National Institute for Health and Care Excellence

Multimorbidity
Scope Consultation Table
06/08/14- 10/09/14

	ID	Type	Stakeholder	Order No	Section No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
1.	137	SH	Royal College of Physicians (RCP)	3	General	In the section on management, in addition to the length of consultation – the guideline should explore the use of remote consultation, the use of telemedicine and technology for remote monitoring of physiological parameters.	Thank you for your comment. We acknowledge this developing area and the interest in potential use of telehealth in medical care. However we need to prioritise what will be included in the guideline and do not consider use of telehealth applicable specifically to people with multimorbidity. In particular, we will not be looking at specific conditions and the monitoring of physiological parameters.
2.	17	SH	Alzheimer's Society	1	General	Alzheimer's Society believes that this guidance is too simplistic and is not helpful or useable in its current from given the narrow circumstances that it covers.	Thank you for your feedback. We acknowledge that the guideline will cover only some aspects of care of people with multimorbidity. NICE is developing guidance in other areas of the programme which will cover areas complimentary to this guideline. We have clarified our wording about what is excluded from the guideline and removed the two previously excluded groups which included people with dementia. The guideline will not cover the management of specific

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							conditions, but the principles for assessing and prioritising care will not be different for these groups.
3.	198	SH	Royal Pharmaceutical Society	1	General	As part of reviewing equality, we would support consideration of the local language needs of local communities which may differ from community to community. This would offer those patients who may wish to conduct a conversation in Welsh the necessary support where it is safe and beneficial to do so for the patient.	Thank you for your comment. We agree that implementation of guidance and local service delivery need to be responsive to local communities. Any equality issues are considered at all stages of guideline development.
4.	205	SH	British Acupuncture Council	2	general	As with other interventions acupuncture has largely been evaluated for single conditions. There is powerful evidence is in respect of chronic pain [Vickers 2012; Smith 2014], which tends to feature in most MM. Focusing on single conditions is not, however, characteristic of normal practice, which favours a more holistic approach. The usual patient profile in acupuncture clinics is one with more than one, often many, conditions, of long duration and a severity equivalent to hospital out-patients [Shaw 2007]. Broad holistic benefits, covering multiple physical and mental symptoms and self-empowerment outcomes are characteristic of acupuncture [Rugg 2011]. In one randomised controlled trial with a multi-condition approach acupuncture was associated with positive outcomes for medically unexplained disorders in a population with a high level of social deprivation [Paterson 2011]. Trials where comorbid conditions are measured indicate that acupuncture does best in the sub-groups exhibiting the comorbidity, for example treatment for depression in people also suffering physical pain [Hopton 2014]. In this large RCT patients with depression but no pain responded similarly across the three treatment arms; when there was comorbid pain then acupuncture treatment was substantially superior to both counselling and usual care. Observational pilot studies in advanced cancer populations have demonstrated change over a wide range of symptoms, alongside	Thank you for your comment. We agree that this is an important area, however, this is outside the remit of this guideline, which is the assessment, prioritisation and management of care. We are not addressing specific treatments for people with multimorbidity.

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						improved quality of life and ability to continue living at home (Dean-Clower 2010, Takahashi 2009). A small RCT of acupuncture compared to nurse-led care in patients with incurable cancer reported global benefits without significant side-effects or other tolerance issues (Lim 2011). People with cancer who use CAM (20-40%) get huge benefits in the ability to self-care: not a cure but part of a long-term survivorship process [House of Commons Health Committee 2014]. That sort of positive feedback from CAM vs non-CAM users is seen more generally across chronic illness.	
5.	204	SH	British Acupuncture Council	1	general	Given the problems for orthodox medicine and the NHS in providing good care for people with multimorbidities (MM) it was surprising that there was nobody else representing complementary and alternative medicine (CAM) at the scoping meeting. Also it is disappointing to see no mention of CAM in the draft scoping document. The nature of CAM practice (the consultation, the consultation environment and the empowerment processes) fits well with the healthcare demands of people with MM and there are high rates of CAM use by such people. Trends towards greater involvement of service users in decisions about their treatment will inevitably increase the demand for commissioning CAM [House of Commons Health Committee 2014]. Making a positive response to such people is therapeutically powerful in its own right. Care of people with MM is particularly relevant to generalist care and most professional acupuncturists are generalists. They can provide the continuity of care and coordinated care that are so often lacking in NHS experiences for these patients. Acupuncturists will refer to other practitioners, orthodox and CAM, if they think that this is appropriate, but they are able to offer a range of therapeutic approaches suited to the healthcare needs of people with various and multiple conditions. Acupuncture can be provided in the NHS by professionals who are well placed to coordinate with others in a NHS team in order to offer an integrated package. Thus there are different possibilities to suit different situations.	Thank you for your comment. We agree that this is an important area, however this is outside the remit of this guideline, which is the assessment, prioritisation and management of care. We are not addressing specific treatments for people with multimorbidity.

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						Unlike orthodox medicine, clinical care by professional acupuncturists is not largely informed by single disease evidence and guidelines. It is largely informed by theory and accumulated experience on a root (underlying illness patterns) and branch (presenting symptoms) basis across all the health aspects of the individual at once. In other words, it is set up to treat the person rather than (or as well as) the disease. In combination with orthodox medicine acupuncture may help with prevention/improvement as well as illness management; for example, hypertension [Li 2014], hyperglycaemia [Lin 2014].	
6.	120	SH	Monitor	5	General	In places, the **scope of the guideline is unclear** and inconsistent and may (albeit unintentionally) reinforce the barriers to more clinical coordination rather than seek to address them (see points 6-13).	Thank you for your comment. We have clarified areas in the scope that stakeholders felt were unclear or inconsistent. We have a specific topic on multi-professional care and on barriers to optimising care for people with multimorbidity.
7.	7	SH	Just the Job	1	General	It seems wrong and lacking in equality that individuals with learning disabilities aren't being considered in the same way as others.	Thank you for your comment. We have clarified the scope and people with learning difficulties are no longer excluded.
8.	77	SH	Royal College of General Practitioners	26	General	It would also be useful to understand whether accumulation of several multimorbidities alters motivation to engage in self-help and lifestyle change. Are these patients more or less likely to be worth targeting for lifestyle support? Should support services - eg health trainer services, access to tier 3 bariatric support, be more geared to patients with multimorbidity or should be perhaps limit referring (ie. focus on patients with single morbidities) this group if evidence shows they are less likely to gain benefit? (RP)	Thank you for your comment. We agree that there are a number of important areas for consideration in care of people with multimorbidity. In this guideline we plan to address the assessment, prioritisation and management of care but not consider how specific interventions may have different outcomes in people with multimorbidity. .
9.	76	SH	Royal College of General	25	General	It would be very useful to understand better the impact of lifestyle change that alters multimorbidity - eg what is the effect of weight loss or stopping smoking or increasing exercise when several co-	Thank you for your comment. We agree that there are a number of important areas for consideration in

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			Practitioners			morbidities co-exist? Are the benefits multiplied? Would this scope extend to comment on the effect of bariatric surgery/significant weight loss on how multimorbidity should be reviewed? It would be important not to overestimate the health benefits as underlying risks may not alter at the same rate - eg resolution of diabetes following rapid weight loss may not reduce the underlying associated cardiovascular risk at the same rate. (RP)	care of people with multimorbidity. In this guideline we plan to address the assessment, prioritisation and management of care but will not consider how specific interventions may have different outcomes in people with multimorbidity.
10.	190	SH	Lundbeck UK	1	General	Lundbeck is an ethical research-based pharmaceutical company specialising in brain disorders, such as **depression and anxiety, bipolar disorder, schizophrenia, Alzheimer's disease, Parkinson's disease and alcohol dependence.** Lundbeck welcomes this NICE consultation on clinical practice guidelines on multimorbidity for use in the NHS and requests that consideration is given to identification and intervention at an early stage to diagnose and treat conditions in order to both alleviate symptoms and to manage further exacerbation of other conditions.	Thank you for this information.
11.	197	SH	Lundbeck UK	8	General	References 1. Public Health England, 'Alcohol treatment in England 2012-13', October 2013. Available online at: http://www.nta.nhs.uk/uploads/alcohol2012-13.pdf 2. Alcohol Concern, 'Guide to alcohol for Councillors', September 2013. Available online at: http://www.alcoholconcern.org.uk/assets/files/Guide%20to%20Alcohol%20160813%20APPROVED.pdf 3. Department of Health written evidence submitted to House of Commons Health Committee Third Report of Session 2012-13:	Thank you for your comment. We have noted your references which we will refer to, if appropriate, during guideline development.

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						Government's Alcohol Strategy Ev73 London: House of Commons, 2012 4. Alcohol Concern, Making alcohol a health priority, 2011, p12, available here: http://www.alcoholconcern.org.uk/publications/policy-reports/making-alcohol-a-health-priority 5. Rehmn J et al., Interventions for alcohol dependence in Europe: a missed opportunity to improve public health, 2012, p7, available here: http://www.interventionsforalcoholdependenceineuropepolicysummary.eu/ 6. Parry CD, Patra J, Rehm J Alcohol consumption and non-communicable diseases: epidemiology and policy implications Addiction 2011;106:1718–1724 7. Ronksley PE, Brien SE, Turner BJ et al Association of alcohol consumption with selected cardiovascular disease outcomes: a systematic review and meta-analysis British Medical Journal 2011;342:d671 8. AHA/ASA Guideline, http://stroke.ahajournals.org/content/42/1/227.full 9. University of East London, Alcohol and Diabetes http://www.uel.ac.uk/hrservices/hs/documents/Alcoholanddiabetes.pdf 10. WHO, User empowerment in mental health – a statement by the WHO and Regional Office for Europe, 2010; British Liver Trust, Reducing alcohol harm: recovery and informed choice for	

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						those with alcohol-related problems, 2011 11. Alcohol Research UK, Working with Older Drinkers http://alcoholresearchuk.org/alcohol-insights/working-with-older-drinkers/ 12 NICE, Alcohol-use Disorders, The NICE guideline on Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence, 2011 13 Alcohol use disorders in elderly people–redefining an age old problem in old age BMJ 2003; 327 doi: http://dx.doi.org/10.1136/bmj.327.7416.664 (Published 18 September 2003) 14 Lakhani N. Alcohol use amongst community-dwelling elderly: a review of the literature. J Adv Nurs 1997; 25: 1227–32.	
12.	206	SH	British Acupuncture Council	3	general	**References** Dean-Clower E et al. Acupuncture as palliative therapy for physical symptoms and quality of life for advanced cancer patients. Integr Cancer Ther 2010; 9: 158-67. Hopton A et al. Acupuncture, counselling or usual care for depression and comorbid pain: secondary analysis of a randomised controlled trial. BMJ Open. 2014 May 2;4(5):e004964 House of Commons Health Committee. Managing the care of people with long-term conditions. Second Report of Session 2014–15. Volume 1. 18 June 2014. Li DZ et al. Acupuncture for essential hypertension: a meta-analysis of randomized sham-controlled clinical trials. Evid Based Complement Alternat Med. 2014;2014:279478.	Thank you for these references. As outlined in our response to your previous comments we are not addressing specific treatments for people with multimorbidity in this guideline.

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						Lim JT et al. Is there a role for acupuncture in the symptom management of patients receiving palliative care for cancer? A pilot study of 20 patients comparing acupuncture with nurse-led supportive care. Acupunct Med 2011; 29: 173-9 Lin RT et al. Acupoint-specific, frequency-dependent, and improved insulin sensitivity hypoglycemic effect of electroacupuncture applied to drug-combined therapy studied by a randomized control clinical trial. Evid Based Complement Alternat Med. 2014;2014:371475.. Paterson C et al. Acupuncture for 'frequent attenders' with medically unexplained symptoms: a randomised controlled trial (CACTUS study). Br J Gen Pract. 2011 Jun;61(587):e295-305 Rugg S et al. Traditional acupuncture for people with medically unexplained symptoms: a longitudinal qualitative study of patients' experiences. Br J Gen Pract 2011;61:e306–315 Shaw J et al. Exploring acupuncture outcomes in a college clinic: Patient profile and evaluation of overall treatment benefit. European J Oriental Med. 2007;5(4):55-63 Smith BH et al. SIGN Chronic Pain Guideline Development Group. Managing chronic pain in the non-specialist setting: a new SIGN guideline. Br J Gen Pract. 2014 Jul;64(624):e462-4 Takahashi H. Effects of acupuncture on terminal cancer patients in the home care setting. Med Acupunct 2009; 21: 123-9. Vickers AJ et al. Acupuncture for Chronic Pain: Individual Patient Data Meta-analysis. Arch Intern Med 2012;172(19):1444-1453	
13.	20	SH	Rethink Mental	1	General	Rethink Mental Illness welcomes this new guideline on multimorbidities. People affected by mental illness die, on average, 20 years younger than the general population, often due to preventable physical health	Thank you for your comment. We have clarified the scope to make it

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	0		Illness			conditions. Compared to the general population, this group has twice the risk of developing diabetes and three times the risk of dying of heart disease. We know that despite extensive evidence highlighting these risks, people affected by mental illness are not receiving the right support for their physical health. The 2012 National Audit of Schizophrenia showed that only 29% of people using community mental health services had received all the NICE recommended physical health checks in the previous year. We are therefore encouraged that this particular issue is picked out in the 'Epidemiology' section of the scope and think the guidance could play a key role in setting out a framework for holistic care. Rethink Mental Illness has long been interested in this topic and has recently developed a range of resources to support better physical health care in mental health settings in line with the 2014/15 CQUIN (Commissioning for Quality and Innovation) to improve the physical health of people affected by mental illness. These resources are available at www.rethink.org/phc.	clear that we are excluding people who only have multiple mental health problems and no physical health problems. We will refer where appropriate to other NICE guidance highlighting the issues you raise.
14.	119	SH	Monitor	4	General 3.2 (a), 4.5.1, 4.5.2, 4.5.3	Risk stratification and population profiling. Monitor believes that the way care is delivered must suit local circumstances and the needs of local populations and will differ depending on the needs of particular patient cohorts, such as those with multi-morbidities. We would therefore recommend that NICE conducts a thorough empirical or epidemiological analysis of the multi-morbid population before the guideline scope is finalised. This could be done using linked data sets that are often developed by local areas, such as Somerset and Kent, to stratify and prioritise their patient population, based on defined population risk cohorts. Such approaches help to move away from single disease and programme commissioning approaches. The Nuffield trust may also be able to share their linked datasets. In this way, data is linked across all relevant services such as social, primary, community and mental health care to: • improve understanding of multiple morbidities in the population;	Thank you for your comment. We are unable to conduct empirical or epidemiological analysis before the scope is finalised. However, the guideline will consider both individual indicators and multi variable prediction tools for identifying people who most need a tailored approach. We look forward to the publication of your guidance.

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						• consider the impact on health and care services over time for different population cohorts; • assess population resource consumption; and • proactively identify those with the greatest needs who might best benefit from new care models. Monitor's work to help local areas develop linked patient-level data sets has helped them better understand their local populations' resource consumption across providers and we will shortly be publishing some guidance which you may wish to reference in your final guideline.	
15.	138	SH	NHS England (Quality Framework Team)		General	Thank you for the opportunity to comment on the above Clinical Guideline. I wish to confirm that NHS England has no substantive comments to make regarding this consultation.	Thank you for your comment.
16.	103	SH	Department of Health		General	Thank you for the opportunity to comment on the draft scope for the above clinical guideline. **I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.**	Thank you for your comment.
17.	16	SH	Public Health England - Improving Health and Lives Learning Disabilities Observatory	4	General	The Confidential Inquiry found that people with learning disabilities are more likely to have multiple conditions than those in the general population and specifically recommended that NICE guidance should take multi-morbidity into account. We are concerned to see this group excluded from this NICE guidance in a variety of ways.	Thank you for your comment. The scope has been clarified and people with learning difficulties are now included.

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18.	8	SH	Just the Job	2	General	The consultation should include all aspects of multimorbidity for people with learning disabilities, as it does with other patient groups.	Thank you for your comment. The scope has been amended and people with learning difficulties are now included.
19.	100	SH	The Royal College of Psychiatrists	3	general	The proforma states this just applies to the last few days of life but I assume that is an error since improving management of multimorbidity should start much earlier and this is implied in the consultation.	Thank you for your comment. This was an error.
20.	135	SH	Royal College of Physicians (RCP)	1	General	The RCP is grateful for the opportunity to respond to the draft scope. In doing so we would like to endorse the submission of the British Geriatrics Society (BGS) and the Association of British Clinical Diabetologists (ABCD). We would also like to make the following comments.	Thank you for your comment.
21.	31	SH	University of Bristol	1	General	The recent Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD) (http://www.bris.ac.uk/cipold/reports/fullfinalreport.pdf) found that 98% of 247 people whose deaths were reviewed had one or more long term condition in addition to having learning disabilities and 17% had 4 or more long term conditions. International studies suggest that people with learning disabilities have 2.5 times the number of health problems as others (Lantman-De et al. 2000) and a greater variety of healthcare concerns than those of the same age and gender in the general population (Haveman et al. 2010). The management of these healthcare conditions is generally poorly managed and the needs of people with learning disabilities are frequently not met. This would suggest that particular attention must be paid to this population in any NICE Guidelines. Recommendation 3 of the CIPOLD report was that NICE	Thank you for your comment. We have clarified the scope and people with learning difficulties are now included.

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						Guidelines should take into account multimorbidity in relation to people with learning disabilities (Heslop et al. 2013). We welcome that NICE Guidelines on multimorbidity will be produced, but are extremely concerned about a number of aspects of the scope of the draft guidelines and the apparent exclusion of some people with learning disabilities from them. We suggest that such exclusion does not accord with the requirements of the Equalities Act 2010.	
22.	60	SH	Royal College of General Practitioners	9	General	The scope looks broad and seems to cover everything. There is little mention made of the interaction between medical and social care but it does reference the social care guidelines for the elderly and perhaps this is covered there. No mention Is made of personal health budgets and the evidence to support them in this group however this may have been omitted for political reasons? (GR)	Thank you for your comment. Currently a right to have a health budget is available only to people who are eligible for NHS Continuing healthcare which is a small subset of people with multimorbidity.
23.	83	SH	Royal College of General Practitioners	32	General	This is a very difficult guideline regarding specifics as everything to do with multimorbidities is unique to the individual affected. The general principles that are outline are very admirable and I would agree with most of them but I would suggest these are commonsensical and that the guideline would be of little use in specific clinical situations with patients. Unfortunately I do not think this guideline will be of much ***practical*** use to General Practitioners however is a good summary of ***principles*** involved in multimorbidities. (DM)	Thank you for your feedback. Participants at the stakeholder workshop suggested that the inclusion of principles were important in a guideline. The scope includes a number of areas such as consideration of the absolute risks and benefits of interventions which will inform discussion between the clinician and person with multimorbidity regarding when to start and to stop medication.
24.	143	SH	NHS Choices - Digital		General	We welcome this publication and have no comments on its content as part of the consultation	Thank you for your comment. Your support is appreciated.

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			Assessment Service				
25.	125	SH	Monitor	10	General 4	**Suggestion to include care planning for end of life in scope. In terms of care planning for people with multi-morbidities.** You may wish to consider whether this guideline is an appropriate vehicle for addressing some of the difficult questions around when care professionals and patients themselves may wish to start planning for a managed decline (i.e. advance care planning for end of life) rather than actively treating one or more of their conditions.	Thank you for your comment. The guideline addresses care planning under the section on continuity of care and this would include the areas covered in your feedback.
26.	127	SH	Monitor	12	General 4.3.1a) 4.4a)	**Further detail on primary and secondary care required.** We are pleased with the reference in the guideline scope to the fact that multi-morbidity is often associated with unnecessary or unplanned hospital admissions and that a proposed outcome includes the number of primary care appointments. However, no mention is made in the main body of the guideline of the roles of primary and community care in avoiding hospitalisation, arranging discharges and preventing readmissions. The exclusion of e.g. prevention, early intervention and health maintenance does not fit with the Consultation's focus on tackling avoidable admissions, for example.	Thank you for your comment. The section in the scope on managing care will include looking at interventions aimed at avoiding hospitalisation and preventing readmissions.
27.	128	SH	Monitor	13	General 4.3.1f)	**Suggestion to more explicitly include the patient perspective.** We are pleased that the guideline references the importance of a tailored approach to patient care for those with multi-morbidities and that there is some, albeit limited, recognition of the role of self-care and self-management. However, we consider that the patient perspective should be more explicitly covered in this guideline. Ensuring that patients (and their carers) are fully empowered in, and included in all aspects of, their own care is an important element of improving care coordination. The National	Thank you for your comment. We understand the importance of the patient perspective and believe the scope covers this.

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						Voices 'I' statements purposefully set out the experience of integrated care from the individual's own perspective. And they usefully cover areas such as transitions and the importance of understanding their care plan and any medicines they take with them, what to expect and how to keep in contact with previous services and professionals. Including patients and carers within scope, including the recommendations, will help ensure that patient experience is reflected in the outcome measures and helping to ensure that, e.g. readmissions or unnecessary admissions and GP visits are reduced.	
28.	116	SH	Monitor	1	General 3.1 (a), 4.3.1 (a)	**Definition.** We are pleased to see the references made to the importance of coordinated services for patients with multi-morbidities. We consider that this patient group is likely to directly benefit from organisations and care professionals delivering more integrated care. As stated, this can help to address issues such as unnecessary or unplanned hospital admissions, polypharmacy, requiring social care, duplicate testing and medical advice that is not joined up among professionals or care settings.	Thank you for your comment.
29.	118	SH	Monitor	3	General 4.5.3	**Evidence base.** The Consultation asks for evidence on the clinical and cost-effectiveness of different strategies to improve the care of people with multi-morbidity, for example around personal and management continuity. The evidence for integrated care more generally, in terms of improved patient outcomes and financial savings, is limited. However, it is clear that logically (and based on some local evidence and promising international examples), that patient experience should improve service user outcomes and that reducing gaps and inefficiencies in care can offer opportunities for savings. You may wish to review *Policy Summary 11, What is the evidence on the economic impacts of integrated care?,* Ellen Nolte, Emma Pitchforth (World Health Organization), 2014.	Thank you for your comment. We will access the policy summary you refer to.

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30.	54	SH	Royal College of General Practitioners	3	Title	Unsure what common multimorbidities in title of document means? (EE)	Thank you for your comment. We understand this to refer to common patterns of multimorbidity. However, it is intended that the approach of the guideline would be appropriate for people with any pattern of multimorbidity as these will be quite individual.
31.	42	SH	University of Bristol	12		**References** European Consortium in Healthcare Outcomes and Cost-Benefit Research (2013) *European Guidelines for Cost-Effectiveness Assessments of Health Technologies.* http://www.echoutcome.eu/images/Echoutcome__Leaflet_Guidelines___final.pdf Haveman, M., Heller, T., Lee, L., Maaskant, M., Shooshtari, S., & Strydom, A. (2010). Major health risks in aging persons with intellectual disabilities: An overview of recent studies. *Journal of Policy and Practice in Intellectual Disabilities*, 7, 59–69. Heslop, P., Blair, P., Fleming P., Hoghton, M., Marriott, A., Russ, L. (2013) *Confidential Inquiry into premature deaths of people with learning disabilities*. University of Bristol, Bristol. McCarron, M., Swinburne, J., Burke, E., McGlinchey, E., Carroll, R., McCallion, P. (2013) Patterns of multimorbidity in an older population of persons with an intellectual disability: Results from the intellectual disability supplement to the Irish longitudinal study on aging (IDS-TILDA). *Research in Developmental Disabilities* 34, 521–527. Nord, E., Pinto, JL., Richardson, J., Menzel, Pl., Ubel, P. (1999). "Incorporating societal concerns for fairness in numerical	Thank you for your comment. We will refer to your references, if appropriate, during guideline development.

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						valuations of health programmes". *Health Economics* 8 ,1, 25–39. doi:10.1002/(SICI)1099-1050(199902)8:1<25::AID-HEC398>3.0.CO;2-H. PMID 10082141. Office for National Statistics (2012) *Definition of avoidable mortality*. Office for National Statistics, London. van Schrojenstein Lantman-De, H. M. J., Metsemakers, J. F. M., Haveman, M. J., & Crebolder, H. F. J. M. (2000). Health problems in people with intellectual disability in general practice: A comparative study. *Family Practice*, 17, 405–407.	
32.	65	SH	Royal College of General Practitioners	14	3.1 (a)	Again page 2 the final sentence needs to be very clear about treating symptoms rather than treating risk factors. (KG)	Thank you for your comment.
33.	107	SH	NHS England, Thames Valley Area Team	1	3.1 (a)	Consider the following amendment: … care of people with multimorbidity is particularly relevant to generalist *and multiagency* care.	Thank you for your comment. The paragraph has been edited.
34.	117	SH	Monitor	2	3.1 (a)	**Definition.** However, we would question whether the approach, which would largely be the same for any complex, high-risk patients, such as older people, would materially differ in practice when caring for patients with multi-morbidities or co-morbidities.	Thank you for your comment. We agree that the approach would be similar and the different definitions are not necessarily helpful. We have therefore removed this distinction.
35.	121	SH	Monitor	6	3.1 (a), 3.2	**Further detail on polypharmacy required.** We are pleased to see references to polypharmacy (or the concurrent use of multiple medications by one individual), which is increasingly common and driven by similar factors to the need for more integrated care, that	Thank you for your comment. The guideline development group will consider your comments during guideline development. This guideline will also cross refer to the

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					(a)	is, the ageing population and growing prevalence of multi-morbidity. However, we consider that the guideline would benefit from further detail on the common difficult issues associated with this. Evidence (such as by the King's Fund) suggests that medicines management plays a large role in both ensuring: timely discharge of patients (take-home prescriptions are often late); and safe and effective discharge (as many readmissions are due to patients experiencing adverse drug interactions or not taking the medicine as prescribed due to a lack of understanding or agreement). In addition, the role of pharmacists is not always included in the context of integration and coordination of care, yet it may be useful to include hospital and community pharmacy in the scope of this guideline.	NICE guideline on Medicines optimisation which is currently in development.
36.	61	SH	Royal College of General Practitioners	10	3.1 (a)	I don't really get the difference between co- and multi-morbidity. It seems to me that in primary care they will always be multi, because the whole lot has to be dealt with, but in secondary care e.g. a cardiologist will only be dealing with the heart one of them and ignoring the rest. The term depends on the perspective of the physician, not the patient! (JS)	Thank you for your comment. Following stakeholder consultation we have removed this distinction as the different definitions are not necessarily helpful.
37.	64	SH	Royal College of General Practitioners	13	3.1 (a)	I think that it must be very clear the difference between co morbidity and multimorbidity for example diabetes, cardiovascular disease and CKD where at the time of an acute event one may be dominant but they are all so closely linked that it is difficult to assess which is dominant. (KG)	Thank you for your comment. We agree that the approach would be similar and the different definitions are not necessarily helpful. We have therefore removed this distinction.
	122	SH	Monitor	7	3.1 (a), 4.1.2a), 5.2	Inconsistency in scope – exclusion of children young people. We consider that children and young people under 18 years should be within the scope of the guideline, particularly as there is reference in the guideline to the fact that multi-morbidity is found in younger people. A real problem in this area is the transition to adult services for children with complex problems with multiple conditions who	Thank you for your comment. We considered we could not adequately address the needs of younger people with multimorbidity within this guideline. The incidence of multimorbidity in children and young people is much lower than in

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						might significantly benefit from this guideline on multi-morbidity, such as those accessing CAMHS (particularly the highly specialised Tier 4 services) or with learning disabilities. You might therefore consider cross-referencing the NICE guidance to help tackle transition from children's to adult services which we understand is currently under development.	adults. Making recommendations for people under 18 years requires a different GDG constitution and reviews of different evidence. NICE is developing guidance on transitions between child and adult care for children using health or social care services.
38.	123	SH	Monitor	8	3.1 (a), 3.1c), 4.1.2b)	Inconsistency in scope – parity of esteem for mental health. Monitor agrees that an important group of people with multi-morbidities is those with both physical and mental health needs. Of particular importance are those with long-term physical problems that may not have their mental health needs identified and effectively managed and vice versa. We therefore recommend that you reconsider the intended exclusion from the scope of this guideline those people with more than one mental health problem but no physical problems, not least because it will automatically exclude those whose physical needs are as yet unidentified and unmet. Such an omission is unlikely to be in the spirit of the current policy drive to ensure the parity of esteem between mental and physical health. You may wish to consider NHS England's recently introduced policy for mental health staff to provide physical 'MOTs' to mental health patients to help reduce avoidable deaths. In addition, *Lethal Discrimination*, Rethink, September 2013, is a useful reference.	Thank you for your comment. The screening of people for physical conditions is not within the remit of this guideline, which is the assessment, prioritisation and management of care. People who only have multiple mental health problems and no physical health problems are excluded because their care will be largely delivered by psychiatric services rather than by multiple services.
39.	55	SH	Royal College of General Practitioners	4	3.1	The definition of mutitmorbidity and comorbidity is confusing. Need to ensure you are framing the definitions of comorbidity and multiple morbidity appropriately. Goldberg (2011) thinks that 'co-morbidity' is a term which might be better employed to refer to patients whose physical illness is accompanied by a	Thank you for your comment. This paragraph has been edited and references to co-morbidity removed. Following stakeholder comment it seems that using strict

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						mental disorder. In the draft document, multiple morbidity is stated as physical and mental health problems co-existing. But multimorbidity in the draft scope states it 'is also found in younger people, especially in socially deprived areas where the co-existence of physical and mental health problems is particularly common.' Might help to give an example of comorbidity and multi morbidity? Important as unsure as to whether we are thinking of management of complex multiple different conditions with coexisting mental health problems e.g. raised incidence and prevalence of depression and anxiety in people with diabetes; co morbidity in terms of diabetes and conditions related to diabetes such as amputations, blindness, renal disease or multiple conditions coexisting together- diabetes, epilepsy, asthma. Important as management may be different and adherence to guidelines different for different scenarios. Also may require different outcome measures. So the evidence for a case manager being helpful may be different for example when someone has multiple different unrelated conditions requiring the input of a number of specialists but not so helpful when someone has diabetes and related diabetic complications or diabetes and anxiety for example. Comorbidity among this population has contributed to an increased risk of morbidity and mortality, which places a significant economic burden and an increased demand for medical resource in health care system. Also, managing multiple comorbid conditions is a challenging task for healthcare providers and patients, which in turn can intensify the risk of being poor clinical outcomes and economic burden to healthcare system. For clinicians, patients having multiple medical conditions could create considerable management complexity, forcing clinicians to consider and prioritize a large array of recommended care, possibly replacing valuable time in the office visit that could be	definitions may not be helpful as the burden of the disease and its treatment, and the possible approaches may be the same. The guideline includes a question about how to identify people who would most benefit from a tailored approach.

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						spent addressing issues which have a greater impact on patient health outcomes, therefore, physicians may have a difficulty to adhere to certain disease- specific treatment guidelines, such as diabetes care, when facing patients with multimorbidity.	
40.	78	SH	Royal College of General Practitioners	27	3.1 (a)	The use of the term 'generalist' – we feel this would be better stated as 'led and co-ordinated by primary care with specialist support where needed' Re the point about co-morbidity – yes it is important to define co-morbidity and multi-morbidity and acknowledge they are separate but the management principles will be the same. (LR & JR)	Thank you for your comment. A generalist approach may be taken by other healthcare professionals such as specialists in care of the Elderly. This paragraph has been edited. We have removed reference to co-morbidity as the different definitions are not necessarily helpful and as you indicate the principles may be the same.
41.	139	SH	Royal College of Nursing	1	3.1 (c)	We feel consideration needs to be given to housebound patient and care home patients who are unable to leave their residences (due to physically frailty or cognitive distress) and therefore unable to access certain types of healthcare.	Thank you for your comment. The guideline does include the identification of people who would benefit from a tailored approach and these types of indicators will be considered.
42.	66	SH	Royal College of General Practitioners	15	3.2 (a)	I think that the issues are around system specific specialists rather than professionals trained in holistic care and acting as generalists. (KG)	Thank you for your comment. We have edited this paragraph.
43.	67	SH	Royal College of General Practitioners	16	3.2 (a)	There is actually little evidence from clinical trials for the treatment of people with multimorbidity. Most cardiovascular trials will have excluded people with diabetes, CKD or over 75 for example and we may be using evidence from the treatment of younger adults with normal kidney function. (KG)	Thank you for your comment. The limitations of evidence will be considered by the Guideline Development Group
44.	10	SH	NHS England,	2	3.2 (a)	To clarify, consider the following amendment: … lack of information to guide decisions about *multiple* medicine use,	Thank you for your comment. We have edited this sentence.

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	8		Thames Valley Area Team			including information on the effect of stopping *some* treatments, information comparing the benefits of different *medicine combinations and regimens, and information to support self management*.	
45.	56	SH	Royal College of General Practitioners	5	3.2	Valuable opportunity to address role of mental health and complex multimorbidity or comorbidity. In either case coexisting common mental health problems such as depression and anxiety can impact on the choice of medication, medication tapering, prediction and avoidance of unwanted side-effects, follow-up treatment and achieving full recovery (Jakovljević 2009, Jakovljevic et al. 2010). In patients with somatic disorders, comorbid mental disorders may 1. Modify subjective reactions to somatic symptoms (amplification, diminution and neglect), 2. reduce motivation to care for somatic illness (demoralization), 3. lead to direct maladaptive physiological effects on bodily symptoms, and 4. reduce the ability to cope with somatic illness through limitation of energy, cognitive capacity, affect regulation, perception of shame or social stigma. Importantly in severe and enduring mental illnesses such as schizophrenia and bipolar disorder, there is an argument that they should be considered as chronic diseases in their own right as they are independent risk factors in their own right for cardiovascular and metabolic disease making a focus on the management of physical healthcare and health promotion and ill health prevention work even more important. Maj 2009, identified that in people with SMI, there were more and severe adverse events during psychopharmacotherapy, 3. More treatment noncompliance and nonadherence, 4. Lower quality of life and lower subjective and objective wellbeing in general. (EE)	Thank you for your comment. People who only have multiple mental health problems and no physical health problems are excluded because their care will largely be delivered by psychiatric services rather than by multiple separate services. We recognise that people who have severe and enduring mental illness should be screened and assessed (for example, for cardiovascular disease) but the planning and organisation of this is outside the remit of this guideline.
46.	62	SH	Royal College of General	11	4.1.2 (b)	Is it reasonable to exclude people with more than 1 mental health problem? This could be important if a patient has say depression and a drug and alcohol problem. The medications for both could	Thank you for your comment. We recognise that people who have multiple mental health problems

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			Practitioners			interfere with one another, just as in a physical health problem. Excluding more than one mental health problem if there are no physical problems is irrational because these patients also have poor outcomes in just the same way as the outcome from physical problems. I get the feeling the guideline is more biased towards physical than mental health problems, when it should embrace both. (JS)	may have poor outcomes. However, people who only have multiple mental health problems and no physical health problems are excluded because their care will largely be delivered by psychiatric services rather than by multiple agencies.
47.	68	SH	Royal College of General Practitioners	17	4.1.2	Is the plan to include people with learning disabilities or dementia? Because in section 4.3.2.a and b they are excluded. (KG)	Thank you for your comment. The scope has been amended and people with learning difficulties and people with dementia are now included.
48.	98	SH	The Royal College of Psychiatrists	1	4.1.2 (b)	Should include two mental health diagnoses regardless of a physical diagnosis if one of the diagnoses was either somatoform disorder or factitious disorder - since these two mental disorders usually present to physical health services in the manner of a comorbidity with any other mental health problems such as depression or personality disorder	Thank you for your comment. We recognise that people with the mental health problem you describe can present to physical health services. The recognition of these presentations is important but would require a different GDG and a different set of evidence reviews than could be contained in this guideline.
49.	201	SH	Rethink Mental Illness	2	4.1.2 (b)	We are interested in the rationale for why people with more than one mental health problem, but no physical health problems, are excluded from the scope. Even within mental health services, co-occurring mental health problems are often not well managed. Local referral criteria and commissioning arrangements mean that people may not be able to access multiple mental health services at the same time for different mental health conditions. From a parity of esteem perspective, we feel that this should be included if co-occurring physical health conditions are covered by the scope.	Thank you for your comment. We have clarified the scope and are including people with more than one mental health problem if they have co-occurring physical problems.

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50.	202	SH	Rethink Mental Illness	3	4.1.2	We would ask for clarification around whether co-occurring mental health conditions and substance misuse issues, or 'dual diagnosis' will be covered by this guideline. Again, this is an area where people often fall between the gaps in services, as mental health services will not work with people until substance use has been addressed and drug and alcohol services will not work with someone until their mental health is being treated. This guideline could be a real opportunity to bridge this gap and ensuring people can access the right support.	Thank you for your comment. NICE will be developing separate guidance on health and social care needs of people with severe mental health problems who misuse substances. This guideline does not intend to include people with dual diagnosis and no physical disease.
51.	63	SH	Royal College of General Practitioners	12	4.1.3 (a)	Should you also include an aspect of non-compliance, such as difficult to engage, persistent failure to attend, difficult behaviour as this is very important in multi-morbidity management? (JS)	Thank you for your comment. 4.3.1 (a) refers to examples of people who may require a tailored approach. The guideline development group will define this question in more detail during development.
52.	20	SH	Alzheimer's Society	4	4.2	Alzheimer's Society has concerns that the scope is limited to all NHS settings. Health and social care services are inextricable. Many people, including people with dementia, use both health and social care services and this is necessary for managing their condition. For example, a person with dementia living alone in their own home may need support from a paid carer to remind them to take medication. Alzheimer's Society recommends that social care settings are included in the guidance.	Thank you for your comment. The guideline will not be covering aspects of care for people with individual conditions and in particular aspects of care such as medicines adherence and medicine optimisation which are covered by other NICE guidance. Social care needs require assessment by social services and we will include referral to these where appropriate. The integration of health and social care needs for people with dementia is already in included in NICE guideline 42.
53.	12	SH	Monitor	11	4.2	**Further clarity on settings required.** We agree that all settings	Thank you for your comment. The guideline does include all areas

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	6				(a)	in which NHS care is delivered should be within the scope of this guideline. However, we think it would be helpful to clarify whether this definition covers the broader definition of NHS- funded care, which might potentially entail care delivered in settings other than primary, community, secondary, specialist and ambulance, such as in a patient's home, in social care settings or by independent or voluntary providers. Ensuring that a full range of providers and settings is included is essential to ensure that care for multi-morbid patients is coordinated across their whole care pathway.	where NHS care is delivered.
54.	79	SH	Royal College of General Practitioners	28	4.3.1	▪ We would add the term 'holistic' to tailored ▪ Re the criteria listed in bullet points we would add Living alone People with LD and with dementia ▪ Re measures, we would add **quality of life** in addition to life expectancy as this can be measured formally too ▪ Continuity of care – should social care be added to the term health care ▪ Co ordination of care – should Multi-disciplinary meetings be included? (LR & JR)	Thank you for your comment. The term tailored was used to describe people who may require additional support without defining what this may be (as this is the purpose of the guideline). We have added burden of disease to this point rather than quality of life as we considered it unlikely that we would wish to recommend that practitioners make a decision about treatment using quality of life tools These are examples of people who may benefit from a tailored approach are presented and the guideline development group will define this topic in detail during guideline development. The identification of social care needs will be included in this guideline but how this care is provided is outside of the remit.

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							We have added models of multi-professional care.
55.	111	SH	NHS England, Thames Valley Area Team	5	4.3.1 (f)	… length *and frequency of* consultations. How will 'length of consultations' be measured?	Thank you for your comment. We have edited this to refer to the format of consultations.
56.	186	SH	East & South East England NHS Specialist Pharmacy Services	3	4.3.1 (f)	2nd Bullet point- we suggest a named *"community based-health care professional"* appropriate to the patients need rather than a named *"GP"*.	Thank you for your comment. We have edited this and now refer to a healthcare professional.
57.	185	SH	East & South East England NHS Specialist Pharmacy Services	2	4.3.1 (a)	A combination of indicators would probably best reflect the need for a tailored approach rather than a single indicator in isolation	Thank you for your comment. We have edited this section and now refer to individual indicators and multi-variable prediction tools
58.	69	SH	Royal College of General Practitioners	18	4.3.1 a4.3.1.2	All people over 90 have a limited life expectancy and so would they all need a tailored approach? How do you define limited life expectancy? We all have a limited life expectancy. (KG)	Thank you for your comment. We have deleted this. Examples of who may benefit from a tailored approach are presented and the guideline development group will define this topic in detail during guideline development.
59.	22	SH	Alzheimer's Society	6	4.3.1	Alzheimer's Society welcomes that continuity of care is a key issue with regards to managing care. However, we believe that	Thank you for your comment. The guideline is a clinical guideline

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						the guidance must be extended to include social care settings to ensure continuity of care between health and social care settings. Many people with dementia report that they do not receive any appropriate support following a diagnosis. It is for this reason that the Society calls for an integrated system of health and social care and recommends that NICE includes social care in this guidance.	which will include the identification of social care needs and appropriate referral for these. The guideline will not be making comprehensive recommendations for the care of people with dementia as NICE already have a guideline for people with dementia which includes recommendations on integrated health and social care for people with dementia.
60.	129	SH	Monitor	14	4.3.1 (f)	**Continuity of care and multi-disciplinary team working.** We agree with the inclusion of approaches such as personal continuity (such as lead coordinator or care navigator), management continuity through care planning and multi-disciplinary team working. These are often key (and connected) elements of an integrated care approach for older people or those with multiple or complex conditions. Care coordination is a targeted, community-based and proactive approach to care that involves case-finding, assessment and care planning. It can be led by clinical staff such as nurses or GPs, or non-clinicians in a named care navigator or coordinator role. Such individuals are often supported by multi-professional teams (including generalists working alongside specialists from health and social care), that are often based in primary or community care settings. These teams will be involved in care planning and co-ordinating care for individuals that have been proactively selected and co-producing personalised care plans that match needs with service provision. As such, there will be: joint discussion of cases; joint decision making and multi-disciplinary assessments; a single point of access for assessment and the joint care plan; and assigned accountability of an individual or	Thank you for your comment and information.

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						team to the patients being case-managed. Examples include the Virtual Ward model of case management developed in the UK (e.g. Croydon) where the concept of the hospital ward, with its multi-disciplinary team, ward clerk and regular ward rounds, is replicated in the community. Patients at highest risk are identified, assessed and, where appropriate, admitted to the 'ward' and much of the care and care planning takes place in the patient's home. In PACE (USA), case management of older people is organised from daycare centres through multi-disciplinary teams of nurses, physicians, therapists, social workers and nutritionists and has been shown to reduce bed days, admissions and lengths of stays.	
61.	70	SH	Royal College of General Practitioners	19	4.3.1 (c)	I find this quite exciting!!! (KG)	Thank you for your comment.
62.	26	SH	Pfizer Ltd	1	4.3.1 (a)	Identifying people taking a specified number of drugs as a means to inform a tailored approach is not necessarily straight forward. There will be patients who have a relatively low number of medicines, perhaps 3 or 4, but who still have multiple-morbidity and do need a tailored approach. Importantly this needs to be recognised in the guideline, as not all these patients will be on high numbers of medicines, but will still need support.	Thank you for your comment. We have changed this. Examples of who may benefit from a tailored approach are presented and the guideline development group will define this topic in detail during guideline development. Our presumption is that each individual indicator will have some advantages and disadvantages and these will be explored.
63.	130	SH	Monitor	15	4.3.1 (f)	**Importance of information-sharing.** Monitor agrees that the continuity of information, e.g. across settings and within e.g. multi-disciplinary teams, is essential. Ensuring that the right information is collected and effectively disseminated to the right	Thank you for your comment. We have noted your references for use during guideline development.

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						organisations (across both health and social care) at the right time can play a critical role in ensuring that care is delivered in a coordinated way, but is often regarded as a barrier to more integrated care. This subject is addressed in *Integrated Care and Support: Our Shared Commitment* (National Collaboration for Integrated Care and Support, 2013). You may also find it helpful to link in with the work that is currently ongoing by the integrated care pioneers and those national partners supporting the programme.	
64.	32	SH	University of Bristol	2	4.3.1 (a)	In addition to the factors already mentioned in the draft scope at 4.3.1a that indicate a need for a tailored approach, please also include: • Living alone with minimal support • People with learning disabilities Our evidence from the Confidential Inquiry into premature deaths of people with learning disabilities (CIPOLD) suggests that people living alone with minimal support are very vulnerable people with multimorbidity, and that the lack of effective advocacy for them can be a contributory factor to premature death. In addition, the findings of CIPOLD suggest that despite the Equality Act and the duty to make Reasonable Adjustments, systems are currently not sufficiently responsive to meet the needs of people with learning disabilities who have multimorbidity, and clear guidance needs to be provided for this. Brian's case example highlights this: *Brian lived on his own with 12 hours of support each week. He had diabetes and a severe visual impairment. He was diagnosed with leukaemia and prescribed oral chemotherapy. Brian did not receive his oral chemotherapy for 3 months, largely because the haematology team had understood there to be more support available for Brian to help him with his drug regimens than there*	Thank you for your comment and information. We have included some examples of people who may benefit from a tailored approach and the guideline development group will define this topic in detail during guideline development.

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						actually was. Although the Overview Panel agreed that Brian's death was not premature because of the aggressive nature of his leukaemia, they did identify his 3 months of missed treatment as being a potentially modifiable factor in relation to the timing of his death.	
65.	57	SH	Royal College of General Practitioners	6	4.3.1	Indicator - having a diagnosis of schizophrenia or Bipolar disorder? Significantly increases your physical healthcare risk as a stand alone indicator. Indicator - requiring the support of one or more healthcare professionals or health and social care organisations including third sector? Having a diagnosed alcohol problem? Multiple morbidities and comorbidities are more common in vulnerable populations: deprivation/ lower income, more ethnically diverse population have higher percentages of participants with chronic illness, multiple chronic conditions, disabilities, severe mental illness, and substance use disorders. From Fam Pract. 2013 Apr;30(2):172-8. doi: 10.1093/fampra/cms060. Epub 2012 Oct 8. A model containing demographics and GP practice alone explained 22% of the uncertainty in consultation rates. The number of prescribed drugs, ACG category, EDC count, RUB category, QOF disease count, or Charlson index increased this to 42%, 37%, 36%, 35%, 30%, and 26%, respectively. Measures of multimorbidity made little difference to the fit of a model predicting 3-year mortality. Nonetheless, Charlson index score was the best performing measure, followed by the number of prescribed drugs. There is no gold standard for measuring multi or comorbidity and different outcome measures may have different validity dependent on combinations of diseases and stage of disease.	Thank you for your comment and information. We have included some examples of people who may benefit from a tailored approach and the guideline development group will define this topic in detail during guideline development.

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						(EE)	
66.	140	SH	Royal College of Nursing	2	4.3.1 (a)	Key issue need that need to be covered should include cognition	Thank you for your comment. We have included some examples of people who may benefit from a tailored approach and the guideline development group will define this topic in detail during guideline development.
67.	184	SH	East & South East England NHS Specialist Pharmacy Services	1	4.3.1 (a)	Key issues to be covered under identification- We suggest to add "Having problems with day to day functioning or functional decline" as a potential indicator as this is a common reason for needing a tailored approach in older people.	Thank you for your comment. We have included some examples of people who may benefit from a tailored approach and the guideline development group will define this topic in detail during guideline development.
68.	187	SH	East & South East England NHS Specialist Pharmacy Services	4	4.3.1 (f)	Key issues to be covered under managing care - We suggest to add "Interventions or strategies to improve medicines adherence and reduce polypharmacy	Thank you for your comment. This guideline will cross refer to the NICE guideline on Medicines Optimisation which is currently in development. The effects of stopping treatments is specified in item (d).
69.	105	SH	Society of Academic Primary Care	2	4.3.1 (f) Managing care	Managing care needs to include explicit reference to the decision making process, not just the context in which decisions are made (see Lewis The 2 faces of generalism. J Health Services Research and Policy 2014;19:1. Also Reeve J. **Reeve** J. Interpretive Medicine: supporting generalism in a changing primary care world. London: Royal College of General Practitioners Occasional Paper Series 2010, Series issue 88.)	Thank you for your comment. We will refer to your reference in guideline development if appropriate.
70.	13	SH	Monitor	18	4.3.1 (g),	**More fundamental and targeted questions required on relevant barriers.** Monitor considers that the questions asked	Thank you for your comment. We have edited this and now refer to

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	3				4.5.4	relating to the barriers to the management of people with multi-morbidity are unlikely to yield answers that will help in the development of this guideline. In terms of the literature review around the barriers and enablers to implementing effective transition strategies and practice, you may wish to review Monitor's publication *Enablers and barriers to integrated care and implications for Monitor* (June 2012) as well as *Integrated Care and Support: Our Shared Commitment* and draw on the wider work of the Integrated Care and Support Collaborative. These publications also set out a number of case studies and learning from both national and international experience which may helpfully inform your research.	barriers to optimising care for people with multimorbidity. We have noted your references for use during guideline development.
71.	104	SH	Society of Academic Primary Care	1	4.3.1 (a) Identifying people with MM who need individually tailored approach	Needs to include **treatment burden** as a factor predicting need for individualised care	Thank you for your comment. We have included some examples of people who may benefit from a tailored approach and the guideline development group will define this topic in detail during guideline development. We now refer to treatment burden in 4.3.1 (c).
72.	52	SH	Royal College of General Practitioners	1	4.3.1 (b)	Principles of care are going to be different between primary and secondary care. Should this be two separate sections? (CB)	Thank you for your comment. The guideline development group will consider making separate recommendations for primary and

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							secondary care during guideline development.
73.	203	SH	Rethink Mental Illness	4	4.3.1 (a)	Regarding the indicator around people taking a specified number of drugs, we would like to highlight that taking just one antipsychotic medication can significantly impact on someone's physical health. Research shows that people can experience weight gain of 5-6kg within two months of first taking antipsychotic medication and this continues over the first year. This weight gain contributes to the increased risk of developing physical health conditions such as diabetes and heart disease among this group. We would therefore hope that other considerations around medication, such as side effect profiles, will be taken into account here.	Thank you for your comment. We recognise that each potential indicator will have limitations and these will be explored during guideline development.
74.	109	SH	NHS England, Thames Valley Area Team	3	4.3.1 (a)	Taking a specified number of *prescribed?* drugs	Thank you for your comment. 'Prescribed' has been added.
75.	99	SH	The Royal College of Psychiatrists	2	4.3.1 (a)	The current potential indicators may skew findings towards only the frail elderly and exclude younger adults with multimorbidity where there is less often a risk of falls, social care and being housebound. It would be helpful to also include • having more than one specialist involved in ongoing care • having a specified number of repeat investigations within a defined period of time • being prescribed long term opiates for chronic pain • having a diagnoses personality disorder •	Thank you for your comment. We have included some examples of people who may benefit from a tailored approach and the guideline development group will define this topic in detail during guideline development.
76.	112	SH	NHS England, Thames Valley Area Team	6	4.3.1 (f)	To clarify, consider the following amendment: … self-management and expert patient programmes *(availability for, and impact on, common multimorbidities)*	Thank you for your comment. The evidence review question will be further defined by the guideline development group.

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77.	110	SH	NHS England, Thames Valley Area Team	4	4.3.1 (d)	To clarify, consider the following amendment: Effect of stopping *one or more* common drug *treatments in order to reduce the number of medicines taken, improve adherence and reduce the risks of adverse events.*	Thank you for your comment. The current wording would include one or more treatments. The outcomes for the clinical evidence review will be defined by the guideline development group.
78.	33	SH	University of Bristol	3	4.3.1 (f)	We agree that 'Co-ordinated care for common patterns of co-morbidity' is important. However, co-ordination of care for all people with multimorbidity is vital, irrespective of whether they have a common pattern of co-morbidity, and this should be reflected in any NICE Guideline. A striking finding of the CIPOLD study was the multiplicity and complexity of clinical problems that people with learning disabilities had, and a key problem leading to premature death was the lack of coordination of care across and between different disease pathways and service providers. This was largely because of the way in which secondary services are organised for adults, which limits the opportunity for a holistic focus on a person's health and for effective coordination of the various specialists involved. CIPOLD frequently reviewed the deaths of people with learning disabilities whose multiple needs were being served by different specialists, sometimes in different hospitals, with no designated or responsible coordinator for their care. This resulted in each hospital admission being micro-managed as a distinct entity, but without any consideration of the whole picture and the overall pattern of the person's illnesses, so contributing to their vulnerability, deteriorating health and sometimes their death. The review of the circumstances leading to David's death illustrated these problems: *David had multiple morbidities and faced considerable difficulties as a result of receiving care from different hospitals and different departments within each of those hospitals. Referrals were made internally and externally with no apparent systematic tracking,*	Thank you for your comment. We have edited the scope as we agree that the recommendations will be applicable to all patients with multimorbidity if possible. We focus on common morbidity for the topic on ranking absolute risks and benefits of treatments for prevention or improving prognosis.

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						coordination or follow-up of responses or actions, and the transfer of information or access to David's medical notes between departments and hospitals was problematic. It was felt that there was confusion about who was taking responsibility for David's overall care within secondary services, and this impacted on his speed of access to appropriate care and to pre-existing conditions never being satisfactorily resolved. His social care provider appeared to be neither equipped nor resourced to chase up appointments or monitor his progress through so many different systems, and there was no one else to do this on his behalf. Managing multi-morbidity care in the learning disability population requires structured case coordination, by a named clinician, and clear guidance is required for this.	
79.	27	SH	Pfizer Ltd	2	4.3.1 (a)	We appreciate that this guide does not cover patients with learning disabilities or dementia, however there may be patients who do not have identified mental health problems, but who are non the less still easily confused. For example, some elderly patient will typically require a more tailored approach and we believe a further bullet should be added to recognise this.	Thank you for your comment. People with learning difficulties and people with dementia are now included. We have included examples of who may benefit from a tailored approach and the guideline development group will define this topic in detail during guideline development.
80.	34	SH	University of Bristol	4	4.3.1 (f)	We are pleased to see the inclusion of 'self-management and expert patient programmes' as an issue that will be covered in the guidelines. We expect this to include guidelines about adapting such programmes to the needs of people who require reasonable adjustments made to the traditional approach.	Thank you for your comment. The specific needs of people with multimorbidity will be considered by the guideline development group when making their recommendations.
81.	136	SH	Royal College of Physicians (RCP)	2	4.3.1	We believe that this should include a section defining professional groups required for delivering co-ordinated and effective care for people with multimorbidity. This must include psychological support and mental health support for people with long-term	Thank you for your comment. The issues you raise are important. However, it would not be possible to provide recommendations for

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						conditions. In addition to ranking of absolute risks and benefits of treatment it would be helpful for the guideline to address levels of treatment goals that are appropriate for patients with multimorbidity. For example: levels and aim of glycaemic control in a person with diabetes who has multimorbidity would be different for someone without depending on the multimorbidity. Realistic and practical levels of intervention in patients who have multimorbidity. For example, for a patient with COPD would the use of more nebulised therapy at home be more beneficial in those with multimorbidity. This is opposed to the more conservative strategy that suggests using inhalers only with limited access to nebulisers. It would also be useful to look at supporting measures such as at home non-invasive ventilation, such as BIPAP treatment and the appropriateness of such intensive supportive measures in the overall context of the patients with multimorbidity, their functionality and quality of life. The guideline could also do with addressing the location of care to be delivered at times of stability of the multiple morbidities as well when there is decompensation and acute deterioration ie can some patients be managed in a community setting (eg home COPD services. On the same note the responsiveness of services to ensure rapid return to residence with supported discharge on the immediate resolution of the deterioration should the patient require hospitalisation to avoid deconditioning and the risks of prolonged hospital stay.	specific treatments such as nebulisers. The guideline aims to identify people who need a tailored approach and evidence on relative benefit of treatments from current evidence. Decisions for individual patients will need to be made with their healthcare professionals. We have clarified that symptomatic treatment is excluded from the scope of this guideline (4.3.2) and that also state in 3.1 (d) that the management of individual conditions is not within the scope of this guideline.

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82.	28	SH	Pfizer Ltd	3	4.3.1 (c)	We understand the need for this ranking of absolute benefits and risks, but it is important to understand how these morbidities will be compared and ranked against one another, in the absence or presence of other co-morbidities. It is also reasonable to assume that the absolute benefits of managing these different morbidities will be affected by how engaged patients are with their conditions and its management. There should be some direct cross referencing this aspect with the Medicines Optimisation guideline in development	Thank you for your comment. These points will be considered during guideline development. This guideline will cross refer to the Medicines Optimisation guideline
83.	71	SH	Royal College of General Practitioners	20	4.3.1 (f)	What about the role of telehealth? (KG)	Thank you for your comment. We acknowledge this developing area and the interest in potential use of telehealth in medical care. However, we need to prioritise what will be included in the guideline and do not consider use of telehealth applicable specifically to people with multimorbidity.
84.	29	SH	Pfizer Ltd	4	4.3.1 (f)	Care management as described here is often desirable, but often at odds with the circumstances in which healthcare professionals work and care delivered. For example, the length of a consultation is often limited by resource within a particular healthcare setting. We would ask that incentives are included, such as within QOF, as part of the scope to incentivise some aspects of management such as increasing the length of a consultation.	Thank you for your comment. It is not within the remit of NICE clinical guidance to indicate what should be included in the Quality and Outcomes Framework. We will pass your comment on to the NICE implementation team.
85.	18	SH	Alzheimer's Society	2	4.3.2	Alzheimer's Society has concerns that the management and organisation of care for people with dementia with multimorbidities will not be covered by this guidance. There are 800,000 people living with dementia in the UK today and the condition is more prevalent in people over 80 years old. These people are likely to be living with numerous long-term conditions. We know that this guidance will not replace the dementia	Thank you for your comment. People with dementia are now included in the scope of this guideline.

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						guidance, but dementia cannot be separated from multimorbidities as a whole. Alzheimer's Society would like to know the rationale for not including dementia in the guidance and seeks assurances from NICE that there will be specific guidance for the management and organisation of care for people with dementia who are living with other conditions.	
86.	19	SH	Alzheimer's Society	3	4.3.2	Dementia has an impact on the management and assessment of other conditions. As a person's dementia progresses, they will require support with managing other long-term conditions. They may also lose the ability to communicate that they are in pain or discomfort making assessment for another long-term condition difficult for a person who does not have the specific skills or knowledge to support a person with dementia. Dementia can complicate the management of other long-term conditions as each condition has an impact on the other. For this reason Alzheimer's Society recommends that either dementia is included either in this guidance or NICE develops guidance specific to dementia.	Thank you for your comment. People with dementia are now included in the scope of this guideline.
87.	113	SH	NHS England, Thames Valley Area Team	7	4.3.2	Excluded? End of life care for people with multimorbidity	Thank you for your comment. We have edited the scope in accordance with your suggestion.
88.	2	SH	National Family Carer Network	2	4.3.2 (a)	Following on from the point above, I do not understand why respiratory problems have been cited as an example of "specific morbidities associated with learning disability". Certainly people with learning disabilities are at high risk of respiratory problems, but the evidence indicates that these risks are amenable to good health care, not intrinsic to the person's learning disability (unlike the risk of thyroid problems, say, in a person with Down syndrome).	Thank you for your comment. People with learning difficulty are now included in the scope and this example has been deleted.

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89.	3	SH	National Family Carer Network	3	4.3.2 (b)	I do not understand why "management and organisation of care" for people with learning disabilities or dementia have been excluded. No other vulnerable groups have been singled out (e.g. management and organisation of care for people with mental health problems, homeless people, travellers). Neither is it clear what is meant by "management and organisation of care". Does this mean: • social care? • specialist health services that are just for people with learning disabilities? • the response of the mainstream NHS to the multiple general health problems experienced by many people with learning disabilities? Surely the whole point of guidance on multimorbidity is to focus on the latter issue for anyone – not just people with learning disabilities but not excluding them?	Thank you for your comment. We have clarified the scope and people with learning difficulties and people with dementia are now included in the scope. Our intention is not to make recommendations for health services for any individual condition but to consider the response of mainstream NHS as your comment suggests.
90.	1	SH	National Family Carer Network	1	4.3.2 (a)	I do not understand why identification and management of specific morbidities associated with learning disability are proposed for exclusion. No justification is given for this. Identification and management of specific morbidities associated with other conditions are not excluded (for example, diabetes, as cited earlier in the document). This looks like unequal treatment.	Thank you for your comment. We have clarified the scope and people with learning difficulties and people with dementia are now included in the scope. Our intention is not to make recommendations for health services for any individual condition but to inform care for people with multimorbidity.
91.	38	SH	University of Bristol	8	4.3.2 (b)	It is not clear what is meant by 'the management and organisation of care'. NICE Guidelines should be applicable for anyone, including people with learning disabilities with comorbidities, and need to take account of health and social care, specialist services and that provided by family carers or paid support staff. Guidelines about communicating effectively with others involved in the care of an individual must be included.	Thank you for your comment. This sentence has been deleted. We have clarified the scope and people with learning difficulties and people with dementia are now included in the scope. Our intention is not to make recommendations for health

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							services for any individual condition but to inform care for people with multimorbidity.
92.	72	SH	Royal College of General Practitioners	21	4.3.2 a and b	Should these groups be included in 4.1.2? see point 5(KG)	Thank you for your comment. These groups are now included.
93.	36	SH	University of Bristol	6	4.3.2 (a)	The draft scope notes respiratory problems as being an example of a specific morbidity associated with learning disabilities. This is incorrect. The CIPOLD study found that people with learning disabilities were at high risk of respiratory problems, but that these are largely amenable to good quality healthcare. McCarron et al (2013) in a study of multimorbidity in an older population of people with learning disabilities in Ireland reported only a 7.5% age-standardised prevalence of lung conditions in people with learning disabilities, and an insignificant odds ratio of for the presence of lung disease.	Thank you for your comment and this information. This sentence has been deleted.
94.	35	SH	University of Bristol	5	4.3.2 (a)	The draft scope specifies that clinical issues that will not be covered include: 'Identification and management of specific morbidities associated with learning disabilities'. No justification for this exclusion is given, and it appears to be arbitrary, discriminatory and contrary to the requirements of the Equality Act 2010. This is of particular concern. There are four points that we would like to raised here: 1) What does 'associated with' mean in practice, and what would the threshold be for a disorder to be 'associated with' learning disabilities? People with learning disabilities commonly experience a range of disorders that is similar to other people e.g. asthma, diabetes. In addition, some disorders have a higher prevalence in people with learning disabilities, and other disorders have a lower prevalence. But what threshold for those with a higher prevalence will be used, and what evidence (which is	Thank you for your comment. This sentence has been deleted. We have clarified the scope and people with learning difficulties and people with dementia are now included in the scope.

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						currently poor) will this decision be based upon? 2) Some people with the same condition (e.g. autism, cerebral palsy) may or may not have learning disabilities. As it stands, the NICE Guideline would include people with autism and associated multimorbidity (e.g. anxiety-related disorders) who do not have learning disabilities, but would exclude those who do have learning disabilities. Clearly, this would be a nonsense. 3) No other groups with protected characteristics under the Equality Act are excluded; one could wonder, for example, why people with mental health support needs and related comorbidities are included but people with learning disabilities are not. 4) No other groups of people with conditions that themselves have associated comorbidities are excluded. Again, one could wonder why people with diabetes and associated vascular problems are included, but people with learning disabilities and epilepsy are not. The assumption that this invites is that the basis on which people with learning disabilities and associated conditions are excluded is discriminatory. As an illustration (from correspondence - case studies not investigated as part of CIPOLD): Tom had severe learning disabilities, with microcephaly, spastic quadriplegia, and was blind. He died because early symptoms of an empyema were not noticed. Alex had Down's Syndrome, bowel problems and mental health problems. He died because of faecal impaction. Clearly, both Tom and Alex had multimorbidities, but would either of them/both of them be included in the NICE Guidelines? How should clinicians make a decision as to who the guidelines are appropriate for or not?	

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95.	37	SH	University of Bristol	7	4.3.2 (b)	The exclusion of people with learning disabilities and people with dementia from guidelines for 'the management and organisation of care' is unjustifiable. No other vulnerable groups have been excluded (e.g. homeless people, travellers, people with mental health support needs) and in practice, people with learning disabilities might also be homeless/have mental health support needs etc.).	Thank you for your comment. We have clarified the scope and people with learning difficulties and people with dementia are now included in the scope.
96.	14	SH	Public Health England - Improving Health and Lives Learning Disabilities Observatory	2	4.3.2 (b)	The second clinical issue which is identified as not within your remit is the "management and organisation of care for people with learning disabilities and people with dementia". Again, other vulnerable patient groups are not being excluded from this guidance.	Thank you for your comment. We have clarified the scope and people with learning difficulties and people with dementia are now included in the scope.
97.	13	SH	Public Health England - Improving Health and Lives Learning Disabilities Observatory	1	4.3.2 (a)	We are disappointed to see that identification and management of specific morbidities associated with learning disabilities (for example, respiratory problems) are being excluded from NICE guidance on multi-morbidity. From an equalities perspective it is concerning that you appear to be treating people with learning disabilities in a different way to other patient groups. It is unclear to us why conditions that are associated with learning disabilities are not included. Other patient groups may also have specific morbidities associated with their condition and yet these are not being excluded. In relation to respiratory problems there are other groups of patients for whom this is an issue, such as those with dementia.	Thank you for your comment. We have clarified the scope and people with learning difficulties are now included in the scope.

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						Moreover, evidence suggests that the reason more people with learning disabilities die of respiratory problems is as a consequence of factors related to the healthcare they received. The Confidential Inquiry into premature deaths of people with learning disabilities showed that a large proportion of deaths of people with learning disabilities could have been avoided through the provision of good quality healthcare (Heslop at al, 2013).	
98.	80	SH	Royal College of General Practitioners	29	4.3.2	We found this exclusion criteria targeted to people with dementia and learning disabilities surprising -we are not sure how you can exclude PWD as they often have multi-morbidities due to their age and are a key group to look at in terms of management in this area(LR & JR)	Thank you for your comment. We have clarified the scope and people with learning difficulties and people with dementia are now included in the scope.
99.	12	SH	Getta Life	1	4.3.2	Why are specific morbidities assessed? Learning disabilities are excluded; we feel these should be included to ensure people with learning disabilities get the best clinical outcomes. The management and organisation of care for people with learning disabilities and people with dementia should be included too. This is a complicated area of care and people with learning disabilities and dementia are often poorly served by the health service. Clinical guidance would give services a baseline of good practice to start from. As multimorbidity was one of the factors in premature deaths for people with learning disabilities, it is hard to see why these areas have been excluded. People with learning disabilities are at great risk of discrimination from health practitioners on a daily basis; being excluded from	Thank you for your comment. We have clarified the scope. We will not be providing recommendations for any specific condition. People with learning difficulties are now included in the scope.

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						NICE guidelines doesn't model valuing people with learning disabilities and risks colluding with discrimination. Please reconsider this part of the guidance.	
100.	124	SH	Monitor	9	4.3.2 4.3.1a), 4.3.1f)	**Reconsideration of exclusion of those with learning disability and dementia.** We consider that those with learning disabilities and dementia should be within the scope of the guideline. Mental health and learning disability are areas where service users most often need complementary physical and mental health and social care approaches to care. People with dementia often have physical co-morbidities (particularly cardiovascular) and, in particular, early onset dementia is poorly diagnosed, which can lead to confusion and can extend lengths of stay for those suffering falls or infections. Evidence shows that patients with mental health conditions and dementia experience longer lengths of stay and often need much more support on discharge. Additionally, liaison psychiatry and dementia consultants in A&E departments play a crucial role in both preventing admissions (through A&E case finding) and facilitating discharges. There is good evidence of cost effectiveness for this service, such as the specialist multi-disciplinary Rapid, Assessment, Interface and Discharge (RAID) model. And regarding the extent to which the health and care sector seeks to care for people within the community (i.e. not in residential care settings or nursing homes), it is likely to be the same multi-disciplinary teams that will be providing this care.	Thank you for your comment. People with learning difficulties and people with dementia are now included in the scope.
101.	39	SH	University of Bristol	9	4.4 (a)	Additional outcome measures should be: • Readmissions within 30 days of hospital discharge • Cause of death amenable to good quality healthcare	Thank you for your comment. We have edited the introductory sentence to explain that the

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						(ONS 2012).	outcomes will be decided by the guideline development group and the outcomes below are examples. We have noted your suggestions and we will discuss these with the guideline development group.
102.	21	SH	Alzheimer's Society	5	4.4	Alzheimer's Society recognises the importance of the outcomes in the scope. Nevertheless, as expressed above in this response, health and social care services are dependent on one another. Therefore, the Society cannot see how unplanned hospital admissions, length of hospital stay and the number of primary care appointments can be used for determining outcomes if social care settings are not included in the scope. Alzheimer's Society recommends that social care settings are included in the guidance.	Thank you for your comment. The remit for this guideline is the assessment, prioritisation and management of care for commonly occurring multimorbidity. The guideline will be relevant to any setting where NHS care is delivered including social care settings.
103.	114	SH	NHS England, Thames Valley Area Team	8	4.4 (a)	Consider including: number of medication reviews in primary care; frequency of diagnostics for monitoring purposes.	Thank you for your comment. We have edited the introductory sentence to explain that the outcomes will be decided by the guideline development group and the outcomes below are examples. We have noted your suggestions and we will discuss these with the guideline development group.
104.	141	SH	Royal College of Nursing	3	4.4 (a)	EQ-5D is a difficult measure to use when people have cognitive problems –other measures should be sought.	Thank you for your comment. We have edited the introductory sentence to explain that the outcomes will be decided by the guideline development group and the outcomes below are examples. We have noted your suggestions and we will discuss these with the guideline development group.

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105.	58	SH	Royal College of General Practitioners	7	4.4	Is there specific evidence that these are appropriate outcome measures for the management of multiple morbidities? There is a Cochrane database 2012 interventions for improved outcomes in patients with multiple morbidities in primary care and community settings. Setting and outcomes are important as validity may be affected in different contexts- care or nursing homes, hospitals, primary care and ambulatory clinics. Outcome measures can be dependent on whether we are considering comorbidity or multimorbidity. Also measurement dependent on a number of confounding factors which can affect the predictive performance of comorbidity scores (1) the clinical conditions included in a comorbidity score and their relative weights, which attempt to account for differential impact of individual comorbidities; (2) the endpoints of study interest (e.g., mortality, healthcare utilization and expenditures); (3) the distribution of comorbid conditions in the source population, which could depend on target study population (e.g., higher prevalence of comorbidities in the elderly, compared to the younger); and (4) the accuracy of the administrative data. The predictive performance of two comorbidity scores can validly be compared when factors 2-4 are held constant. Several studies have explored the predictive validity of comorbidity measures in claims data. However, only a few publications compared the performance of two comorbidity scores in the same populations and for the sample endpoints. (EE)	Thank you for your comment. We have edited the introductory sentence to explain that the outcomes will be decided by the guideline development group and the outcomes below are examples. We have noted your suggestions and we will discuss these with the guideline development group. We have noted your points for discussion with the guideline development group.
106.	75	SH	Royal College of General Practitioners	24	4.4 and 4.5.3 and 4.5.4	It is not just number of primary care appointments that could be used to assess main outcomes, but efficiency of arranging blood test monitoring. A current issue that results in inefficiency for both patient and NHS is where a patient is seen in several separate chronic disease clinics, and blood tests generated in one clinic do not include all the tests that relate to other conditions - because	Thank you for your comment. We have edited the introductory sentence to explain that the outcomes will be decided by the guideline development group and the outcomes below are examples.

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						the clinic is set up to follow a template for a single disease. QOF has really pushed this single disease focus, resulting in patients being recalled time and again to different clinics and further monitoring tests. Development of a multimorbidity template - to ensure comprehensive assessment at a single visit - would be a big step forward for all. Some surgeries may already have addressed this and set up processes for this. However primary care nurses are not all trained in all chronic conditions, meaning that a multimorbidity clinic may not be easily feasible, would generate increased training costs and as well as knock on impact on salary following that training. Having a 'named GP' would not necessarily address this issue of silo care in current separate chronic disease clinics. (RP)	We have noted your suggestions and we will discuss these with the guideline development group.
107.	134	SH	Monitor	19	4.4	**Outcomes.** There are a number of key areas that you have identified that we are particularly pleased to see will be covered by the guidelines. This includes outcomes. One of the main objectives for more integrated care is to improve the user's experience and care outcomes. Including patient and user satisfaction in the scope is helpful, but we suggest that you may wish to include the measurement of user and carer experience in this area, as you did for your guideline scope on the coordinated transition between health and social care. However, many of the outcomes suggested in this consultation are unlikely to provide specific information relating to multi-morbidity, although we recognise the difficulty of measuring improvement or otherwise in this area. We would also like to draw your attention to the 'I' statements developed as part of our National Voices' integrated care Narrative. These may also form a good basis for the development of person-centred outcome measures. You may also wish to consider the numerous ambulatory care measures associated	Thank you for your comment. We have edited the introductory sentence to explain that the outcomes will be decided by the guideline development group and the outcomes below are examples. We have noted your suggestions and we will discuss these with the guideline development group. We now refer to 'patients and carer's experience of care'. We have noted your references for use during guideline development

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						with the Alternative Quality Contract (Blue Cross Blue Shield of Massachusetts, USA) – see *Health care spending and quality in year 1 of Alternative Quality Contract*, New England Journal of Medicine, 8 September 2011.	
108.	81	SH	Royal College of General Practitioners	30	4.4	Re outcomes and measure: should primary care appointments also include other community care resource use like social care referrals Pharmacy is not mentioned at all – number of drugs and use of pharmacist times is very relevant (LR & JR)	Thank you for your comment. We have edited the introductory sentence to explain that the outcomes will be decided by the guideline development group and the outcomes below are examples. We have noted your suggestions and we will discuss these with the guideline development group.
109.	59	SH	Royal College of General Practitioners	8	4.4 (a)	Wellbeing? Activities of daily living? Patient reported outcome factors? Are these outcomes that need consideration? Outcome measures need to represent the biopsychosocial and spiritual model of care- holistic whole person care. (EE)	Thank you for your comment. We have edited the introductory sentence to explain that the outcomes will be decided by the guideline development group and the outcomes below are examples. We have noted your suggestions and we will discuss these with the guideline development group.
110.	40	SH	University of Bristol	10	4.5	Given the comparative dearth of Randomised Control Trials (RCTs) including people with learning disabilities, we expect that the systematic review will include a range of studies and sources of evidence in relation to people who are more commonly excluded from RCTs.	Thank you for your comment. The evidence reviews will include non RCT evidence where appropriate.
111.	1911	SH	Lundbeck UK	2	4.5.1 (a)	We agree that at a high level the indicators outlined would identify people who need a tailored approach to the care of their multimorbidity, however we would argue that the nature of the	Thank you for your comment. The guideline development group will consider all appropriate indicators

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						conditions should also be considered. For example mental health conditions such as depression, anxiety and alcohol dependence are complex conditions, and subtle differences in their treatments, be they psychological or pharmacological, can impact significantly on the outcomes experienced by an individual. Furthermore, every patient's mental health condition is different and therefore the same treatment can affect different people in different ways. As such, meaningful and comprehensive choice of evidence based treatment within mental health is of particular importance in successfully managing these types of conditions. Finally whilst we agree that the number of medications an individual may be taking can be an indicator of complex needs, we would support the approach for ensuring appropriate medicines management programmes are in place to review medications at appropriate junctures including disinvesting in medications that are no longer clinically effective.	for a tailored approach to care, which may include people with mental health conditions. NICE's Medicines Optimisation guideline and Medicines Adherence guidelines cover medicines review.
112.	1311	SH	Monitor	16	4.5.2	**Assessment.** With regard to assessment, it would be helpful to know if NICE is considering the various assessment tools currently in use, such as FACE (Functional Analysis of Care Environments) and comprehensive geriatric assessment tools, and whether there is likely to be a recommendation made for one tool over another. We would also like to note that many leading edge areas, such as the integrated care pioneers, are moving away from the 'assessment' label and are instead using the terms 'guided conversation' and 'goal setting' as better descriptors of the process.	Thank you for your comment. The guideline development group will define what assessment tools are included in the evidence review and we have noted your examples for consideration. At this stage in guideline development, we are unable to state whether one tool will be recommended over another.

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113.	188	SH	East & South East England NHS Specialist Pharmacy Services	5	4.5.2 (e)	Our comment is that this is fundamental to supporting practitioners to provide evidence based care to patients with multimorbidities e.g balancing the risk of polypharmacy with the benefits of medicines for individual conditions	Thank you for your comment.
114.	192	SH	Lundbeck UK	3	4.5.2 (b)	We fully support this aspect of the scope for the following reasons. Priority should be given to ensuring that conditions are managed in such a way as not to exacerbate their effects or increase the risk of developing further health problems. Both screening for additional health issues and early intervention for emerging conditions should be considered. An estimated 1.6million people in England – one in 20 adults – are dependent on alcohol and many more are damaging their health by drinking at unsafe levels.[1] In 2011/12 there were approximately 1.2 million alcohol-related hospital admissions in England, representing a 135% increase since 2002/03,[2] and alcohol is estimated to cost £21bn per year.[3] Alcohol has been implicated to a broad range of diseases and injury including pancreatitis, high blood pressure, depression, stroke and liver disease.[4]In most cases, the relationship between alcohol and a disease is 'dose-dependent' – that is the more alcohol consumed, the greater the risk of disease.[5]	Thank you for your comment. The screening of people for physical conditions is not within the remit of this guideline. The remit is for the assessment, prioritisation and management of care. There is a NICE guideline on Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence.

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						Screening and brief interventions for alcohol misuse have been shown to be both clinically and cost-effective in changing a person's behaviour in reducing their alcohol intake over a period of time; screening and brief interventions in general practice will save £58,000 for every 1,000 patients screened.[4]	
115.	193	SH	Lundbeck UK	4	4.5.2 (e)	We support this aspect of the scope and believe it is important to understand the nature of the interaction between different conditions in order to inform a ranking of treatments. Condition-specific guidance may not provide a complete data set if it does not include information on this interaction. Alcohol, for example, is the second biggest cause of cancer after smoking. There is now a consensus that alcohol causes cancers of the oral cavity, pharynx, larynx, oesophagus, liver, colon, rectum and female breast. The risk of these cancers increases steadily with greater consumption. Each 10 g of pure alcohol per day increases the risk of breast cancer by 7%. Regularly consuming approximately 50 g of pure alcohol increases the relative risk of colorectal cancer by between 10% and 20%, and malignancies of the larynx, pharynx and oesophagus by more than 100%.[6] Alcohol use also contributes to numerous adverse cardiovascular outcomes, including hypertension, haemorrhagic stroke and atrial fibrillation.[6] Studies have demonstrated an association between alcohol and ischemic stroke. Drinking between 30g and 60g of alcohol a day increases the risk of suffering and dying from a stroke by 15% and 10% respectively. Drinking more than 60g increases the risks by 62% and 44% respectively.[7]Research indicates that stroke recurrence is	Thank you for your comment. The guideline development group will consider the limitations of this approach when making their recommendations. There is a NICE guideline on Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence.

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						significantly increased among ischemic stroke patients with prior heavy alcohol use.[8] Alcohol consumption can also exacerbate conditions such as hypertension; the NICE guidelines on hypertension recommend lifestyle advice on alcohol use for patients. NICE guidelines on diabetes recommend advice on alcohol intake for patients with type 2 diabetes. A study of 12,261 middle-aged subjects found that men who drank more than 21 drinks a week were more likely to develop type 2 diabetes compared with men who drank one or less drinks a week. Diabetes is also a common side effect of chronic pancreatitis, which is overwhelmingly caused by heavy drinking. One in three people who have chronic pancreatitis will develop diabetes.[9] We would therefore argue that a holistic approach is taken when ranking treatments that includes consideration of exacerbating and interacting factors, such as alcohol misuse including alcohol dependence.	
116.	132	SH	Monitor	17	4.5.2, 4.5.3	**Clarity required on definition of 'prioritisation'.** We think that it would be helpful to clarify what is meant by 'prioritisation' in this regard and whether it is equivalent to risk stratification as set out under item 4. From the guideline scope it appears that NICE may be referring to a combination of risk stratification and the identification of people whose needs are amenable to healthcare intervention (such as by reviewing Patient Activation Measures). Overall, we consider that it is important that, as shown by international evidence and early indications from the integrated care pioneers, the guideline should emphasise the need to prioritise and manage care based on clinical needs and psychosocial factors.	Thank you for your comment. We have clarified the scope to indicate how we are using these terms.

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117.	30	SH	Pfizer Ltd	5	4.5.2. (e)	Conducting this type of analysis will be difficult. Similar to our comment number 3, it is very important to understand how condition-specific guidance will be relevant in the context of other morbidities. It is difficult to make meaningful comparisons.	Thank you for your comment. This topic was highlighted as high priority during stakeholder consultation. The limitations will be carefully considered by the guideline development group.
118.	5	SH	National Family Carer Network	5	4.5.3	A proportion of people with multimorbidity may lack capacity to make some or all decisions about the management of their conditions. I hope the guidance will reflect the recommendations of the House of Lords report on implementation of the Mental Capacity Act and reinforce the importance of: • provision of information in ways the person can understand • other support for decision making so the person can make as many decisions for themselves as possible • proper involvement of people who know and care about the person in any best interests decisions • proper interpretation of 'best interests' (not 'what we think is best').	Thank you for your comment. All NICE guidelines include introductory paragraph on patient centred care which makes explicit reference to capacity and the Mental Capacity Act.
119.	53	SH	Royal College of General Practitioners	2	4.5.3 (f)	Again different settings – primary and secondary care will need different strategies (CB)	Thank you for your comment. The GDG will specify the relevant settings during guideline development.
120.	115	SH	NHS England, Thames Valley Area Team	9	4.5.3 (f)	Consider including: What is the clinical and cost-effectiveness of different strategies to improve the care of people with multimorbidity, *including support to general practice by specialists in the care of people with multimorbidity, and polypharmacy*	Thank you for your comment. The guideline development group will consider your suggestion and the review questions will be refined during guideline development.

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121.	73	SH	Royal College of General Practitioners	22	4.5.3	I would like to know what a Gold Standard for the care of people with multimorbidites would look like. (KG)	Thank you for your comment and suggestion.
122.	4	SH	National Family Carer Network	4	4.5.3	Many people with multimorbidity may rely wholly or in part on support from family carers or paid support workers to manage their conditions. I hope the guidance will say something about the importance of health services communicating with and supporting these supporters effectively.	Thank you for your comment. Patient and carer experience of care is included in the examples of outcomes. The guideline development group will consider the role of carers when making their recommendations.
123.	189	SH	East & South East England NHS Specialist Pharmacy Services	6	4.5.3	Review questions for management of care - We suggest to add "What strategies or interventions are effective in improving patient outcomes by reducing inappropriate polypharmacy and improving medicines adherence"	Thank you for your comment. This question has been left general as it may include strategies and interventions to improve a broad range of outcomes, which may include reducing inappropriate polypharmacy and improving medicines adherence. The guideline development group will refine these questions during development.
124.	194	SH	Lundbeck UK	5	4.5.3 (h)	The act of involving a person with a mental health condition such as depression, anxiety or an addiction such as alcohol dependence in the management of their condition can help them to feel empowered and thereby have a positive impact on their condition, in addition to that achieved by any intervention[10].We would therefore argue that to improve outcomes for people with multimorbidities there should be an increase in patient involvement and management of their own treatment as covered in 4.5.3 i).	Thank you for your comment. Patient involvement and management of their treatment will be included in this question.

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125.	101	SH	Association of British Clinical Diabetologists and RCP	1	4.5.3	The membership of the Association of British Clinical Diabetologists has frequent clinical contact with people who have multiple morbidities. Diabetes clusters with a number of common disease patterns and we have an acute awareness of the practical problems in managing multiple medical conditions. The Association welcomes the proposed consultation and is in agreement with the scope which is sensible, albeit ambitious. In terms of clinical management of care, the scope will consider continuity of care and coordination of care. It would be useful to be explicit in the inclusion of the issue of data sharing (with or without expressly mentioning IT) within the scope. Although case management will be included, the reality is that the separate disease entities will be managed by multiple specialties and agencies. This can only be effectively coordinated if each of those involved has access to the information generated by the other. The role of care coordinator, if the consultation recommends such an entity, will need to have ready access to all information.	Thank you for your comment. Your points will be considered under barriers to optimising care for people with multimorbidity
126.	142	SH	Royal College of Nursing	4	4.5.3	The RCN recommend that much greater consideration should be given to evaluating the roles of nurses in case management; Community matrons, district nurses and practice nurses	Thank you for your comment. All health professionals providing case management will be included in this question.
127.	15	SH	Public Health England - Improving Health and Lives Learning Disabilities Observatory	3	4.5.3 (i)	We note that one of the review questions relates to the clinical and cost effectiveness of self-management and expert patient programmes in improving outcomes for people with multi-morbidity. There is a need for such self-management programmes to be accessible to patients with learning disabilities. Unless they are available to people in an appropriate format for them then it is not possible to assess their effectiveness accurately.	Thank you for your comment. People with learning disabilities and multimorbidity will be included in the evidence for this review.
128.	19	SH	Royal Pharmaceuti	2	4.5.3	We welcome a structure that aims at a holistic multidisciplinary approach to the treatment of these patients and invests in making	Thank you for your comment. This guideline will cross reference to the

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	9		cal Society			that work across the entire patient pathway. These patients will often move to and from hospital or other care settings as the level of support they need at different times changes, it is vital that any changes to their regimen are communicated with the whole team in particular that any medicine changes are communicated to the GP and regular community pharmacy to ensure smooth transition of care. Existent community pharmacy services such as the Discharge Medicine Use review service available in Wales should be fully utilised to assist this process. Pharmacists are the experts in medicines and their use and should be responsible and accountable for the pharmaceutical care of patients. This includes medicines adherence and safe and effective treatment with medicines. This care should encompass the monitoring of the patient's response to treatment, covering side effects and the monitoring and use of laboratory results to optimise the use of medicines for the patient. In addition as the experts in medicines pharmacists, working alongside multidisciplinary teams, have a role in identifying those patients on multiple medicines who would benefit from a review in their medicines and in stopping medicines that are inappropriate for individual patients. Proposed future models and information flows should enable and support pharmacists to do this and should also include the many ways in which community pharmacy services can be better integrated into the patient care pathway to ensure that all parts work together.	NICE guideline on Medicines Optimisation. All health professionals providing case management will be included in this question.
129.	102	SH	Association of British Clinical Diabetologis	2	4.5.4	An issue which may be raised as a barrier in the management of multimorbidy may well be the increasing trend towards healthcare professionals with single organ specialisation. There may therefore be merit in including assessment of the qualifications	Thank you for your comment and suggestion.

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			ts and RCP			required to manage multimorbidity and perhaps the manpower requirements for suitably qualified generalists.	
130.	106	SH	Society of Academic Primary Care	3	4.5.4 (j) Barriers to mmt	Barriers that prevent health care professional stopping preventative/risk management treatments needs to include anyone vulnerable to treatment burden, not just elderly and terminally ill eg see Vijan et al. 2014. JAMA, 174(8): 1227-1234; Boyd et al. Medical care 2014; 3 (S2): S118-S125; Teljeur et al. 2013 European Journal of General Practice; 19(1): 17-22; Sav et al 2013; Health and Social Care in the Community; 21(6): 665-674 Oni et al. BMC Public Health 2014; 14(1): 575; Tinetti & Fried. 2012. JAMA; 307 (23): 2493-2494	Thank you for your comment. Older people and people with life-limiting conditions have been removed. The guideline development group will refine this question during guideline development. We have noted your references which we will refer to, if appropriate, during guideline development.
131.	196	SH	Lundbeck UK	7	4.5.4 (k)	The impact of alcohol misuse cuts across the healthcare system, but responsibility for the funding of many treatment services, including alcohol misuse, now sits with local authorities. NHS England and Clinical Commissioning Groups meanwhile are also responsible for the delivery of aspects of the alcohol pathway, including enhanced services and funding for NICE recommended treatments Where alcohol misuse is a contributing factor or an additional condition there must be clear responsibility and accountability for the provision and funding of treatment. This lack of clarity may be a barrier to healthcare professional prioritising treatment and leading to a focus on other conditions and other areas of treatment. It is also important to ensure that health practitioners fully understand the link between alcohol and other conditions.	Thank you for your comment and this information. The management of alcohol misuse is outside the scope of this guideline.

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132.	195	SH	Lundbeck UK	6	4.5.4 (j)	We want to highlight that preventative treatment in some cases should be maintained for older people and people with life-limiting conditions. 20% of men and 10% of women aged 65 and over exceed recommended drinking guidelines and 3% of men and 0.6% of women aged 65-74 are alcohol dependent[11], which as discussed above exacerbate and in some cases lead to notable health problems. Yet NICE has noted that the prevalence of alcohol-use disorders among older people may be under-detected "because of a lack of clinical suspicion or misdiagnosis"[12]. This is despite an increasing proportion of older people drinking above recommended levels[12]and older people being "uniquely vulnerable to alcohol problems" because of changes related to the ageing process.[11] In addition public health initiatives linked to alcohol misuse tend to focus on younger people[13], as are screening instruments and diagnostic criteria.[14]	Thank you for your comment and this information about alcohol problems. We agree that preventative treatment may be appropriate in older people. This question has been edited.
133.	74	SH	Royal College of General Practitioners	23	4.5.4 (j)	What are the barriers to STARTING and stopping treatments for example anticoagulation in AF where people who are older and have multimorbidities are at highest risk of a stroke but are often not treated. (KG)	Thank you for your comment. We are more concerned with people not stopping treatment where it may only have marginal or no benefit to patients.
134.	82	SH	Royal College of General Practitioners	31	4.53	f) – should specific 'drug and non-drug interventions g) – pharmacist time use? i) should the effectiveness of '3rd sector support' also be included here (LR & JR)	Thank you for your comment. f) Strategies to be considered will be defined by the guideline development group (GDG) during guideline development. g) This question has been edited. The outcomes for this question will

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							be defined by the GDG during guideline development. i) Effectiveness of third section support is outside the remit of NICE clinical guidance.
135.	6	SH	National Family Carer Network	6	4.6	It will be important to ensure that tools such as QALYs do not make unwise assumptions about quality of life of disabled people.	Thank you for your comment. NICE have established processes for ensuring equality issues are taken into consideration when developing guidelines. The guideline development group will therefore take into account any equality issues throughout development and when making recommendations.
136.	41	SH	University of Bristol	11	4.6	We have concerns about using QALY as the preferred unit of effectiveness. On the QALY scale, the quality of life of those with illness or disability is ranked below that of someone without a disability or illness, suggesting that QALY gives a lower value to preserving the lives of people with a permanent disability or illness than to preserving the lives of those who are healthy and not disabled. Nord et al (2009) suggest that QALY favours those with more "treatable conditions and those with greater potentials for health- be it in terms of functioning or longevity". Further, the European Guidelines for Cost-Effectiveness Assessments of Health Technologies (2013) conducted the largest experimental survey ever undertaken in Europe which tested the validation of QALY assumptions, and concluded that the QALY indicator does not constitute a scientifically validated measure and the use of QALY indicators should be abandoned for healthcare decision	Thank you for your comment. Please note that the QALY is only the preferred unit of effectiveness for economic evaluations (in line with the NICE reference case). Other outcomes of effectiveness will be included in the clinical review; examples are listed in section 4.4 of the scope. NICE has established processes for ensuring equality issues are taken into consideration when developing guidelines. The guideline development group will therefore take into account any equality

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						making. Our own research supports that assumptions are frequently made by healthcare professionals about the quality of a person with learning disability's life, and that subsequent judgements made can contribute to premature death.	issues throughout development and when making recommendations. .

These organisations were approached but did not respond:

5 Borough Partnership NHS Foundation Trust

Action on Hearing Loss

Arthritis Research UK

Association of Ambulance Chief Executives

Association of Anaesthetists of Great Britain and Ireland

Barnsley Hospital NHS Foundation Trust

Belfast Health and Social Care Trust

Bristol City Council

British Academy of Childhood Disability

British Geriatrics Society

British Infection Association

British Medical Association

British Medical Journal

British Nuclear Cardiology Society

British Psychological Society

British Red Cross

British Specialist Nutrition Association

British Thoracic Society

Care Not Killing Alliance

Care Quality Commission

Cumbria Partnership NHS Foundation Trust

CWHHE Collaborative CCGs

Cystic Fibrosis Trust

Department of Health, Social Services and Public Safety - Northern Ireland

Diabetics with Eating Disorders

East and North Hertfordshire NHS Trust

Economic and Social Research Council

Four Seasons Health Care

Gloucestershire Hospitals NHS Foundation Trust

GP update / Red Whale

Grunenthal Ltd

Health & Social Care Information Centre

Health and Care Professions Council

Healthcare Improvement Scotland

Healthcare Quality Improvement Partnership

HIV Pharmacy Association

HQT Diagnostics

Humber NHS Foundation Trust

Intuitive Surgical

Joint Royal Colleges Ambulance Liaison Committee

Lancashire Care NHS Foundation Trust

Manchester Centre for health Economics, University of Manchester

Marie Curie Cancer Care

Medicines and Healthcare products Regulatory Agency

Ministry of Defence (MOD)

National Clinical Guideline Centre

National Collaborating Centre for Cancer

National Collaborating Centre for Mental Health

National Collaborating Centre for Women's and Children's Health

National Deaf Children's Society

National Institute for Health Research

NHS Choices

NHS Hardwick CCG

NHS Health at Work

NHS Sheffield CCG

NHS South Norfolk CCG

Northern Health and Social Care Trust

Nottinghamshire Healthcare NHS Trust

Novo Nordisk Ltd

Nursing and Midwifery Council

Older People's Advocacy Alliance

Pathfinders Specialist and Complex Care

PHE Alcohol and Drugs, Health & Wellbeing Directorate

Picker Institute Europe

Public Health England

Public Health England - Improving Health and Lives Learning Disabilities Observatory

Public Health Wales NHS Trust

Public Health Wales NHS Trust

Royal College of Anaesthetists

Royal College of General Practitioners in Wales

Royal College of Midwives
Royal College of Obstetricians and Gynaecologists
Royal College of Paediatrics and Child Health
Royal College of Pathologists
Royal College of Physicians of Edinburgh
Royal College of Radiologists
Royal College of Speech and Language Therapists
Royal College of Surgeons of England
Royal Cornwall Hospitals NHS Trust
Royal Mencap Society
Scottish Intercollegiate Guidelines Network
Self Management UK
Sheffield Teaching Hospitals NHS Foundation Trust
Social Care Institute for Excellence
Society for Acute Medicine
South Eastern Health and Social Care Trust
South Gloucestershire Council
South Somerset Healthcare Foundation
South West Yorkshire Partnership NHS Foundation Trust
Southern Health & Social Care Trust
St Mungo's Broadway
Surrey and Borders Partnership NHS Foundation Trust
Sutton Council
The Symphony Project
Treating Autism
University of East Anglia
University of Salford

Welsh Government

Welsh Scientific Advisory Committee

Western Health and Social Care Trust

WHSSC