reflected in the language of the recommendations, which advise readers to consider using an approach to care that takes account of multimorbidity in the population taking 10 or more drugs or less than 10 but who are for some reason at particular risk of adverse events. These recommendations are not meant to restrict the population in whom this approach could be used, but to help identify those for whom it is most likely to be beneficial. The GDG are aware that performance of risk tools is an important consideration when making a decision to use them and this is discussed in chapter 7 of the Full guideline.
Royal College Of General Practitioners	Short	5	23	The bar of 10-15 medications may be too high and that medication adherence also needs to be taken into account here.	Thank you for your comment. The GDG noted that the evidence demonstrated that people taking 15 or more drugs may be at significantly higher risk of unplanned hospital admissions and agreed via consensus that they may also be at increased risk of mortality. On this basis the GDG agreed that people taking 15 or more drugs would benefit from an approach to care that takes account of multimorbidity and this can be considered on the basis of the number of drugs alone, independent of other risk factors. The GDG agree that some people prescribed less than 15 medications will still benefit from an approach to care that takes account of multimorbidity, hence the recommendation to consider this approach in those prescribed 10 to 14 medications and in

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					those using less than 10 but who are at high risk for other reasons. These recommendations do not override recommendation for medicines review and optimisation in other NICE guidance which address issues of adherence. (Please see CG76, the Medicines adherence guideline).
Royal College Of General Practitioners	Short	6	1	We appreciate that the PRISMA 7 is well validated. However, following analysis of the results of 600 PRISMA 7 questionnaires that some patients have completed in a specific practice, there is a huge amount of over-diagnosis of "frailty". Some patients with a PRISMA 7 scoring 3 or more do not consider themselves frail.	Thank you for your comment. We are aware of the limitations of the Prisma 7. However, on the balance of the evidence available the GDG considered its performance was adequate to help identify frailty in adults with multimorbidity aged 65 years and over.
Royal College Of General Practitioners	Short	6	5	Helpful advice to assess frailty, though giving specific instructions for which instruments to use does not add any value. The Edmonton scale is most popular in general practice but is not mentioned in this guidance. The guidelines refer to: 'self-reported health status (that is, 'how would you rate your health status on a scale from 0 to 10?', with scores of 6 or less indicating frailty)'. We consider that asking patients with long-standing pain to assess pain on a scale of 0-10 will not yield a useful answer. This could lead to subject bias depending on temperament, past experience, social networks etc. It would be useful to set out a range of options for the assessment of frailty so GPs can decide what to use.	Thank you for your comment. The Edmonton scale was not known to the GDG nor found in the literature search which looked for validated tools. The GDG recognise that different tools may be of use for different patients and settings which is why a range of tools is included.
Royal College Of General Practitioners	Short	7	14	These few sections outlining tailored approach to care contain very good content but make it sound like this is something that happens as a discrete event, announced to the patient and	Thank you for your comment. The recommendations do include the need to consider follow up and review. Please see section 1.5 of the NICE version,

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				their carers. This might occasionally happen, but it is more likely to be an ongoing and evolving process over years, during which this principles can be applied. As such, the way in which the approach is portrayed feels too prescriptive.	entitled 'principles of an approach to care that takes account of multimorbidity'. Section 1.6 on 'delivering an approach to care that takes account of multimorbidity' also addresses this. Following stakeholder consultation the wording and ordering of the recommendations has been changed to reduce any impression of a clinician driven process.
Royal College Of General Practitioners	Short	7	15	The RCGP feels that the purpose of this statement is to explore what is best for the individual, according to their own values, hopes etc. The RCGP agrees that the purpose of individual care 'tailored care' is to improve the quality of life, not necessarily reducing the treatment burden, though this may also happen. It may be appropriate to use 'disease and treatment and care' instead of 'disease burden'.	Thank you for your comment. The recommendation has been edited to emphasise improvement in quality of life as follows: Discuss with the person that the purpose of the approach to care is to improve quality of life. The GDG considered that 'treatment burden' is the appropriate phrase in this recommendation as this is the area most likely to be amenable to change.
Royal College Of General Practitioners	Short	8	10	The RCGP notes there is no evidence that treating anxiety/depression in people with multi morbidity is the same as for those without. It may be dangerous to assume that they need the same treatment.	Thank you for your comment. The GDG accept that there is not specific evidence to guide many aspects of care for people with multimorbiditiy. The NICE guideline on common mental health disorders provide pathways to care and this includes reference to NICE guideline on Depression in Adults with a Chronic Physical Problem.
Royal College Of General Practitioners	Short	8	14	There will be a need in Primary Care to clearly record the persons consent to discuss their care with a carer or next of kin. A note should also be made of the contact details of those individuals. Regular recording of weight, sight and hearing status should be undertaken.	Thank you for your comment.

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Royal College Of General Practitioners	Short	8	20	It should be recognised that not everyone has 'priorities' that can be neatly categorised. This will lead to goal setting and feelings of failure for some. A Holistic Needs Assessment Tool has been created and well tested by Macmillan Cancer Support as part of the development of the Recovery Package. This could be transferrable for use in people with multimorbidity as many of them will also have a cancer diagnosis as one of their co-morbidities. There has been experience in carrying out this needs assessment on paper and on tablet form - see http://www.macmillan.org.uk/aboutus/healthandsocialcareprofessionals/macmillansprogrammesandservices/recoverypackage/holisticneedsassessment.aspx Use of pre-existing tools will facilitate the spread and uptake of this assessment.	Thank you for your comment. Thank you for the information about the Macmillian tool. Within the evidence review for the guideline we sought evidence for the effectiveness of an intervention that comprises of holistic assessment followed by the development and action of an individualised care plan to improve outcomes for people with multimorbidity. To be relevant for inclusion, any intervention that included a holistic assessment would be included, provided that the assessment took into consideration physical, mental, functional, and wider wellbeing and social considerations. The assessment should also be followed by the development of a care plan (i.e. it is not enough that an assessment is conducted, but that this assessment should be used to inform care). We looked for evidence of the impact of the intervention on clinical outcomes for people with multimorbidity; including quality of life and function. The document you have referenced regarding the Macmillan assessment tool does not meet our inclusion criteria as a primary research study, and we did not find any randomised clinical trials that evaluated the impact of using the Macmillan assessment tool on clinical outcomes for people with multimorbidity. As a consequence, this tool is not considered within this guideline. The GDG recognise that this is an important area and have made a research recommendation in this area.
Royal College Of General Practitioners	Short	9	1	The RCGP recommends talking also about harms and impacts, not just benefits.	Thank you for your comment. This recommendation has been amended and now reads: Explore the person's

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					attitudes to their treatments and the potential benefits and harms of those treatments.
Royal College Of General Practitioners	Short	9	5	The RCGP welcomes this database and finds it useful. The guideline could also reference the database of individual patient experience that might help patients clarify their own preferences. (http://www.healthtalk.org/)	Thank you for your comment. We will pass your comment to the NICE team for information when considering resources to support the guideline.
Royal College Of General Practitioners	Short	9	17	The RCGP feels that this should be referred to as an n=1 trial and pharmaceutical companies should be asked to provide easy access to placebo treatments for individual trials.	Thank you for your comment. The GDG recognise that this could be referred to as a n=1 trial but consider the current description more useful in practice. It is outside the scope of guideline development to make recommendations to pharmaceutical companies.
Royal College Of General Practitioners	Short	9	23	It would be useful to explain that e.g. antihypertensives/statins are designed to provide benefit over 5+ years and should be reconsidered if lifespan is unlikely to exceed this.	Thank you for your comment. The GDG agree that this is the type of information that may be appropriate to discuss with patients.
Royal College Of General Practitioners	Short	11	14	It is unclear how much of this can be measured, and what measurements would demonstrate good improvement. There is no acknowledgement here that the need to gain QOF points is likely to inhibit the kind of approach that the guideline seems to be advocating. This problem needs to be addressed directly, in order to encourage a tailored approach.	Thank you for your comment. The GDG acknowledge the effect of pay for performance measures and hope that this guideline will contribute to a different approach to people with multimorbidity.
Royal College Of General Practitioners	Short	14	7	The RCGP would like to highlight how hard it is to assess accumulated benefit and harm for patients with multimorbidity. There is not access to the data that would be required to do this.	Thank you for your comment. The GDG agree that there is very little evidence regarding the benefit and harm of medications specifically in population of people with multimorbiditiy.
Royal College Of	Full	79	5	These two pages contain statements that are contradictory.	Thank you for your comment. The GDG do not agree that

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General Practitioners		and 173	1	The statement in the first point under "improving quality of life by reducing treatment burden" is not supported by page 173 that says 'no relevant clinical studies investigating the prognostic accuracy of polypharmacy for predicting reductions in health-related quality of life were identified.'	these statements are contradictory. No evidence was identified that evaluated the prognostic accuracy of polypharmacy to identify people who will experience future reductions in quality of life. However, this does not mean that polypharmacy does not affect quality of life or that it is not associated with a risk of future reductions in quality of life. Indeed, qualitative evidence identified in this guideline suggests that the complexity of treatments received by people with multimorbidity may affect quality of life. The GDG also note that polypharmacy and treatment burden are separate constructs; polypharmacy refers to the number of medications a person is taking, while treatment burden relates to the impact of treatment on a person's wellbeing. A person may be taking many medications but have low levels of treatment burden, while a person taking a small number of medications may still experience burden.
Royal College Of General Practitioners	Full	103	Second paragraph	Pharmacists might deserve a particular mention when considering/identifying persons receiving multiple medications who might benefit from a more tailored approach to care.	Thank you for your comment. The GDG agree that pharmacists are likely to have a role in this process. We have not specified which healthcare professionals are involved and have altered the information in the context section of the short guideline to make this clear.
Royal College Of General Practitioners	Full	225	13	Does assessment of all treatments taken by patient to assess which could be stopped include assessment of over the counter (OTC) medicines a person is taking? Professional carers may be charged with helping patient take these and may be adding to treatment burden or interfering with prescribed drugs.	Thank you for your comment. The GDG consider that all aspects of disease and treatment burden should be included.
Royal College Of	Full	240	Econo	These sections have resource and organisation implications.	Thank you for your comment. The guideline does not suggest

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General Practitioners		and 245	mic considerations (no line number)	Generally practice nurses are tasked with routine chronic disease management and have expertise in diabetes, COPD management, which should not be denied to patients with multimorbidity (which might be the case if only the GP sees them.) Detailed GP assessment will have time implications, and the uncertainties will be difficult to explain and discuss with patients in the detail mentioned in guidelines.	that only GPs would see patients. The GDG discussed the time implications of the recommendations at length. The GDG considered that the recommendations inform the content and approach of consultations with this group of patients. Review of medicines and treatments is a core part of the delivery of medical care and already part of the role of healthcare practitioners. The GDG considered that discussions are likely to be spread over several consultations in primary care and therefore could be carried out as part of usual medical practice when providing and reviewing care for people with multimorbidity. The GDG recognised that current practice is highly variable with many healthcare practitioners already using longer consultations or double appointments for people with complex needs. We did search for evidence to evaluate the clinical and cost-effectiveness of alternative formats of health consultations, including longer appointment times. However, no evidence was identified. The GDG have specified a research recommendation for research to evaluate different strategies of organising primary care for people with multimorbidity to further inform this area.

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Royal College Of General Practitioners	Full	245	Medicines optimisation	The section in guidance about stopping drugs is a useful resource. To fully implement all the points included as part of the suggested medication review process would involve time and significant change to current medication review practice for prescribers.	Thank you for your comment. The GDG discussed this at length. The GDG considered that the recommendations inform the content and approach of consultations with this group of patients. Review of medicines and treatments is a core part of the delivery of medical care and already part of the role of healthcare practitioners. The GDG considered that discussions are likely to be spread over several consultations in primary care and therefore could be carried out as part of usual medical practice when providing and reviewing care for people with multimorbidity. The GDG recognised that current practice is highly variable with many healthcare practitioners already using longer consultations or double appointments for people with complex needs. We did search for evidence to evaluate the clinical and cost-effectiveness of alternative formats of health consultations, including longer appointment times. However, no evidence was identified. The GDG have specified a research recommendation for research to evaluate different strategies of organising primary care for people with multimorbidity to further inform this area.
Royal College Of General Practitioners	Full	376	PICO characteristics	Unfortunately as traditional approaches to the research on self- management support programmes have been applied these programmes are not being recommended for those people with multimorbidity, instead it is recommended that a patient can be given literature and advise about how to	Thank you for your comment. We are unsure what you mean by 'traditional approaches' to research on self-management support programmes. This review sought to include evidence of any intervention delivered to either people with multimorbidity or to healthcare professions that was aimed at

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				manage their medication when they attend for a consultation. Depending on a patients activation level this may or may not be an effective intervention.	supporting people with multimorbidity to better manage their multiple conditions. As a consequence, a broad range of interventions would have been included in the review if evidence was identified. The GDG are aware of evidence that patient activation may impact on the likelihood that people will engage in health behaviour, however this evidence was not considered for this guideline. The GDG believe that empowering people with multimorbidity in managing their conditions is important, and suggest ways in the LETR for this review how clinicians can seek to empower people with multimorbidity within their consultations.
Royal College of Nursing	General	General	General	The Royal College of Nursing welcomes proposals to develop this guideline. It is topical. The RCN invited members and colleagues to review the draft guideline on its behalf. The comments below also includes the views of our colleagues who work in Wales and care for people with multiple morbidities.	Thank you for your comment.
Royal College of Nursing	Short version			It is good to see that consideration has been given in these guidelines to those who suffer from more than one chronic condition and that the guideline developers have considered people who have chronic conditions, those who are frail and who might also have a mental health illness. It is pleasing to have multimorbidity and frailty recognised generally in clinical practice. There is documented evidence that people with a mental heal illness are more likely to have poor physical health.	Thank you for your comment
Royal College of Nursing	General	General	General	The summary guidance provides clear triggers for further assessment.	Thank you for your comment.

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Royal College of Nursing	General	General	General	It is welcome to see a tailored approach that aligns with Welsh policy: prudent health care and co-production.	Thank you for your comment.
Royal College of Nursing	General	General	General	It is welcomed that the guidelines recognise the interdependency of physical, physiological, psychological and social components of health and wellbeing. The guidelines support advance planning and communication which is a helpful position in the event that the individual becomes acutely unwell or altered cognitive abilities and would support best interests decision making in the event that the person at a later stage lacks the mental capacity to make specific decisions.	Thank you for your comment.
Royal College of Nursing	General	General	General	Whilst it is necessary to assign responsibility for coordinating care – it would have been helpful to have a 'how to do guide' - this guide is lacking in the guidelines.	Thank you for your comment. This recommendation was based on evidence that poor coordination of care may act as a barrier to providing optimal care for people with multimorbidity. The GDG note that there may be multiple ways of assigning responsibility and using this responsibility to coordinate care, and that the way this is done may vary depending on the context and patient. Within the scope of this guideline it was not possible to evaluate different methods of coordinating care.
Royal College of Nursing	Short version	11	12	There is one reference to patients being old and frail which is suggestive of 'a label' rather than providing due consideration to the clinical concept of frailty and person centred, tailored, risk benefit assessments. It would have been helpful to see some concept on care of provision for the frail and older person.	Thank you for your comment. This is a definition of comprehensive assessment of older people taken from Social care guideline on Transition between inpatient hospital settings and community or care homes for adults with social care needs (NG43).

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Royal College of Nursing	General	General	General	The lack of robust empirical evidence for the management of multimorbidity is evident.	Thank you for your comment. The GDG agree with you about the lack of evidence for the effectiveness of interventions for people with multimorbidity. The GDG have prioritised a number of areas for future research, and believe generally that there is a need for research to include people with multimorbidity.
Royal College of Physicians of Edinburgh	Short	General	General	The RCPE is generally supportive of this guideline which puts quality and patient centred care at the centre of decision making. However, such an approach will need to be recognised in the many programmes that set out to monitor management of certain conditions and use of prescription drugs. For example, prescription of bisphosphonates is used by the National Hip Fracture database as a marker for good management of osteoporosis, but this NICE guidance would see some people stopping this treatment. Clinicians may find themselves caught between two seemingly opposing views and this could be addressed through negotiations between organisations. The RCPE welcomes the overall recognition of frailty in the guideline (and suggest that perhaps specific reference to the British Geriatrics Society's Fit for Frailty campaign would be helpful). Implementation of the guideline should recognise that the increase in quality of care due to the delivery of tailored, patient centred care may come at the cost of increased time in patient contact. Given the present issues with recruitment and retention in some medical specialties, this is likely to be challenging. However if these issues can be addressed this guideline would likely see a long term improvement in patient	Thank you for your comment and for participating in the consultation process. The GDG recognise that prescription of medicines is used in some programmes to monitor activity. This guideline does not aim to make comprehensive recommendations for management of frailty but the GDG recognise the overlap between the recommendations and the British Geriatric Society's campaign. The GDG recognise that increased patient contact may be required but on balance recognised that many of these patients are already in regular contact with healthcare services and that the approach recommended in the guideline could inform the content and approach of those contacts.

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				care and increased efficiencies in drug usage.	
Royal College of Physicians of Edinburgh	short	3	11	Suggest add to list of 'who may benefit' – - 'At patient's request'; - 'When the management (eg drugs, hospital visits, monitoring tests etc) of their multimorbidity is causing excessive symptoms'	Thank you for your comment. The GDG has considered your suggestion and edited the recommendation as follows: Consider an approach to care that takes account of multimorbidity if the person's requests it or if any of the following apply: • they find it difficult to manage their treatments or day-to-day activities • they receive care and support from multiple services and need additional services • they have both long-term physical and mental health conditions • they have frailty (see section 1.4) or falls • they frequently seek unplanned or emergency care (see also recommendation 1.3.2) • they are prescribed multiple regular medicines (see section 1.3). , Additionally, recommendations in the section entitled 'principles of an approach to care that takes account of multimorbidity' encourage health care professional to focus on how the person's health conditions and their treatments interact and how this affects quality of life.
Royal College of Physicians of Edinburgh	short	6	5	Make clear that frailty gait assessments assume previously normal gait ie. an amputee may not be frail.	Thank you for your comment. The GDG discussed your comment but considered that clinical judgement is required in application of any

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					assessment tool and this did not require specific change to wording of the recommendation.
Royal College of Physicians of Edinburgh	short	9	5-8	The wording of 1.6.9 could be improved, eg 'Use all appropriate resources when reviewing likely benefit or harm of commonly prescribed medicines in patients with multimorbidity, including database of Treatment Effects'.	Thank you for your comment. The GDG considered re-wording the recommendation but agreed that unless there were clear resources to refer to the recommendation would not be helpful. The recommendation has therefore not been altered as you suggest.
Royal College of Physicians of Edinburgh	short	9	7	The Database of Treatment Effects will help clinicians to explain to patients the balance of risk of certain medications for their condition. It may be helpful if the database style in which it is presented is replaced by a web based or PDF version (which will need ongoing review and update) in a similar way to the Medical Rules on the DVLA website. This will make it more accessible on all platforms and increase its utility. An app would likely be very popular with those on the wards as opposed to in clinic or practice settings.	Thank you for your comment. The GDG agrees that the format has limitations. Unfortunately no further resource is available to fund development of a web-based tool or equivalent. However the data is open source and there is potential for the incorporation of the data feeding the tool into more user-friendly formats.
Royal College of Physicians of Edinburgh	short	11	20-24	The statement that such changes in prescribing can be implemented quickly is true in as much as the message can be disseminated. Some consideration might have been given to the role of nurse specialists in dealing with this aspect. As experts in their chosen specialty they would be a superb asset in helping patients navigate through difficult issues.	Thank you for your comment. This is standard wording for this section. The guideline did not examine role of specific healthcare professionals.
Royal College of Physicians of Edinburgh	short	14	12	It may be helpful to consider the addition of a sentence on planning return to work for people with multimorbidity.	Thank you for your comment. We are unclear where this suggestions fits.
Royal College of Physicians of Edinburgh	short	14	14	The research recommendations listed are fairly limited and it may also be useful to see qualitative studies mentioned in this section.	Thank you for your comment. The research recommendations address those areas identified during guideline development as particularly

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					important in improving the evidence base for this population. The areas identified have to be those examined during the guideline and are those limited to those areas included in the guideline scope.
Royal College of Psychiatrists	short	4	18-24	These recommendations may fail in practice if not supplemented by the review of psychological and mental health problems impairing the patient's self-management or access to services or increasing the health burden. The liaison faculty of RCPsych suggest adding another bullet point 'Establish psychological or mental health problems adding to the disease burden'	Thank you for your comment. These aspects are included in recommendations 1.6.3 and 1.6.5.
Royal College of Psychiatrists	short	4	18-24	Liaison Psychiatry services have demonstrated expertise in establishing the mental health and psychological burden added to patients with multimorbidities and using these in effective individualised care plans to reduce disability and healthcare utilisation. Examples of this integrated care include the Psychological Medicine Service in Oxford Universities Hospital and the Oldham Psychological Medicine Service run by Pennine Care NHS Foundation Trust.	Thank you for your comment and this information.
Royal College of Psychiatrists	short	4/5	24-26	These recommendations may fail in practice if the plan does not involve management of mental, physical and social needs where appropriate. The liaison faculty of RCPsych suggest altering line 25/26 to 'Develop an individualised management plan covering mental and physical health needs with the person'	Thank you for your comment. The GDG considered that it was better not to specifically mention aspects of care in the recommendation to allow the plan to be tailored to the needs of the person with multimorbiditiy.
Royal College of Psychiatrists	short	5	21-25	This recommendation will be a challenging change in practice for people with significant mental health needs and physical health comorbidities due to well-recognised difficulties for	Thank you for your comment. The GDG reviewed the wording of the recommendation and did not agree with your suggestion. People with mental illness and physical condition

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				people with severe mental illness accessing services and challenges for physical healthcare staff recognising and managing long term conditions in this population. We recommend an additional bullet 'have severe mental illness and a long term physical health condition'	are already included in the guideline.
Royal College of Psychiatrists	short	8	10-12	These recommendations may fail in practice if somatoform disorders (also known as medically unexplained symptoms) are not recognised. Severe forms of these disorders have the highest levels of avoidable healthcare utilisation although the appropriate mentioned depression and anxiety are more common mental health problems relevant in patients with multimorbidities. The liaison faculty of RCPsych suggest adding 'Be alert to somatoform disorders and if suspected, obtain advice from Liaison Psychiatry or Psychological Medicine experts'	Thank you for your comment. Within the scope of this guideline, it is not possible to make comprehensive recommendations for the care of people with somatoform disorders.
Royal College of Psychiatrists	short	10	19	Section 1.7: Comprehensive assessment in hospital may fail to produce expected gains if restricted to the elderly. We suggest adding a second group 1.7.1 as 'Any patient with frequent admissions even if involving different specialities' and ensuring Liaison Psychiatry is involved with physical healthcare specialists in reviews.	Thank you for your comment. The clinical and cost effectiveness review in the guideline did not support a recommendation for comprehensive assessment outside this group.
Royal College of Psychiatrists	full	13	1-8	See comment 2 and 3. The liaison faculty of RCPsych suggest adding a bullet for a step in tailored planning to include 'Establish psychological or mental health problems adding to the disease burden'	Thank you for your comment. The recommendations (recommendation 1.6.2) already includes the assessment of mental health and of how disease and treatment burden may impact on the mental health and wellbeing of people with multimorbidity as part of the assessment of disease burden.
Royal College of	full	13	18	See comment 4. The recommendations may be a challenging	Thank you for your comment. The GDG agree that people

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Psychiatrists				change in practice for people with significant mental health needs and physical health comorbidities due to well-recognised difficulties for people with severe mental illness accessing services and challenges for physical healthcare staff recognising and managing long term conditions in this population. The liaison faculty of RCPsych recommend an additional bullet 'have severe mental illness and a long term physical health condition'	with comorbid physical and mental health conditions may require additional support, and have highlighted this group as potentially benefiting from an approach to care that takes account of multimorbidity (please see recommendation 1.6.3 in the NICE version (recommendation 21 in the full guideline) which states: Establish disease burden by talking to people about how their health problems affect their day-to-day life. Include a discussion of: • mental health • how disease burden affects their wellbeing • how their health problems interact and how this affects quality of life.
Royal College of Psychiatrists	full	15	18	See comment 5. These recommendations may fail in practice if somatoform disorders (also known as medically unexplained symptoms) are not recognised. Severe forms of these disorders have the highest levels of avoidable healthcare utilisation although the appropriate mentioned depression and anxiety are more common mental health problems relevant in patients with multimorbidities. The liaison faculty of RCPsych suggest adding 'Be alert to somatoform disorders and if suspected, obtain advice from Liaison Psychiatry or Psychological Medicine experts'	Thank you for your comment. This guideline concerns the identification and management of people with multimorbidity. Within the scope of this guideline, it is not possible to make comprehensive recommendations for the recognition and care of people with somatoform disorders.
Royal College of Psychiatrists	full	17	2	These recommendations may fail to identify crucial areas for innovation if secondary care is omitted. The liaison faculty of RCPsych suggest adding a recommendations for 'What is the clinical and cost effectiveness of alternative approaches to	Thank you for your comment. The GDG agree that further research on organisation of secondary care is required. The GDG however considered that research on organisation in primary and community care was a higher priority.

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				organising secondary care compared with usual care for people with multimorbidity including those with mental and physical health comorbidity?	
Royal College of Psychiatrists	full	general	general	The addictions faculty commented that it does not seem sufficiently to factor in substance disorders, especially alcohol use disorders as important co-occurring conditions, and as an important source of rising hospital admissions for physical disorders directly due to or related to alcohol. Patients with Drug and Alcohol Use Disorders should be considered for this draft guideline In particular the treatment burden of Drug and Alcohol Use Disorders on patients with multimorbidity. Consider referral to other NICE guidelines such as methadone and buprenorphine, drug misuse and alcohol guidelines. It would be useful to consider patients on prescribed opioids and benzodiazepines and prescription medicine addiction. Dr Anne Lingford-Hughes echoes the worry that there is no mention of substance misuse (drug/alcohol) and its impact given it is another form of polypharmacy which is mentioned. At the very least there should be a link to NICE guidance as there are for others in this document. To ignore such comorbidity would not be sensible and could have dire / unintended consequences.	Thank you for your comment. Text has been added to the section 'Terms used in this guideline' in the short guideline to clarify that multimorbidity in this guideline does include conditions such as alcohol and substance misuse. Consideration of specific issues related to substance abuse are beyond the scope of the guideline.
Royal College of Psychiatrists	full	general	general	The old age faculty is concerned that in the guidance there is no mention of importance of assessment of capacity or best interest meeting when making decisions about medications in cases where there the person lacks capacity . With research showing 61 %people with dementia are also living with three or more medical condition it is likely (particularly in those with	Thank you for your comment. All NICE guidelines include an introductory paragraph on patient centred care which makes explicit reference to capacity and the Mental Capacity Act. NICE are currently updating their guideline on Dementia. Co-morbidities and multimorbidity is included in the scope of the

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				severe dementia) that the issue of capacity will arise.	Dementia guideline as well as consent and advance decision-making.
Royal College of Psychiatrists	full	general	general	The rehabilitation and social faculty commented that there should be something about considering mental health within multimorbidity as a significant issue. This is almost completely ignored in the guideline recommendations, which appear to focus on elderly and frailty. There are snippets in the full guideline but this isn't taken forward. Such guidelines may suggest the GP/primary care working in liaison with the CMHT or other mental health service provider. It might also be helpful to give some examples of multimorbidity and people with mental health conditions e.g. SMI and cardiovascular, Diabetes etc. Chronic pain, anxiety/depression/personality disorder. Frailty is discussed only in the context of physical frailty not mental. There should be a note that those with co-morbid mental health disorders may need additional attention and time to explain and deliver a tailored approach to care. Reduction or discontinuation of some medications may need joint working in conjunction with a treating consultant/specialist. Again this isn't clearly mentioned.	Thank you for your comment. People who only have multiple mental health problems and no physical health problems are excluded because their care will largely be delivered by psychiatric services rather than by multiple separate services. However the guideline does include recommendations to be alert to the presence of common mental health disorders and to treat these in line with NICE guidance. The GDG acknowledge that as the evidence base was primarily in the elderly and frail, the recommendations do reflect this. We have added to the LETR that those with co-morbid mental health disorders may need additional attention and time to explain and deliver a multimorbidity approach to care and the potential requirement to work across boundaries when considering reducing or discontinuing medicines.

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Royal College of Surgeons	Short	General	General	The Royal College of Surgeons would like to express its disappointment that little reference is made to the large impact that the presence of multiple morbidities has on patients undergoing major surgery. This is a considerable gap in this guidance and involves some of the treatments with the highest risk for patients.	Thank you for your comment. The guideline concerns the assessment and management of care for people with multimorbidity and does not address specific interventions such as surgery and the management of people with multimorbidity in these circumstances.
Royal College of Surgeons	Short	3	13-21	Please include pre-operative patients who will have major surgery e.g. hip replacement. This is a very high risk group for post-operative morbidity and mortality who also require a personalised assessment and management plan	Thank you for your comment. The GDG reviewed the wording of the recommendation following stakeholder comment and did not think pre-operative patients should be listed here. The need for assessment and management throughout surgical treatment may have quite specific concerns such as blood glucose control, and would not be relevant for longer term management.
Royal College of Surgeons	Short	4	3-13	Please also include: • Individual chance of harm or benefit from surgery (or no surgery) based on predicted 30-day mortality, long term survival with or without surgery and postoperative morbidity. Multimorbidity is associated with an increased risk of complications following surgical intervention and in some cases an increased risk of death • Need to identify alternative interventions, with risks and benefits, for patients with multimorbidity in whom some interventions e.g. surgery would be high risk	Thank you for your comment. The GDG have considered your suggestions and believe that the recommendation is clear, as originally drafted. The GDG accept that multimorbidiity can be a significant issue when considering surgical interventions but that is an issue about risk of intervention rather than about management of multimorbidity and as such was not prioritised during scoping process.
Royal College of Surgeons	Short	5	7-12	Please include additional points within the care pathway: • At time of decision making about most effective treatment for a condition e.g. surgical outpatient clinics • At pre-assessment after surgical interventions are	Thank you for your comment. The GDG considered that while multimorbidity is an important consideration when deciding on risks of surgical intervention, the considerations for management of multimorbidity are different e.g. tighter

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				chosen	blood glucose and blood pressure control may be appropriate pre-operatively but may be a cause of treatment burden at other times.
Royal College of Surgeons	Short	5	21-25	Please also include: • Patients identified to be at high risk of death or post-operative complications following major surgery	Thank you for your comment. The GDG considered that while multimorbidity is an important consideration when deciding on risks of surgical intervention, the considerations for management of multimorbidity at the time of surgery are different e.g. tighter blood glucose and blood pressure control may be appropriate pre-operatively but may be a cause of treatment burden at other times.
Royal College of Surgeons	Short	6	20-30	Please also consider including: • ASA grading of anaesthetic risk • P- POSSUM score- to use to predict operative outcome • Surgical Outcome Risk Tool (SORT): NCEPOD tool • Cardiopulmonary exercise testing • Risk to inform surgical choices	Thank you for your comment. Following your comment, we have conducted additional searches specifically for these tools and have not identified any evidence that meets the criteria of our reviews. As such we cannot include them in our recommendations.
Royal College of Surgeons	Short	8	1-9	Please also include: • patients with multimorbidity can have a worse outcomes after surgery in terms of short and long term survival and morbidity	Thank you for your comment. The recommendation concerns day to day treatment burden and not consequences of multimorbidity and its effect on overall risk from surgical interventions.
Royal College of Surgeons	Short	9	4	Please also include the importance of discussion of the following for any patient, where surgical treatment is being considered: • That the pre-operative assessment provides an opportunity to review medications and screen for	Thank you for your comment. The guideline makes recommendations for care of people with multimorbidity but specific issues relating to medical management of people with multimorbidity pre-operatively and peri-operatively is outside the scope of this guideline.

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				health conditions which might require new treatment • That the peri-operative period presents a particular risk/ disruption of treatment regimens which require careful coordination between the entire multidisciplinary team (surgery, anaesthesia, pharmacy, primary care). For example ensuring optimal glucose management in diabetics, patients on anticoagulants, and any medications that may be influenced by starvation in preoperative period	
Royal College of Surgeons		14	14	Patients with multimorbidity are often not included in studies on outcomes after surgery. This could be identified as an area requiring greater research.	The GDG agrees that many trials of health interventions do not include people with multimorbidity, and this limits the generalisability of this research to people with multimorbidity. The GDG agree that the people with multimorbidity need to be included in studies of all interventions, medical and surgical, and have specifically stated this in the made research recommendations specifically for this population. Within the scope of this guideline, we did not evaluate the effectiveness of surgical interventions for specific conditions, and therefore we are not able to make a research recommendation specifically for evaluating outcomes after surgery in people with multimorbidity. However, the GDG agree that future research to evaluate surgical techniques should consider including patients with multimorbidity
Royal Pharmaceutical Society	Full	General	General	The RPS welcomes this guidance although the length of the guidance will deter some people from reading it. We are pleased to see the strong focus on patient involvement and patient centred care. We welcome the need to have a tailored approach for the individual and that this would include care, treatment and support.	Thank you for your comment and for participating in the consultation process. Regarding your comment on the length of the guideline, please note that the version you have referred d to is the full version of the guideline which includes all evidence reports related to the review questions. We can confirm that there are other shorter versions of the guideline,

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					including the NICE version which summarises the recommendations and the NICE electronic pathway which provides easy access for clinical staff throughout the service.
Royal Pharmaceutical Society	Full	General	General	The term 'tailored approach' is used throughout the guideline and would perhaps better be described as a 'personalised' approach which would then support the personalisation approach of adult social care and its continued spread and development in healthcare.	Thank you for your comment. The GDG has amended the terms used in the guideline and has replaced 'tailored approach' with 'an approach to care that takes account of multimorbidity'; the group considers this term to effectively describe the explicit steps that would allow an individualised approach to care. Additionally, a definition of the term can now be found in both the full and NICE versions of the guideline.
Royal Pharmaceutical Society	Full	General	General	The guidance suggests the development of an individualised management plan for patients with multimorbidity. In what way is this different from a 'care and support plan' and should there not just be one care plan for each patient, personalised to them, and including the medicines elements of care? In this way, everyone involved in the patient's care inputs into the same plan and everyone can see what the intended goals are. We are also aware that it is the process of care planning that actually makes the difference to patient outcomes rather than the care plan itself so there should be more emphasis on this process.	Thank you for your comment. The GDG recognise that multiple different terms are used when discussing plans for patient care and that plans mean different things to different professional groups and in different settings. The GDG therefore chose to emphasise the aspects they considered important for clinical assessment. The decisions can be also recorded in other plans if these are available. The GDG agree that process is what is important and have also included a glossary of terms used within both the full and NICE versions of the guideline.
Royal Pharmaceutical Society	Full	General	General	We have several examples of where pharmacists have led patient centred medicines reviews with patients who have multimorbidities and are taking a large number of medicines. This has led to improved patient outcomes and we would be happy to share these with NICE for example the Sine project in Care homes in Northumbria	Thank you for your comment and for you offer to share your information. We will pass this information to our local practice collection team. More information on local practice can be found here https://www.nice.org.uk/about/what-we-do/into-practice/local-practice-case-studies

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				http://www.health.org.uk/programmes/shine-2012/projects/multidisciplinary-review-medication-nursing-homes-clinico-ethical	
Royal Pharmaceutical Society	Full	General	General	There is a need to enable healthcare professionals involved in a person's care to be able to communicate between each other. This is particularly important for people with MM as they are likely to be accessing many different services. It is important that all healthcare professionals involved in a patient's care know what goals have been agreed with the patient (and carer) and also including social services. There should be a recommendation in this guideline that NHS England enable this to happen at pace and scale.	Thank you for your comment. The GDG agrees that this is a challenging and are recommending that clinician and patient agree how this might be done. The GDG considered that developments such as Summary Care Record (SCR) and Local care records (LCRs) are already improving communication.
Royal Pharmaceutical Society	Full	13	32-37	We would suggest that the guideline recommends a personalised approach to care for all people of any age who are prescribed 10 or more medicines, otherwise decisions could be financially led rather than person led.	Thank you for your comment. The available evidence is of association between polypharmacy and adverse outcomes without clear evidence of clinical and cost effectiveness of any specific intervention. Given the large number of people on multiple medicines the GDG were not in a position to recommend an approach to care that takes account of multimorbidity, to all people who are prescribed 10 medicines or more. The use of the term 'consider' reflects the level of evidence and the GDG hoped the wording would be permissive and allow healthcare practitioners to provide this approach where appropriate. The guideline excludes children under 18 years old, but recommends an approach to care that takes account of multimorbidity for all adults. This has been emphasised in

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					the revision of all recommendations.
Royal Pharmaceutical Society	Full	14	37	We agree that part of the purpose of a personalised approach is to find ways of reducing treatment burden and optimising care. However, the main purpose of a personalised approach is to find the most appropriate ways to support each individual to live well with their condition(s). This should be expressed in the language of the person and in relation to their self-identified goals. If this primary purpose is achieved it is likely to reduce the treatment burden and optimise care; but these are secondary purposes. A third is to avoid unnecessary episodes of recourse to urgent and emergency care.	Thank you for your comment. The wording of the recommendations has been changed to indicate the importance of quality of life when considering an approach to care that takes account of multimorbidity. The GDG also agrees that the a reduction of recourse to urgent and emergency care would be positive for patients and healthcare professionals. The amended recommendation can be found in the NICE version at 1.6.2 and reads as follows: Discuss with the person that the purpose of the approach to care is to improve quality of life'. This might include reducing treatment burden and optimising care and support by identifying: • ways of maximising benefit from existing treatments • treatments that could be stopped because of limited benefit

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					• treatments and follow-up arrangements with a high burden • medicines with a higher risk of adverse events (for example, falls, gastrointestinal bleeding, acute kidney injury) • non-pharmacological treatments as possible alternatives to some medicines • alternative arrangements for follow-up to coordinate or optimise the number of appointments.
Royal Pharmaceutical Society	Full	16	22	An addition should be 'Share decisions with patients and use evidence based patient decision aids, where available, to help patients reach informed decisions about their treatment options'.	Thank you for your comment. The use of decision aids where these are available is already recommended in NICE patient Experience guideline (CG138). The guideline committee were not aware of any decision aids that address issues of polypharmacy and multimorbiditiy.
Scottish Government	Database of treatment effects	General	General	Evidence primarily for clinicians but only in the sense that they need to understand it to help the patients understand it eg we expect patients and doctors to understand Diabetes but educate clinicians first as they are the main educators/ interpreters for patients. I expect that this guideline will change practice (largely by reintroducing the idea that guideline recommendations do not and are not intended to fit all adults in all scenarios) but also by giving prescribers a better idea of medication efficacy. As such this file will be an excellent resource to enable	Thank you for your supportive and helpful comments. Following stakeholder comments the GDG foresees the database principally as a tool to inform clinicians to subsequently help people make decisions.

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				educational tools to be developed. There would be a strong advantage in this being based and recurrently updated by NICE as an offshoot of information that arises from there guideline development process. Having this information in a single place v scattered through guidelines and papers would be a big assistance to many working in this area. Experience in Scotland has been the NNT table has been the most asked about element nationally and internationally and a well maintained resource hosted by NICE I suspect could become an internationally used resource. There would be an advantage in making it open access but from experience can be helpful if something can be sorted out IT to see where in the world and by what professional group the information was downloaded by (this was something that the early Scottish versions did not do and in retrospect would have wished to It is likely that this product would be used by the NHS Polypharmacy Guideline in future editions as a resource to obtain data on NNTs on which there is reasonable consensus due to the recognition that it has been produced from a robust process. The table is excellent but there is information that could valuably be added 1. Details of the papers from which the numbers were derived (this could be in a hidden column that appears	

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				in the same way as the NNT data if selected. This gives idea of the age of the data and allows the data to be cross checked by others should they require it. It also would evidence whether the numbers are directly from systematic reviews or papers or second hand via a guideline or abstract. Ideally references should be to the trials NICE guidance was based rather than just the NICE guideline. 2. Due to the strength of the statement in the guideline Point 30 line 24 on stopping osteoporosis medications it would be wise to include NNT type data on these medications. It would be reasonable to also include the data on stopping Etidronates that informed that statement. It is not a tidy fit to the file (could be on another page of the excel sheet) but it would be consistent with the concept that evidence on magnitude of effect should exist somewhere. 3. Ideally (in time) this sort of data would include how long it takes effect to show in trials (how long for curves to separate.) Important information if dealing with limited life expectancy. Not necessarily for this addition.	The evidence supporting the recommendation around stopping bisphosphonates comes from trials that particularly assess the impact of stopping (i.e. people on bisphosphonates are randomised to stop or continue), The evidence in this database is from trials of starting medications and therefore it is not appropriate to add the bisphosphonates data here. The evidence supporting starting bisphosphonates from NICE TA 160 and 161 is not currently available in sufficient detail (i.e. control group risk, relative risk, trial duration for each outcome) to include in the database of treatment effects.
Scottish Government	Database of treatment effec	General	General	This attempts to do two things. First it attempts to show the benefits and limitations of the database and as such is good and could be expanded extracting from the full guideline where appropriate. This is likely to expand following comments but would include a section on applicability and generalisability. Also include a section re stating that the recommendations in	Thank you for your comment. The data brought together in this database comes from condition specific guidelines, the trials have been conducted in the populations identified in those guidelines as being appropriate. Some information on the trial populations are available within the database. The GDG agree that this evidence will not be applicable to all

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	ts:- user guide			the recommendations column are recommendations and not directives (in whatever terms this is normally covered. A statement here (and perhaps highlighted in example cases) around population level treatment would be good. Many treatments are made with long term (decades) of risk reduction in mind and are not developed to alter outcome in last years of life. Lots of interventions are aimed at the cumulative effect of tiny interventions across large populations. There is then a separate section looking at a number of cases. Suggest having this as an entirely separate document on this. A number of case examples could be used that take various patients through the process described in the guideline. This could be used to highlight areas that may commonly come up and act as caution to use of the NNT data. (for example highlighting common harms (eg NSAID + ACE + Diuretic + low eGFR) that would not be picked up just by NNT. Examples of this sort of approach can be found in the NHS Scotland Polypharmacy Guideline (the full guideline v app.) It should allow the guideline to showcase the holistic elements as well as 'what drugs to stop and when elements' The guideline itself should have clear warnings regarding medications to be cautious stopping rapidly and perhaps better titrated down (and this could and should be highlighted in example cases). Non exhaustive list includes • Rate limit medication >> avoid crash stop	people with the condition in question; however it is not obvious how a section on applicability and generalizability could readily be added into the database. The recommendations are derived from NICE guidelines and are provided merely for context. The GDG agree that they are not directives and standard NICE wording about recommendations is sufficient to explain this. The GDG agree that many treatment recommendations are made with long term risk reduction in mind and not developed to alter outcome in last years of life. Further text highlighting this has been added to the introductory sheet of the database. The resources available have not allowed the development of more detailed information about specific drug combination and how some drugs should be stopped.

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				• Diuretics from high dose • ACE inhibitors where LV function not known	
Self management uk	Full	400	general	Self management uk is disappointed to learn that there is no evidence to recommend self-management programmes for people with multimorbidities. This is disappointing especially as over 40% of attendees to our self-management programmes have self reported more than one long-term condition. (Nolte &Berry, 2015). Frequently reported conditions include diabetes, musculoskeletal disease, COPD and depression by those who attend our generic courses. Our approach is lay-led or co-delivered (lay-facilitator and healthcare professional facilitator) which we believe is important for outcomes. The White Paper Our Health, Our Care, Our Say (2006), recognised that services need to be integrated, and personalised to the individual's needs, and this approach is included in the Care Act 2013. As this supports shared-decision making and 'no decision without me'. (DOH, 2010, p. 3). It is known that self-management interventions are cost effective and our paper Social Return on Investment: The study, Healthy lives equal healthy community – the social impact of self management, looked at the wider benefits of self-management courses in The Wirral. This was based on a Social Return On Investment (SROI) research completed by Richard Kennedy, Head of Social Investment at CAN, carried out between April 2010 and November 2011. For every £1 invested in self-management, approximately £6.50 of social value was created. These wider social and cost effective	Thank you for your comment. This review sought to include evidence of any intervention delivered to either people with multimorbidity or to healthcare professions that was aimed at supporting people with multimorbidity to better manage their multiple conditions. As a consequence, a broad range of interventions would have been included in the review if evidence was identified. The economic paper cited in your comment was a non-comparative study and it was not a cost effectiveness study as it does not compare the incremental cost against the incremental effectiveness (expressed as clinical benefit) of two or more alternative interventions. For these reasons it did not meet our inclusion criteria, which are explained in chapter 4.4 of the guideline, and was not included in the economic literature review. The GDG noted that very little evidence was identified that evaluated the effectiveness of self-management or expert patient interventions in people with multimorbidity. Furthermore, much of the evidence evaluated interventions that involved an exercise component, which may not be appropriate for all people with multimorbidity. The GDG therefore did not consider there to be sufficient evidence to recommend the use of self-management interventions in people with multimorbidity. The GDG agree that care for people with multimorbidity should be personalised to a person's needs, and have made several recommendations to this effect.

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				benefits do seem to be missing from this review and document.	
Self management uk	Full	12	general	We would recommend changing 'tailored approach' to 'personalised approach'. It is important to be consistent with language in use and other publications.	Thank you for your comment. The group has amended the terminology in the guideline. 'An approach to care that takes account of multimorbidity' now reflects their intended meaning. A definition can now be found in both the NICE and full versions of the guideline.
Self management uk	Full	12	26	We believe that the proposed approach should be for all persons with long-term conditions not just those with more than one condition.	Thank you for your comment. The GDG agree that the approach outlines may be appropriate for people without multimorbidity. This guideline is intended to cover the identification and management of people with multimorbidity, and therefore it is not possible to make a recommendation on the care of people with single conditions. This guideline does not replace the recommendations on the care of people with single conditions in other NICE guidance, which include consideration of individualised care or the approach outlines in the Patient Experience guideline (CG138).
Self management uk	Full	12	26	We believe that 'individualised planning' is the same as Care Planning. It is important to be consistent with language in use.	Thank you for your comment. During guideline development and following stakeholder comment the GDG reviewed the terms used and consider that there is no consistency in use of terms. The term 'care plans' is commonly used for social care.
Sheffield Teaching	Full	13	29	Whilst QAdmission and PEONY may be useful for identifying	Thank you for your comment. Within this guideline we

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Hospitals NHS Foundation Trust				risk of hospital admission they are not predictors of response either beneficial or harmful to drug treatment and therefore are irrelevant in this guideline. At least you need to make a better case for their use. In contrast Charlson has been linked to risk of drug adverse effects and might be more appropriate	sought tools that could be used to identify people with multimorbidity who are at risk of adverse outcomes, and therefore may benefit from an approach to care that takes account of multimorbidity. These adverse outcomes may be caused by a variety of factors, including but not limited to drug adverse events. We identified evidence that evaluated the prognostic accuracy of the Charlson Comorbidity Index to identify people at risk of adverse outcomes; however the GDG did not consider that the evidence supported its use in clinical practice.
Sheffield Teaching Hospitals NHS Foundation Trust	Full	14	41	I fully agree that medicines with an increased risk of future adverse events should be considered for stopping but make this other than rhetoric you need to provide some practical help as to the absolute risk. Summary of product characteristics for individual drugs could be searched but often do not give risks, never give placebo corrected values and are derived from populations other than the Frail or those with multimorbidity. The workload is beyond individual clinicians.	Thank you for your comment. The GDG recognise the difficulties in finding appropriate evidence as you describe. Absolute benefit and risk data is provided in relevant NICE guidance, and wider research. However, the GDG agree that the vast majority of evidence concerning the benefit and risks of medications is derived from populations excluding those with multimorbidity. Within this guideline, the GDG have proposed a method of summarising relative and absolute benefit and risk data for commonly prescribed medications in a way that can be readily accessed by clinicians (database). At present, this resource does not provide data that is adjusted for alternative levels of baseline risk than may be represented by the original study sample, and which may provide greater guidance to clinicians who are treating people with multimorbidity and frailty who may be at an increased risk of adverse outcomes. The GDG also note that many trials that evaluate the effectiveness of medications do not comprehensively report adverse event information, and

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					therefore information about the risks of treatments was not always available for inclusion in this resource.
Sheffield Teaching Hospitals NHS Foundation Trust	Full	15	16	Depression is remarkably common in the Frail and elderly and may alter a person's abilities both to enjoy life and to involve themselves in discussions about treatment changes. However there is very little evidence for the efficacy of either pharmacological or non-pharmacological treatments for depression in the Frail. That evidence which is available suggests that drug treatment is ineffective for those with the commonest co-morbidity of dementia. The NICE mental health guideline suggests referral to collaborative care without any provision of evidence or guidance as to what they should do.	Thank you for your comment. This guideline concerns the identification and management of people with multimorbidity, which necessarily includes people with a variety of long-term conditions, including depression. Within the scope of this guideline, it is not possible to make comprehensive recommendations for the care of people with depression, and as a consequence we did not include evidence that evaluated the effectiveness of interventions that were specifically intended to improve symptoms of depression (i.e. rather than improve overall health and wellbeing all of a person's comorbid conditions). The treatment of depression in people with comorbid depression and physical health conditions is covered by existing NICE guidance (Depression and Physical Health guideline). NICE are currently updating the guideline on Dementia.
Sheffield Teaching Hospitals NHS Foundation Trust	Full	15	43	Whilst STOPP may have some helpful general guidance as to which drugs may be of less use in the elderly the START recommendations come from clinical trials carried out in patients without Frailty or multimorbidity. You must justify why the extrapolation from one population to another is warranted particularly when there are reasonable observational data to show that risk factors such as high blood pressure or total cholesterol are no longer as influential in the very elderly or Frail.	Thank you for your comment. The GDG agree that recommendations in the START tool are predominantly drawn from an evidence base that may not include people with multimorbidity. However the recommendations were refined through a Delphi consensus technique and were considered appropriate for older people. The GDG believe it is reasonable to recommend the consideration of the advice in this tool for people with multimorbidity on this basis. The recommendation is only to consider, not offer, and STOPP/START is included as an example. Overall the GDG agree that there will be some people with multimorbidity for

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					whom these indications are not appropriate but the GDG are keen to remind people that medicines reviews should consider inappropriate omissions as well as inappropriate inclusions on the prescription list.
Sheffield Teaching Hospitals NHS Foundation Trust	Full	16	32	When stopping drugs due consideration needs to be given to the possibility of withdrawal reactions and the patients need to be made aware of these. They are of course most common with centrally acting drugs but problems can be seen with some antihypertensives, analgesics and diuretics. There may also be impacts on the efficacy of other interventions with no evidence of benefit of anticoagulants for atrial fibrillation in patients who no longer have controlled hypertension because of treatment withtdrawal.	Thank you for your comment. The GDG has made a recommendation that encourages clinicians to plan a review to monitor effects of any drugs stopped and to decide whether any further changes to treatments are needed (including restarting a treatment). Please see recommendation 1.6.17 in the NICE version which states: After a discussion of disease and treatment burden and the person's, personal goals, values and priorities, develop and agree an individualised management plan with the person. Agree what will be recorded and what actions will be taken. These could include: • starting, stopping or changing medicines and non-pharmacological treatments • prioritising healthcare appointments • anticipating possible changes to health and wellbeing • assigning responsibility for coordination of care and ensuring this is communicated to other healthcare professionals and services • other areas the person considers important to them • arranging a follow-up and review of decisions made. Share copies of the management plan in an accessible format with the person and (with the person's permission) other people involved in care (including healthcare

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					professionals, a partner, family members and/or carers).
Sheffield Teaching Hospitals NHS Foundation Trust	Full	25		In the "Bespoke Review" you unfortunately omit the requirement that the data relating to efficacy should come directly from studies of the populations with Frailty or multimorbidity. Failing to do this has produced a more or less irrelevant data set. Not only can't we be sure that the relative risk reductions seen with treatment in the clinical trial populations would apply to the population with Frailty and multimorbidity but the values for baseline risk and absolute risk reduction will also be incorrect. Even the "Hypertension in the Very Elderly Trial" excluded several forms of comorbidity and had a population with a low Frailty Index. If these data are to be included there needs to be helpful guidance on factors to consider when extrapolating results from clinical trials to populations with Frailty and multimorbidity perhaps with consideration of the epidemiology of the impact of risk factors and the patently less scientifically robust observational studies mainly of harms.	Thank you for your comment. The GDG are aware that people with multimorbidity and frailty are unlikely to be included in trials. It was agreed to use data from existing single-condition NICE guideline where this data has been used to make recommendations for the care of people including those with multimorbidity and/or frailty. Where separate recommendations were made for a multimorbid population, these would have been extracted preferentially. A discussion on this issue is included in the LETR for this review (p.250). As noted in the LETR, the GDG are aware of evidence that indicates that relative effect data is frequently (but not always) stable across populations although note that the absolute effect of treatment will also vary according to the baseline risk of the study population. The GDG considered calculating alternative absolute effect data to provide guidance for clinicians on how the absolute effect of treatment may change according to the baseline risk of their patient. However, the GDG were concerned that this approach would require a number of assumptions, and therefore may not add meaningfully to clinical practice. The GDG considered that clear information about the evidence such as length of trials, people in studies does provide more information to inform treatment decisions for people with multimorbidity. In the meantime, even though the GDG agree that it is also helpful for clinicians to be able to identify treatments whose effectiveness has different orders orders of magnitude difference to inform decisions. Clinicians will still

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					have to consider how the absolute benefit or harm of treatment may differ for each individual patient according to their other health needs, but there is not any simple way to systematically calculate those figures.
Sheffield Teaching Hospitals NHS Foundation Trust	Full	25		Glaring omissions are the absence of consideration of withdrawal of anticoagulation in patients with Atrial Fibrillation of importance because of the high risks of stroke and of haemorrhage in the Frail and multimorbid population and consideration of withdrawal of antidepressants.	Thank you for your comment. The scope for the guideline included reviewing evidence for the effect of stopping drugs. As part of guideline development initial review protocols were developed to examine the effect of stopping antihypertensives, statins and 6 drugs for treatment of osteoporosis. The paucity of evidence available caused the GDG to agree to complete these reviews but not to look for evidence for other possible topics. A research recommendation for stopping drugs was however developed. NICE have developed a decision aid for the consideration of the use of anticoagulation for people with atrial fibrillation which examines risks and benefits of anticoagulation treatment.
Sheffield Teaching Hospitals NHS Foundation Trust	Full	237		When discussing treatment burden with patients it is important to consider immediate harms and possible future benefits from treatment. However risk of future harm should be included and some treatments e.g. diuretics for hypertension and heart failure offer immediate symptomatic benefit (less breathlessness), immediate burden (diuresis), possibility of future benefits (lower risk of stroke) and risk of future harms (increased risk of falls). This discussion can be challenging for clinicians and patients but without access to some pertinent data however crude it becomes impossible. The guideline may have come up pretty empty handed in its evidence search	Thank you for your comment. The GDG agree that discussions with people with multimorbidity around treatment burden and initiating/stopping treatments should take into consideration both the potential benefits and risks of a change in management, as well as the values and preferences of the person. The GDG also agree that greater access to evidence for the benefits and risks of treatment would inform these discussions, and have created the database of treatment to showcase how this evidence may be usefully provided to clinicians for this purpose.

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				so it should try to give advice as to how to proceed in the absence of data.	
Sheffield Teaching Hospitals NHS Foundation Trust	Full	240	General	To suggest that there will be no resource implications is at best naïve. Such discussions are time consuming especially if quantitative information about benefits and harms have to be provided. It is impossible to keep all this in your head all the time. Importantly this is not a one of discussion. Patients priorities may change with time especially if they develop new problems. Improving leg claudication may well cease to have great priority in a patient who has subsequently suffered a dense hemiplegia.	Thank you for your comment. The GDG discussed this at length. The GDG considered that the recommendations inform the content and approach of consultations with this group of patients. Review of medicines and treatments is a core part of the delivery of medical care and already part of the role of healthcare practitioners. The GDG considered that discussions are likely to be spread over several consultations in primary care and therefore could be carried out as part of usual medical practice when providing and reviewing care for people with multimorbidity. The GDG recognised that current practice is highly variable with many healthcare practitioners already using longer consultations or double appointments for people with complex needs. We did search for evidence to evaluate the clinical and cost-effectiveness of alternative formats of health consultations, including longer appointment times. However, no evidence was identified. The GDG have specified a research recommendation for research to evaluate different strategies of organising primary care for people with multimorbidity to further inform this area.
Sheffield Teaching Hospitals NHS Foundation Trust	Full	241	6	Where is pain or more specifically non-surgical management of osteoarthrosis? A large proportion of Frail and multimorbid elderly patients will be taking analgesics. The fact that	Thank you for your comment. Within this guideline, the GDG have developed the database of treatment effects as an example of how evidence from single-condition guidance

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				response is measurable ignores the possibility that treatment might impact on decisions of other conditions. These add to tablet burden, have significant adverse effects, have the potential to impact on other co-morbid conditions e.g. heart failure, and interact with many drugs for other conditions.	may be usefully presented to inform treatment decisions for people with multimorbidity. The GDG chose to prioritise the inclusion of treatments with prognostic benefit, since the effect of these may be difficult for individual patients and healthcare professionals to judge. The GDG considered that symptomatic treatments can be discussed and evaluated and have included recommendations to do this. Following stakeholder comment specific reference to pain has been added to the recommendations. In recommendation 1.6.5 clinicians are encouraged to: Be alert to the possibility of: • depression and anxiety (consider identifying, assessing and managing these conditions in line with the NICE guideline on common mental health disorders) • chronic pain and the need to assess this and the adequacy of pain management
Sheffield Teaching Hospitals NHS Foundation Trust	Full	243	10	All these guidelines are based on evidence from clinical trials which excluded patients with multimorbidity. Providing numerical estimates in the "Database of treatment effects" give a false sense of precision as any benefit needs to be extrapolated from one population to another. As you suggest benefit might be smaller, reversed or even larger in the Frail multimorbid population. Your guess is that the size of the benefit will be smaller but can you provide any help to readers to quantitate the actual reduction. After all they are going to have to explain it to patients	Thank you for your comment. The GDG agree with the difficulty of knowing effect of treatments in people not included in trials. A discussion on this issue is included in the LETR for this review (p.250). As noted in the LETR, the GDG are aware of evidence that indicates that relative effect data is frequently stable across populations, although note that absolute effect data is variable according to the baseline risk of the study population. The GDG considered calculating alternative absolute effect data to provide guidance for clinicians on how the absolute effect of treatment may change according to the baseline risk of their patient. However, the GDG were concerned that this approach would

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					require a number of assumptions, and therefore may not add meaningfully to clinical practice and would give an indication of precision where none exists . The GDG considered that ability to examine magnitude of benefit across several conditions may be helpful.
Sheffield Teaching Hospitals NHS Foundation Trust	Full	247	General	You suggest that the length of the clinical trial might indicate the time needed for a treatment to produce benefit so that patients can compare what with their likely life expectancy. Unfortunately the one thing controlled clinical trials do not test is time to effect. The time needed to show a significant difference has much more to do with the size of the effect and the size of the trial than it does about time of onset of effect.	Thank you for your comment. The GDG agree that evidence that indicates the expected time to benefit from a treatment would be useful for informing treatment decisions but that this information is not always available. The GDG agreed to include the duration of the trial in the database of treatment effects as information about the evidence for use of the treatment.
Sheffield Teaching Hospitals NHS Foundation Trust	Full	255	Quality of evidence	As there is no evidence of benefit from the treatment of hypertension in patients with multimorbidity or Frailty (the proportion of Frail patients in "Hypertension in the Very Elderly Trial" was very small and benefit fell with increasing Frailty index) why did the guideline development group assume that the effect of stopping treatment would be the same in people with and without multimorbidity?	Thank you for your comment. The guideline searched for evidence on the effect of stopping treatment and not for evidence for treatment. As a consequence, we did not search for evidence on the effectiveness of hypertensive medication in people with or without multimorbidity. The GDG were not aware of evidence that demonstrates differential effectiveness of anti-hypertensives in people with multimorbidity compared to the general population. They chose to assume that the effectiveness would be the same, and sought evidence for the impact of stopping the medication in people with and without multimorbidity. If sufficient evidence had been identified, sensitivity analysis to compare the effect between people with and without multimorbdity would have been conducted if inconsistency was identified between studies with these populations. The

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					GDG did not make recommendation on stopping antihypertensives due to insufficient evidence for the impact of this.
Sheffield Teaching Hospitals NHS Foundation Trust	Full	262	33	A simple recommendation would be to document the date a bisphosphonate is first prescribed. Otherwise this information gets lost easily and patients often can't remember.	Thank you for your comment. The GDG agree that documentation of treatment decisions in a person's medical records is important, however it is not possible within the scope of this guideline to comment on what information should be documented for individual conditions. The GDG considered that this information is already widely available in primary care electronic records.
Sheffield Teaching Hospitals NHS Foundation Trust	Full	267	19	These may be very poor data but you should acknowledge that there are no data for the benefit of statins in a Frail or multimorbid population. This would then give clinicians something to discuss with patients	Thank you for your comment. The scope for the guideline included reviewing evidence for the effect of stopping drugs, including statins. We did not review evidence for the effect of starting statins, and therefore cannot comment on the populations included in this literature.
Social Care	Short	1	6-7	Would the guidance not be helpful for social workers and other social care staff?	Thank you for your comment. The guidance may be helpful for social workers and social care staff but is not directed specifically to them.
Social Care	Short	4	3	Whilst the guidance recognises multimorbidity and also the connections between conditions and everyday activities etc, does it make a strong enough connection with other non-health services, particularly with regard to the planning of care and treatment?	Thank you for your comment. The GDG recognise that for some people with multimorbidity non-health services will also be important in their care. The recommendations in the guideline primarily relate to clinical care but recommendations from NICE guideline NG22 Older people with social care needs and multiple conditions and CG138 Patient experience guideline may also be relevant to some people with multimorbidity.
Social Care	Short	3	11	The Guidance makes specific reference to 'people who may benefit from a tailored approach to care'. However, elsewhere NICE guidance makes reference to 'Person Centred Care' as	Thank you for your comment. The GDG has amended the terms used in the guideline to describe the approach for the care of people with complex multimorbidity. Given the

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				an over-arching approach and, whilst recognising the desire to identify and specify those people to whom the guidance is relevant, it is unclear as to why new and different terminology is being used here. Also, how does 'Tailored Care' differ from 'Person –Centred Care?)	epidemiology of multimorbidity the GDG considered that that they wished to highlight an approach for those most likely to benefit where there is an emphasis on assessing and reducing treatment burden. The guideline now uses the term 'an approach to care that takes account of multimorbidity' and a definition of this term can be found in both the NICE and Full versions of the guideline.
Social Care	Short	4	25	The guidance makes reference to 'an individualised management plan' – is this the right terminology given the general use of 'care plan' (or 'care and treatment plan')'	Thank you for your comment. The GDG specifically chose not to use the term 'care plan' because it has a specific meaning in social services.
Social Care	Short	5	1	Coordination of care may often need to be wider than just healthcare professionals – particularly if care/medication being delivered by social care practitioners	Thank you for your comment. The GDG recognise that for some people with multimorbidity co-ordination of care will require discussion with social care. This guidance should be used in conjunction with NICE Social Care guidance on Older people with social care needs and multiple long-term conditions (NG22).
Social Care	Short	5	18	Is there a solid evidence base for the threshold of 15 regular medicines as this seems very high. Also, is the guidance clear enough about conditions as opposed to prescribed medications?	The GDG noted that the evidence demonstrated that people taking 15 or more drugs may be at significantly higher risk of unplanned hospital admissions and agreed via consensus that they may also be at increased risk of mortality. On this basis and on considering the number of people who might need assessment the GDG agreed that people taking 15 or more drugs would benefit from an approach to care that takes account of multimorbidity and this can be considered on the basis of the number of drugs alone, independent of other risk factors. Further details can be found in the identification chapter in the full guideline.
Social Care	Shor	6	2	Will everyone using (or just reading) the guidance know what a	Thank you for your comment. Following stakeholder

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	t			'performance tool' is in this context? Also, is the guidance clear about whether/how much at all frailty should be assessed when a person is acutely unwell?	comment the wording has been changed to have 3 separate recommendation as follows: 1.4.1 Consider assessing frailty in people with multimorbidity. 1.4.2 Be cautious about assessing frailty in a person who is acutely unwell. 1.4.2 Do not use a physical performance tool to assess frailty in a person who is acutely unwell. The GDG considered that this formulation made the intention clear.
Social Care	Short	8	14	What does 'First point of contact' mean in this context given the reference earlier as to how people with a need for tailored care might be identified- presumably the point at which the possible need for tailored care is identified?	Thank you for your comment. 'First point of contact' has been removed from the recommendation.
Social Care	Short	8	21	Should this say 'These may include'?	Thank you for your comment. The GDG has considered your suggestion and the recommendation has been edited accordingly. Please see recommendation 1.6.7 which states: Encourage people with multimorbidity to clarify what is important to them, including their personal goals, values and priorities. These may include: • maintaining their independence • undertaking paid or voluntary work, taking part in social activities and playing an active part in family life • preventing specific adverse outcomes(for example, stroke)

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					• reducing harms from medicines • reducing treatment burden • lengthening life.
Social Care	Short	10-11	26-5	The definition of 'Tailored Care' provided here does perhaps confirm the concerns raised above about terminology and where/how the concept fits with others commonly used such as 'person-centred care' and 'care plans'.	Thank you for your comment. The GDG have discussed the terminology following stakeholder comment and recognise that there is generally inconsistency in how terms are used across all settings. The GDG did not wish to use the term 'care plan' because that has a specific meeting in social services which is not relevant here. The terms in the guideline are explained in the Glossary.
Social Care	Short	6	General	Section 1.5 – settings seem arbitrary rather than comprehensively covering all relevant settings, and social care settings may well be relevant here too. Why are the tests to be conducted different in different settings?	Thank you for your comment. The GDG agreed to provide options for tools that could be used to assess frailty and included simpler tools for primary care and community settings and more formal assessment tools for specialist settings. Assessment of frailty taking place in social care settings is covered by 'community settings'
Social Care	Short	10	20	Should there be a link to the source guideline here?	Thank you for your comment. This has been added.
Social Care	Short	General	General	The structure of the recommendations doesn't seem intuitive.	Thank you for your comment. Following consultation comments, the recommendations have been reordered.
Social Care	Short	General	General	Has an approach been considered for people who may lack mental capacity?	Thank you for your comment. All NICE guidelines include an introductory paragraph on patient centred care which makes explicit reference to capacity and the Mental Capacity Act. The GDG consider that the principles of care are similar.

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					NICE are currently updating the guideline on Dementia which includes issues of consent and management of co-morbidities.
Social Care	Short	3	3	Section on how to use this guideline – it may be helpful to add a recommendation that says the guideline should be used in conjunction with the "Social care of older people with multiple long-term conditions" where relevant for older people.	Thank you for your comment. We have listed the 'Older people with social care needs and multiple long-term conditions' guideline (NG22) in the related NICE guidance section of the full version of this guideline.
Social Care	Short	General	General	The guideline in some places seems very general/broad but in others is very specific with supporting material focussing on medicines. If the guideline is primarily a medicines focused guideline, it would be helpful for this to be clear from the start of the guideline. If the guideline is intended to be broader, inclusion of social care practitioners as a key audience would be helpful, particularly where integrated health and social care teams are in place.	Thank you for your comment. The recommendations are influenced by the evidence available and are more detailed where the evidence allowed. The areas identified at scoping primarily aim at medical management and issues associated with multimorbidity.
The Chartered Society of Physiotherapy	Short	General	General	The Chartered Society of Physiotherapy (CSP) welcome this guideline. We recognise that a huge amount of work has gone into producing this highly nuanced guideline which retains a focus on patient-centred care throughout.	Thank you for your comment and for participating in the consultation process.
The Chartered Society of Physiotherapy	Short	6	1-18	We welcome the pragmatic approach to assessing frailty, with options for either formal or informal assessment. It is often more appropriate with the very elderly to use an informal assessment of gait speed e.g. Time taken to walk to the kitchen, and this has been recognised by the guidelines.	Thank you for your comment.
The Chartered Society of	Short	8	13-19	The recommendation on establishing patient preferences, values, and priorities at first point of contact is important and	Thank you for your comment.

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Physiotherapy				very necessary.	
The Chartered Society of Physiotherapy	Short	8	20-27	The recommendation on encouraging those with multimorbidity to clarify goals and priorities is especially important in order to tailor a successful treatment approach.	Thank you for your comment.
The Migraine Trust	Full	General	General	The Migraine Trust welcome the recognition that people with multiple health needs require a tailored approach to the treatment, care and support they receive. However, the need for a 'personalised' approach is not limited to people with multimorbidities as recognised by NHS England in the need for every person with a long term condition to have a care plan. We think it important that the guideline does not give the impression that this tailored/personalised approach to treatment, care and support is limited to a sub-group of "complex" patients.	Thank you for your comment. The GDG agree that the approach included in the guideline is also appropriate for many people who do not have multimorbidity. This guideline is however directed to people with multimorbidity.. This guideline does not replace the recommendations on the care of people with single conditions in other NICE guidance, which may include consideration of individualised care.
The Migraine Trust	FULL	12	14	Changing the word from "consider" to "take" to ensure that all patients with multiple health conditions receive a personalised/tailored approach to care.	Thank you for your comment. We feel that the wording accurately reflects the strength of the evidence. Consider' in the context of NICE recommendations indicates that the GDG could not make a strong recommendation based on the evidence because the balance between benefits and harms was less definitive.
The Migraine Trust	FULL	12	26-36	Please provide clarity if an 'individualised management plan' for people with multimorbidities is the same or in some way differs as a personalised care plan for people with long-term health conditions. We recommend a rewording here of 'provide the person with an individualised management plan' since this is contrary to the partnership planning between patient and health professional which is central to personalised care plans. Clarification of the intention of this section needs to given since so few people with long-term conditions actually receive care	Thank you for your comment. During the development of the guideline and following stakeholder comment the GDG reviewed the terminology used in the recommendations. There is an overlap between personalised care plan for people with long term conditions and an individualised management plan. The recommendations in this guideline are geared however to people with complex multimorbidity and the aim of a discussion and plan with person is more specifically to look at issues such as treatment burden across

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				plans in practice. In 2015 the National Audit Office identified that the government has failed to ensure that everyone with a long- term neurological condition has a care plan which means that their changing care needs are simply not being met. The Neurological Alliance patient experience survey found that 71.5% of respondents with a neurological condition have not been offered a care plan to help manage their condition www.neural.org.uk Since personalised care plans are not being routinely provided for these patients there may need to be further resource considerations in how these can be made more widely available to ensure that this recommendation will be implemented.	the range of problems a person has. The GDG were aware that there is a risk that specifying that someone should have a plan resulted in an emphasis on outcome and wanted to be clear that it was up to agreement between professional and patient as to what, is anything, was written.
The Migraine Trust	FULL	13	35-39	A personalised approach for all people who are using 10+ medications or more seems sensible to ensure that they are supported in self-management, not just drug interactions. Therefore this recommendation could be mandated rather than optional to reduce variation in care.	Thank you for your comment. The quality of the evidence did not allow the GDG to mandate this approach for all people who are using 10 or more medications. The available evidence is of association between polypharmacy and adverse outcomes without clear evidence of clinical and cost effectiveness of any specific intervention.
The Migraine Trust	FULL	14	37	Consider wording of this section to ensure that language reflects patients' need to live well with their long-term condition(s), thus making the plan personalised rather than 'prescribed' for them.	Thank you for your comment. The wording has been changed to include emphasis on improving quality of life.
The Migraine Trust	FULL	14	37-44	We recommend also including non clinical referrals/interventions here. For example directing people to sources of support and information regarding their health conditions and the impact they have on the patient's life e.g. patient organisations, support groups, charities, advocates etc. Migraine sufferers report issues with the impact of their condition on employment highly and this can be an added	Thank you for your comment. The NICE guideline on Patient Experience (CG138) already includes recommendations to refer people to support and other groups as required and is not specific to people with multimorbidity. This guideline should be used in conjunction with other NICE guidance.

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				stress factor in living with a long-term condition. The Migraine Trust's patient experience survey found that 45% of patients saw their GP at least 6 times about the impact of their condition on employment. Referral to non-clinical services such as The Migraine Trust's employment advocacy service should therefore be highlighted at the earliest opportunity for patients..	
The Migraine Trust	FULL	16	19	For health professionals to be 'alert' to symptoms of depression and anxiety the necessary mechanisms must be in place to support this. For example, routine screening should take place for depression and anxiety for conditions where there is a known high rate of co-morbidity e.g. migraine, and vice-versa. Depression and anxiety mean that some migraineurs can be less able to take a proactive approach to managing their migraine condition. Better coding at primary care level would also help to identify multimorbitidites where there is known high comorbidities of conditions.	Thank you for your comment. NICE has developed guidance on Common mental health conditions which includes advice on case-finding. Improved detection of mental health problems should improve coding.
The Migraine Trust	FULL	16	28-37	We recommend also including non clinical referrals/interventions here. For example directing people to sources of support and information regarding their health conditions and the impact they have on the patient's life e.g. patient organisations, support groups, charities, advocates etc.	Thank you for your comment. Information about support and other groups is already included in the NICE guideline on Patient Experience (CG138).
University of Bristol	Full	62	Table 16	Whilst we welcome the NICE Guidelines on multimorbidity and for the opportunity to comment on these draft guidelines. We also welcome the integrated inclusion of people with learning disabilities and multimorbidity within the scope of these guidelines and the recommendations for better multi-agency	Thank you for your comment. These issues are covered in the NICE guideline on Patient Experience (CG 138) to which this guideline refers. All NICE guidelines include a standard statement about capacity. NICE are also updating the guideline on Dementia which

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				communication and a tailored approach and appropriate adjustment to methods of delivery of care to meet individuals' needs which take account of disability or impairment. We also welcome recommendations for improving communication between healthcare professionals and people with multimorbidity and the use of appropriate and varied methods of communication. We would, however, welcome more clarify around the following issues: Sub-theme: Discussing evidence and supporting decisions Whilst there is mention of using decision aids to support the understanding of decisions about health care, a concern would be around ensuring an assessment of a person's capacity to make decisions around their care and management of their health needs, together with an understanding of the implications of treatment or refusal of treatment is undertaken. This is relevant not only to people with learning disabilities but also people who have cognitive difficulties or deterioration due to strokes, dementia etc.	includes specific attention to issues of consent and capacity.
University of Bristol	Full	62	Table 16	Sub-theme: Medication review Supporting adherence A concern is around clarity of meaning of "adherence support" and whether this means advocacy support.	Thank you for your comment. This refers to support for adherence to medication.
University of Bristol	Appendic			Whilst most of the recommendations would appear to be appropriate for all age groups, a general concern is the focus	Thank you for your comment. The scope of the guideline covers the identification and

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	es			on an older population of people. Evidence from the Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD, 2013) suggests that the average age of death of people with learning disabilities is 65 year of age. Much of the focus of the studies included within the scope of this guideline would seem to be on an older population of people aged 65 year or older.	management of adults of all ages with multimorbidity. Unfortunately, the vast majority of evidence identified for the guideline was conducted with an older adult population. Some of the recommendations are therefore limited to older adults, as the GDG were concerned about generalising the evidence available to younger adults with multimorbidity. The GDG agree that further research concerning the management of multimoridity should seek to include younger people. However, where it was possible to generalise, they have done so. In the research recommendation on predicting life expectancy the GDG have emphasised the need to include younger people with multimorbidity and reduced life expectancy as they may benefit from additional preventive treatments. Additionally, we have amended the guideline to clarify our definition of multimorbidity to include adults with learning disabilities. Please see recommendation 1.1.1 which states: Be aware that multimorbidity refers to the presence of 2 or more long-term health conditions, which can include: • defined physical and mental health conditions such as diabetes or schizophrenia • ongoing conditions such as learning disability • symptom complexes such as frailty or chronic pain • sensory impairment such as sight or hearing loss • alcohol and substance misuse.
University of	Full	42-		We understand the PTROBAST tool has been used. However	Thank you for your comment. We acknowledge that the

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Nottingham		43		discussions with a member of the PROBAST steering group (Dr Gary Collins) suggests there are concerns around the PROBAST tool being used since the tool hasn't been finalised; its has changed since the version used by the GDG (so the version used by the GDG is out of date). Also there is no publically available information on how the tool should be used and what is meant by items in the tool (some items require background in statistics and prediction modelling). Dr Collins (Oxford) is happy to be contacted about the use of the PROBAST tool.	PROBAST tool is still under development, and is due to be published later this year. We received permission from the study author to use a draft version of PROBAST, and have cited the tool as being based on this personal communication in the guideline. For the purpose of this guideline, an amended version of the tool has been used, and this has been noted in the methods chapter of the guideline.
University of Nottingham	Full	106		Hippisley-Cox study included two validation cohorts, one a separate sample of QResearch practices and the other was an external cohort of patients from CPRD. Only the QResearch cohort has been included in the tables.Please include the results for the CPRD cohort which had 2,475,360 patients.	Thank you for your comment. This information has been added.
University of Nottingham	Full	115-117		It is unclear why QAdmissions has been classified as "very high risk of bias" we think this may be a misunderstanding of the preliminary PROBAST tool since this tool hasn't been finalised and there is written guidance on how to use the tool. Please review this using another method apart from PROBAST which is under development and not finalised.	Thank you for your comment. We acknowledge that the PROBAST tool is still under development, and is due to be published later this year. We received permission from the study author to use a draft version of PROBAST, and have cited the tool as being based on this personal communication in the guideline. For the purpose of this guideline, an amended version of the tool has been used, and this has been noted in the methods chapter of the guideline (page 42-43 in the full guideline). This study reporting on the predictive ability of QAdmissions was assessed as being at very high risk of bias as the publication did not report a significant amount of the information required to assess risk of bias using the amended

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					PROBAST tool. Following publication of the draft guideline, we have re-assessed all of the studies that were downgraded for missing information, and have adjusted the risk of bias ratings. The methods used to do this have been reported in the methods chapter. This study now has received a rating of high risk of bias.
University of Nottingham	FULL	122		It is possible to get a higher resolution figure directly from the BMJ Open website http://bmjopen.bmj.com/powerpoint/3/8/e003482/F1	Thank you for your comment. This higher resolution figure has now been included.
University of Nottingham	Full	123	20	We don't agree that it is a very low quality study – no information to support this statement has been presented. The pseudo R2 values are measures of discrimination not calibration.	Thank you for your comment. This paper was originally rated as very low quality due to there being a significant amount of the information required to assess risk of bias We have re-assessed the risk of bias assessments for this review and have adjusted the risk of bias rating for this study. **Thank you for your comment about pseudo R2 values**, however we disagree. Pseudo R2 values are a measure of model performance (Steyerberg EW, Vickers AJ, Cook NR, et al. Assessing the performance of prediction models a framework for traditional and novel measures. Epidemiology2010;21:128-38). As they provide an indication of goodness of fit, they are more closely related to calibration. This is distinct from discrimination, which refers to the ability of the prediction model to distinguish between those who do or do not experience the event of interest (typically assessed by the area under the receiver operating characteristic curve

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					(c-statistic) or the Somer's D-statstic). Pseudo R2 values are a measure of model performance; not discrimination or calibration (Steyerberg EW, Vickers AJ, Cook NR, et al. Assessing the performance of prediction models a framework for traditional and novel measures. Epidemiology2010;21:128-38).
University of Nottingham	Full	124		We disagree with the statement "Sensitivity data only was available for QAdmissions with HES–GP linked data." Since this was also provided in the paper for QAdmissions (GP data linked)	Thank you for your comment. This statement has been edited to make it clearer that the data that was unavailable was the specificity data for either set of data, rather than the sensitivity data for the GP data linked set.
University of Nottingham	FULL	125		The numbers of patients in the QAdmissions validation sample with multiple morbidity can be provided on request	Thank you for your comment. The aim of this review was to specifically include studies that evaluated the performance of risk tools in a multimorbid population. As explained in the introduction to this review, we opted to include data for the QAdmissions tool, even though it was not evaluated in strictly a multimorbid population, as the GDG were aware that the tool is widely used in clinical practice. Across the guideline, we identified many research studies that did not clearly specify whether the study population was multimorbid, or the proportion of participants with multimorbidity. Within the timescale of the guideline it was not possible to contact all study authors to require additional information about the population. Where the population was unclear, the guideline committee considered what impact this would have on the interpretation of the evidence and how this was used to inform the recommendation. This discussion is captured in the LETR for the reviews, as for QAdmissions in this review.
University of	Gen			There are multiple places where the research underpinning	Thank you for your comment. We acknowledge that the

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Nottingham	eral			QAdmissions is described as "very low quality" or "very high risk of boas" but no evidence to support these classifications is presented. We are concerned that these arise misuse or misunderstanding of the preliminary PROBAST tool and think this should be reassessed.	PROBAST tool is still under development, and is due to be published later this year. We received permission from the study author to use a draft version of PROBAST, and have cited the tool as being based on this personal communication in the guideline. For the purpose of this guideline, an amended version of the tool has been used, and this has been noted in the methods chapter of the guideline (please see chapter 4). This study reporting on the predictive ability of QAdmissions was assessed as being at very high risk of bias as the publication did not report a significant amount of the information required to assess risk of bias using the amended PROBAST tool. Following publication of the draft guideline, we have re-assessed all of the studies that were downgraded for missing information, and have adjusted the risk of bias ratings. The methods used to do this have been reported in the methods chapter. This study has received a rating of high risk of bias.
University of Nottingham	FULL	117		Please add footnote to distinguish between 1 year risk and 2 year risk for QAdmissions	Thank you for your comment. This information has been added.
University of Surrey	Full	P20	31	We are concerned that the link to policy documents does not include a relationship between a cancer diagnosis, in policy guidance cancer survivorship is now considered a long term disease due to the longevity of ongoing therapies, maintenance and long term treatment effects for some cancer survivors and requirements of supportive care. Over 14% of elderly patients are likely to have had a cancer diagnosis and treatment during their life time which impacts on	Thank you for your comment. Following stakeholder comment the GDG discussed whether specific comment should be made about inclusion of cancer or cancer survivorship. The GDG have added more detail to the recommendations to indicate that long term conditions should include a variety of conditions and symptom complexes. The GDG preferred not to add cancer survivorship specifically to this list ahead common problems such as pain.

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				cardiovascular and wider health in relation to multi-morbidity. Identifying NICE guidance for supportive care https://www.nice.org.uk/guidance/GID-CGWAVE0799/documents/html-content would be valuable	
University of Surrey	Full	188		Review Question: what is the most accurate tool for assessing frailty? The assessment of frailty focuses on the subjective spectrum rather than early identification of problems through more objective measures. Muscle strength and sarcopenia are not assessed however evidence from cohort studies would suggest that simple measures like grip strength and sit to stand can detect sarcopenia and can be predictive of deterioration. Measures that reflect health nutrition should be included at a primary care and community setting such as BMI or hip to waist ratio. To reverse decline and improve patients risk factors then this is essential to prevent deterioration and improve cardiovascular health.	Thank you for your comment. The GDG examined evidence for the diagnostic accuracy of a variety of tools to assess for frailty, including tests of muscle strength (including grip strength and chair stand) and nutritional measures. The GDG chose to recommend several tests on the basis of their accuracy as well as ease of use within clinical practice.
University of Surrey	Full	219	28	The physical activity scale (PRISMA) was evaluated in only 1 study of 102 patients, in health exercise there are many measures of physical activity used in research such as the Godin that are short easy to use for physical fitness and activity and used in a variety of age ranges. The PRISMA tool has high sensitivity but does not have standardised parameters for comparison. Recommending a tool based on such a small amount of evidence seems unrealistic for a national recommendation. Identifying the key elements for measurement as tools may be different for patients who are older to those that are younger in relation to frailty could be a way of recommending measurement parameters rather than a specific tool	Thank you for your comment. The PRISMA-7 is not a measure of physical activity; this scale assesses a person's age, gender, and the impact of health problems on their functioning. The GDG considered that these factors were also in other tools identified in the review, which also demonstrated acceptable accuracy in identifying frailty relative to the reference standard. As a consequence, while the GDG acknowledge that the evidence for PRISMA-7 is only based on one study, they considered that the evidence in the review indicated that this tool may be useful for identifying people with frailty in clinical practice. Furthermore, the study was of high quality; meaning that it is not expected that further evidence would substantially change the findings.

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University of Surrey	Full	220		Recommendations for hospital and outpatient setting should also include nutritional health parameters	Thank you for your comment. The GDG discussed whether the recommendation should include the mini-nutritional assessment (short form) as a tool to identify frailty. This tool demonstrated high accuracy for diagnosing frailty relative to the reference standard (the phenotype model). However, the GDG opted not to include this tool in the final recommendation as there were other tools of similar accuracy and these were available without cost, and would therefore were considered to be more cost-effective. This review also identified evidence for the accuracy of a person's BMI to diagnose frailty; however, the sensitivity of this tool was considered to be too low for the tool to be used for this purpose in clinical practice. No further evidence for the accuracy of nutritional parameters to diagnose frailty was identified in this review.
University of Surrey	Full	225		Tailored approaches to care should include physical health and activity management. The focus on stopping therapies, polypharmacy and medications management is good but leaves out the evidence for the benefits of improving functional health through exercise or dietary interventions to reverse frailty.	Thank you for your comment. The GDG acknowledge the overlap between frailty and multimorbidity but the guideline is addressing multimorbidity and not the management of frailty.
University of Surrey	Full	241	6	Review question: How might data from condition-specific guidance best be used and presented to inform a ranking of treatments as part of decisions to optimise care amongst people with multi-morbidity ? Prostate cancer patients who have ADT have a 30% risk of cardiovascular disease or stoke	Thank you for your comment and this information. Following stakeholder comment the GDG added a recommendation to indicate that the term multimorbidity is used in the guideline to designate a variety of types of longterm conditions. The GDG discussed whether cancer survivorship should be

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				and this is increased if they have a prior cardiac event or stroke. Cancer survivors have a higher risk of multi morbidity and a prior cancer treatment especially therapies that impact on cardiovascular health should be highlighted within the guidance as they may have been treated 10 years previously and multiple health problems.	added to this list. They considered that any ongoing symptoms as a result of cancer would be considered a condition but that while risk of conditions in the future as a result of cancer treatment is important it is not necessarily a condition in itself.
University of Surrey	Short	11	14	In putting the guideline into practice consideration of the wider multi-disciplinary team in providing dietetics and physical and functional support should be encouraged. Secondary prevention and health promotion measures such as early identification of deterioration should be included in recommendation	Thank you for participating in the consultation process. The guideline examined models of care for people with multimorbidity some of which included physical and functional assessment and support and general health assessment. The GDG did not consider there was adequate evidence to recommend these approaches.
Year of Care Partnerships	Full	General		The Year of Care Partnership programme has demonstrated what is needed and provides expertise, support, resources and quality assured training to support local communities (including general practice, multidisciplinary and specialist teams) to make systematic and collaborative care and support planning (previously called care planning in health and support planning in social care) the norm for all those living with long term conditions (LTCs) (Year of Care – Report of the Pilot programme.www.yearofcare.co.uk/sites/default/.../YOC_Report%20-%20correct.pdf) including multi morbidity. (Eaton S, et. al. Delivering person centred care in long term conditions. BMJ 2015;350:h181 and http://www.yearofcare.co.uk/examples) From this perspective YOCP welcomes the emphasis on a tailored approach to care, treatment and support for people living with multi morbidity. However, we have concerns that the approach in this guideline makes it appear that tailored	Thank you for your comment. This guideline is intended to cover the clinical assessment and management of people with multimorbidity, and therefore it is not possible to make a recommendation on the care of people with single conditions. This guideline does not replace the recommendations on the care of people with single conditions in other NICE guidance, which may include consideration of individualised care. Within this guideline we conducted evidence reviews to evaluate the effectiveness of service-level and self-management interventions to improve the care of people with multimorbidity, and have made recommendations on the basis of the available evidence. We did not include evidence evaluating the effectiveness of medication management interventions, as these are covered

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				personalised support applies only to those living with multi morbidity who also fall into service defined subgroups with particular complexities. We read this guidance as implying that a tailored approach can be ignored and should not already be the norm for others living with LTCs, who do not fulfil the criteria outlined in this guideline. There is an added danger that this will encourage the focus, resources, training and support for personalised care to be diverted away from this larger group where the potential to avoid deterioration towards greater complexity in the future needs to be reduced. The principles and practice of tailored support and care coordination is just as relevant to this larger group and have been recommended as the core approach to care for everyone with LTCs, however many conditions they live with, since the publication of the Wagner Chronic Care Model more than 25 years ago. This was subsequently adopted as the universal approach to LTC care by WHO and by the NHS in 2003. Since then it has been emphasised in all policy documents which refer to LTCs, including the 5-year Forward View. Recently the Avoiding Unplanned Admissions Enhanced Service (ES) which involves incentivising the identification of people with the most complex needs for special, tailored intervention has diverted focus and effort in general practice teams away from providing a tailored approach to all people registered with LTCs. Its perceived inappropriateness and lack of effectiveness means that this scheme is now under review by NHSE. YOCP would ask the guideline group to consider placing their aspiration for a tailored personalised approach within the	in other NICE guidance (Medication Adherence (CG76) and Medicines Optimisation (NG5)). Decision-making has been examined and recommended in the NICE Patient Experience guideline (CG138).

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				delivery framework of care and support planning. A recent Cochrane review (Cochrane review: Coulter A et al. Personalised care planning for adults with chronic or long-term health conditions. Cochrane Database of Systematic Reviews 2015, Issue 3, Art. No.: CD010523. DOI: 10.1002/14651858.CD010523.pub2.) would support this. It describes the key components and benefits of personalised care planning emphasising that it appears to be most successful when integrated as part of routine systematic care. YOCP welcomes the emphasis on polypharmacy for those living with multiple conditions and the challenges raised by trying to combine previous condition specific NICE guidance. Our suggestion is that it is this component of management which is most closely related to those with multi morbidity rather than those with single or less complex LTCs, and should become the primary focus of the recommendations in this guideline. We would suggest that the guideline acknowledges that personalised tailored support is the core of care for everyone living with LTCs in a much briefer section, highlights that the purpose is to provide additional guidance on polypharmacy and recognises that care and support planning provides the ideal organisational arrangement in which this should take place. YOCP also asks the guideline group to consider readjusting the balance of their recommendations to include both better management of the biomedical components of the conditions (medicines management, shared decision making around	

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				treatment choices) and recognition of the therapeutic benefit of support in the wider community, ideally identified during the care and support planning process. This includes not only better coordination of traditional community services but sign posting (sometimes called social prescribing) to activities (such as peer support, addressing social isolation, falls prevention, physical activity, nutrition, arts for health as well as specific self-management programmes) in a supportive community for which there is a growing evidence base for effectiveness, an economic argument and practical understanding.	
Year of Care Partnerships		12	14	Suggest: Ensure a tailored approach to all people living with long terms conditions recognising that that for those with more than one condition, and complex physical and mental and social care issues the following may apply more frequently ……	Thank you for your suggestion. This guideline is intended to cover the identification and management of people with multimorbidity, and therefore it is not possible to make a recommendation on the care of people with single conditions. This guideline does not replace the recommendations on the care of people with single conditions in other NICE guidance, which include consideration of individualised care.
Year of Care Partnerships		12	26	Suggest: When offering a tailored approach do this within the context of systematic personalised care and support planning which focusses on….. The emphasis on the plan rather than the process of care planning is unhelpful here and ignores the benefits of a partnership approach focussed on what is most important to the individual and for which any written plan acts as the summary rather than the main purpose.	Thank you for this suggestion. The GDG disagree that the emphasis is on the plan. The guideline makes specific recommendations for process such as explaining the aim of review, eliciting people's values and concerns, reviewing treatments. The GDG agree that any written plan is a summary rather than the purpose. Recommendation 1.6.17 recommends agreeing the actions to take and what to record and does not emphasise a written plan.
Year of Care Partnerships		12	38	Suggest: That the practitioner takes active steps to prepare the patient for the discussion ensuring that they have information	Thank you for this suggestion. The GDG considers that the recommendations include these

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				in a form they can understand, any personal information which will enable them better to take part in the discussion and time to reflect on what is important to them, prior to the consultation.	points. Please see recommendations 1.6.6, 1.6.7 and 1.6.8 in the section entitled: Delivering an approach to care that takes account of multimorbidity. The subsection entitled 'establishing patient goals, values and priorities' addresses this issue.
Year of Care Partnerships		13	19	We would suggest that limiting the selection process to the tools and decisions of the practitioner may miss individuals who can benefit from a tailored approach such as personalised care planning. There is evidence from the self-management literature that practitioners are poor at assessing who can benefit and there is no reason to think that people with multi morbidity are any different.	Thank you for your comment. The recommendations do include tools and processes but also include a recommendation that people may be identified opportunistically. Please see recommendation 1.3.1 which states: Identify adults who may benefit from an approach to care that takes account of multimorbidity (as outlined in section 1.5): • opportunistically during routine care • proactively using electronic health records. Use the criteria in recommendation 1.2.1 to guide this. The guideline committee considered that this allowed practitioners to be responsive to individual patients' presentations.
Year of Care Partnerships		14	37	YOCP would dispute that 'the purpose of a personalised approach is to find ways of reducing treatment burden and optimising care'. The primary purpose of a personalised approach is to find the most appropriate ways to support each individual to live well with their condition(s). If this is achieved, it is likely to involve reducing the treatment burden and will optimise care for that person	Thank you for your comment. We have altered the wording of this recommendation to include improving quality of life as aim and highlights that this may include reducing treatment burden and optimising care and support. Please see recommendation 1.6.2 which states: Discuss with the person that the purpose of the approach to care is to improve quality of life'. This might include reducing

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					treatment burden and optimising care and support by identifying: • ways of maximising benefit from existing treatments • treatments that could be stopped because of limited benefit • treatments and follow-up arrangements with a high burden • medicines with a higher risk of adverse events (for example, falls, gastrointestinal bleeding, acute kidney injury) • non-pharmacological treatments as possible alternatives to some medicines • alternative arrangements for follow-up to coordinate or optimise the number of appointments.
Year of Care Partnerships		14	43	Make it clear that non pharmacological treatments may include non-traditional therapeutic activities within a supportive community not necessarily provided by the statutory services.	Thank you for your comment. Within this guideline we conducted evidence reviews to evaluate the effectiveness of service-level and self-management interventions to improve the care of people with multimorbidity, and have made recommendations on the basis of the available evidence. We did not identify evidence for the clinical and/or cost-effectiveness of community-based interventions, and therefore cannot recommend that they should be used in the care of people with multimorbidity.
Year of Care Partnerships		15	26	We suggest including 'maintaining independence' and 'feeling in control of my life' added to the list below.	Thank you for your comment. The GDG has considered your suggestions and reworded the recommendation. The recommendation encourages health care professionals to clarify the patient's goals, values and priorities and

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					'maintaining independence' has been added to the list of examples provided. Please see recommendation 1.6.7 which states: Encourage people with multimorbidity to clarify what is important to them, including their personal goals, values and priorities. These may include: • maintaining their independence • undertaking paid or voluntary work, taking part in social activities and playing an active part in family life • preventing specific adverse outcomes(for example, stroke) • reducing harms from medicines • reducing treatment burden • lengthening life.
Year of Care Partnerships		16	29	We would suggest that the guideline should attempt to move away from a practitioner /service focussed set of activities following the discussion, recognising that these should include actions the person has decided to do for themselves either immediately or in the future as well as the actions that will be taken by the service /practitioner. The emphasis should be on demonstrating that the person is the main actor in determining the outcomes of their conditions (including for instance whether they take, or do not take the medication prescribed).	Thank you for your comment. The GDG agrees with you and so have drafted recommendations that highlight the importance of eliciting and understanding patient preferences, values and priorities during decision making. Please see recommendations in the NICE version in the section on Delivering an approach to care that takes account of multimorbidity. The subsection entitled 'establishing patient goals, values and priorities' addresses this issue.

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					See recommendations 1.6.6, 1.6.7 and 1.6.8. Additionally the care team is encouraged to explore the person's attitudes to their treatments and to follow the recommendations on involving patients' decisions about medicines in the NICE guideline on medicines adherence. Further details on this guidance can be found at: https://www.nice.org.uk/guidance/cg76
Year of Care Partnerships		18	30	In our general comments on previous sections we have asked the guideline committee to emphasise that a tailored personalised approach should be the norm for everyone living with one or more LTCs. This line (and the previous paragraph) makes a convincing argument that the benefits of an individual approach for those living with multi-morbidity, and complex symptomatology relate largely to medication and poly pharmacy.	Thank you for your comment. The GDG agree that the approach included in the guideline is also appropriate for many people who do not have multimorbidity. This guideline is however directed to people with multimorbidity. .
Year of Care Partnerships	Full	General		The Year of Care Partnership programme has demonstrated what is needed and provides expertise, support, resources and quality assured training to support local communities (including general practice, multidisciplinary and specialist teams) to make systematic and collaborative care and support planning (previously called care planning in health and support planning in social care) the norm for all those living with long term conditions (LTCs) (Year of Care – Report of the Pilot programme.www.yearofcare.co.uk/sites/default/.../YOC_Report%20-%20correct.pdf) including multi morbidity. (Eaton S, et. al. Delivering person centred care in long term conditions. BMJ 2015;350:h181 and	Thank you for your comment. This guideline is intended to cover the clinical assessment and management of people with multimorbidity, and therefore it is not possible to make a recommendation on the care of people with single conditions. This guideline does not replace the recommendations on the care of people with single conditions in other NICE guidance, which may include consideration of individualised care. Within this guideline we conducted evidence reviews to evaluate the effectiveness of service-level and self-management interventions to improve the care of people with

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				http://www.yearofcare.co.uk/examples) From this perspective YOCP welcomes the emphasis on a tailored approach to care, treatment and support for people living with multi morbidity. However, we have concerns that the approach in this guideline makes it appear that tailored personalised support applies only to those living with multi morbidity who also fall into service defined subgroups with particular complexities. We read this guidance as implying that a tailored approach can be ignored and should not already be the norm for others living with LTCs, who do not fulfil the criteria outlined in this guideline. There is an added danger that this will encourage the focus, resources, training and support for personalised care to be diverted away from this larger group where the potential to avoid deterioration towards greater complexity in the future needs to be reduced. The principles and practice of tailored support and care coordination is just as relevant to this larger group and have been recommended as the core approach to care for everyone with LTCs, however many conditions they live with, since the publication of the Wagner Chronic Care Model more than 25 years ago. This was subsequently adopted as the universal approach to LTC care by WHO and by the NHS in 2003. Since then it has been emphasised in all policy documents which refer to LTCs, including the 5-year Forward View. Recently the Avoiding Unplanned Admissions Enhanced Service (ES) which involves incentivising the identification of people with the most complex needs for special, tailored intervention has diverted focus and effort in general practice teams away from providing a tailored approach to all people registered with LTCs. Its	multimorbidity, and have made recommendations on the basis of the available evidence. We did not include evidence evaluating the effectiveness of medication management interventions, as these are covered in other NICE guidance (Medication Adherence (CG76) and Medicines Optimisation (NG5)). Decision-making has been examined and recommended in the NICE Patient Experience guideline (CG138).

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				perceived inappropriateness and lack of effectiveness means that this scheme is now under review by NHSE. YOCP would ask the guideline group to consider placing their aspiration for a tailored personalised approach within the delivery framework of care and support planning. A recent Cochrane review (Cochrane review: Coulter A et al. Personalised care planning for adults with chronic or long-term health conditions. Cochrane Database of Systematic Reviews 2015, Issue 3, Art. No.: CD010523. DOI: 10.1002/14651858.CD010523.pub2.) would support this. It describes the key components and benefits of personalised care planning emphasising that it appears to be most successful when integrated as part of routine systematic care. YOCP welcomes the emphasis on polypharmacy for those living with multiple conditions and the challenges raised by trying to combine previous condition specific NICE guidance. Our suggestion is that it is this component of management which is most closely related to those with multi morbidity rather than those with single or less complex LTCs, and should become the primary focus of the recommendations in this guideline. We would suggest that the guideline acknowledges that personalised tailored support is the core of care for everyone living with LTCs in a much briefer section, highlights that the purpose is to provide additional guidance on polypharmacy and recognises that care and support planning provides the ideal organisational arrangement in which this should take place.	

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				YOCP also asks the guideline group to consider readjusting the balance of their recommendations to include both better management of the biomedical components of the conditions (medicines management, shared decision making around treatment choices) and recognition of the therapeutic benefit of support in the wider community, ideally identified during the care and support planning process. This includes not only better coordination of traditional community services but sign posting (sometimes called social prescribing) to activities (such as peer support, addressing social isolation, falls prevention, physical activity, nutrition, arts for health as well as specific self-management programmes) in a supportive community for which there is a growing evidence base for effectiveness, an economic argument and practical understanding.	
Year of Care Partnerships	Full	General		The Year of Care Partnership programme has demonstrated what is needed and provides expertise, support, resources and quality assured training to support local communities (including general practice, multidisciplinary and specialist teams) to make systematic and collaborative care and support planning (previously called care planning in health and support planning in social care) the norm for all those living with long term conditions (LTCs) (Year of Care – Report of the Pilot programme.www.yearofcare.co.uk/sites/default/.../YOC_Report%20-%20correct.pdf) including multi morbidity. (Eaton S, et. al. Delivering person centred care in long term conditions. BMJ 2015;350:h181 and http://www.yearofcare.co.uk/examples) From this perspective YOCP welcomes the emphasis on a	Thank you for your comment. This guideline is intended to cover the clinical assessment and management of people with multimorbidity, and therefore it is not possible to make a recommendation on the care of people with single conditions. This guideline does not replace the recommendations on the care of people with single conditions in other NICE guidance, which may include consideration of individualised care. Thank you for the reference of the recent Cochrane review. The GDG were aware of this publication, however as the review aimed to evaluate personalised care planning in people with long-term conditions generally, and not specifically those with multimorbidity,

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				tailored approach to care, treatment and support for people living with multi morbidity. However, we have concerns that the approach in this guideline makes it appear that tailored personalised support applies only to those living with multi morbidity who also fall into service defined subgroups with particular complexities. We read this guidance as implying that a tailored approach can be ignored and should not already be the norm for others living with LTCs, who do not fulfil the criteria outlined in this guideline. There is an added danger that this will encourage the focus, resources, training and support for personalised care to be diverted away from this larger group where the potential to avoid deterioration towards greater complexity in the future needs to be reduced. The principles and practice of tailored support and care coordination is just as relevant to this larger group and have been recommended as the core approach to care for everyone with LTCs, however many conditions they live with, since the publication of the Wagner Chronic Care Model more than 25 years ago. This was subsequently adopted as the universal approach to LTC care by WHO and by the NHS in 2003. Since then it has been emphasised in all policy documents which refer to LTCs, including the 5-year Forward View. Recently the Avoiding Unplanned Admissions Enhanced Service (ES) which involves incentivising the identification of people with the most complex needs for special, tailored intervention has diverted focus and effort in general practice teams away from providing a tailored approach to all people registered with LTCs. Its perceived inappropriateness and lack of effectiveness means that this scheme is now under review by NHSE.	it was not relevant for inclusion in this guideline. The GDG believe that the provision of personalised care as well as the management of multiple treatments and polypharmacy are both important issues for people with multimorbidity. As a consequence, both of these topics were considered within the guideline. Within this guideline we conducted evidence reviews to evaluate the effectiveness of service-level and self-management interventions to improve the care of people with multimorbidity, and have made recommendations on the basis of the available evidence. Based on the evidence identified, it was not possible to make further recommendations about the way support should be provided to people with multimorbidity, including making further recommendations on community support. The GDG agree that this is an important area for consideration, and have made a research recommendation for this. We did not include evidence evaluating the effectiveness of medication management interventions, as these are covered in other NICE guidance (Medication Adherence (CG76) and Medicines Optimisation (NG5)). Decision-making has been examined and recommended in the NICE Patient Experience guideline (CG138).

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Registered stakeholders https://www.nice.org.uk/guidance/GID-CGWAVE0704/documents/stakeholder-list-3