NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Multimorbidity

Date of quality standards advisory committee post-consultation meeting:
22 March 2017

2 Introduction

The draft quality standard for multimorbidity was made available on the NICE website for a 4-week public consultation period between 24 January and 20 February 2017. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 19 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the quality standards advisory committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the committee as part of the final meeting where the committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in the appendices.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

3. Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

4. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

Stakeholders were also invited to respond to the following statement specific questions:

5. For draft quality statement 3: In practice, would statement 3 be covered as part of statement 5 on reviewing medicines and other treatments?

6. For draft quality statement 4: Is there overlap between this statement and having a named GP as set out in the 2016/17 standard GP contract?

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- The quality standard was welcomed by a number of stakeholders.
- Although broad support was indicated, some stakeholders felt that the emphasis within the quality standard needed to change. Comments and suggestions included:
  - The quality standard needs to be more relevant to people with mental health problems as it is oriented towards physical conditions (e.g. the definition of multimorbidity used requires one condition to be physical).
  - There is an overemphasis on GPs and practice nurses at the expense of the wider primary care team.
  - Reference to carers, relatives and care and support planning, is lacking.
  - More emphasis is needed on collaboration and partnership with the person with multimorbidity (as opposed to seeing the person with multimorbidity as a passive recipient); the planning process is seen as the job of the healthcare professional using prescriptive approach.
- The quality standard should include provision of knowledge, resources and support to allow a person to manage their condition at home.
- The quality standard should recognise that not all conditions will progress; some may improve whilst others may be constant.
- A multimorbidity score should be used to quantify the level of the problem
- Training and education for healthcare professionals to implement statements should be mentioned.

- The draft quality standard would complement the Comprehensive Geriatric Assessment as promoted by the British Geriatric Society and the Acute Frailty Network
- The quality standard should make clear when care moves away from disease based guidance to multimorbidity guidance; the onset of frailty was suggested as the point.
- Additional equality and diversity considerations were suggested including:
  - People in prison (higher incidence of multimorbidity).
  - Ethnicity, as black people are more likely to have a stroke at a younger age; have high blood pressure; diabetes and sickle cell disease.

Consultation comments on data collection

- Patient surveys would be difficult to implement in terms of routine care. A survey of care co-ordinators or an audit of care plans were suggested as alternatives.
- Systems and structures are ‘not completely’ in place, but routine frailty identification would help. New coding may also be needed, as will consistency with language and documentation to ensure information can be shared across the system.
- Some stakeholders suggested measures relating to contacts with the care co-ordinator.
- The GP contract should allow for most of the statements to be measured (apart from statement 2).

Consultation comments on resource impact

- The statements are potentially achievable given the resources available and possible cost savings include reduced prescribing costs, appointments, travel, and diagnostics.
- There would not be sufficient resource to deliver individualised care to an appropriate standard for everyone with frailty. Resources inputs would include training, and in secondary care investment to secure a change in culture and practice.

- There are some potential cost savings relating to drugs, and hospital admissions or other institutional care but the latter may take years to achieve, and there is no evidence to show the savings would actually occur.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

Adults with multimorbidity are identified by their GP practice.

Stakeholders made the following comments in relation to draft statement 1:

- Whilst multimorbidity and frailty overlap, the two are distinct and can be mutually exclusive. Using eFI will identify those who are frail and therefore more likely to have concomitant multimorbidity, but could miss those with multimorbidity who are not yet frail and include those living solely with frailty.
- The 2017/18 GP contract includes routine frailty identification using the eFI or (other validated tool). The routine identification in the quality standard should align with the GP contractual wording.
- Chronic pain is correctly identified as one of the long term health conditions that contribute to multimorbidity, but there is no agreed assessment scale nor is it routinely recorded in GP records.
- Commissioners need to ensure that technology and other key services are available to aid the identification of multimorbidity.
- Information on people identified with multimorbidity needs to be consistent, flow across care settings and between the different practitioners providing care.
- Different views were expressed as to whether an opportunistic or proactive approach to identification would be better.
- Contrasting comments were made on resources in relation to this statement:
  - Practices with an older demographic patient profile could see a substantial increase in workload and need extra resources.

  - IT and electronic record keeping systems primary care are well suited to identifying those who require to be identified; the challenge is whether there is resource to deliver the discussions to make this of value.
  - Systems are not in place to collect this data, but minimal additional resource would be needed to create a multimorbidity register (if appropriate READ codes are identified).
- The statement should be explicit about tools that should be used, as users of the guidance may not know which to use or which are validated.
- The wording should recognise that treatment burden is not simply related to number of medications but may also relate to the number of associated diagnostic tests, hospital or clinic attendances.
- The statement should recognise that there are different 'clusters' of multimorbidity, where different conditions commonly occur together, that require different actions and approaches.
- 'Additional support', referred to in the rationale, should be described.
- Some stakeholders said that the audience descriptors are too narrow in terms of who performs the actions and suggested including or giving greater emphasis to community pharmacists; healthcare professionals outside of GP practice settings and allied health professionals; carers; statutory social care commissioners and providers; and third sector organisations such as charities.
- The wording of the audience descriptors is not in the spirit of the collaborative care and supporting planning model (e.g. as it says the professional decides who would benefit from additional support).

5.2 Draft statement 2

Adults with multimorbidity who are assessed for frailty are evaluated using gait speed, self-reported health status or a validated tool**.**

Stakeholders made the following comments in relation to draft statement 2:

- The statement should apply to a narrower target population (say people aged over 65) as assessment of some people with multimorbidity for frailty is unlikely to be useful (e.g. adults with learning difficulty, alcohol or drug misuse are likely to be of a younger age range).

- The description of tools for identifying frailty suggests a more definitive relationship with the presence of frailty than the evidence shows, e.g. the gait speed test could be simply indicative of an underlying musculoskeletal condition such as arthritis.
- The separation of frailty seems artificial as frailty is also a multimorbidity condition in its own right.
- The statement should say that people with a diagnosis of frailty should be considered to have a diagnosis of multimorbidity.
- The statement should recognise the complex relationship between frailty, disability and multimorbidity.
- The statement should include documenting disability and examining the psychological effects of long term conditions.
- Frailty should be defined as there is a lack of awareness and understanding of what it entails.
- Frailty assessment (and care planning) should happen through comprehensive geriatric assessment.
- Statement 2 should include the eFI and other validated tools for frailty, such as the clinical frailty scale (as recommended by NHS England and the Acute Frailty Network); clearer reference to eFI would help align the statement with the new GP contract.
- People assessed as having frailty should be assessed and reviewed for multimorbidity (as well as vice versa).
- The statement wording reads as if the gait speed test and self-reported questionnaires are not validated approaches.
- Many patients are already coded as frail and re-evaluating this diagnosis to fit with the statement could become a tick box exercise.
- The statement wording should reflect the NHS England approach being taken to routine identification of frailty (with co-occurrence of frailty and multi-morbidity): ‘Adults with multi-morbidity and those who are identified as living with frailty are evaluated using validated tools’.

- GP resources are stretched and this could present a challenge in the effective delivery of this statement. A drive to build capacity to support the measuring of frailty services provided by most NHS trusts may be needed.
- The audience descriptors should be widened to:
  - Reflect the multidisciplinary approaches required to deliver multimorbidity management
  - Include pharmacists as an example.

5.3 Draft statement 3

Adults with multimorbidity are asked about their goals, values and priorities.

Stakeholders made the following comments in relation to draft statement 3:

- Goals, values and priorities should be expanded to cover emotional, practical and psychological needs, which are often increased in people with multiple conditions.
- Chronic pain, pain management, comfort and functional limitations should be addressed.
- Goals, values and priorities of people with multimorbidity will be related to their knowledge, skills and confidence (also called patient activation) about managing their condition(s) so these should be considered.
- There needs to be regular review of goals, values and priorities (although there was not a consensus on how often this should be).
- Conversations about goals provide opportunities to link people with other sources of emotional, practical, psychological support; and identify informal carers and act on their support needs.
- Some stakeholders suggested that the statement should be extended in terms of who should ask about goals, values and priorities and include:
  - Other healthcare professionals in primary care such as physician associates and paramedics.
  - Community pharmacists.
  - Non-medical staff and the voluntary sector.
- Some stakeholder recommended that the statement should address how goals, values and priorities are recorded, including:

  - The statement should emphasise documentation to ensure that a person's care team will know the goals, values and priorities.
  - Information should be recorded in a standardised format on clinical information systems to ensure easy access and exchange with other providers.
  - Goals and problems should be captured in a care and support plan.
  - Records of conversations should be patient held.
- There should be explicit reference to advance care planning; the concept of advance care planning should be introduced as part of the discussions and wishes to refuse treatments should be documented in an Advance Decision to Refuse Treatment.
- The statement should recognise that some people, such as older people with dementia and other morbidities, will have communication difficulties and struggle to adequately convey their goals, values and priorities without appropriate support; Independent Mental Capacity Advocates, Independent Mental Health Advocates and independent advocacy should be referenced.
- The statement should be reworded to be more inclusive and co-operative; it does not currently describe the patient as a true partner in their care and narrows the conversation to discussing the benefits/side effects of treatment when it should be an opportunity to discuss overt and softer goals.
- The treatment burden example in the rationale is too narrow and focuses on medicines as opposed to frequent attendance at health appointments and requirements for diagnostic evaluation. Reference to delivery of 'minimally disruptive treatment' should also be made.
- Contrasting comments were made on resource impact:
  - The statement is not achievable with current resources. It would require substantial resourcing and incentivising; significant leadership input; training of individuals; commissioning of service development; and monitoring. No savings would be achieved in the short term, and there would be no opportunity for disinvestment.
  - Healthcare professionals must be allowed the space and time for meaningful and potentially difficult goal-setting conversations alongside their already heavy workload. This is possible: pilots have shown that change is neutral in terms of

  the resources required as people got what they needed in one longer conversation rather than through several shorter ones.
- Comments on process and outcome measures included:
  - The process measure assumes that all those with multimorbidity have an individualised management plan, but this is not the case.
  - A quantitative measure is proposed but it measures things that are mostly qualitative.
  - Measurement should include clinical and patient identified outcomes.
  - Outcomes from the action of asking about goals, values and priorities should be included.
- The inclusion of equalities and diversity considerations for the statement were welcomed, but additions were suggested including:
  - Wider patient circumstances and context such as customs, language, culture, ethnicity, family role and religious beliefs which may influence behaviours, choices and decision making.
  - People with low confidence, knowledge and skills may need additional support to understand and express their goals, values and priorities.

Consultation question 5

Stakeholders made the following comments in relation to consultation question 5:

- Most stakeholders considered there to be a degree of overlap between the statements 3 and 5 but wanted two separate statements to be retained as:
  - They are based on different ideas, have a different focus and consolidating them may diminish their impact.
  - Separate statements reflect the distinction between the areas made in the underpinning guideline.
  - Combining statements would not ensure that matters are covered to an appropriate depth and extent.
- No stakeholders recommended combining the statements.

5.4 Draft statement 4

Adults with multimorbidity know who is responsible for coordinating their care.

Stakeholders made the following comments in relation to draft statement 4:

- The wording needs to be more inclusive and cooperative as not enough emphasis is placed on the person having a role in managing their care.
- The statement should read ‘Adults with multi-morbidity or identified as living with frailty…’ as this will align with the NHS England approach to routine frailty identification (now incorporated, into the GP contract); and ensure effective care coordination for both multi-morbidity and frailty.
- Information sharing between the health care professionals involved in the care and the other parts of the health and social care system should be referenced.
- A separate ‘care coordinator role’ can more effectively manage the coordination of care for larger numbers of people with high levels of need and reduce pressure on healthcare professionals.
- Collaboration with the third sector around care-navigator / coordinator roles would be beneficial.
- The statement should recognise others involved in the care of a person (such as carers) as being involved in deciding who coordinates care.
- Stakeholders recognised the importance of individualised care plans and suggested that:
  - The expectation of a co-ordinated care plan should be more explicit.
  - The plan should identify carers.
  - The term ‘management plan’ is too medicalised and should be replaced with ‘personalised care and support plan’.
  - The existence of a plan should be documented in the summary care record so it can be shared with other health care professionals, and services (consistent with the approach being taken in the GP contract 2017/18).
  - The importance of communication and shared decision-making when developing care plans should be recognised.

- Several stakeholders emphasised that it does not have to be a GP who is responsible for coordinating care and that the statement should make clear that this person is not responsible for delivering / providing all the care.
- Suggestions of others who could perform the coordinating role included:
  - Nurses
  - Therapists
  - Health and wellbeing co-ordinators
  - Community pharmacists
  - Professional from primary, secondary or community care or social services.

Consultation question 6

Comments made in relation to consultation question 6:

- Some stakeholders said there is no overlap between the statement and having a named GP.
- Others said that there could be a degree of overlap but the two are distinct in many respects including:
  - Patients and carers are included in discussions on who is involved with co-ordination of their care which makes it distinct from having a named GP.
  - The individual responsible for coordinating the care of a person with multimorbidity may not be their GP.
  - The coordination of care should not just focus on their health care needs.
  - Many patients do not always see their own named GP.
  - Capacity issues in primary may mean that in practice the work is devolved.

5.5 Draft statement 5

Adults having a review of their medicines and other treatments for multimorbidity discuss whether treatments can be stopped or changed.

Stakeholders made the following comments in relation to draft statement 5:

- Although the statement wording refers to medicines and other treatments, some stakeholders felt the main focus was on medicines. Some welcomed such a focus whilst others felt it should be widened. Comments included:

  - The statement on medicines optimisation is welcome.
  - The statement should make clear that it is about addressing inappropriate polypharmacy.
  - Non pharmacological treatment burden should be included.
  - The focus should not be so heavily on medication but on reviewing a patient's complete health and social care needs.
  - Medications and other treatment does not take in the scope of wider treatment burden.
  - Reducing inappropriate treatments can improve the lives of carers, family and others involved in a person's care the statement wording should reflect this.
  - Discontinuing a medication is not about cost savings; it is about the patient's health and wellbeing along with the goals and aspirations they have set out.
  - There is no treatment for multimorbidity itself but the statement wording implies there is.
  - The outcomes of the statement are around the avoidance of adverse events from medicines but should include other objectives such as avoiding episodes of ill health.
- The need for a review was generally welcomed, but comments emphasised the need for this to be regular and also that the actions resulting from the review should be wider than stopping or changing treatments. Comments included:
  - Focus should not just be on whether treatments can be stopped or changed but on finding the most appropriate ways to support each individual to live well with their condition(s).
  - A review to discuss stopping or altering treatments will not address medicines adherence, or changes in needs requiring new treatments.
  - Looking at aspects that involve stopping/changing a medication will not address the routine implementation of medication reviews.
  - Statement should encourage medication review on a regular basis as this is not routinely happening at the moment.
  - Ongoing review is needed to recognise and address changing needs or developing side effects/adverse events.

  - Transitions from one setting to another can act as a prompt to review and discuss medications
- A person’s ability to actively participate in a discussion about their medicines and treatments will be dependent on their levels of knowledge, skills and confidence, and that the statement should recognise that some people would benefit from advocacy support.
- Stakeholder comments on those performing the reviews included:
  - GPs and practice based pharmacists should undertake face to face dedicated medicine reviews for all patients with multimorbidity.
  - Healthcare professionals doing medication reviews need to be empowered through evidence, training or through access to colleagues with relevant expertise (say to challenge specialists’ recommendations on treatment).
  - Community pharmacists already provide Medicines Use Reviews; they could also discuss medicines and other treatments as part of this review.
  - Engagement in discussion, evaluation and care planning should extend beyond health providers and commissioners to other parts of the health and social care system.

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements.

- A statement supporting the person with multimorbidity to take an active role in managing their lives by building their knowledge, skills and confidence.
- A statement supporting families and carers of people with multimorbidity to help them perform their vital roles.
- A statement to reflect the links between multimorbidity and psychological status.

Appendix 1: Quality standard consultation comments table – registered stakeholders

General comments and comments on introductory / end sections of document		
ID	**Stakeholder**	**Comments[1]**
1	Age UK	Age UK welcomes this Quality Standard on multimorbidity as a valuable contribution to improving the care and outcomes of older people living with multiple long-term conditions. Multimorbidity and the increasingly complex health conditions that older people are living with are among the most important issues facing our health and social care system.
2	Compassion in Dying	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; • supplying a free resource www.mydecisions.org.uk so that people can make an Advance Decision to Refuse Treatment online; • 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 Quality Standard, particularly in the ways it reflects the full guidance by focussing on the need for individualised care for adults with multimorbidity. However, there are some specific areas highlighted below where we think improvements could be made.
3	National Community Hearing Association	The requirement that one long-term condition has to be a physical health condition appears to be at odds with the NHS Mandate and NHS/Government policy to ensure parity between mental and physical health.

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[1] PLEASE NOTE: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

General comments and comments on introductory / end sections of document		
ID	**Stakeholder**	**Comments[1]**
		Do people only benefit from this quality standard if they have two physical conditions or one physical condition and a mental health condition, but not two mental health conditions? We recommend that the text is changed from “This quality standard covers clinical assessment, prioritisation and arrangement of healthcare for adults aged 18 years and over with 2 or more long-term health conditions (multimorbidity). At least 1 of these conditions must be a physical health condition” to “This quality standard covers clinical assessment, prioritisation and arrangement of healthcare for adults aged 18 years and over with 2 or more long-term health conditions (multimorbidity).”
4	National Community Hearing Association	We welcome that hearing loss is specifically mentioned in the Quality Standard. This is important because awareness about the impacts and prevalence of hearing loss is poor, despite it being one of the most common long-term conditions in older people and a leading and growing cause of years lived with disability in England. We think it is therefore important that this remains in the final version of the Quality Standard. Evidence: • 9 million people in England have a hearing loss and this will increase as the population grows older[2] • adult hearing loss is the third most common long-term condition and the 6th leading cause of years lived with disability in England[3] • age-related hearing loss is the main cause of hearing loss, accounting for nine out of ten cases of permanent hearing loss. The majority of older people with multimorbidities will have hearing loss in addition to another long-term condition – e.g. seven out of ten 70 year olds have hearing loss • unsupported hearing loss is correlated with increased risk of depression[4], social isolation[5], premature retirement[6], reduced quality of life[7], loneliness[8] and cognitive decline[9]. Unsupported hearing loss – as other NICE quality

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[2] Action on Hearing Loss (2016). Hearing Matters, p.104

[3] Global Burden of Disease Study Collaborators, June 8, 2015, Lancet http://dxdoi.org/10.1016/S0140-6736(15)60692-4

[4] Acar, B. et al. 2011. Effects of hearing aids on cognitive functions and depressive signs in elderly people. Archives of Gerontology and Geriatrics, 52(3), pp. 250-252.

[5] Hidalgo, J. L. et al. 2009. Functional status of elderly people with hearing loss. Archives of Gerontology and Geriatrics, 49(1), pp. 88-92

[6] Helvik, A. 2012. Hearing loss and risk of early retirement. The Hunt study. European Journal of Public Health, 23(4), pp. 617-622

[7] Appollonio, I. et al. 1996. Effects of Sensory Aids on the Quality of Life and Mortality of Elderly People: A Multivariate Analysis. Age and Aging, 25(2), pp. 89-96.

[8] Cacioppo JT, Hawkley LC, Norman GJ, Berntson GG. Social isolation. Ann N Y Acad Sci. 2011;1231:17-22

General comments and comments on introductory / end sections of document		
ID	**Stakeholder**	**Comments[1]**
		standards state – can also have a negative impact on medicine adherence and health and wellbeing in older people. For example, NICE Quality Standard 50 states that undiagnosed hearing loss remains a significant issue, especially in care homes • hearing intervention and ongoing support improves quality of life by reducing the psychological and social effects associated with hearing loss[10]. Early intervention can also reduce pressure on health and social services by reducing the risks associated with unsupported hearing loss[11].
5	NHS England	There is an over emphasis on GPs and Practice Nurses when referring to 'Healthcare Practitioners' throughout the document. This is a missed opportunity to emphasise the importance of the wider primary care team and just serves to reinforce expectations about the 'status quo' (this is also a problem in the public facing documents for NG56). Reference to carers is completely lacking and should be introduced in 3 and 4 in particular.
6	Obesity Group of the British Dietetic Association.	In our view additions to this list should be made to include Nutritional Support in adults (QS24, 2012), Eating disorder pathway (2016) and Obesity in adults: prevention and lifestyle weight management programmes (QS111, 2016).
7	Royal College of General Practitioners	• A sensible document, which requires formal screening, recording and updating of GP records. This is welcome but has a significant resource implication. It is couched very generally. It would be helpful to consider some worked examples and to consider the implications thereby for further treatment, monitoring, and family/patient involvement. • The level of the problem needs to be quantified: i.e. the degree and severity of the conditions and the resulting can/cannot-bathe, toilet, walk 100metres etc. with an overall multimorbidity score (with physical, mental and social dimensions). The score would be re-assessed annually and would enable providers to best direct resources of prevention and care. E.g. prostheses, aids, adaptations, medication and medical/surgical intervention. • Not all conditions will necessarily continue to progress. Some like an alcohol problem may even improve, others

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[9] Lin, F. R. et al. 2011 Hearing loss and cognition in the Baltimore Longitudinal Study of Aging. Neuropsychology. 2011; 25(6):763-770.

[10] Chisolm, T. et al. 2007. A Systematic Review of Health-Related Quality of Life and Hearing Aids: Final Report of the American Academy of Audiology Task Force on the Health-Related Quality of Life Benefits of Amplification in Adults. Journal of the American Audiology, 18(2), pp. 151-183; Davis, A. et al., 2007. Acceptability, benefit and costs of early screening for hearing disability: a study of potential screening tests and models. Health technology assessment,11(42) pp. 75-78; Acar, B. et al. 2011. Effects of hearing aids on cognitive functions and depressive signs in elderly people. Archives of Gerontology and Geriatrics, 52(3), pp. 250-252.

[11] Hjalte, F. et al. 2012. Societal costs of hearing disorders: A systematic and critical review of literature. International Journal of Audiology, 51(9), pp. 655-662. Monitor, 2015. NHS adult hearing services in England: exploring how choice is working for patients.

General comments and comments on introductory / end sections of document		
ID	**Stakeholder**	**Comments[1]**
		like blindness will be constant. • This NICE quality standard can be viewed as a significant step forward. The RCGP Collaborative care and Support planning Network and Integrated Personal Commissioning (IPC) Network appreciate that NICE is attempting to tackle this whole issue of Multimorbidity seriously especially with the development of standards 3,4 & 5. Given the links between long-term conditions and mental heath it would be useful to have something that linked multimorbidity and an assessment of mental health. • There needs to be more emphasis on collaboration and partnership with both the person with multimorbidity and local partners. • There is a tension between the quality standards on multimorbidity and quality standards for disease-specific conditions. This makes life very difficult for clinicians as they are presented with difficult dilemmas • Access to results: Access to results and updates on prescriptions (and not whole online record) should/could be part of the quality standard as it's an important part of enabling the person to coordinate their care. • Too focused on biomedical approach: The assumption which underpins the guidance is the belief that the person living with multimorbidity is a passive recipient of medical care and expertise, rather than the person who does the daily work of living with complex challenge and an expert on their own unique situation. It describes the planning process as a job for the healthcare professional to undertake without really departing from the traditional prescriptive version of care. The scope of this document does not include care and support planning - and whilst it has elements of asking about goals it doesn't include all the steps (e.g. preparation). A purely bio-medical model doesn't work when caring for patients with any long-term conditions. The best model of care encompasses the physical, emotional, social and spiritual factors (e.g. loss of income, status in society and family role). The assessment of mental health and social factors is vital for all patients with any long-term condition (LTC).
8	Royal College of Nursing	The Royal College of Nursing welcomes this quality standard.
9	Royal College of Nursing	We also know that people in prisons have recognised higher incidence of co-morbidity and multi-morbidity. Due to the complexity of their physical and mental health, and with this group being a proportionately ‘underserved’ community, due consideration should be given to this point when environments such as prisons are a part of the community where care takes place.
10	Royal College of Physicians of Edinburgh	This draft quality standard accurately reflects the key areas for quality improvement. Fellows of the College have indicated that the draft quality standard would complement the Comprehensive Geriatric Assessment as promoted by the British Geriatric Society and the Acute Frailty Network (part of NHS Elect). http://www.bgs.org.uk/cga-managing/resources/campaigns/fit-for-frailty/frailty-cga
11	Royal College of Psychiatrists	The guidance is orientated in my opinion to physical illness. It mentions schizophrenia at the start but then goes on to measure in more depth physical frailty and outcome measures. Frailty as a result of a serious mental illness is something entirely different. It might mean not being able to administer or collect your own medication, attend your

General comments and comments on introductory / end sections of document		
ID	**Stakeholder**	**Comments[1]**
		GP, nourish yourself etc. This important point needs to be fully addressed for the document to remain relevant to psychiatric multi-morbidity.
12	Royal College of Psychiatrists	The document mentions elderly patients on several occasions because they are presumably those who most commonly suffer with multimorbidity but don't forget that this can affect children and adolescents too.
13	Royal College of Psychiatrists	We strongly recommend that this document is reviewed to increase the relevance to people suffering multiple morbidities which include mental health problems.
14	Royal Pharmaceutical Society	It is not clear as to why this quality standard only covers adults with multimorbidities as many children also live with multiple conditions.
15	Stroke Association	Around 15 million people in England alone have long-term conditions which cannot be cured but are managed with drugs or other treatments. 1 Stroke survivors often live with a range of multimorbidities. As an illustration, a Scottish study looking at a cross-section of over 1.4 million adult participants examined 36,000 stroke survivors against 39 comorbidities. 35 of these comorbidities were significantly more common in people who had experienced stroke. Of those with stroke, the proportion (94%) that had one or more additional morbidities was almost twice that in the study's control group. 2 According to the Stroke Association's State of the Nation report (2017), around half of stroke survivors are left with a requirement for speech and language therapy, half of stroke survivors report fatigue, half have problems swallowing, half experience bladder control problems and 1 in 5 experience emotionalism in the first six months after stroke.[12]
16	Stroke Association	We welcome the mention of those from lower socioeconomic groups as a potential equality issue. In general, people from more deprived areas have an increased risk of stroke and people from more deprived areas are likely to experience more severe strokes.[13] We would like to see ethnicity considered as an equality issue. Black people are twice as likely to have a stroke and at a younger age than white people. Black people are more likely to have high blood pressure and diabetes than

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[12] Stroke Association, 'State of the Nation', January 2016, Available: https://www.stroke.org.uk/resources/state-nation-stroke-statistics

[13] Marshall IJ, et al (2015) 'The effects of socioeconomic status on stroke risk and outcomes'. Lancet Neurology 14: 1206-1218.

General comments and comments on introductory / end sections of document		
ID	**Stakeholder**	**Comments**[1]
		white people, potentially contributing to higher stroke risk in black people. Black people are also more likely to have sickle cell disease, which increases the risk of a stroke.14 15 There are strong links between ethnicity and stroke and given the prevalence of multimorbidities in stroke survivors, we believe that it is crucial to include ethnicity.
17	The Richmond Group of Charities	We believe every one with a long-term condition should be provided with the right knowledge, resources and support to manage their condition effectively at home. The Quality Standard should reflect the responsibility of healthcare professionals to provide this.
18	The Richmond Group of Charities	Another key focus for the Richmond Group is prevention and early intervention. The Quality Standard should reflect the responsibility of primary care providers to recognise and tackle harmful behaviours that may exacerbate health problems, particularly in people with multiple conditions or who are frail.
19	The Richmond Group of Charities	The voluntary and patient sector has a key role to play in developing our understanding of and approach to multimorbidity. The Richmond Group of Charities is currently in the early stages of a project on multimorbidity. Whilst on a learning curve ourselves, we are keen to share our knowledge with the NHS and provide support where possible.
20	The Richmond Group of Charities	In taking on additional responsibilities to improve care for people with multimorbidity, including the goal-setting conversations, care coordination and anything following on from this, healthcare professionals should be properly supported in their understanding of multimorbidity and the benefits of this approach. The Quality Standard should explicitly mention the importance of wider training and education for healthcare professionals to enable this.

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14 Wang Y, Rudd AG, Wolfe CD (2013). Age and ethnic disparities in incidence of stroke over time: the South London Stroke Register. Stroke 44: 3298-3304.
15 Ohene-Frempong K, et al (1998). Cerebrovascular accidents in sickle cell disease rates and risk factors. Blood 91: 288-294

Consultation question 1: Does this draft quality standard accurately reflect the key areas for quality improvement?		
ID	**Stakeholder**	**Comments**
21	Royal College of General Practitioners	• One of the issues encountered now is identifying the point at which care needs to move away from disease based guidance to the recognition of multimorbidity. Just having 2 long-term conditions LTC does not necessarily denote that point. Therefore more guidance might be needed to help GP's and others work out for exactly whom and at what point this guidance is intended. The identification of the onset of Frailty marks this point. • QS 2 says that.. ' Adults with MM who are assessed for frailty…' – it should say '…Adults with MM must be assessed for frailty using …'. • QS 3 and 4 – Should be rewritten to be a more cooperative venture, including the person with the MM. In other words – 'people with MM should be invited to work with a named care coordinator (CC) to identify their goals, values and priorities. This should lead onto the production of an individualised care and wellbeing plan which supports self-care'. More detail could then be offered regarding the content of the individualised plan. This should certainly include the patients being able to access their own electronic notes.
22	Royal College of Nursing	On the whole this is an important document which reflects the key areas for improvement.
23	Royal College of Psychiatrists	Two significant omissions: 1. Patients with multimorbidity are likely to be under the care of at least one and possibly more specialists and the quality standard does not expand on how these different clinicians should work with the GP or specify how the case manager will be allocated. Is it assumed that the GP will case manage all cases of multimorbidity? 2. There are likely to be a significant number who lack capacity due to significant mental health issues like Dementia and also Schizophrenia. In these circumstances, the role and involvement with carers/relatives who speak on behalf of the patients and may very well have legal authority to manage the patient's affairs have not been discussed.

Consultation question 2: Are local systems and structures in place to collect data for the proposed quality measures?		
ID	**Stakeholder**	**Comments**
24	British Geriatrics Society	Patient surveys are likely to be difficult to implement in terms of routine care. For some, for example, those with marked frailty or dementia, survey of care givers may be preferable. Asking them about how easy it was to access the care co-ordinator would be important to ensure that the care co-ordinator is practically useful for them, and would provide feedback for developing services forward. Number of encounters with care co-ordinators could be used as a marker of how well the process is working.

Consultation question 2: Are local systems and structures in place to collect data for the proposed quality measures?		
ID	**Stakeholder**	**Comments**
25	NHS England	Not completely but routine frailty identification will help. As it stands there will probably need to be a parallel system of coding for multi-morbidity in the health record. It may be that new codes with frailty and MM can be developed to assist this. There will be key issues with language and documentation to identify how discussions are completed and shared meaningfully across the system. This raised a number of IG and inter-operability issues particularly at the health and social care interface.
26	Royal College of General Practitioners	• Local systems will, in general, not include patient surveys, which will be very difficult to implement, particularly in the case of frailty. The most useful method of assessing identification of goals etc. will be an audit of care plans from each sector. • This will also assess the identification of the care coordinator (CC)- and further audit should enable what proportion of future contacts with the individual patient were with the named CC. A CC process which works well would imply that more than 50 % of contacts in a year with the adult with MM were with the named CC.

Consultation question 4: Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them?		
ID	**Stakeholder**	**Comments**
27	British Geriatrics Society	4.1 No – there will not be enough resources to deliver individualised care planning to an appropriate standard for everyone with frailty. Even providing the training to enable staff to understand this guidance and what is needed in care planning(including coaching methodology, motivational interviewing and strength based assessments) will be a significant challenge in both primary care and community care. In secondary care, with the exception of some areas of psychiatry and rehabilitation medicine where this approach already works, this standard represents a change in culture and a change in practice which will require considerable investment to achieve. 4.2 Specifically for the meds reviews- even for someone experienced in care and wellbeing planning, there is scant information available to help make informed decisions about the relative benefits of medications in the face of a number of priorities. For example – optimum BP control in someone with cognitive impairment due to vascular dementia. Optimum sugar levels in dementia given the increasing evidence for decreasing cognitive performance with higher sugar levels. 4.3 For frailty, cost savings (largely assumed to be a reduction in admissions to hospital or other institutional care) may take years to achieve – and as yet there is no evidence on which to base this assumption. 4.4 It may be possible to reduce drug costs by rationalising the use of statins, antihypertensives and some diabetic drugs(notwithstanding the point in 4.2).
28	NHS England	Potentially yes but highly contingent on how well NG56 is operationalised. As written the QS might be possible to evaluate purely

Consultation question 4: Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them?

ID	Stakeholder	Comments
		on the basis of prescribing costs but the wider system benefits (reduced appointments, travel, diagnostics etc) might yield significant benefits. Evaluating this will be challenging unless there is a system of audit supported by adequate data collection and sharing. Benchmarking via Rightcare probably gives the best opportunity to do this.
29	Royal College of General Practitioners	• No – there will not be enough resources to deliver individualised care planning to an appropriate standard for everyone with frailty. Even providing the training to enable staff to understand this guidance and what is needed in care planning (including coaching methodology, motivational interviewing and strength based assessments) will be a significant challenge in both primary care and community care. In secondary care, with the exception of some areas of psychiatry and rehabilitation medicine where this approach already works, this standard represents a change in culture and a change in practice, which will require considerable investment to achieve. • Specifically for the medication reviews - even for someone experienced in care and wellbeing planning, there is scant information available to help make informed decisions about the relative benefits of medications in the face of a number of priorities. For example – optimum BP control in someone with cognitive impairment due to vascular dementia. Optimum sugar levels in dementia given the increasing evidence for decreasing cognitive performance with higher sugar levels. • For frailty, cost savings (largely assumed to be a reduction in admissions to hospital or other institutional care) may take years to achieve – and as yet there is no evidence on which to base this assumption. • It may be possible to reduce drug costs by rationalising the use of statins, antihypertensives and some diabetic drugs (notwithstanding the point in 4.2).

Comments on Draft Statement 1: Adults with multimorbidity are identified by their GP practice

ID	Stakeholder	Comments
30	Age UK	We are concerned the quality standard doesn't adequately recognise the role that third sector organisations can play in the lives of people living with multimorbidity. In our report 'Untapped Potential: Bringing the voluntary sector's strengths to health and care transformation' published by the Richmond Group of Charities (of which Age UK is a member), we outlined the case for the third sector in providing care and support services. The third sector represents a trusted and active presence embedded in many local communities with great reach and flexibility. In particular, charities are generally well-placed to support the identification of older people living with multimorbidity in the community. They can also provide a space where people feel able to share their views and manage their long-term conditions, within a package of integrated and coordinated care. For example, Age UK's Personalised Integrated Care programme has shown how adopting person-centred design principles can improve wellbeing and resilience in people living with multiple long-term conditions. Through our programme, we support people to express important values, goals and challenges in their lives. These "guided conversations" result in a collaborative care planning based on shared-decision making between an older person and our Age UK staff. This is then fed back into the care team, to help refine care plans. This allows individuals to better identify the services that are right for them. The effectiveness of this approach is well-documented. The average mental wellbeing of an older person involved in our programme increased by 2.24 points on the Short Warwick-Edinburgh

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		Mental Wellbeing Scale from 21.66 to 23.91. This increase moves the average of the assessed cohort (n=932 people) significantly above the England mean of 23.61. Reductions in pressure on local health and social care systems have also been reported and 8 out of the 9 of our Integrated Care programme pilot sites have been recommissioned. We feel including voluntary sector partners in care-coordination, in leading roles as appropriate, would be beneficial for many people living with multimorbidity and help improve their health and wellbeing.
31	Age UK	Within this statement, there may also need to be a greater acknowledgement of the role of the community pharmacist in identifying and managing multiple long term conditions, as outlined in a recent report by The Royal Pharmaceutical Society- ‘Frontline pharmacists: Making a difference for people with long term conditions.’ Community pharmacists are highly accessible and well placed to identify multimorbidity either through their direct contact with a person or through dispensing habits. In some places, the infrastructure for sharing information gained in the pharmacy with a person’s GP and other primary care professionals is underdeveloped and may need to be enhanced.
32	Age UK	Regarding Question 2 on page 3, how data is currently shared across the NHS and care services can sometimes lead to difficulty in keeping those involved in a person’s care aware of changing circumstances such as the development of new health conditions. This can be prominent between primary care providers and hospitals. In identifying multimorbidity and developing an appropriate person-centred response, the lines of communication must be effective between different groups and current structures may not facilitate this.
33	Age UK	We welcome the recommendation for using primary care electronic health records to identify markers of increased treatment burden, particularly around medications. With regards to question 4 on page 3, it is unclear at present what the tools and protocols for identifying inappropriate polypharmacy and other treatment burdens from electronic records would be. Sample tools as given for assessing frailty in later statements would be a useful addition here.
34	Age UK	Following on from the above, we recommend the term ‘polypharmacy’ is defined within this statement. For many people living with multimorbidity, taking multiple medications is a necessary part of their treatment and can improve their quality of life. If optimised properly, a state of ‘appropriate’ polypharmacy may be the most effective way of managing their conditions. A clear definition of what polypharmacy is and how taking too many medications can lead to unanticipated adverse effects if not optimised properly would be welcome here.
35	Age UK	Age UK believes that service providers should not only identify multimorbidity but should also aim to segment and understand the needs and care requirements of people living with multiple long-term conditions. We believe that pertinent data, best practice and a consensus of approaches between organisations should be captured in Joint Strategic Needs Assessments and Joint Health and Wellbeing strategies. This supports later commissioning and accountability.
36	British Geriatrics Society	Broadly speaking. However the eFI is recommended as a tool to identify those with multimorbidity. While it would flag a range of issues and the overlap between frailty and multimorbidity is high, they can also be mutually exclusive. It would be misleading therefore to recommend using eFI to identify multimorbidity. It will identify those who are frail and therefore more likely to have concomittent multimorbidity but could miss those with multimorbidity who are not yet frail and include those living solely with frailty. eFI and other validated tools for frailty such as CFS are then lacking in the assessment of frailty section where it should be

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		present. Multimorbidity and frailty are distinct and non-geriatrician users of this guidance may not know this. Nor may they know which validated tools there are or which to use. Being explicit with options would make this easier. Similarly, for a non GP reading and implementing this guidance, e.g. hospital based teams, TUG and PRISMA-7 may not be suitable.
37	British Pain Society	The identification of Chronic Pain is often not routinely performed or recorded in GP records. We would note that a Read code for chronic pain has only just been developed and introduced – we would encourage it's use.
38	British Pain Society	We would fully agree with chronic pain being one of the long term health conditions that contribute to multimorbidity – however at present there is no agreed assessment scale. The Pain Consortium (The British Pain Society along with the Chronic Pain Policy Coalition, Faculty of Pain Medicine, representation of the RCGP) presently has a programme of work to make recommendations regarding pain assessment scales and tools to measure outcomes for chronic pain
39	NHS England	Service providers: the 2017/18 GP contract places routine frailty identification into the core GP contract using the eFI or (other validated tool). We expect 99% practices in England to have access to the eFI via their EPR system by April 2017. The contract requires routine identification and recording of moderate and severe frailty diagnosis and a medication review annually for patients with severe frailty. While there may still be an element of opportunistic identification of frailty, We suggests that the routine identification reflected in the quality standard in line with the GP contractual wording https://www.england.nhs.uk/gp/gpfv/investment/gp-contract
40	NHS England	Healthcare practitioners: For consistency with other work on-going at NHS England in respect of multi-morbidity management and falls identification, we suggest that the wording '..have frailty or falls' is changed to '..are identified as living with frailty or have sustained a fall in the last 12 months'. The latter is also consistent with the approach taken in NICE CG 161 at1.1.1.1
41	NHS England	Healthcare practitioners: The new GP contract also requires that patients living with severe frailty be routinely identified as having had a fall within the last 12 months. We suggests this is reflected in the quality standard and linked to the falls system consensus statement: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/586382/falls_and_fractures_consensus_statement.pdf
42	NHS England	Adults with 2 or more LTCs: We suggest this be reworded to reflect the new GP contractual requirements that all patients identified as living with severe frailty are invited for annual medication review and are routinely asked if they have sustained a fall in the last 12 months. It is also suggested that the rationale given within this paragraph should contain a reference to prevention through care tailoring and falls risk identification.
43	NHS England	We suggest this paragraph could be strengthened and worded to reflect the new GP contractual requirement: that is GP practices 'should use a validated tool…' (rather than 'can consider')
44	NHS England	Given that treatment burden does not simply related to number of medications but may also relate to the number of associated diagnostic tests, hospital or clinic attendances we suggest these factors are also included in the wording.
45	NHS England	This narrows the audience to health care practitioners who are GPs, nurses, practice managers and providers who are GP practices. We suggest a much wider audience be included. Allied health professionals comprise 1/3 of the NHS workforce and many have roles in prevention and intervention, which are relevant to the care of multi-morbidity, disability and frailty and should also be referenced in the QS https://www.england.nhs.uk/wp-content/uploads/2017/01/ahp-action-transform-hlth.pdf . Carers are another group who should be referenced within the QS. There is evidence that people with advanced multi-morbidity do not

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		receive support commensurate with their care burden: for example http://spcare.bmj.com/content/6/1/60 . In light of this we also suggest the audience for this QS should include statutory social care commissioners and providers, together with voluntary and charitable sectors care providers.
46	NHS England	Patients with low or very low knowledge, skills and confidence also need additional support as evidence shows that they are also at a higher risk of unplanned admissions and poorer health outcomes. Services such as self-management education and tailored health coaching can help to increase their knowledge, skills and confidence and their ability to self care.
47	Obesity Group of the British Dietetic Association	We agree with this statement in principle but in practice it will be impossible to assess the extent to which adults with multimorbidity are not being identified. The number of adults identified with multimorbidity will not ascertain the total numbers who actually have multimorbidity, only those who are picked up. We agree that systems need to be in place but there is a risk that these may chiefly benefit new patients who have an initial assessment when they join the practice, or existing patients who already have one condition and present with a new additional diagnosis. To avoid missing those already registered who have multimorbidity an audit (for example of those requiring frequent appointments and/or polypharmacy) may be needed.
48	Obesity Group of the British Dietetic Association	In practice many GP practices are not routinely recording weight, body mass index or obesity staging, which are important measures which could be used to help identify multimorbidity.
49	Obesity Group of the British Dietetic Association	There is limited mention of nutritional aspects of multimorbidity. For example alcohol dependence is mentioned but disordered eating is not.
50	Pharmacy Voice	Statement 1 should be expanded to include other healthcare professionals. Adults with multimorbidity can be identified by healthcare professionals and service providers working outside of GP practice settings, such as community pharmacists, who are equally well-placed to opportunistically identify (and proactively support) individuals with two or more long-term health conditions. Adults with multimorbidity are likely to be in contact with their community pharmacist as, if not more, regularly than with their GP practice.
51	Public Health England	This standard assumes that everyone is registered with a General Practitioner (GP), and for some vulnerable groups that is not the case. For example, Homeless Link's data suggest that nearly one in ten (8%) homeless people are not registered with a GP.
52	Royal College of General Practitioners	• This standard will be helpful in identifying which patients require close attention. It will be achievable if there are clear definitions of exactly which clinical conditions are to be included in a Multimorbidity register. • The relevant READ codes can then be used for searches with little extra resource required. • Proactive creation of a practice multimorbidity register would be more accurate than opportunistic identification. • Such a register could then be used as the denominator for subsequent metrics. • Practices with older demographic patient profile could have a large register, management of which would result in a substantial increase in workload and so require extra resources. • At present there are not the systems in place to collect this data, but it is anticipated that it would require minimal additional resource to create a multimorbidity register when the appropriate codes have been identified. • As the majority of patients over a certain age have more than one long term condition providing extra to all these patients seems overwhelming to overworked GPs particularly those working in rural areas. In 2011, Residents of rural areas have an older age profile than urban residents with a median age of 45 in rural areas compared with 37 in urban areas. (2011 census

Comments on Draft Statement 1: Adults with multimorbidity are identified by their GP practice		
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		analysis http://webarchive.nationalarchives.gov.uk/20160105160709/http://www.ons.gov.uk/ons/rel/census/2011-census-analysis/rural-urban-analysis/comparing-rural-and-urban-areas-of-england-and-wales.html) • We work from the recognition that general practice has a crucial role in working with people with multimorbidity. The professional deciding who would benefit from additional support (page 4) is not in the spirit of the collaborative care and supporting planning model. This should read "adults with multimorbidity are identified by their GP practice in conjunction with the person".
53	Royal College of Physicians of Edinburgh	Fellows were of the view that IT and electronic record keeping systems utilised in Primary Care are well suited to identifying those who require to be identified. The issue is likely to be whether there is enough resource to deliver the discussions that are required to make this of value.
54	Royal Pharmaceutical Society	This statement should be expanded to include other healthcare professionals in the identification of adults with multimorbidity. For example, community pharmacists are well situated to identify such people in line with NICE guidance. Currently they would need to feed back this information to the person's GP so a note could be made in the electronic patient record but over time pharmacists should be able to write to the electronic patient record themselves.
55	Stroke Association	Identification by GPs of multimorbidities is key if chronic conditions are to be effectively managed, so we therefore welcome this quality statement. Of particular concern to us is the number of people living with a key stroke comorbidity – Atrial Fibrillation. Identifying atrial fibrillation (AF) is vital in reducing stroke risk, particularly given AF-related strokes tend to be more devastating. There are over one million people living with AF in the UK and we know that if someone has AF, there are five times more likely to have a stroke.1617 Given that stroke is the fourth largest cause of death in the UK and the single largest cause of complex disability, it is essential that as many people with AF – and other multimorbidities - are identified and treated as possible. For service providers and practitioners, identification or the chronic conditions closely association with stroke, such as AF, requires simple opportunistic checks such as pulse checks. We therefore strongly welcome the inclusion in this standard of opportunistic testing. AF is more prevalent amongst people with existing cardiovascular conditions. However, AF also has a higher prevalence in patients with a number of other conditions, including lung diseases such as chronic bronchitis and pneumonia, overactive thyroid, and even drug or alcohol abuse. Commissioners need to ensure that technology and other key services are available to aid the identification of multimorbidities. Again with reference to AF, immediate access to twelve lead ECG equipment (vital for diagnosing AF) can vary across practices, meaning some people are not being diagnosed with AF due to a lack of suitable equipment. This, however, need not necessarily be the case given the availability and low purchase cost of simple single lead ECG equipment. There are also increasingly affordable and usable smartphone applications which are recommended and used by a growing number of practitioners. Many of

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16 Health and Social Care Information Centre. (2015). Quality and Outcomes Framework (QOF) - 2014-15. Available: http://bit.ly/1PhPYmL

17 Savelieva I, Bajpai A, Camm AJ (2007) Stroke in atrial fibrillation: Update on pathophysiology, new antithrombotic therapies, and evolution of procedures and devices. Annals of Medicine 2007;39: 371-391.

Comments on Draft Statement 1: Adults with multimorbidity are identified by their GP practice		
ID	**Stakeholder**	**Comments**
		these have been validated in published literature and should therefore be treated as a viable and reliable detection option. We would, however, like to see this quality statement address the currently poor interconnectedness between secondary and primary care. Data transfer within the NHS, for example, is poor and we know that GPs do not always know if one of their patients has had a stroke or TIA. There must be consistent data flow from hospitals to GP practices. We would also like to see consideration given to patients with communication difficulties such as aphasia (see also statement 4 comments). Communication problems are a real barrier to effective treatment for a significant number of stroke survivors and GPs practices therefore need to be supported to deal with this and support people with communication problems. On a practical level, we would encourage longer appointment times for those with communication problems.
56	The Richmond Group of Charities	To benefit patients and support healthcare professionals in a meaningful way information identifying people with multimorbidity should be available beyond primary care, following patients through the health and care system. However, data is not always effectively shared across the NHS and care system. Particularly in acute and specialist care settings we often see lower awareness of multimorbidity and a lack of accountability for the effective management of multiple conditions. Guidance should clearly set out how data identifying people with multimorbidity and their specific needs should travel through the system, e.g. into acute care settings.
57	The Richmond Group of Charities	The statement doesn't specify what form the 'additional support' offered by primary care providers may take. Providers will need clear guidance on what this additional support should look like.
58	The Richmond Group of Charities	Research has identified different 'clusters' of multimorbidity, where different conditions commonly occur together, that require different actions and approaches. This should be reflected in guidance on how people are identified and the support they are offered.
59	The Richmond Group of Charities	Local authorities and CCGs should identify, segment and understand the needs and requirements of people living with multimorbidity in their populations. Local data and agreed approaches should be captured in Joint Strategic Needs Assessments and Joint Health and Wellbeing strategies to support commissioning of services and GP practice accountability.

Comments on Draft Statement 2: Adults with multimorbidity who are assessed for frailty are evaluated using gait speed, self-reported health status or a validated tool.		
ID	**Stakeholder**	**Comments**
60	Age UK	We believe it would be useful to define frailty in this statement as there is still a lack of awareness and understanding of what it entails. Age UK understands frailty to be a distinctive state of health related to the ageing process where the body's inbuilt reserves are eroded and people become increasingly vulnerable to physical and emotional setbacks. We would consider frailty to be one of several long-term conditions that a person may be living with. However, we would caution healthcare professionals when working with this statement against using a medical definition of frailty with their patients. In our collaborative work with the British

Comments on Draft Statement 2: Adults with multimorbidity who are assessed for frailty are evaluated using gait speed, self-reported health status or a validated tool.		
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		Geriatric Society and Britain Thinks entitled 'Frailty: Language and Perceptions' we recommend avoiding using the term 'frailty' or any other all-encompassing term altogether. Using 'frailty' with older people was found to elicit strong negative reactions due to an association with a loss of independence and end of life. The work instead found that people prefer to frame their needs in more 'everyday' terms, e.g. as not recovering as well when they get ill or struggling with some daily tasks. We therefore recommend that healthcare professionals use specific examples of living with frailty in order to foster positive and supportive conversations with patients and drive self-identification when performing their assessments.
61	Age UK	We feel the language used when describing tools for identifying frailty suggests a more definitive relationship with the presence of frailty than the evidence shows. For example, the gait speed test could be simply indicative of an underlying musculoskeletal condition such as arthritis. The tools described provide strong indicators of frailty but should not be used as a diagnostic tool, as the language in the quality statement implies. Likewise, it is not clear in this quality statement how other conditions, factors, and the general cumulative effect of multimorbidity will impact on the outcomes of these tests, which should be taken into account. Assessment and care planning for frailty should happen through comprehensive geriatric assessment (CGA) or similar multi-disciplinary approach with the tools listed here acting as one form of identifying people that are likely to benefit from these approaches. This could help to ensure that all underlying issues and conditions are fully identified in a person who may be living with frailty so as to develop a holistic response to their needs, looking at both the medical and non-medical.
62	British Geriatrics Society	The eFI is recommended as a tool to identify those with multimorbidity. While it would flag a range of issues and the overlap between frailty and multimorbidity is high, they can also be mutually exclusive. It would be misleading therefore to recommend using eFI to identify multimorbidity. It will identify those who are frail and therefore more likely to have concomitant multimorbidity but could miss those with multimorbidity who are not yet frail and include those living solely with frailty. eFI and other validated tools for frailty such as CFS are then lacking in the assessment of frailty section where it should be present. Multimorbidity and frailty are distinct and non-geriatrician users of this guidance may not know this. Nor may they know which validated tools there are or which to use. Being explicit with options would make this easier. Similarly, for a non GP reading and implementing this guidance, e.g. hospital based teams, TUG and PRISMA-7 may not be suitable.
63	NHS England	We suggest this be reworded to include the clinical frailty scale specifically as a validated tool and one which is increasingly recommended by NHS England and the Acute Frailty Network http://geriatricresearch.medicine.dal.ca/clinical_frailty_scale.htm
64	NHS England	We suggest the wording of the QS be strengthened to reflect the NHS England approach being taken to routine identification of frailty. We suggest the co-occurrence of frailty and multi-morbidity be reflected in revised wording of Quality Statement 2 as follows: 'Adults with multi-morbidity and those who are identified as living with frailty are evaluated using validated tools'.
65	NHS England	The rationale should draw attention to the complex relationship between frailty, disability and multi-morbidity should be reflected in this statement. Frailty often accompanies multi-morbidity and disability: only approximately 14% of all frail people appear to be only frail and the adverse health risks associated with frailty in older people are driven by increased disease burden and disability: for example https://www.researchgate.net/profile/Sil_Aarts/publication/277310997_CO-PRESENCE_OF_MULTIMORBIDITY_AND_DISABILITY_WITH_FRAILTY_AN_EXAMINATION_OF_HETEROGENEITY_IN_THE_FRAIL_OLDER_POPULATION/links/5567180308aec2268300f45b.pdf and https://www.ncbi.nlm.nih.gov/pubmed/24091565 . This suggests that people routinely identified as living with frailty should be evaluated for the presence of multi-morbidity, and vice

Comments on Draft Statement 2: Adults with multimorbidity who are assessed for frailty are evaluated using gait speed, self-reported health status or a validated tool.		
ID	**Stakeholder**	**Comments**
		versa.
66	NHS England	Although this statement is addressed to a wider audience than QS 1 we suggest the audience should be widened in a similar way to that suggested at comment 6 [see comment ID 45] to reflect the multidisciplinary approaches required to deliver multi-morbidity management and system wide potential to support this, particularly in primary health care and social care settings.
67	NHS England	In view of the new GP contract this needs updating, particular in the subsections dealing with primary care - need much clearer reference to eFI. Also, particularly in view of the latest developments, it would be helpful to point out that people assessed as having frailty should be assessed and reviewed for multimorbidity (as well as vice versa). In my opinion the description of approaches to frailty assessment is a bit confusing. I think it would be better phrased as "should be assessed using a validated approach to frailty assessment, e.g.,...." because to me at the moment it reads as if the gait speed test and self-reported questionnaires aren't validated approaches.
68	Obesity Group of the British Dietetic Association.	In practice tools such as MUST screening are not routinely used by many GP practices, therby limiting opportunities to opportunistically identify multimorbidity.
69	Royal College of General Practitioners	• This statement definition of numerator and denominator as they stand appears to be addressing two separate points, assessment of people with mulitmorbidity for frailty, and then what tool is used in that assessment. • This statement is a bit confused; there should certainly be a quality standard that links frailty and multimorbidity but frailty is also a multimorbidity condition in its own right. The separation of frailty seems artificial. It should read "People with a diagnosis of frailty as evaluated by gait speed, self reported health status or a validated tool should be considered to have a diagnosis of multimorbidity in their own right". • Many patients are already coded as frail. Re-evaluating this diagnosis to fit with this way of thinking will take some resources, time to implement, and the quality standards if measured would not reflect at least initially “bad” practice There is a danger it will become a tick box exercise unless the benefits form this practice can be seen by those implementing it- i.e. that performing these measurements in patients already identified will add something more to their standard of care. • It is also noted that adults with learning difficulty, alcohol or drug misuse are likely to be of a younger age range and their assessment for frailty a less useful exercise in their clinical management. • This quality statement could be improved if an age range is included e.g. >65yrs. • Documenting disability and examining the psychological effects of long term conditions (LTCs) all need to be highlighted. There should be a quality standard to reflect the links between multimorbidity and psychological status.
70	Royal College of Nursing	Most of the statements should be able to be measured via GP contracts apart from Statement 2 as most of the Frailty Services are specialist. Some of the standards in this statement may be met in primary care e.g. self-identification but the therapy input would need to be measured via specialist or other community services. The measurement of the need for specialist input could be made a quality measure for most trusts and is likely to be recorded in some form by most community trusts and GPs already.
71	Royal College of Nursing	We are aware that some trusts are starting to measure Frailty Assessment as a quality improvement marker
72	Royal College of Nursing	We are aware of discussions across the UK that GPs are overwhelmed, mostly due to GP shortages. With this in mind, this could

Comments on Draft Statement 2: Adults with multimorbidity who are assessed for frailty are evaluated using gait speed, self-reported health status or a validated tool.		
ID	**Stakeholder**	**Comments**
		present a challenge in the effective delivery of these quality standards. The main challenge is likely to be around statement 2 as frailty is still a developing area amongst healthcare professionals and the public alike. We consider that there may need to be a drive to build capacity to support the measuring of frailty services provided by most NHS trusts. Encouraging trusts to do so is the right approach, therefore lack of immediate resources should not put one off trying to achieve this aspiration over a two year period.
73	Royal Pharmaceutical Society	We agree with this statement as it stands. In the supporting text it would be useful if pharmacists are included as an example of healthcare professionals who are trained in the use of validated tools to assess frailty as they are often the healthcare professional who discharges people from hospital as community pharmacists are often the first point of contact with people in the community, particularly whilst undertaking medicine reviews.
74	The Richmond Group of Charities	The language used describing tools for identifying frailty suggests a more definitive relationship with the presence of frailty than the evidence shows. For example, the gait speed test could be simply indicative of an underlying musculoskeletal 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. Likewise, it is not clear in this Quality Statement how other conditions, factors, and the general cumulative effect of multimorbidity will impact on the outcomes of these tests, which should be taken into account. Assessment and care planning for frailty should happen through comprehensive geriatric assessment (CGA) or similar multi-disciplinary approach with the tools listed here acting as one form of identifying people that are likely to benefit from these approaches. This could help to ensure that all underlying issues and conditions are fully identified in a person who may be living with frailty so as to develop a holistic response to their needs, looking at both medical and non-medical needs.
75	The Richmond Group of Charities	In order to properly assess quality in terms of patient outcomes quality measures should include an audit of the support received after a person is recognised as frail, rather than simply the number of people assessed for frailty.

Comments on Draft Statement 3: Adults with multimorbidity are asked about their goals, values and priorities		
ID	**Stakeholder**	**Comments**
76	Age UK	Age UK believes that chronic pain, pain management and comfort are key considerations in many people’s goals and priorities around their care so should be explicitly addressed in this statement. We would welcome a sentence inserted after ‘….side effects because they value the benefits offered by the treatment’ that would read along the lines of the following: ‘Discussion with patients around their acceptable levels of pain and what pain management might mean for their overall treatment should be an important consideration’.

Comments on Draft Statement 3: Adults with multimorbidity are asked about their goals, values and priorities		
ID	**Stakeholder**	**Comments**
77	Age UK	We recommend highlighting here the ability of the types of conversations suggested by this statement in signposting to other types of emotional, physical, social and psychological support. People living with multimorbidity often have greater needs in these areas and it is important to ensure every opportunity is taken to make people aware of the support available to them.
78	British Geriatrics Society	Rewording statements 3 and 4 to be more inclusive and co-operative would be welcomed. The language throughout the document could also be altered to reflect a less paternalistic approach. Similarly, expectation of a co-ordinated care plan itself needs to be more explicit. A care co-ordinator must have access to all relevant information and keeping these plans together in one place would be useful for different sectors being involved. Patients should have the option to have access to these plans. The care co-ordinator does not have to be their GP, it could be any member of the team who is best suited to meet their individual needs. In statement 3, advance care plans should be introduced as part of goals and priorities. Similarly there should be an expectation for regular review after identification with minimum time periods e.g. every 2 years or sooner if change in condition. This would also allow for care coordination to pass between individuals depending on their changing needs should it be decided on both sides that it would be of benefit.
79	British Pain Society	We would agree with the development of individualised management plans with goals, values & priorities
80	Compassion in Dying	Reference to advance care planning was made on page 8 of the full guidance. We feel this reference should also be made in the quality standard, either in 'Rationale' or 'What the quality statement means for different audiences' sections of Statement 3. More specifically, the quality standard should stress the need for healthcare professionals to document or encourage people to document their goals, values and priorities. This ensures that other professionals in the person's care team will know what is important to them. In circumstances where the person expresses a wish to refuse treatments these should be documented in an Advance Decision to Refuse Treatment, so that if the person is, at a future date, unable to communicate these decisions for themselves, healthcare professionals will still be legally obligated to respect their wishes. Reference to Advance Decisions to Refuse Treatment should be included wherever the most explicit reference to stopping treatments is made (currently this is Statement 5 though this may change depending on whether or not the committee intends to merge Statements 3 and 5).
81	NHS England	This focuses significantly on treatment burden in relation to medicines, yet much of the burden may also relate to frequent attendance at health appointments and requirements for diagnostic evaluation. It is suggested the rationale includes reference to delivery of 'minimally disruptive treatment ' as described in: http://eprints.soton.ac.uk/383933/1/Thinking%20about%20the%20burden%20of%20treatment%20bmj%20g6680.pdf
82	NHS England	It is suggested that this should include an explicit reference to advance care planning, defined as a voluntary process of discussion between an individual retaining the mental capacity to do so, and their care providers to identify their concerns, wishes, values, personal goals for care, understanding about their illness and prognosis, and their preferences for future care and treatment that may be beneficial: http://www.nhs.uk/Planners/end-of-life-care/Pages/planning-ahead.aspx

Comments on Draft Statement 3: Adults with multimorbidity are asked about their goals, values and priorities		
ID	**Stakeholder**	**Comments**
83	NHS England	This paragraph is too narrow in scope and should also consider wider patient circumstances and context including their language, culture, ethnicity and religious beliefs, which may influence their values, behaviours, choices and decision making.
84	NHS England	It would be helpful to add in an example of treatment burden which is not just about side effects of medication - although these are of course important the concept is a much broader one and the current focus feels too narrow - the same also applies in the section starting "adults with 2 or more long term conditions" on page 11.
85	NHS England	The E&D section could be strengthened – it seems quite 'soft' at the moment. The importance of language, cultural and cognitive barriers, and the need to find ways to overcome them, should be emphasised more strongly.
86	NHS England	The goals, values and priorities of people with multimorbidity will be related to their knowledge, skills and confidence (also called patient activation) about managing their condition(s). Health and care systems that know the activation level of their populations can begin to tailor their services in order to support people to develop their ability to self-manage through increasing their knowledge, skills and confidence.
87	NHS England	People with low confidence, knowledge and skills will be able to understand and express their goals, values and priorities which will have an impact on equalities and health inequalities.
88	Obesity Group of the British Dietetic Association.	We agree with this in principle. In our view patient goals, values, priorities and treatment expectations should be linked with measurement of treatment outcomes (i.e. a treatment which achieves at least some of the patient identified outcomes may be successful even if clinical outcomes are not as good as hoped for). We strongly agree that management plans should be individualised and quality of life considered.
89	Older People's Advocacy Alliance UK	OPAAL has concerns that some older people including those with dementia and other morbidities will struggle to adequately convey their goals, values and priorities without appropriate support. Taking into account equality issues, this Quality Standard should call for the automatic provision of an Independent Mental Capacity Advocate (IMCA) or Independent Mental Health Advocate (IMHA) where appropriate. In addition, consideration should be given to the provision of independent advocacy support where it is apparent that it's provision might be beneficial. Older people tell us that they often struggle to understand and take in everything that they are told by health professionals. As a result, they lose confidence in themselves. An example of how this can be overcome, is explained by Tony, one of our service-users: "Moving forward with the assistance of my advocate I became more confident and better enabled to meet with health professionals. I would be encouraged to write a list in relation to my physical symptoms prior to appointments. This allowed me to ensure that all my symptoms would be addressed and that I would leave my medical appointment fully mentally satisfied. My advocate would also attend them with me which gave me reassurance that I had an independent person with me. My advocate would also take notes during the appointments which we would then discuss straight after. This has helped me feel more in control and I feel better safeguarded."
90	Pharmacy Voice	We are fully supportive of this statement and rationale. However, community pharmacists are additionally well-placed to work with individuals to understand their goals and aspirations and how their use of medicines contributes to these, and can help to build effective medicines use into a personalised care and support plan. As such, they should be recognised in the Standard document itself. Community pharmacists can also work closely with an individual, their carers (as appropriate), GPs, and wider healthcare team to ensure medicines-related elements of their personalised plan are regularly reviewed and adjusted as necessary.

Comments on Draft Statement 3: Adults with multimorbidity are asked about their goals, values and priorities		
ID	**Stakeholder**	**Comments**
		In practice, statement 3 could be covered as part of statement 5 on reviewing medicines and other treatments, however, this can also sit separately as not all goals, values and priorities will be directly related to medicines use. In 2016, a Pharmacy Care Plan service was provided by 42 community pharmacies in the North Kirklees and Wakefield areas. People taking multiple medicines were identified through the patient medication record (PMR) system or their regular medicines and supported by their community pharmacist through the development of individually tailored care plans, based on their health and wellbeing goals. Data collected from patients in relation to their conditions, adherence, quality of life and activation (in relation to managing their own health and wellbeing) is being analysed by independent academics from the University of East Anglia and will be submitted for peer-reviewed publication this year. We would be happy to share the details of this evaluation once it is made available.
91	Royal College of General Practitioners	• As with the previous quality statement, the definitions of numerator and denominator also appear to be assessing separate metrics. Firstly, the number of people with multimorbidity who have and those with an individualised management plan are assumed to be the same, whereas they are separate metrics. The secondary metric will then be what details are assessed and recorded as part of that management plan. • It is important that carer's details should also be noted and assessment for their goals and priorities included in any care plan. • This holistic assessment and creation of a plan in the community would not be achievable with the current resources. This quality standard will in fact require substantial resourcing and incentivising to ensure that implementation is universal and to an acceptable standard. It will require significant leadership input; training of individuals and commissioning of service development; as well as monitoring. No savings would be achieved in the short term, and there would be no opportunity for disinvestment. • On p11 health care professionals should include other healthcare professionals in primary care other than just Doctors and nurses and include pharmacists, physician associates and paramedics • Quality statement 3 is given as a quantitative measure- the things it is measuring are to most part qualitative and part of general good medical practice. Again there is the danger of it being a tick box exercise. • Quality statement 3 does not go far enough to make the patient a true partner in their care, i.e. this statement still sounds like the practitioner helps the patient pick out what treatment fits them best with best hopes for treatment rather than a whole-person conversation where the most energising, life-enhancing values/priorities are given centre stage. This narrows the conversation to discussing the benefits/side effects of a tablet when it should be an opportunity to discuss overt and softer goals. There is also no mention of advanced care planning in palliative care and the Gold Standard Framework guidance. There are many challenges facing patients, carers and all the different professionals involved when a patient moves from a curative to a palliative pathway, with often frequent oscillations en route. Amending to "Care of adults with multimorbidity, including those with end of life needs, should routinely take into account their goals, values and priorities and they should ideally be supported to achieve their goals" can strengthen this statement. • CCGs and local systems have a responsibility to develop supporting informatics with regard to person-centred goals and interoperability. Though paper is a marvellous medium, it cannot provide the structure for the process of patient-centred goals or interoperability. • Equality and diversity: This section could be strengthened. This is a great opportunity to capture the diversity of patients' habits, customs, culture, family role and how taking these factors into consideration is vital as part of a holistic model of care.

Comments on Draft Statement 3: Adults with multimorbidity are asked about their goals, values and priorities		
ID	**Stakeholder**	**Comments**
		An exemplar around chronic pain would be a useful. • Consideration needs to given to how to record this information in a standardised format on clinical information systems to ensure information captured is easily available and in a format that can be exchanged with other providers of community based care. There is a lack of standardised paper based systems which means that different provider often overlook important information.
92	Royal College of Nursing	We are pleased that the standards recognise that people with learning disability (LD) will need more adjustments to be made to facilitate optimum care particularly so where there is multi morbidity. People with LD are commonly over prescribed psychotropic medication and there is current guidance to address this (Stopping Over-Medication of People with Learning Disabilities (STOMPLD)). The Royal College of Nursing are signatories to this work and strive to look for more appropriate care interventions. This will require further investment in nursing resource.
93	Royal Pharmaceutical Society	We agree with the statement but it should be expanded to include outcomes from the action of asking adults with multimorbidity about their goals, values and priorities. This could be in the form of then delivering personalised care to that person. This could be achieved by ensuring shared decisions with patients by using evidence based patient decision aids, where available, to help patients reach informed decisions about their treatment options.
94	Stroke Association	In order to make their best possible recovery and live the fullest possible life, those with multimorbidities should be asked about their goals, values and priorities so we welcome this quality statement. We want stroke survivors to make their best possible recovery and a significant factor in this is setting and then assessing goals and priorities. Unfortunately, only 56% of survivors are discharged from hospital having been assessed for all appropriate therapies and with agreed rehabilitation goals.[18] Without these goals, rehabilitation, if it exists at all, can lack focus and structure. A crucial consideration in this quality statement is those patients with communication difficulties. Around a third of stroke survivors experience some level of aphasia – a complex disorder of language and communication caused by damage to the language centres of the brain. People with aphasia can have difficulty speaking, reading, writing or understanding language.[19] It is essential that those with communication difficulties and their families/carers fully understand and are fully supported when developing goals, values and priorities. We would like this to be explicitly set out in the statement. Also, given that stroke is very often a regenerative rather than a degenerative condition (unlike many long-term conditions), we would like specific mention given to goals for stroke patients including improving independence and quality of life.
95	The Association for Family Therapy and Systemic Practice in the UK	AFT welcomes the consideration of multimorbidity by NICE. AFT anticipates that this will be relevant for a significant proportion of the population and may help drive changes for the benefit of all. In Bath and North East Somerset (B&NES) we recently piloted a thorough assessment and brief intervention model with people with complex symptoms (or multimorbidity) in primary care. A key finding from this project was that people welcomed 'everything being thought about all together'.

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[18] Royal College of Physicians Sentinel Stroke National Audit Programme (SSNAP). Acute organisational audit 2016 prepared on behalf of the Intercollegiate Stroke Working Party. Available http://bit.ly/2ivXRdv
[19] Stroke Association (2017) 'State of the Nation' Available: https://www.stroke.org.uk/sites/default/files/state_of_the_nation_2017_final_1.pdf

Comments on Draft Statement 3: Adults with multimorbidity are asked about their goals, values and priorities		
ID	**Stakeholder**	**Comments**
		B&NES MUS Project 2015-2016 (local report) Drs H.van der Woude, H.Schur, L.Ewins et al. It seems beneficial that adults with multimorbidity are asked about their goals, values and priorities, in the context of ‘everything being thought about all together’. However, it is important that the person responsible for coordinating care (statement 4) is then able to effectively sign post the adult with multimorbidity.
96	The Richmond Group of Charities	To prove effective, these conversations would need to be repeated annually or so, or following significant changes in health, lifestyle or living arrangements.
97	The Richmond Group of Charities	If healthcare professionals are expected to lead meaningful and potentially difficult goal-setting conversations alongside their already heavy workload, they must be allowed the space and time to do so. This is possible: when collaborative care planning was trialled in the Year of Care pilots they found that the change was neutral in terms of the resources required because it meant that people got what they needed in one longer conversation rather than through several shorter ones.
98	The Richmond Group of Charities	Following on from comment 8 [see comment reference ID 97], evidence shows goal-setting conversations can be effectively led by non-medical staff and the voluntary sector, an approach which can allow more time and space for discussion and to identify appropriate support. The statement should reflect this.
99	The Richmond Group of Charities	Goal-setting conversations provide opportunities to link with other types of support, as well as informing clinical decisions. The statement should highlight the potential of these conversations to link people with other sources of emotional, practical, psychological support.
100	The Richmond Group of Charities	Goal-setting conversations are also an opportunity to identify informal carers and take action on their support needs.
101	The Richmond Group of Charities	The term ‘individualised management plan’ could be made more accessible. Engagement work should be carried out to determine the best way to describe this.
102	The Richmond Group of Charities	The record of these conversations should be patient held, so they can amend their wishes.
103	The Richmond Group of Charities	It is important that healthcare professionals understand the impact of an individual’s condition on daily living and ability to live independently.
104	The Richmond Group of Charities	A bio-psycho-social approach should be used to assess people’s problems and goals and should be captured in a care and support plan. Such an approach should include consideration of the domains of pain and functional limitations, and a person’s confidence, capability and knowledge to manage their health (patient activation).
105	The Richmond Group of Charities	Statement 3 represents a step in the right direction in terms of delivering person-centred care. The suggested questions recognise the struggle many people with multiple long-term conditions face managing treatment whilst maintaining good quality of life. This should be expanded to cover emotional, practical and psychological needs, which are often increased in people with multiple conditions, and to direct people to appropriate support. Much of this is addressed through the Year of Care Partnership approach which has been recognised by NICE in the Quality Standard statement pertaining to care planning, and the Quality Standard on

Comments on Draft Statement 3: Adults with multimorbidity are asked about their goals, values and priorities		
ID	**Stakeholder**	**Comments**
		multimorbidity should reflect and align with this.

Consultation question 5: In practice, would statement 3 be covered as part of statement 5 on reviewing medicines and other treatments?		
ID	**Stakeholder**	**Comments**
106	Age UK	With regard to question 5 on page 3, we believe that keeping the two separate statements represents the best format. We see these two statements as touching upon two related but different ideas: 1. Promoting informed and person-centred medicines optimisation. 2. Promoting broader discussion between healthcare practitioners and patients around social/lifestyle goals, values and plans. This would encompass the non-medical aspects of their care and social prescribing. Statements 3 and 5 overlap in scope but we feel consolidating them may diminish their impact and reiterating them separately is more powerful.
107	British Geriatrics Society	Yes but it is useful to be explicit.
108	Compassion in Dying	Question 5 of the consultation document asks if Statement 3 would be covered as part of Statement 5. We strongly recommend that Statement 3 remains. Having these statements separate is more reflective of the full guidance. In the full guidance there is a clear distinction between ‘Reviewing medicines and other treatments’ and ‘Agreeing the individualised management plan’, the latter of these incorporates the person’s goals, values and priorities, which are clearly much broader in scope than a clinical decision about whether or not to stop a treatment. Removing Statement 3 would mean the Quality Standard ignored the most person-centred aspect of the full guidance. The consequence of this is that less emphasis is placed on the tailored approach to care for adults with multimorbidity, which is a key principle of the guidance. If the committee wishes to combine these statements then it would be better to incorporate Statement 5 into Statement 3, so that the emphasis is on the person’s wishes, not the purely clinical decisions. A suggested wording of such a statement can be found below: Adults with multimorbidity are asked about their goals, values and priorities and medicines and treatments are reviewed accordingly
109	NHS England	No: Statement 3 rightly places the person at the centre of the decision-making and ensures that ‘what matters to them’ is

Consultation question 5: In practice, would statement 3 be covered as part of statement 5 on reviewing medicines and other treatments?		
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		considered prior to making plans based on treatment burden. This ensures a wider discussion focused on overall patient contextualised to their perceptions and experiences of treatment burden rather than simply focusing on medication and treatment interventions in isolation.
110	NHS England	I do not think that in practice, statement 3 will be covered as part of statement 5.
111	Royal College of General Practitioners	Statement 5 should stand alone – as noted in point above - QS 3 needs to be reworded [see comment ID 91].
112	Royal College of Nursing	We agree that statement 3 could be met whilst implementing statement 5 (the medication review) if staff were skilled to do both. Ensuring the goals, values and priorities are communicated to all other healthcare professionals is an important issue and lack of effective communicative systems between provider services may be an issue here.
113	Royal College of Physicians of Edinburgh	Statement 3 would be touched on in a medication review (statement 5) but this may not be to the depth and extent that would make it of value in improving care consistently.
114	Royal College of Psychiatrists	No, because statement 5 relates to an issue specific to medicines management while statement 5 depending on the conditions can be a lot broader, including areas such as employment, accommodation social support etc
115	Royal Pharmaceutical Society	This statement is partly covered by statement number 5 but it is potentially wider than medicines and other treatments so we believe it should remain as a separate statement with the addition of ensuring outcomes are acted on.

Comments on Draft Statement 4: Adults with multimorbidity know who is responsible for coordinating their care		
ID	**Stakeholder**	**Comments**
116	Age UK	Regarding Question 4 on page 3, we would be concerned about the capacity of healthcare professionals to coordinate the care of many different people, each with complex, long-term needs. Following on from the previous points, we would argue that collaboration with the third sector around care-navigator/coordinator roles would be beneficial in this area for many local healthcare economies.
117	Age UK	We also feel that others involved in the care of a person with multiple conditions (such as carers) should be included briefly in this section of Statement 4 and their (central) role in care plans clarified. We recommend an amendment such as that outlined below: ‘Adults with 2 or more long-term conditions and, with consent, their carers are involved in an overall discussion with their GP or practice nurse about deciding who is responsible for coordinating their care. This should make sure that everyone is clear about this and is happy with the decision’.
118	British Geriatrics Society	Rewording statements 3 and 4 to be more inclusive and co-operative would be welcomed. The language throughout the document could also be altered to reflect a less paternalistic approach. Similarly, expectation of a co-ordinated care plan itself needs to be more explicit. A care co-ordinator must have access to all relevant information and keeping these plans together in one place would be useful for different sectors being involved. Patients

Comments on Draft Statement 4: Adults with multimorbidity know who is responsible for coordinating their care		
ID	**Stakeholder**	**Comments**
		should have the option to have access to these plans. The care co-ordinator does not have to be their GP, it could be any member of the team who is best suited to meet their individual needs. In statement 3, advance care plans should be introduced as part of goals and priorities. Similarly there should be an expectation for regular review after identification with minimum time periods e.g. every 2 years or sooner if change in condition. This would also allow for care coordination to pass between individuals depending on their changing needs should it be decided on both sides that it would be of benefit.
119	British Geriatrics Society	All patients with multimorbidity and frailty will benefit from having a named GP. However, the GP will not always be the most appropriate person to be the care-coordinator for them. Use should be made of nurses, therapist, health and wellbeing co-ordinators according to the primary needs of the person.
120	NHS England	We suggest this statement is aligned with the NHS England approach to routine frailty identification, which is now incorporated, into the GP contract as set out at comment 1. Given the significant overlap between the presence of multi-morbidity and frailty this provides an opportunity to ensure explicit care coordination for both multi-morbidity and frailty to reduce the risk od duplication of care coordination or no care coordination for one or other condition. A suggested reworded statement could read: ‘Adults with multi-morbidity or identified as living with frailty know who is responsible for coordinating their care’. We also suggest that the existence of a management plan should be documented in the summary care record, which can then be shared with other health care professionals, and services (subject to patient permission) as set out in the rationale. This is consistent with the approach being taken in the GP contract 2017/18 and in line with NG56.
121	NHS England	As noted in comment 6 we consider this to be too narrow and should include references to sharing information about care coordination (where permission is granted from the patient) with other parts of the health and social care system. This provides a much better opportunity to integrate care centred on the needs and preferences of the patient identified via Statement 3.
122	NHS England	‘Management plan’ is too medicalised – it can be replaced with the personalised care and support plan to make it more person-centred and include what is important to them.
123	Obesity Group of the British Dietetic Association.	We strongly agree that a single coordinator should be identified for each individual. This is likely to be easier to achieve for those patients newly diagnosed with multimorbidity, and there is a risk of lack of coordinated care for individuals with unrecognised multimorbidity (see 1).
124	Pharmacy Voice	We support this statement and the rationale behind it. We do not believe there is overlap between this statement and having a named GP as set out in the 2016/17 standard GP contract, because the individual responsible for coordinating the care of a person with multimorbidity may not be their GP. As set out in the rationale section, a key aspect about an individualised management plan is agreement between the person with multimorbidity and the healthcare professional about who is responsible for coordinating care. This decision ultimately should sit with the person with multimorbidity and as such could include other healthcare professionals such as community pharmacists. As set out in the Community Pharmacy Forward View, community pharmacists are ideally situated to deliver personalised support for people with long-term conditions and multimorbidity, and can play an important role as an identified care coordinator.

Comments on Draft Statement 4: Adults with multimorbidity know who is responsible for coordinating their care		
ID	**Stakeholder**	**Comments**
125	Royal College of General Practitioners	• In answer to question 6, this guidance includes an aim for patients and carers to be included in discussions as to who is involved with the co-ordination of their care. This is distinct from having a named GP as in the 2016/17 standard GP contract, and perhaps should not be assumed to be the one and the same person. • An effort should be made to avoid this being a tick box exercise. • The introduction of someone who is coordinating care is interesting – it is not the same as a named GP (as in the enhanced service) although for some people it could be the GP. It is important that everyone has a 'key worker' but they could be from primary, secondary or community care or even social services – so coordinating that will present an interesting reporting challenge. This doesn't mean it shouldn't be included though. While we support this quality standard it should be clear that the person (often the GP) who has responsibility for coordination should not mean that the GP does all of it. • Not enough emphasis is placed on the person having a role in managing their care. It must be someone the person can work with collaboratively to write a support plan, which identifies specific things they can do to enhance their wellbeing. This should read, "Adults with multimorbidity know who is responsible for coordination of care and supporting their wellbeing".
126	Royal college of physicians	There is a misrepresentation of the frail elderly patient being the sole clinical scenario for the multi morbid issue. Although undoubtedly these are the most vulnerable we also highlighted many individuals under several specialists in ambulatory care settings with multi morbid complex issues. The meeting recommended the vital role for a clinical navigator that would not necessarily be the named GP. In addition the information exchange between the various health care professional involved in the care - primary care and often 3-4 separate clinical specialist departments was identified as a vital priority when changes in management plans -therapy advocated by one dept could potentially conflict with advice from another. In summary, clinical navigator and clear communication between all HCOs in care are relevant QS.
127	Royal Pharmaceutical Society	We agree with this statement.
128	Stroke Association	We strongly welcome this quality standard because there is a serious lack of joined-up and co-ordinated care for stroke survivors, particularly after leaving hospital. The Stroke Association conducted a survey of stroke survivors last year and we found that 45% of them felt 'abandoned' after leaving hospital. This highlights how serious the problem is in the post-acute pathway. We agree that those with multimorbidities such as many stroke survivors should have a named co-ordinator as part of a single multi-disciplinary team delivering care. The co-ordinator should work closely with the hospital discharge co-ordinator so that relevant information can be shared, and we would like to see the statement's wording reflected to reflect this as well. A smooth, joined-up system, involving both health and social care professionals ensures that when they return home from hospital, stroke survivors receive the support they need. Care plans are absolutely essential. Without them, stroke survivors leave hospital with no idea if they will receive vital rehabilitation, let alone who will administer it and how often. Too many stroke survivors feel like they have 'fallen off a cliff' when

Comments on Draft Statement 4: Adults with multimorbidity know who is responsible for coordinating their care		
ID	**Stakeholder**	**Comments**
		they leave hospital because they are not supported with their additional needs resulting from their stroke. Our survey shows that almost 40% of stroke survivors did not have a care plan in place when they went home from hospital. 30% of stroke survivors did not feel prepared when it was time to return home. There is a need for joined up working between health and social care when preparing for the discharge of a stroke survivor. According to the latest Sentinel Stroke National Audit Programme (SSNAP) data, 10% of stroke survivors do not receive a joint health and social care plan on discharge20, and our survey shows an even greater problem in this area than the SSNAP figures suggest.21 Given that 48% of stroke survivors and their carers report problems caused by either poor or non-existent co-working between health and social care, this is clearly an area where improvements need to be made.22 There needs to be a recognition of the importance of communication and shared decision-making when developing care plans, particularly when dealing with people with communication problems such as aphasia who may find it more difficult to contribute to and understand their care plans. We would like to see the wording of this statement amended to cement these two critical aspects of effective care plans.
129	The Association for Family Therapy and Systemic Practice in the UK	The identified person who is responsible for coordinating care, also needs to be able to effectively signpost, i.e. have a good awareness of interventions and services to help the person live their life in accordance with their goals, values and priorities.
130	The Richmond Group of Charities	The statement implies that the person responsible for coordinating care would be a healthcare professional, e.g. a practice nurse or GP. In this case, we would question whether healthcare professionals have time to properly coordinate care for large numbers of people with very complex needs. The statement should clarify whether the person responsible for coordinating care will be a healthcare professional and, if so, whether there is a limit to the number of patients one healthcare professional can do this for, as this would necessarily restrict a person's choice over who coordinates their care.
131	The Richmond Group of Charities	Following on from comment 16, patients with complex needs requiring care coordination may be well served by a separate 'care coordinator role', whether filled by the GP practice or through collaboration with local voluntary groups. The statement should reflect the potential for the 'care coordinator' role to more effectively manage the coordination of care for larger numbers of people with high levels of need and to reduce pressure on healthcare professionals.
132	The Richmond Group of Charities	Following on from comment 17, there are some places where care coordinator roles already exist as part of community and voluntary sector care coordination or integrated care programmes. The statement should reflect the need to 'join up' with such programmes, and that people should be made aware of local voluntary sector care coordination services where they exist.

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20 RCP Sentinel Stroke National Audit Programme Acute Organisational Audit Report (November 2016), Available: https://www.strokeaudit.org/Documents/Results/National/2016/2016-AOANationalReport.aspx

21 Royal College of Physicians, 'SSNAP Clinical Audit October-December 2015 Public Report', March 2016, https://www.strokeaudit.org/Documents/Results/National/OctDec2015/OctDec2015-PublicReport.aspx

22 Stroke Association 'Struggling to recover' (2012), Available: https://www.stroke.org.uk/sites/default/files/Struggling_to_recover_report.pdf

Comments on Draft Statement 4: Adults with multimorbidity know who is responsible for coordinating their care		
ID	**Stakeholder**	**Comments**
133	The Richmond Group of Charities	Following on from statement 11, the 'individualised management plan' should identify carers.
134	The Richmond Group of Charities	Healthcare coordinators should also be aware of the impact of chronic pain and pain management as part of an individual's care plan.

Consultation question 6: For draft quality statement 4: Is there overlap between this statement and having a named GP as set out in the 2016/17 standard GP contract?		
ID	**Stakeholder**	**Comments**
56	NHS England	No: the coordination of care for people with multi-morbidity should not just focus on their health care needs but their wider needs for health and social care which are contextualised to their individual circumstances. A health, social care professional, voluntary sector provider, family member or other advocate could therefore feasibly undertake the coordination role. As personal health budgets become more widespread individuals will be empowered to make decisions themselves about how their care is coordinated and by whom and it is important that the QS reflects this.
98	Royal College of General Practitioners	It will need to be acknowledged that for a number of people, the named GP will not necessarily be the best person to act as the care coordinator (CC 1.3 above). However all people including those with MM and frailty need a named GP.
105	Royal College of Nursing	There could be some overlap between statement 4 and the existing GP contract of having a named GP but there are two main issues with this: a) Many patients do not always see their own GP (There are many reasons for this) b) Sometimes the person who would be best placed to coordinate someone's care is not their GP.
113	Royal College of Physicians of Edinburgh	There is some overlap between statement 4 and having a named GP as set out in the 2016/17 standard GP contract. However given the current manpower issues facing primary care, Fellows anticipate that much of this work will be devolved so although there is overlap in theory there may only be a little in practice.
116	Royal College of Psychiatrists	The quality statement sets out that GP's will be responsible for identifying patients with multimorbidity, not necessarily that they will be the care coordinator as GP's might not be the most suited professional to coordinate the care dependent on the condition and input required (eg if care needs are more social care driven a social worker might be the most appropriate care coordinator).
125	Royal Pharmaceutical Society	We do not believe there is overlap between this statement and having a named GP as the person who is responsible for the coordination of care may be someone other than a GP, such as a care coordinator.

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Comments on draft statement 5		
ID	**Stakeholder**	**Comments**
135	Age UK	We believe the addition of a quality statement on medicines optimisation is welcome, however we fear this quality standard may be missing an important point by not promoting the routine implementation of medication reviews and only looking at aspects that involve stopping/changing a medication. First of all, as highlighted in previous comments, this quality standard should overall be clearer about what polypharmacy entails, be it appropriate or inappropriate polypharmacy. It should also make clear that this particular quality statement is about addressing inappropriate polypharmacy, outlining why this is a particular issue for people living with multiple conditions in the 'rationale' for example. Secondly, it should also make recommendations to encourage healthcare professionals to undertake medication reviews on a regular basis, be it as part of this statement (as suggested below), or through a

Comments on draft statement 5		
ID	**Stakeholder**	**Comments**
		separate quality statement, as we know this is not routinely happening at the moment. Changing needs or developing side effects/adverse events must be recognised and addressed promptly through ongoing review processes. It is particularly important that it happens when someone moves from one care setting to another, for example when they are discharged from hospital. We are often told that people are discharged without sufficient information on how, when or for what duration people should take new medications at discharge or indeed whether new prescriptions following an admission are replacing or complementing existing treatments. Professionals should use such transitions as a prompt to review and discuss medications, including what they entail and whether they align with the patient's aims and aspirations, with clear communication between secondary and primary care settings and this should be reflected in this guidance. As such, we would recommend amending the quality statement so that it reads as: "Adults have a regular review of their medicines and other treatments for multimorbidity and discuss their treatment regimens, including whether treatments can be stopped or changed".
136	Age UK	The rationale at present suggests that 'Optimising treatments according to individual preferences can reduce adverse events and improve quality of life'. We recommend that in the same vein, it is also made clear that discontinuing a medication isn't (and shouldn't be) about cost savings or patients knowingly being offered substandard care. As such, and building on the comments above, it should be about the patient's health and wellbeing along with the goals and aspirations they have set out as part of the care planning process.
137	Age UK	More clarification in this quality statement would be useful as to who is providing the medication reviews. For example, community pharmacists offer medication review as well through two services (the New Medicines Service and the Medicines Use Review) already included in the Community Pharmacy Contractual Framework with NHS England. We recommend this is referenced in the Statement.
138	Age UK	Age UK also believes that 'The aim of this [treatment review] is to improve the person's quality of life' may not be specific enough although we welcome the acknowledgment that this should be the primary goal of a review. The effect of reducing inappropriate treatments can also greatly improve the lives of carers, family and others involved in a person's care and we would recommend this is included alongside. In light of this, we would recommend the wording 'The aim of this is to improve the quality of life and outcomes for the person, their family and their carers.'
139	British Pain Society	If high levels of uncontrolled chronic pain exist with associated psycho-social issues, then we would encourage referral to an appropriate MDT
140	British Pain Society	Painkillers are the commonest medications that patients take so we would fully agree with their regular assessment especially if the patient is taking opioids or gabapentinoids. Risk/benefit of treatment should be assessed with common side effects treated appropriately. Are there alternative treatment methods for the patient's pain?
141	NHS England	We suggest that this statement be widened in scope to reflect the wider scope of decision making involved in tailoring care. As written it focuses on the need to review medications and treatment but does not take in the scope of wider treatment burden noted in earlier comments. We suggest the Statement would be better entitled: 'Reviewing the burden of care'. Further we suggest the statement be reworded to: 'Adults with multi-morbidity or identified as living with frailty discuss how their care burden can be minimised'.
142	NHS England	As noted in comment 6 we consider that achieving the objective of minimally disruptive or burdensome, tailored, personalised care

Comments on draft statement 5		
ID	**Stakeholder**	**Comments**
		should include the possibility of engagement in discussion, evaluation and care planning with other parts of the health and social care system beyond simply health providers and commissioners.
143	NHS England	non pharmacological treatment burden should be included. Also in QS3 it would be helpful to emphasise that treatment is not just about medication.
144	NHS England	A person's ability to actively participate in a discussion about their medicines and treatments will again be dependent on their levels of knowledge, skills and confidence, so important for the health services to understand 'where they are'.
145	Older People's Advocacy Alliance UK	There is evidence that one-to-one interventions, with advocates to help support and speak up for older people, appear to have the potential to help older people to cope better with long-term conditions and their effects, access appropriate services and help, and to empower them to take greater control of their health. Public Health England and UCL Institute of Health Equity found that qualitative evidence suggests that independent advocacy is having a positive impact on older people's critical and interactive health literacy, from helping them to understand their illness to voicing concerns, exploring health options and claiming benefits. Please see Public Health England & UCL Institute of Equity report: "Local action on health inequalities Improving health literacy to reduce health inequalities" Practice resource: September 2015 https://www.gov.uk/government/publications/local-action-on-health-inequalities-improving-health-literacy Please also see Cancer, Older People and Advocacy programme blog about cancer and co-morbidities: https://opaalcopa.org.uk/2016/03/16/coping-with-more-than-cancer/ One of our service users, Diane, who lives in an area of multiple deprivation, and who has multimorbidities including OPD and cancer, says of Andy, her peer advocate: "He supports me at meetings as well as talking through my treatments and their possible consequences. I have never really trusted services to provide the support that I need and have been cautious in accessing them. Andy's continuing support enables me to get the type of help that meets my own particular individual needs." We have case evidence to demonstrate the life changing, and in some cases life-saving impact of advocacy for people with multimorbidities, as Mike describes, he was recovering from alcoholism and had recently been diagnosed with diabetes when he was "hit with the double whammy of a cancer diagnosis" he was suicidal and his recovery lapsed – Mike describes how his advocate Bob helped him take back control of the situation, gain confidence to speak up in health appointments and make decisions about his treatment. https://www.youtube.com/watch?v=I2KPasvjbiI Independent advocacy support is a vital element in supporting older people with multimorbidities to overcome health inequalities and to ensure that they are able to put a voice to their concerns, feel listened to and have adequate understanding of treatment options available to them. This understanding then supports self-management of multimorbidities and also improves patient experience.
146	Pharmacy Voice	We agree with the quality statement and the rationale behind it. However, the healthcare professionals included in the audience section should include community pharmacists as an example. Community pharmacists are the best-placed healthcare professionals to discuss medicines and other treatments with people as part of Medicines Use Reviews (MURs), which they already provide regularly as part of the NHS Community Pharmacy Contractual Framework.

Comments on draft statement 5		
ID	**Stakeholder**	**Comments**
		The Four or More Medicines service and Pharmacy Care Plan service trialled as part of the Community Pharmacy Future project are good examples of the ways in which community pharmacy teams can build on MURs to play a bigger role in optimising a person's medicines, including by using the STOPP/START tools specified in the Standard. Recommendations can be made to prescribers for changes in medication and patients can receive ongoing support from their pharmacist whenever they return to collect regular prescribed medication.
147	Royal College of General Practitioners	• This quality statement does reflect an important area of quality improvement and is separate from Statement 3, which focuses on identifying patient's aims and goal. • Medicines management should be implemented with the adoption of face to face dedicated medicine reviews for all patients with MM – ideally incorporating the skills of both GPs and practice based pharmacists
148	Royal college of physicians	Although we agree with the need for regular medication review, in addition all multi morbid patients are liable to polypharmacy. In addition to the point above regarding communication between specialists who may start or stop therapy that other departments may have started, there is an important QS regarding managing sick day guidance especially in this scenario with advance patient friendly advice regarding temporary cessation of therapies especially in avoidance of acute kidney injury and acute metabolic emergencies with a process between GP and acute services to ensure agreed process for resting medication (or not) after an acute event.
149	Royal Pharmaceutical Society	Whilst we agree that part of the purpose of a personalised approach is to find ways of reducing treatment burden and optimising care the focus should not just be on whether treatments can be stopped or changed. The main purpose of a personalised approach for adults with multimorbidity 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 purpose is to avoid unnecessary episodes of recourse to urgent and emergency care.
150	Stroke Association	We very much welcome this statement as we know that stroke survivors are not receiving the reviews they are entitled to and that are set out in guidelines, so this is a key improvement area. Indeed, we would like to see this statement augmented so that the focus is not so heavily on medication but on reviewing a patient's complete health and social care needs, including secondary prevention advice where appropriate. The current emphasis of reviewing only to determine whether treatments should be stopped or altered is problematic because we know medicines adherence is a huge issue. Also, people's needs may have changed so they need more, or new, treatments and not necessarily a review to discuss what treatment should be stopped. If NICE wants to have a statement purely on the management of medicines then there should certainly be a separate statement on adequate needs assessments and regular reviews. We are concerned that all the measures and outcomes of this statement are around the avoidance of adverse events from medicines. We believe they should include a range of other objectives such as avoiding episodes of ill health (for example having a stroke through not taking anti-coagulants or blood pressure medicine.)

Comments on draft statement 5		
ID	**Stakeholder**	**Comments**
		According to the National Clinical Guideline for Stroke, stroke survivors should be receiving reviews at 72 hours, 6 months and then annually[23], but we know that this is not happening nearly enough. Not enough stroke survivors are receiving vital 6 month assessments of their care needs, including assessing whether the medicines they may be taking are appropriate. Nationally, only 3 in 10 of eligible stroke survivors are receiving a six month assessment.[24] Our recent survey of stroke survivors found that almost half (47%) were not contacted at all when they returned home from hospital to check on progress or to identify additional support needs. Without proper reviews, we cannot be sure that stroke survivors are getting access to the important rehabilitation services they need to continue to make progress. This is especially important for those who are more likely to be living with multiple long term conditions such as stroke survivors. There is still too much geographical and quality variation in relation to six month reviews. According to SSNAP, only 30% of patients considered applicable actually receive a six month assessment and this is clearly unacceptable given the importance of six month reviews to a stroke survivor's recovery.[25] As the Royal College of Physicians has said, a structured six month review of health and social care "allows patients and their carers to discuss the issues that continue to concern them and formulate action plans to deal with them. These may include reinforcement of lifestyle advice for secondary prevention, discussion of medication needs, on-going medication needs, on-going mobility, communication or rehabilitation needs, "silent symptoms" such as fatigue, memory or mood disturbance, pain and return to work or usual activities."[26] We also know that the lack of 6 month reviews means people aren't being sign posted to community services that could help them, so this needs to be addressed.
151	The Richmond Group of Charities	The statement reads: 'Adults having a review of their medicines and other treatments for multimorbidity discuss whether treatments can be stopped or changed.' This should be changed to 'Adults having a review of their medicines and other treatments for their conditions discuss whether treatments can be stopped or changed' or similar, as there is no treatment for multimorbidity itself.
152	The Richmond Group of Charities	The addition of a quality statement on medicines optimisation is welcome but we fear this quality standard may be missing the point by not promoting the routine implementation of medication reviews and only looking at aspects that involve stopping/changing a medication. The quality standard should be clearer about what polypharmacy entails, be it appropriate or inappropriate polypharmacy, and should outline why this is a particular issue for people living with multiple conditions in the 'rationale'. In addition,

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[23] RCP 'National clinical guideline for stroke 5th edition' (2016), Available: https://www.rcplondon.ac.uk/guidelines-policy/stroke-guidelines

24 RCP Sentinel Stroke National Audit Programme Acute Organisational Audit Report (November 2016), Available: https://www.strokeaudit.org/Documents/Results/National/2016/2016-AOANationalReport.aspx

25 RCP Sentinel Stroke National Audit Programme Acute Organisational Audit Report (November 2016), Available: https://www.strokeaudit.org/Documents/Results/National/2016/2016-AOANationalReport.aspx

26 RCP Sentinel Stroke National Audit Programme Acute Organisational Audit Report (November 2016) p 47, Available: https://www.strokeaudit.org/Documents/Results/National/2016/2016-AOANationalReport.aspx

Comments on draft statement 5		
ID	**Stakeholder**	**Comments**
		recommendations should encourage healthcare professionals to undertake regular medication reviews, whether within this statement (see suggested wording in comment 23) or through a separate quality statement, as we know this is not routinely happening at the moment.
153	The Richmond Group of Charities	Following on from statement 22, an ongoing review process is crucial in enabling healthcare professionals to recognise changing needs, developing side effects and adverse events, particularly when someone moves from one care setting to another. For example, we have heard how people are often discharged from hospital without sufficient information on how, when or for what duration people should take new medications or whether new prescriptions following an admission are replacing or complementing existing treatments. Professionals should use such transitions as a prompt to review and discuss medications, including what they entail and whether they align with the patient's aims and aspirations. As such, we would recommend amending the quality statement so that it reads as: "Adults have a regular review of their medicines and other treatments for multimorbidity and discuss their treatment regimens, including whether treatments can be stopped or changed".
154	The Richmond Group of Charities	The rationale at present suggests that 'Optimising treatments according to individual preferences can reduce adverse events and improve quality of life'. We recommend that in the same vein, it is also made clear that discontinuing a medication isn't (and shouldn't be) about cost savings or patients knowingly being offered substandard care. As such, and building on the comments above, it should be about the patient's health and wellbeing and the goals and aspirations they have set out as part of the care planning process.
155	The Richmond Group of Charities	The healthcare professionals doing medication reviews need to be empowered through evidence, training or through access to colleagues with relevant expertise. The statement should explicitly mention the need for connections and communication between GPs or pharmacists and secondary care providers to enable this. For example, GPs should be empowered to challenge specialists' recommendations on treatment and vice versa.

Suggestions for additional statements		
ID	**Stakeholder**	**Comments**
156	Royal College of General Practitioners	Gap in the statements: There should be a statement around knowledge, skills and confidence (e.g. "Adults with multimorbidity are supported to take an active role in managing their lives with the varying long-term conditions"). This needs to be recognised as a culture shift that requires proper training and on-going continuous professional development (CPD).
157	Stroke Association	We would like to see a quality standard which specifically recognises the vitally important role that families and carers play in supporting older people with social care needs and multiple long term conditions. The quality standard should make clear that carers should be offered support, particularly given that – as NICE's own assessment has shown – fewer people involved in delivering social care are actually getting paid for it. This suggests that families and unpaid carers are playing an ever-increasing role in helping those with social care needs.

Suggestions for additional statements		
ID	**Stakeholder**	**Comments**
		Stroke is the leading cause of disability in the UK, with almost two thirds of stroke survivors in England, Wales and Northern Ireland leaving hospital with a disability as a result of their stroke. 41% of stroke survivors need help with activities of daily living when they are discharged and almost a third receive no social service visits, suggesting that they are often dependent upon their carers. In 2015, 1 in 3 commissioning areas in England, Wales and Northern Ireland did not commission family and carer support services. Currently, many families and carers do not feel prepared when a stroke survivor is discharged. According to our recent survey of stroke survivors, almost 40% did not feel that their carer had enough support when they returned home. 53% of carers either disagreed or strongly disagreed with the statement, “I felt prepared when the person I care for was discharged from hospital”. This is an area where improvement is clearly needed, which would benefit from being explicitly named in this set of quality standards.

Registered stakeholders who submitted comments at consultation

- Age UK
- British Geriatrics Society
- British Pain Society
- Compassion in Dying
- National Community Hearing Association
- NHS England
- Obesity Group of the British Dietetic Association.
- Older People's Advocacy Alliance UK
- Pharmacy Voice
- Public Health England
- Royal College of General Practitioners

- Royal College of Nursing
- Royal college of physicians
- Royal College of Physicians of Edinburgh
- Royal College of Psychiatrists
- Royal Pharmaceutical Society
- Stroke Association
- The Association for Family Therapy and Systemic Practice in the UK
- The Richmond Group of Charities