NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

Health and social care directorate

Quality standards and indicators

Briefing paper

Quality standard topic: Multimorbidity

Output: Prioritised quality improvement areas for development.

Date of Quality Standards Advisory Committee meeting: 16 November 2016

Contents

1 Introduction

This briefing paper presents a structured overview of potential quality improvement areas for multimorbidity. It provides the committee with a basis for discussing and prioritising quality improvement areas for development into draft quality statements and measures for public consultation.

1.1 Structure

This briefing paper includes a brief description of the topic, a summary of each of the suggested quality improvement areas and supporting information.

If relevant, recommendations selected from the key development source below are included to help the committee in considering potential statements and measures.

1.2 Development source

The key development source referenced in this briefing paper is:

Multimorbidity: clinical assessment and management (2016) NICE guideline NG56. No review schedule presented.

2 Overview

2.1 Focus of quality standard

This quality standard covers the clinical assessment, prioritisation and management of health care for adults with 2 or more long-term health conditions (multimorbidity).

2.2 Definition

Multimorbidity is defined as when a person has 2 or more long-term health conditions. At least 1 of these conditions must be a physical health condition.

A long-term condition is 'a condition that cannot, at present, be cured but is controlled by medication and/or other treatment and therapies'[1].

Long-term health conditions include:

- defined physical and mental health conditions such as diabetes or schizophrenia
- ongoing conditions such as learning disability
- symptom complexes such as frailty or chronic pain

[1] Department of Health (2012) Long-term conditions compendium of Information: 3rd edition

- sensory impairment such as sight or hearing loss
- alcohol and substance misuse.

2.3 Incidence and prevalence

Multimorbidity is common, becomes more common as people age, and is more common in people from less affluent areas. The number of people with comorbidities is set to increase in England from 1.9 million in 2008 to 2.9 million by 2018[2]. A large UK based study found that two-thirds of people aged 65 years or over had multimorbidity, and 47% had 3 or more conditions[3]. Whereas in older people multimorbidity is largely due to higher rates of physical health conditions, in younger people and people from less affluent areas, multimorbidity is often due to a combination of physical and mental health conditions for example depression.

Many people with multimorbidity will also have frailty, a distinctive health state related to the aging process in which multiple body systems gradually lose their in-built reserves. Around 10% of people aged over 65 years have frailty, rising to between a quarter and a half of those aged over 85 years[4]. Older people living with frailty are at risk of adverse outcomes such as dramatic changes in their physical and mental wellbeing after an apparently minor event which challenges their health, such as an infection or new medication.

2.4 Management

Multimorbidity is associated with reduced quality of life, higher mortality, polypharmacy and high treatment burden, higher rates of adverse drug events, and much greater health services use (including unplanned or emergency care).

For people with multimorbidity, treatment regimens (including non-pharmacological treatments) can easily become very burdensome, and care can become uncoordinated and fragmented. Polypharmacy is often driven by the introduction of multiple medicines intended to prevent future morbidity and mortality. However, the case for using these medicines weakens if life expectancy is reduced by other conditions or frailty. The impact of multimorbidity for healthcare organisation is dependent on which conditions a person has. Groups of conditions that have closely related or concordant treatment, such as diabetes, hypertension and angina, pose fewer problems for coordination than conditions needing quite different treatment (for example, physical and mental health conditions).

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[2] Department of Health (2012) Long-term conditions compendium of Information: 3rd edition
[3] Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, Guthrie B (2012) Epidemiology of multimorbidity and implications for health care, research, and medical education: a cross-sectional study. The Lancet.380 (9836):37-43
[4] British Geriatric Society (2014) Fit for Frailty

Data from the Health and Social Care Information Centre on medicine utilisation shows that between 2004 and 2014, the average number of prescription items a year for every person in England increased from around 14 to 20. With an ageing population, the use of multiple medicines is increasing.

2.5 Resource impact assessment

The resource impact report for NG56 did not anticipate an overall impact on resources following implementation. Initially there may be costs in primary care from longer appointments, optimising treatments and care, and associated training. However, this is expected to be offset by savings from better and more streamlined management of multimorbidity, from fewer unnecessary appointments, fewer medicines prescribed and fewer unplanned hospital admissions.

2.6 National outcome frameworks

Tables 1 and 2 show the outcomes, overarching indicators and improvement areas from the frameworks that the quality standard could contribute to achieving.

Table 1 NHS outcomes framework 2016–17

Domain	Overarching indicators and improvement areas
2 Enhancing quality of life for people with long-term conditions	***Overarching indicator*** 2 Health-related quality of life for people with long-term conditions** ***Improvement areas*** **Ensuring people feel supported to manage their condition** 2.1 Proportion of people feeling supported to manage their condition **Improving functional ability in people with long-term conditions** 2.2 Employment of people with long-term conditions*, ** **Improving quality of life for people with multiple long-term conditions** *2.7 Health-related quality of life for people with three or more long-term conditions***
4 Ensuring that people have a positive experience of care	***Overarching indicators*** 4a Patient experience of primary care i GP services *4d Patient experience characterised as poor or worse* *I Primary care* ***Improvement areas*** **Improving access to primary care services** 4.4 Access to i GP services and ii NHS dental services
Alignment with Adult Social Care Outcomes Framework and/or Public Health Outcomes Framework * Indicator is shared ** Indicator is complementary Indicators in italics in development	

Table 2 Public health outcomes framework for England, 2016–2019

Domain	Objectives and indicators
1 Improving the wider determinants of health	***Objective*** Improvements against wider factors which affect health and wellbeing and health inequalities ***Indicators*** 1.08 Employment for those with long-term health conditions including adults with a learning disability or who are in contact with secondary mental health services*, **
2 Health improvement	***Objective*** People are helped to live healthy lifestyles, make healthy choices and reduce health inequalities ***Indicators*** 2.23 Self-reported well-being
4 Healthcare public health and preventing premature mortality	***Objective*** Reduced numbers of people living with preventable ill health and people dying prematurely, whilst reducing the gap between communities ***Indicators*** 4.13 Health-related quality of life for older people
Alignment with Adult Social Care Outcomes Framework and/or NHS Outcomes Framework * Indicator is shared ** Indicator is complementary	

3 Summary of suggestions

3.1 Responses

In total 13 stakeholders responded to the 2-week engagement exercise 22/09/16 – 06/10/16. 1 stakeholder did not submit areas for quality improvement.

Stakeholders were asked to suggest up to 5 areas for quality improvement. Specialist committee members were also invited to provide suggestions. The responses have been merged and summarised in table 3 for further consideration by the committee.

Full details of all the suggestions provided are given in appendix 2 for information.

Table 3 Summary of suggested quality improvement areas

Suggested area for improvement	Stakeholders
Identification	NHSE, SCM x3
Frailty	BGS, NHSE, RCPE, SCM x3
Assessment • Establishing the effects of health problems and treatment on day-to-day activities • Establishing patient goals, values and priorities	 NHSE, RCGP, RCPsy SCM x3 SCM
Reviewing medicines and other treatments	BGS, PUK, RCGP, RCPE, SCM
Management plan • Developing a management plan • Reviewing the management plan	 NHSE, PUK, RCGP NHSE, RCGP, SCM
Additional areas • Self-management • Carer assessment • Training • Integrated personalised commissioning • Comprehensive geriatric assessment • Shared decision making • Surgical care • Access to services • Outcomes	 OPAAL, PUK, RCN RCGP, RCN NHSE, RCGP, RCN NHSE RCPE, SCM NHSE, RCA, RCGP RCA PHE, RCPsy RCPsy, SCM

BGS, British Geriatric Society
NHSE, NHS England
OPAAL, Older Peoples Advocacy Alliance UK
PUK, Parkinson's UK
PHE, Public Health England
RCA, Royal College of Anaesthetists
RCGP, Royal College of General Practitioners
RCN, Royal College of Nursing
RCPE, Royal College of Physicians of Edinburgh
RCP, Royal College of Physicians*
RCPsy, Royal College of Psychiatrists
SCM, Specialist Committee Member

* The RCP wish to endorse the comments made by the British Geriatric Society

3.2 Identification of current practice evidence

Bibliographic databases were searched to identify examples of current practice in UK health and social care settings; 4055 papers were identified for multimorbidity. In addition, 125 papers were suggested by stakeholders at topic engagement and 10 papers internally at project scoping.

Of these papers, 3 have been included in this report. Appendix 1 outlines the search process.

4 Suggested improvement areas

4.1 Identification

4.1.1 Summary of suggestions

Stakeholders suggested use of an appropriate tool to routinely identify people with multimorbidity in primary care who may benefit from a tailored approach to care. This would provide an opportunity to bring together the care people may receive from a variety of services. They felt optimising care may reduce treatment burden, improve quality of life and maximise therapeutic benefit from treatments. Stakeholders reported that this is not yet routine practice.

4.1.2 Selected recommendations from development source

Table 4 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 4 to help inform the committee's discussion.

Table 4 Specific areas for quality improvement

Suggested quality improvement area	Suggested source guidance recommendations
Identification	NICE NG56 recommendations 1.2.1, 1.3.1and 1.3.2

NICE NG56 – Recommendation 1.2.1

Consider an approach to care that takes account of multimorbidity if the person requests it or if any of the following apply:

- they find it difficult to manage their treatments or day-to-day activities
- they receive care and support from multiple services and need additional services
- they have both long-term physical and mental health conditions
- they have frailty or falls
- they frequently seek unplanned or emergency care
- they are prescribed multiple regular medicines.

NICE NG56 – Recommendation 1.3.1

Identify adults who may benefit from an approach to care that takes account of multimorbidity:

- opportunistically during routine care

- proactively using electronic health records.

Use the criteria in recommendation 1.2.1 to guide this.

NICE NG56 – Recommendation 1.3.2

Consider using a validated tool such as eFI, PEONY or QAdmissions, if available in primary care electronic health records, to identify adults with multimorbidity who are at risk of adverse events such as unplanned hospital admission or admission to care homes.

4.1.3 Current UK practice

No data on current practice was found related to identification. This area is based on stakeholder's knowledge and experience.

4.2 Frailty

4.2.1 Summary of suggestions

Stakeholders highlighted that older people with frailty and multimorbidity are frequently admitted to hospital as unplanned emergency admissions and nursing homes. Stakeholders suggested the identification of people with frailty in primary care using the electronic frailty index and in secondary care so that evidence based interventions can be delivered to improve outcomes. Stakeholders reported that frailty assessment is not well implemented across the country.

4.2.2 Selected recommendations from development source

Table 5 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 5 to help inform the committee's discussion.

Table 5 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Frailty	NICE NG56 recommendations 1.4.1, 1.4.2, 1.4.3, 1.4.4 and 1.4.5

NICE NG56 – Recommendation 1.4.1

Consider assessing frailty in people with multimorbidity.

NICE NG56 – Recommendation 1.4.2

Be cautious about assessing frailty in a person who is acutely unwell.

NICE NG56 – Recommendation 1.4.3

Do not use a physical performance tool to assess frailty in a person who is acutely unwell.

NICE NG56 – Recommendation 1.4.4

When assessing frailty in primary and community care settings, consider using 1 of the following:

- an informal assessment of gait speed (for example, time taken to answer the door, time taken to walk from the waiting room)
- self-reported health status (that is, 'how would you rate your health status on a scale from 0 to 10?', with scores of 6 or less indicating frailty)

- a formal assessment of gait speed, with more than 5 seconds to walk 4 metres indicating frailty
- the PRISMA-7 questionnaire, with scores of 3 and above indicating frailty.

NICE NG56 – Recommendation 1.4.5

When assessing frailty in hospital outpatient settings, consider using 1 of the following:

- self-reported health status (that is, 'how would you rate your health status on a scale from 0 to 10?', with scores of 6 or less indicating frailty)
- the 'Timed Up and Go' test, with times of more than 12 seconds indicating frailty
- a formal assessment of gait speed, with more than 5 seconds to walk 4 metres indicating frailty
- the PRISMA-7 questionnaire, with scores of 3 and above indicating frailty
- self-reported physical activity, with frailty indicated by scores of 56 or less for men and 59 or less for women using the Physical Activity Scale for the Elderly.

4.2.3 Current UK practice

No data on current practice was found related to identification of frailty. This area is based on stakeholder's knowledge and experience.

4.3 Assessment

4.3.1 Summary of suggestions

Establishing the effects of health problems and treatment on day-to-day activities

Stakeholders suggested people with multimorbidity should be offered a comprehensive assessment of their physical and mental health and wellbeing to reduce the risk of developing further co-morbidity and deterioration or loss of resilience. Stakeholders reported that anxiety and depression increase morbidity and mortality of long term conditions.

Stakeholders reported this area is not yet widely established as part of clinical practice including having a standardised and consistent approach to assessing disease and treatment burden.

Establishing patient goals, values and priorities

Stakeholders highlighted the assessment should establish patient goals, values and priorities as part of a person-centred, goal-orientated approach to care. Stakeholders reported that although it is a key part of clinical practice it is not applied consistently across healthcare settings.

4.3.2 Selected recommendations from development source

Table 6 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 6 to help inform the committee's discussion.

Table 6 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Establishing the effects of health problems and treatment on day-to-day activities	NICE NG56 recommendations 1.6.3 and 1.6.4
Establishing patient goals, values and priorities	NICE NG56 recommendation 1.6.7

Establishing the effects of health problems and treatment on day-to-day activities

NICE NG56 – Recommendation 1.6.3

Establish disease burden by talking to people about how their health problems affect their day-to-day life. Include a discussion of:

- mental health
- how disease burden affects their wellbeing
- how their health problems interact and how this affects quality of life.

NICE NG56 – Recommendation 1.6.4

Establish treatment burden by talking to people about how treatments for their health problems affect their day-to-day life. Include in the discussion:

- the number and type of healthcare appointments a person has and where these take place
- the number and type of medicines a person is taking and how often
- any harms from medicines
- non-pharmacological treatments such as diets, exercise programmes and psychological treatments
- any effects of treatment on their mental health or wellbeing.

Establishing patient goals, values and priorities

NICE NG56 – Recommendation 1.6.7

Encourage people with multimorbidity to clarify what is important to them, including their personal goals, values and priorities. These may include:

- maintaining their independence
- undertaking paid or voluntary work, taking part in social activities and playing an active part in family life
- preventing specific adverse outcomes (for example, stroke)
- reducing harms from medicines
- reducing treatment burden
- lengthening life.

4.3.3 Current UK practice

No data on current practice was found related to assessment. This area is based on stakeholder's knowledge and experience.

4.4 Reviewing medicines and other treatments

4.4.1 Summary of suggestions

People with multimorbidity can take a variety of medication and stakeholders reported that poor prescribing and medicine management is a major cause of morbidity and harm because of drug interactions and adverse events. Poor prescribing can also result in an inefficient use of resources.

Stakeholders suggested medicines and other treatments should be reviewed regularly, specifically looking at how they work together. This ensures that the medicines prescribed are working effectively and are the best option which in turn increases adherence to medication and quality of life. In some cases this may lead to the discontinuation of some medication.

Stakeholders highlighted that people with multimorbidity or frailty should be screened in primary care using the STOP/START criteria to identify medicine safety concerns.

4.4.2 Selected recommendations from development source

Table 7 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 7 to help inform the committee's discussion.

Table 7 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Reviewing medicines and other treatments	NICE NG56 recommendations 1.6.9 and 1.6.10

NICE NG56 Recommendation 1.6.9

When reviewing medicines and other treatments, use the database of treatment effects to find information on:

- the effectiveness of treatments
- the duration of treatment trials
- the populations included in treatment trials.

NICE NG56 Recommendation 1.6.10

Consider using a screening tool (for example, the STOPP/START tool in older people) to identify medicine-related safety concerns and medicines the person might

benefit from but is not currently taking. [This recommendation is adapted from the NICE guideline on medicines optimisation].

4.4.3 Current UK practice

No data on current practice was found related to reviewing medicines and treatments. This area is based on stakeholder's knowledge and experience.

4.5 Management plan

4.5.1 Summary of suggestions

Developing a management plan

Stakeholders suggested that people with multimorbidity should have a single individualised management plan that sets out their goals, identifies care and support needs to manage their physical and mental health and wellbeing and includes their preferences for care. They reported that this reduces the risk of developing further comorbidity or deterioration of existing conditions.

Reviewing the management plan

Stakeholders suggested the management plan should be reviewed when necessary and as a minimum every 12 months to ensure that care planning remains relevant and effective for the individual.

The review should involve the person with multimorbidity and their carers. It should give the opportunity to discuss what is working, where changes to the plan need to be made and changes in personal priorities. A proactive review may help prevent the development of new conditions or slow the deterioration of existing conditions.

Stakeholders suggested that the management plan should be consistently documented and available to all relevant healthcare professionals. This will avoid duplication of tests and information and enhance continuity of care

Selected recommendations from development source

Table 8 below highlights recommendations that have been provisionally selected from the development source that may support potential statement development. These are presented in full after table 8 to help inform the committee's discussion.

Table 8 Specific areas for quality improvement

Suggested quality improvement area	Selected source guidance recommendations
Developing a management plan	NICE NG56 Recommendation 1.6.17
Reviewing the management plan	NICE NG56 Recommendation 1.6.17

NICE NG56 Recommendation 1.6.17

After a discussion of disease and treatment burden and the person's, personal goals, values and priorities, develop and agree an individualised management plan with the person. Agree what will be recorded and what actions will be taken. These could include:

- starting, stopping or changing medicines and non-pharmacological treatments
- prioritising healthcare appointments
- anticipating possible changes to health and wellbeing
- assigning responsibility for coordination of care and ensuring this is communicated to other healthcare professionals and services
- other areas the person considers important to them
- arranging a follow-up and review of decisions made.

  Share copies of the management plan in an accessible format with the person and (with the person's permission) other people involved in care (including healthcare professionals, a partner, family members and/or carers).

4.5.2 Current UK practice

No data on current practice was found related to management plans. This area is based on stakeholder’s knowledge and experience.

4.6 Additional areas

Summary of suggestions

The improvement areas below were suggested as part of the stakeholder engagement exercise. However they were felt to be either unsuitable for development as quality statements, outside the remit of this particular quality standard referral or require further discussion by the committee to establish potential for statement development.

There will be an opportunity for the committee to discuss these areas at the end of the session on 16 November 2016.

Self-management

Stakeholders suggested supported self-management through structured education and peer support is important for people with multimorbidity to improve their understanding of their condition and control over their daily lives. Self-management programmes were considered as part of the guideline development process but the GDG felt there was not sufficient evidence to recommend their use for people with multimorbidity.

Carer assessment

Stakeholders highlighted that many people with multimorbidity, especially those with frailty, will be supported by carers who in turn may also have multimorbidity. Stakeholders suggested carers health and support needs should be assessed and documented as they're own physical and mental health are at risk of getting worse when providing care for someone with multimorbidity. Carer assessments are covered by the Care Act, as legislation they are outside the remit of quality standards.

Training

Stakeholders suggested training for healthcare professionals in recognising the prognostic indicators for approaching end of life in multimorbidity. This area is covered by the end of life care quality standard and the care of the dying adult in the last days of life quality standard. Stakeholders also suggested training for staff to provide coaching techniques to support behaviour change and self-management. Training is outside of the remit of quality standards.

Integrated personalised commissioning

Stakeholders highlighted that integrated personalised commissioning is beginning to achieve success in joining up health and social care provision around the needs of an individual at a local level. It is focused on those with the highest levels of need,

including those with multimorbidity. Commissioning models are outside of the remit of quality standards.

Comprehensive geriatric assessment

Stakeholders suggested a comprehensive geriatric assessment for all frail aged over 75 years in secondary care which involves a holistic, multidimensional, interdisciplinary assessment of an individual by a number of specialists of many disciplines. This assessment can improve outcomes by increasing independence and reducing mortality. Comprehensive geriatric assessment is covered by the Transition from inpatient to care settings quality standard which contains the following draft statement 'Older people with complex needs have a comprehensive geriatric assessment started at the point of admission to hospital'.

Shared decision making

Stakeholders suggested that shared-decision making through the provision of clear, accurate, evidence-based, easy to use information can lead to a positive experience of care and improve clinical outcomes. Shared decision making is covered by QS15 patient experience in adult NHS services statement 6 and QS120 Medicines optimisation statement 1.

Surgical care

Stakeholders highlighted the people with multimorbidities are more likely to suffer complications and death following surgery. Multimorbidity management for example exercise training, nutrition support, smoking and alcohol cessation through preoperative clinics can improve clinical outcomes. This area is outside the scope of this quality standard and may be considered in future quality standard on perioperative care.

Access to services

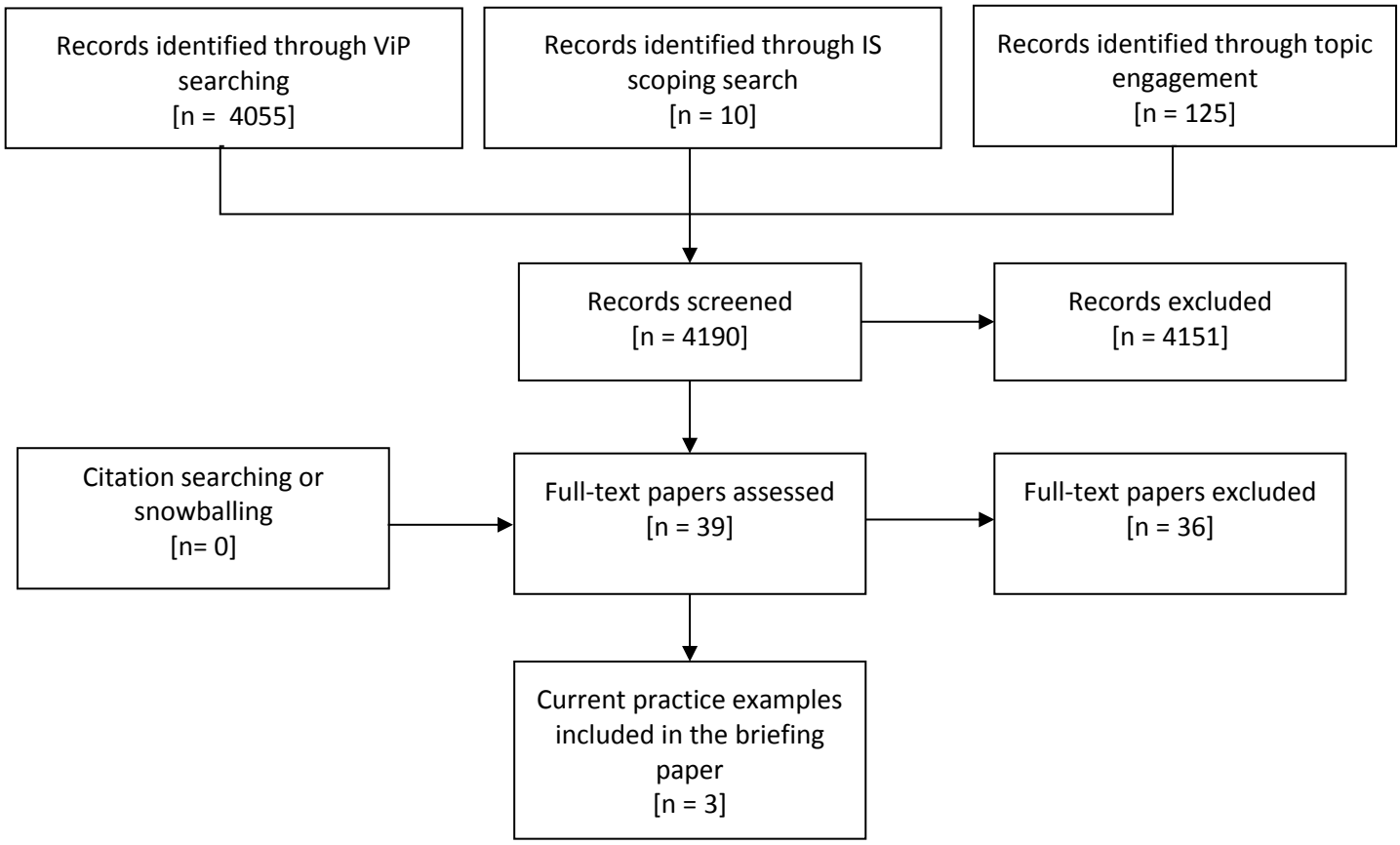
Stakeholders suggested that people with co-occurring conditions are often unable to access the care they need for example those who are not mentally unwell enough to meet the thresholds for mental health services are also excluded from lower threshold mental health services. At the most severe end of the mental health spectrum, it is common to hear of people being excluded from adult mental health services because of co-occurring alcohol/drug use. Stakeholders also highlighted that people with mild to moderate learning disabilities have a high level of physical morbidity and there is variation in adjustments services make for these people. This area is outside the scope of this quality standard.

Outcomes

Stakeholders suggested that for people with multimorbidity use of unscheduled care and patient satisfaction are important outcomes. Multimorbidity was identified as one

of several drivers in the use of unscheduled care in people with long term conditions. This area will be considered as part of the overarching outcomes the quality standard is aiming to achieve.

Appendix 1: Review flowchart



Appendix 2: Suggestions from stakeholder engagement exercise – registered stakeholders

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
General					
1	Pfizer Ltd	Pfizer have no additional comments to add to this consultation.			
2	Public Health England	Particular risks around multimorbidity which includes co-occurring mental health and alcohol/drug use conditions	Prevalence and harm Alcohol and drug dependence is common among people with mental health problems and the relationship between the two is complex. Research indicates that up to 70% of people in drug services and 86% of alcohol services users experienced mental health problems (Weaver et al (2003) Comorbidity of substance misuse and mental illness in community mental health and substance misuse services. The British Journal of Psychiatry Sep 2003, 183 (4) 304-313).	Other evidence from research, national data and population surveys paints a picture of very high levels of need and associated health harms including: Evidence from children and young people's alcohol and drug treatment data which shows high levels of self-harm, domestic violence and sexual exploitation among children and young people, with very low referral rates from mental health treatment into alcohol and drug treatment (Public Health England (2015) Young people's statistics from the National Drug Treatment Monitoring System (NDTMS) 1 April 2014 to 31 March 2015). The national confidential enquiry into suicide and homicide by people with mental illness found that suicides among patients with a history of alcohol or drug misuse (or both) accounted for 54% of the total sample, an average of 671 deaths per year (The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report 2015: England, Northern	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				Ireland, Scotland and Wales July 2015. University of Manchester). Other evidence shows that alcohol use disorder is an important predictor of suicide/premature death (Darvishi, Farhadi, Haghtalab, & Poorolajal, 2015). Co-occurring alcohol use with mental health issues featured prominently in hospital admissions data - of mental health crisis related admissions to acute hospital via A&E in 2012/13, 20% were due to alcohol use (the second highest proportion after self-harm and undetermined injury) (Care Quality Commission (2015) Right here, right now - http://www.cqc.org.uk/sites/default/files/20150611_righthere_mhcrisiscare_summary_3.pdf). A high prevalence among prison populations with the 2009 Bradley report (The Bradley Commission (2009) the Bradley Report http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098698.pdf) recognising that co-occurring mental health and alcohol/drug use conditions are the norm rather than the exception among most	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				offenders. Prisoners with addiction issues are also at increased risk of self-harm and suicide (The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness Annual Report 2015: England, Northern Ireland, Scotland and Wales July 2015. University of Manchester). Data collected from trial sites commissioned by NHSE under the Liaison and Diversion Programme showed that over 55% of service users identified in with mental health needs also had problem with either drug misuse, alcohol misuse or both. Amongst those with alcohol misuse issues, over three-quarters also suffered a mental health problem. In the case of people with other substance misuse, the percentage who also demonstrated mental health needs was even higher at 79%. The 'Making Every Adult Matter' (MEAM) coalition commissioned a report looking at severe and multiple disadvantage in England (Langkelly Chase Foundation (2015) Hard Edges – mapping severe and multiple disadvantage in England). It found that of an estimated 58, 000 people nationally experiencing the most severe and multiple disadvantage (substance misuse, homelessness and criminal justice	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				involvement), over half (55%) had a diagnosed mental health condition and nearly all (92%) had a self-reported mental health problem. There is a growing body of research which describes the use of substances by women to cope with the psychological and physical harm resulting from their experiences of violence (Gilchrist, G, Blazquez, A, Torrens, M (2011) Psychiatric, Behavioural and Social Risk Factors for HIV Infection Among Female Drug Users. AIDS AND BEHAVIOR, Vol. 15, No. 8, 11.2011, p. 1834-1843 and Humphreys, C, Regan, L, River, D and Thiara, R (2005) domestic violence and substance use: tackling complexity. British Journal of Social Work (2005), 1 of 18). Both alcohol and drug misuse and mental health problems are associated with considerable physical morbidity and premature mortality (15-20 years in people with mental health problems and 9-17 years in those with alcohol and drug misuse disorders) compared to national norms (Hayes R, Chang, C, Fernandes A, Broadbent M, Lee W, Hotopf M, Stewart R. Associations between substance use disorder sub-groups, life expectancy and all-cause mortality in a large British specialist	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				mental healthcare service. Drug and Alcohol Dependence, 2011 vol. 116 issue 1). People with mental health problems are more likely to smoke and it is the single largest contributor to their 10-20 year reduced life expectancy. A recent UK study highlighted that men and women living with schizophrenia in the community have a 20.5 and 16.4 year reduced life expectancy respectively (Brown S, Kim M, Mitchell C et al (2010) Twenty-five year mortality of a community cohort with schizophrenia. British Journal of Psychiatry, 196, 116-121). A third (33%) of people with mental health problems and more than two thirds (70%) of people in psychiatric units smoke tobacco. Reductions in smoking rates in the general population over the last 20 years have not been matched by these mental health populations (Royal College of Physicians and Royal College of Psychiatrists (2013) Smoking and Mental Health. A joint report by the Royal College of Physicians and Royal College of Psychiatrists. https://cdn.shopify.com/s/files/1/0924/4392/files/smoking_and_mental_health_-_full_report_web.pdf?753787059509358537 8).	

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				Tobacco smoking is highly prevalent in drug and alcohol users and a significant contributor to illness and death. Many people may recover from their drug or alcohol dependence only to later die of their continued and untreated tobacco dependence (Hurt et al (1996) Mortality following inpatient addictions treatment. Journal of the American Medical Association: JAMA 275:1097–1103).	
3	Royal College of Physicians	The RCP is grateful for the opportunity to respond to the above consultation. We would like to endorse the response submitted by the British Geriatrics Society.			
4	National Community Hearing Association	Key area for quality improvement 1	Hearing loss should be specifically mentioned as an example of a long-term condition in the quality standard, and not grouped under sensory impairment. This is important because awareness of the impact and prevalence of hearing loss is poor and whenever grouped under sensory impairment hearing loss is overlooked. This has been accepted by NICE before, e.g. NICE Quality Standard 50 states that undiagnosed hearing loss remains a significant issue, especially in care homes.	NICE has previously recognised the importance of hearing as a long-term condition. The primary source for this consultation, NG 56, note that: “1.1 General principles 1.1.1 Be aware that multimorbidity refers to the presence of 2 or more long-term health conditions, which can include: defined physical and mental health conditions such as diabetes or schizophrenia ongoing conditions such as learning disability symptom complexes such as frailty or chronic pain sensory impairment such as sight or hearing loss” (p. 5).	Scale of the challenge 9 million people in England have a hearing loss and this will increase as the population grows older[i]. Adult hearing loss is the third most common long-term condition and the 6th leading cause of years lived with disability in England[ii]. Age-related hearing loss is the main cause of hearing loss, accounting for nine out of ten cases of hearing loss. This means that the majority of older people with multimorbidities will have hearing loss in

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
				This should be mirrored in the Multimorbidity quality standard.	addition to another long-term condition – e.g. seven out of ten 70 year olds have hearing loss and this increase to nine out of ten people over the age of 80. Impact Unsupported hearing loss is correlated with increased risk of depression[iii], social isolation[iv], premature retirement[v], reduced quality of life[vi], loneliness[vii] and cognitive decline[viii]. Unsupported hearing loss – as other NICE guidelines state – can also have a negative impact on medicine adherence and health and wellbeing in older people. Benefits of intervention Hearing intervention and ongoing support improves quality of life by reducing the psychological and

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					social effects associated with hearing loss[ix]. Early intervention can also reduce pressure on health and social services by reducing the risks associated with unsupported hearing loss[x].
5	SCM2	Delivering an approach to care that takes account of multimorbidity	Recommended within NICE Multimorbidity guidance.	Although likely an intrinsic component of primary and secondary care practice in the UK, systems of care and incentivisation schemes (e.g. QOF) are not necessarily aligned with approaches to care that take account of multimorbidity.	
Identification					
6	NHS England	Proactive identification: Find (and code) the most vulnerable patients or those with most need: people with multiple LTCs including frailty and dementia, where these present significant problems to everyday functioning, or where the management of their care has become burdensome to the patient, or who are likely	Finding a target population of people who would then benefit from proactive intervention to improve key outcomes is demonstrated to reduce risk of hospital admission, falls and care home admission. Complex interventions can help older people in the identified risk groups to live safely and independently, and could be tailored to meet individuals' needs and preferences. In one large meta-analysis:	In 2016 the National audit Office reported an 18% increase in emergency admissions of older people between 2010/11 and 2014/15 with 2.7 million bed days occupied by older people no longer needing acute care. The NAO made the following recommendation: with the increase in numbers of older patients, it is critical for health and social care providers to work together to minimise the length of time that such patients spend in hospital. This will be through a combination of admitting only those older people who really need treatment in hospital.	Identification and population prevalence of frailty: the Electronic Frailty Index (eFI) uses routine data (GP read codes) to identify older people with mild, moderate and severe frailty, with robust predictive validity for outcomes of mortality, hospitalisation and nursing home admission (Clegg[1]) Routine implementation of the eFI can enable

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		to be within the final year of life and/or whose care involves a number of services working in an uncoordinated way – use of the electronic frailty index (eFI)	Interventions reduced the risk of not living at home (relative risk [RR] 0·95, 95% CI 0·93–0·97). Interventions reduced nursing-home admissions (0·87, 0·83–0·90), but not death (1·00, 0·97–1·02). Risk of hospital admissions (0·94, 0·91–0·97) and falls (0·90, 0·86–0·95) were reduced, and physical function (standardised mean difference −0·08, −0·11 to −0·06) was better in the intervention groups than in other groups. http://www.thelancet.com/pdfs/journals/lancet/PIIS0140673608603426.pdf	With escalating number of older people presenting to urgent care and rising numbers of admissions the proactive identification of those most at risk through the eFI, followed by tailored care planning to reduce the likelihood of requiring hospital care, will help to reduce this burden on acute care systems and unwarranted bed occupancy.	delivery of evidence-based interventions to improve outcomes. The overall prevalence of frailty in the 60+ population is 14% rising exponentially with age (Gale[2]) Impact of End of Life Care: 500,000 people die every year with huge variation in outcomes and experience. Typically palliative care registers identify people with terminal cancer whereas other life-limiting illnesses are forgotten. Whilst the proportion of people dying at home or in care homes continues to increase, 25% hospital beds are still occupied by people who are dying. Patients with an Electronic Palliative Care Co-ordination System (EPaCCS) record and those receiving palliative care services such as hospice at home, Gold Standards Framework or

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					Macmillan services are more likely to die in the place of their preference. Indicators Rate of emergency admission to hospital for people over the age of 75 years and over with a length of stay of less than 24 hours. (Atlas of Variation) Injuries (e.g. fractures) from falls in people aged 65 and over (CCG IAF) % of adult carers who have as much social contact as they would like (PHOF) ICHOM older person standard set Place of death (CCG IAF)
7	SCM1	Identifying multimorbid patients routinely	Allows tailoring of care at the first opportunity	Addresses optimising care to reduce treatment burden for patients, improving quality of life and maximising therapeutic benefit from treatments patients choose to take.	People with multiple physical and mental health condition are often given fragmented care in the health system due to the segmentation of specialities. Identification of multimorbidity provides

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					the opportunity to bring care together offering patients the opportunity for a collaborative approach to managining long term conditions, supporting self management and self care where appropriate
8	SCM2	Identification of people who may benefit from an approach to care that takes account of multimorbidity.	Recommended within NICE Multimorbidity guidance.	Identification of people who may benefit form an approach to care that takes account of multimorbidity is not yet established practice.	
9	SCM4	Identification of people with multiple long-term conditions who may benefit from approach specified in guideline	“Improvement” is dubious, as this is not formally done now, but for the implementation of the guideline to be meaningful we need some idea as to whether GP practices are actually putting it into practice	If the guideline is to be used to improve quality of care and management, there must be identification of those to whom it applies	Guideline recommendations regarding eg medicine counts and other (woolier) indicative factors.
Frailty					
10	British Geriatrics Society	Key area for quality improvement 1	Patients with frailty and multiple comorbidities should be identified in primary care by use of the Electronic Frailty Index.	This facilitates frail older patients with multiple comorbidities to have an individual coordinated management plan	Older patients with frailty and multimorbidity are frequently admitted to hospital and nursing homes as unplanned emergency admissions. Clegg A et al Development and validation of an electronic frailty index

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					using routine primary care electronic health record data. Age and Ageing.2016;45(3):353-360.
11	NHS England	Proactive identification: Find (and code) the most vulnerable patients or those with most need: people with multiple LTCs including frailty and dementia, where these present significant problems to everyday functioning, or where the management of their care has become burdensome to the patient, or who are likely to be within the final year of life and/or whose care involves a number of services working in an uncoordinated way – use of the electronic frailty index (eFI)	Finding a target population of people who would then benefit from proactive intervention to improve key outcomes is demonstrated to reduce risk of hospital admission, falls and care home admission. Complex interventions can help older people in the identified risk groups to live safely and independently, and could be tailored to meet individuals' needs and preferences. In one large meta-analysis: Interventions reduced the risk of not living at home (relative risk [RR] 0·95, 95% CI 0·93–0·97). Interventions reduced nursing-home admissions (0·87, 0·83–0·90), but not death (1·00, 0·97–1·02). Risk of hospital admissions (0·94, 0·91–0·97) and falls (0·90, 0·86–0·95) were reduced, and physical function (standardised mean difference −0·08, −0·11 to −0·06) was better in the	In 2016 the National audit Office reported an 18% increase in emergency admissions of older people between 2010/11 and 2014/15 with 2.7 million bed days occupied by older people no longer needing acute care. The NAO made the following recommendation: with the increase in numbers of older patients, it is critical for health and social care providers to work together to minimise the length of time that such patients spend in hospital. This will be through a combination of admitting only those older people who really need treatment in hospital. With escalating number of older people presenting to urgent care and rising numbers of admissions the proactive identification of those most at risk through the eFI, followed by tailored care planning to reduce the likelihood of requiring hospital care, will help to reduce this burden on acute care systems and unwarranted bed occupancy.	Identification and population prevalence of frailty: the Electronic Frailty Index (eFI) uses routine data (GP read codes) to identify older people with mild, moderate and severe frailty, with robust predictive validity for outcomes of mortality, hospitalisation and nursing home admission (Clegg[1]) Routine implementation of the eFI can enable delivery of evidence-based interventions to improve outcomes. The overall prevalence of frailty in the 60+ population is 14% rising exponentially with age (Gale[2]) Impact of End of Life Care: 500,000 people die every year with huge variation in outcomes and experience.

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			intervention groups than in other groups. http://www.thelancet.com/pdfs/journals/lancet/PIIS0140673608603426.pdf		Typically palliative care registers identify people with terminal cancer whereas other life-limiting illnesses are forgotten. Whilst the proportion of people dying at home or in care homes continues to increase, 25% hospital beds are still occupied by people who are dying. Patients with an Electronic Palliative Care Co-ordination System (EPaCCS) record and those receiving palliative care services such as hospice at home, Gold Standards Framework or Macmillan services are more likely to die in the place of their preference. Indicators Rate of emergency admission to hospital for people over the age of 75 years and over with a length of stay of less than 24 hours. (Atlas of Variation)

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					Injuries (e.g. fractures) from falls in people aged 65 and over (CCG IAF) % of adult carers who have as much social contact as they would like (PHOF) ICHOM older person standard set Place of death (CCG IAF)
12	Royal College of Physicians of Edinburgh	Identification of frailty in primary and secondary care	Hospitals admit older people more frequently than other age groups and so an ageing population creates additional demand for health and social care services. Admissions for this older age group are often unplanned and if older people are also frail they are more susceptible to healthcare associated infections, delirium and difficulties in maintaining good nutrition, hydration and skincare.	Frail older people usually have longer stays, higher mortality and rates of readmission, and they are more likely to be discharged to residential care.	Improving the identification and management of frailty Healthcare Improvement Scotland 2014 http://www.jitscotland.org.uk/wp-content/uploads/2014/11/Frailty-report.pdf The Royal College of Physicians of Edinburgh's Health Priorities 2016, p.5 http://www.rcpe.ac.uk/sites/default/files/files/scotland_health_priorities_2016.pdf Think Frailty diagram http://www.knowledge.scot.nhs.uk/improvingcareforolderpeople/think-frailty.aspx

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					British Geriatrics Society- Fit for Frailty http://www.bgs.org.uk/campaigns/fff/fff_full.pdf
13	SCM1	Identification of people with frailty	Linked closely with multimorbidity and poorer outcomes	There is no standard method of identifying frailty in primary or secondary care. Identifying, recording and monitoring frailty scores will allow active management of multimorbidity aligned with frailty issues which optimises clinician driven patient centred holistic care	Emerging evidence for primary care suggests that electronic tools may support identification of patients to allow optimised management. In secondary care use of tools is sporadic and not standardised.
14	SCM2	Assessment of frailty	Consideration of frailty assessment is recommended as part of NICE Multimorbidity guidance.	Frailty assessment is not well implemented across the UK.	British Geriatrics Society/RCGP/Age UK Fit for Frailty Guideline
15	SCM4	Appropriate use of frailty assessment in primary and secondary care	Frailty has strong impacts on outcomes, and assessing it can be quite easy, as outlined in the guideline. Should encourage GPs and Geriatricians to actually assess frailty, especially in older multimorbid patients (and may be appropriate in younger ones too)	Not aware of any systematic attempt to assess and identify frailty, and it may lead to better identifying those at risk of particularly negative outcomes, including worse results for common adverse events.	
Assessment – Establishing disease and treatment burden					
16	NHS England	Assessment: Ensure this cohort are offered a suitably modified	There is evidence to support comprehensive geriatric assessment for targeted	Targeted assessment is required to trigger care planning as described above.	This would involve ensuring an annual falls assessment and

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		comprehensive and structured assessment of their physical and mental health and wellbeing to reduce the risk of developing further co-morbidity, deterioration or loss of resilience (e.g. CGA) and undertake a care planning discussion. Identify any carers and signpost for a carers assessment. Widespread adoption of Patient Activation Measure (PAM) tool would provide an understanding of the capacity of an individual to manage their own health and care and enable a tailored package of support to be developed to increase an individual's activation level (confidence, knowledge and skills) to manage their own health and care.	assessment of individuals at risk with key benefits to health and wellbeing. For example: In one RCT a single outpatient comprehensive geriatric assessment coupled with an adherence intervention can prevent functional and health-related quality-of-life decline among community-dwelling older persons who have specific geriatric conditions. http://onlinelibrary.wiley.com/doi/10.1111/j.1532-5415.1999.tb02988.x/full Similarly a Cochrane evidence review demonstrated that Comprehensive Geriatric Assessment increases a patient's likelihood of being alive and in their own home at up to 12 months. http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD006211.pub2/full Value of understanding activation		medication review, and appropriate, a cognitive review (dementia assessment). The reviews can be done by any qualified practitioner. Since 2014, NHS England has been supporting a PAM Learning Set of 5 CCGs and the UK Renal Registry have been carrying out projects in their local areas to measure patient activation and find ways to support people to become more involved in their health and care. The various organisations are using PAM for people with LTCs such as diabetes, COPD, chronic kidney disease, mental health, chronic heart failure and rheumatoid arthritis among others. The University of Leicester, carrying out the independent qualitative

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			levels. PAM: Evidence shows that people at higher levels of activation tend to experience better health, have better health outcomes and fewer episodes of emergency care, and engage in healthier behaviours (such as those correlated to smoking and obesity). On the other hand, patients with lower activation have low confidence in their ability to have an impact on their health and often feel overwhelmed with the task of managing their health. Further information: http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/supporting-people-manage-health-patient-activation-may14.pdf A study by Hibbard et al estimated that between 25 and 40 percent of the population have low levels of activation (levels 1 and 2). These people are unlikely to respond to opportunities to improve their health through self-management. They do not understand their role in care process and have limited problem solving skills. As a result, they engage less with preventative		evaluation of the learning set, have found that using the PAM as a tailoring tool encourages the provision of proactive system support for people with long-term conditions to develop the skills, knowledge and confidence to manage health and keep well at home. For example, one GP practice in Sheffield has redesigned their diabetes review process through offering longer appointments using the PAM to tailor discussion according the individual's level of activation. As a quantifiable measure, PAM can be used at scale and to assess whether the services/interventions are providing effective and tailored support to people's needs. For example, Horsham and Mid Sussex CCG's tailored health coaching service used PAM to tailor their

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			healthcare and are involved in more costly emergency care episodes. Evidence from the USA (Hibbard et al, 2013) indicates that very low activation levels are significantly associated with higher health care costs and are predictive of higher future costs, when compared to higher activation levels.		approach when working with patients at different levels of activation. The initial evaluation of their service (not validated/ published yet) has shown an increase in PAM and wellbeing scores, reduced risk scores and reduced healthcare utilisation (overnight stays in hospital, emergencies, A&E episodes) when compared with a control group. The quantitative evaluation of the Islington dataset (part of the learning set) is being done by the Health Foundation. Their initial findings (not validated/published yet) show a 20 points difference in PAM score being associated with a 10% reduction in service usage.
17	Royal College of General Practitioners	Mental health assessment and social benefit advice	The relationship between physical and mental health works in both directions – people with chronic illnesses are more likely to be	Identification of depression and anxiety in this patient group, and appropriate intervention, can improve their quality of life.	Barnett K, Mercer SW, Norbury M, Watt G, Wyke S, et al. (2012) Epidemiology of

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		There is good evidence of hidden depression, linked to social isolation, being associated with multimorbidity. People with multimorbidity and depression have increased unplanned hospital admissions. The relationship and prevalence of comorbid depression and physical health problems is much larger in deprived areas. Patients suffering multiple morbidities should be screened for symptoms of depression regularly.	depressed, and those who are depressed are less likely to manage their long-term conditions well, leading to worse disease control and poorer health outcomes. There is evidence that patients suffering from chronic physical health problems are at greater risk of depression (NICE guidelines on depression and chronic physical health problems).		multimorbidity and implications for health care, research, and medical education: a cross-sectional study. Lancet 380: 37-43. Gunn JM, Ayton DR, Densley K, Pallant JF, Chondros P, et al. (2012) The association between chronic illness, multimorbidity and depressive symptoms in an Australian primary care cohort. Soc Psychiatry Psychiatr Epidemiol 47: 175-184. Payne RA, Abel GA, Guthrie B, Mercer SW (2013) The effect of physical multimorbidity, mental health conditions and socioeconomic deprivation on unplanned admissions to hospital: a retrospective cohort study. CMAJ 185: E221-228. Mercer SW, Gunn J,

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					Bower P, Wyke S, Guthrie B (2012) Managing patients with mental and physical multimorbidity. British Medical Journal 345.
18	Royal College of General Practitioners	The social, mental, physical, dietary and activity perspectives need to be addressed integrally for every patient.	This should include healthcare in prison. The issue of multimorbidity in prisoner populations creates additional challenges in terms of healthcare teams preparations' for resettlement and movement of patients back into society and citizenship. Social care coordination in prison needs to seamlessly interface with social care on release, with a careful step-down to maintain recovery goals. Prison healthcare teams focusing on careful medicines management and reconciliation with complex clients where polypharmacy could be a significant issue.	Care planning supports people to work in partnership with their health and care team. This increases levels of activation, encourages resilience and is more likely to result in people taking action. This will reduce unplanned care and utilisation of services including emergency and out of hours services, outpatient appointments and GP services, and improve patient experience	Patient activation and PAM FAQs https://www.england.nhs.uk/ourwork/patients/patient-participation/self-care/patient-activation/pa-faqs/ Judith Hibbard and Helen Gilburt (May2014) The king's fund. Supporting people to manage their health http://www.kingsfund.org.uk/sites/files/kf/field/field_publication_file/supporting-people-manage-health-patient-activation-may14.pdf NHS England and Coalition for Collaborative Care. (March 2016). Personalised care and support planning

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					handbook https://www.england.nhs.uk/wp-content/uploads/2016/04/core-info-care-support-planning-1.pdf National Voices. Care and support planning http://www.nationalvoices.org.uk/person-centred-care-practice/care-and-support-planning Royal College of General Practitioners. (2015). Stepping forward. http://www.rcgp.org.uk/~/media/Files/CIRC/Quality-Improvement/RCGP-Stepping-Forward-2016.ashx
19	Royal College of Psychiatrists	Multimorbidity and depression Assessment and treatment of depression in patients with multi-morbidity. How many patients have their mental needs assessed,	Depression has a deleterious effect on outcomes in people with LTCs and leads to increased morbidity, and a whole range of negative outcomes. The relationship between multi-morbidity and depression should be a key topic area.	There is evidence that depression is poorly recognised and, even if recognised, is poorly treated either due to sub-optimal treatment or failure to adapt treatment of depression to the physical illness(es) and address adjustment reactions and other aspects of health-related issues in addition to routine depression treatment. Although IAPT is now expanding to address this area,	There is a dose-response relationship between the number of chronic physical problems that a person experiences and depressive symptoms (Smith et al, 2014). A recent study has shown the prevalence of

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		how many receive treatment, if patients fail to respond to initial treatment how many are reviewed by experts who have good understanding of both the physical problems and mental health disorders.		their success is not known and they are increasingly recognised to lack sufficient skills for more complex patients. NICE Guidelines advise assessment of depression in all people with a long term condition on admission to hospital.	depression in a primary care cohort was 23% for people with one LTC; 27% for 2 LTCs; 30% for 3 LTCs; rising to 41% for 5 LTCs (Gunn et al, 2012). Associated mental disorders increase the costs related to comorbid physical long term conditions with 12-18% of all NHS expenditure on long-term conditions is linked to poor mental health and wellbeing – between £8 billion and £13 billion in England each year (Naylor et al. 2012) 1. NICE Clinical Guideline 91: https://www.nice.org.uk/guidance/cg91/chapter/1-guidance 2. Chris Naylor, Michael Parsonage, David McDaid, Martin Knapp, Matt Fossey, Amy Galea (2012). Long-term conditions and mental

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					health: the cost of co-morbidities. Kings Fund. 3. Smith DJ, Court H, McLean G, et al. (2014) Depression and multimorbidity: a cross-sectional study of 1,751,841 patients in primary care. J Clin Psychiatry. 75(11):1202–1208.
20	Royal College of Psychiatrists	Multi-morbidity and unrecognised somatoform disorder Assessment of evidence for multiple physical co-morbidities and of any mental health disorder in people who present frequently to health services.	About 20% of physical presentations to secondary care are not explained by organic disease. For patients with recurrent presentations, their symptoms may be explained by an underlying mental health disorder, especially somatoform disorder (sometimes referred to as medically unexplained symptoms). Identification of underlying mental disorders is recognised to be highly variable and generally poor, amongst physical health specialists and, if somatoform disorder is recognised, resources for treatment are generally lacking due to limited out-patient resource	Unrecognised somatoform disorder results in patients enduring a series of investigations and admissions with negative results or identifying pathology that does not fully explain their disability. This prevents them from receiving appropriate treatment as well as incurring much avoidable cost for the NHS. Organic disease is not mutually exclusive, and will co-exist with somatoform disorder in the most complex cases to manage. Asthma, irritable bowel syndrome and migraine are some of the most common diagnoses in patients who also have a severe somatoform disorder. Treatment of exacerbations of symptoms in line with the underlying physical diagnosis will increase disability unnecessarily if it is not recognised that the exacerbation is largely due to the co-morbid somatoform disorder.	Reid et al (2001) found that 21% of hospital out-patient appointments for those most frequently referred, resulted in lack of diagnosis for symptoms, most commonly with abdominal pain, headache, back pain or chest pain where up to 70% of symptoms remained medically unexplained. Reid et al (2002) found people presenting frequently who had at least two symptoms fully explained by physical disease accounted for disproportionate costs.

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			for Liaison Psychiatry or other integrated mental health specialists.		1. Reid, S., Wessely, S., Crayford, T., & Hotopf, M. (2001). Medically unexplained symptoms in frequent attenders of secondary health care: retrospective cohort study. BMJ, 322(7289), 767-769. 10.1136/bmj.322.7289.767 2. Reid, S., Wessely, S., Crayford, T., & Hotopf, M. (2002). Frequent attenders with medically unexplained symptoms: service use and costs in secondary care. British Journal of Psychiatry, 180, 248 - 253. 10.1192/bjp.180.3.248
21	SCM1	Patient perspective on multimorbidity management	Addresses reduction of treatment burden and how well we optimise care collaboratively with the patient	Improve quality of life through discussion and management of issues that matter to patients eg number of health care appointments, number and type of medicines prescribed, benefit of medication review, including how patient centred the review is (not just how it adheres to clinical guidelines)	We currently dont know how patients with multimorbidity view their care
22	SCM2	Establishment of disease/treatment burden	Recommended within NICE Multimorbidity guideline, and of	Not yet widely established as part of clinical practice, including standardised/consistent	

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		in people with multimorbidity	key importance to patients. families and carers.	approach to assessing disease/treatment burden.	
23	SCM3	Identification and management of depression in LTCs	Ample evidence that anxiety and depression increase morbidity and mortality of LTCs and some evidence that management [within a collaborative care (CC) framework] improves outcomes	Availability of evidence-based interventions (within a CC framework) Referral to such services	Coventry P, Lovell K, Dickens C, Bower P, Chew-Graham CA, Mcevenny D, Hann M, Cherrington A, Gbbons C, Baguley C, Roughley K, Adesanyi I, Reeves D, Waheed W, Gask L. Integrated primary care for patients with depression and long-term conditions: results of a cluster randomised controlled trial of collaborative care. BMJ 2015;350:h638 doi: 10.1136/bmj.h638
Assessment – Establishing the effects of health problems and treatment on day-to-day activities					
24	SCM2	Establishing patient goals, values and priorities	Within NICE Multimorbidity guideline, and of core importance to patients as part of person-centred, goal-orientated approach to care.	Although intrinsic to clinical practice, not applied consistently across healthcare settings.	British Geriatrics Society/RCGP/Age UK Fit for Frailty Guideline; NICE person-centred care guideline; NHS England Person Centred Care for Long-term Conditions
Reviewing medicines and other treatments					
25	British Geriatrics Society	Key area for quality improvement 2	Patients with frailty and multiple comorbidities in primary care should be screened using the	This identifies medicine safety concerns and ensures evidence based treatment.	Patients with frailty and multiple comorbidities frequently suffer

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			STOP/START criteria to identify medicine safety concerns.		medication adverse events which are preventable. O'Mahony D et al. STOPP/START criteria for potentially inappropriate prescribing in older people:version2. Age and Ageing. 2015;44(2):213-218.
26	Parkinson's UK	Assessing drug combinations and potential adverse reactions.	People with Parkinson's often take a variety of medication which has been carefully trialled by their GP and consultant. If they have other long term conditions, they will more than likely be taking medication to treat these symptoms as well. This quality standard must highlight the importance of analysing all the medication someone is taking for every condition they have, and how these medicines work together. It must also recommend that professionals treating the person with Parkinson's have a good understanding of the condition, the importance of timely drug delivery, and the way specific medications interacts with other	Drugs used in the treatment of co-morbidities in an emergency can influence the effectiveness of Parkinson's medications and/or cause significant side effects. It is important to note that Parkinson's medication can easily react to other medication. For example many people with Parkinson's can be very sensitive to neuroleptic (antipsychotic) drugs which can be used to treat dementia.	Drug treatments for Parkinson's https://www.parkinsons.org.uk/content/drug-treatments-parkinsons

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			medicine. It should also be recommended that medicine is reviewed at regular intervals to ensure the medicine prescribed is working effectively, and the best option at the time.		
27	Royal College of General Practitioners	Medication reviews and development of deprescribing guidance Prescribing and medicines management in multi- morbidity, frailty and dementia. Everyone with multimorbidity should have a formal medication review by a clinical pharmacist working with the lead clinician. Use of statins in the elderly	Poor prescribing and medicines management in multimorbidity and dementia is a major cause of morbidity, risk, iatrogenic harm and waste of resources. Polypharmacy is frequently associated with multi-morbidity and there is a lack of evidence of the benefit for many of these drugs in combination. Statins may not benefit the elderly. They should be offered but not recommended.	Action needs to be taken to reduce the risk of harm, falls and hospital admissions, and to improve patient experience and the delivery of cost-effective care. Analysis of the PROSPER trial showed that statins do not reduce overall mortality in the elderly.	Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes NICE 2015 www.nice.org.uk/guidance/ng5/resources/medicines-optimisation-the-safe-and-effective-use-of-medicines-to-enable-the-best-possible-outcomes-51041805253 D Garfinkel, D Mangin Arch Intern Med, 2010;170(18):1648-1654 Mangin D, Risdon C, Parascandalo J. BMJ Open 2016;6:e010903.doi:10
28	Royal College of General	Deprescribing psychotrophic medication	A person with 5 chronic conditions will take an average of 19 doses	A trial of stopping all non-life essential mediation in the elderly found that:	RCGP (March 2016). Continuity of Care in

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	Practitioners	in people with learning disabilities	of 12 medications, 5 times a day. Patients strongly express a desire for discussions about discontinuation of medication. Multiple psychotropic drug use often starts at a specialist level, which is then passed onto primary care for long-term management. Long-term use of these drugs can lead to significant weight gain, organ failure and, in some cases, death.	58% of medications could be stopped 80% of people reported a global improvement in health No adverse effects from discontinuing medication An estimated 35,000 adults with a learning disability are being prescribed an antipsychotic, an antidepressant or both without appropriate clinical justification. Glover et al. (2015) has shown that among adults known to their GP to have a learning disability: 17.0% were being prescribed antipsychotic drugs 16.9% antidepressants 7.1% drugs used in mania and hypomania 4.2% anxiolytics 2.7% hypnotics	modern day general practice http://www.rcgp.org.uk/policy/rcgp-policy-areas/~/media/Files/Policy/A-Z-policy/RCGP-Continuity-of-care-in-modern-day-general-practice-2016.ashx NICE. [NG11] 2015 'Challenging behaviour and learning disabilities: prevention and interventions for people with learning disabilities whose behaviour challenges' www.nice.org.uk/guidance/ng11 Public Health England /CPRD (2015) Prescribing of psychotropic drugs to people with learning disabilities and/or autism by general practitioners in England. http://www.improvinghealthandlives. org.uk/securefiles/160419_1226//Psychotropic%20medication%20a

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					nd%20people%20with%20learning%20disabilities%20or%20autism.pdf
29	Royal College of Physicians of Edinburgh	Reducing harmful and less useful medicines in patients with multi morbidity	There can be a high risk of drug interactions and adverse reactions, and poor evidence of benefit for many of these patients (who are usually excluded from drug efficacy trials); GPs find it very difficult to go against advice of hospital colleagues, who might be numerous and giving conflicting advice; a major source of patient distress is the vast number of drugs prescribed. GPs need empowerment to stop drugs were this would be appropriate, eg clear guidance on what is essential (insulin in type 1 diabetic) and what is more or less advisory for the patient (statins)	Reduce risk of harm, and increase patient adherence to medication and improve quality of life.	Screening Tool of Older Person's Prescriptions (STOPP) trial data http://www.cumbria.nhs.uk/ProfessionalZone/MedicinesManagement/Guidelines/StopstartToolkit2011.pdf See also section 1.6.2 in NICE CG.
30	SCM3	Reducing poly-pharmacy in people with multimorbidity	Evidence that patients are concerned about treatment burden including polypharmacy.	Evidence of medication reviews in primary care/pharmacy	Abu Dabrh AM, Gallacher K, Boehmer KR, Hargraves IG, Mair FS. Minimally disruptive medicine: the evidence and conceptual progress supporting a new era of healthcare. J R Coll Physicians Edinb.

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					2015;45(2):114–7. Mair FS, May CR. Thinking about the burden of treatment. Bmj. 2014;349:g6680.
31	SCM3	Improving patient safety in people with multimorbidity	Errors more likely to occur in patients with complex problems/MM/polypharmacy	Reduction in errors	RCGP Patient safety toolkit http://www.rcgp.org.uk/clinical-and-research/toolkits/patient-safety.aspx
Management plan – Developing a management plan					
32	NHS England	Tailored approach to management of LTCs: Agree and document a shared (personalised care and support plan PCSP (individualised management plan) that sets out the person's goals and care and support needs, self-management support with a focus on prevention including a physical activity plan appropriate to that person's capabilities, where appropriate the	Academic literature supports the view that active engagement of people and their families with frailty can lead to positive benefits to individuals and society: engagement must be formal and embedded within all levels of healthcare including research, interactions with health care providers and policy setting. The resultant coordinated, person-centred care for older adults living with frailty will be more effective in the longer term for both for the individual and our society' https://researchinvolvement.biom	All CCGs need to have the capability to successfully deliver personal health budgets. Currently 7600 people have them, but this number is increasing at pace and by 2020 NHS England expects that up to 100,000 people will benefit from them. The numbers of PHBs is being monitored at CCG level and numbers will be published quarterly	Personalised Care Plan a plan developed by the Provider in partnership with a Service User and/or their Carer or Legal Guardian (as appropriate) to deliver Services appropriate to the Service User's needs, which: reflects the Service User's goals; helps the Service User to manage their physical and mental health and wellbeing to reduce the risk of developing further co-morbidity, deterioration

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		option of a personal health budget, a named care co-ordinator and includes their preferences for care in the last years of life; PAM should be integral to the tailoring process (see above). A range options to enhance quality of care and encourage more self-management should be incorporated into care planning. These include: Self-management education, health coaching, peer to peer support and group activities (social prescribing) and supporting wider community development. This approach is in line with NICE guidelines https://www.nice.org.uk/guidance/NG44 The key implementation	edcentral.com/articles/10.1186/s40900-016-0038-7 There is evidence in the North American literature that enhanced care programs targeted at vulnerable elders yields significant system benefits: http://jama.jamanetwork.com/article.aspx?articleid=2556000 Another study demonstrated the benefits of advance care planning for targeted care planning: http://nej.sagepub.com/content/early/2016/09/12/0969733016664969. abstract A consortia led by Nesta and the Health Foundation funded by NHS England are publishing Realising the Value in Nov 16 – which includes the evidence base to support a range of interventions which support self-care for people with LTC. This will demonstrate impacts on quality and patient outcomes. These approaches will be advocated by NHS England and widespread systematic		or loss of resilience access to support for self-management and a focus on prevention including a physical activity plan appropriate to that person's capabilities; includes their preferences for care in the last years of life; pays proper attention to the Service User's preferences, culture, ethnicity, gender, age and sexuality; takes account of the needs of any children and Carers; names a care coordinator; and is consistently documented across the system to be available electronically (subject to permissions) at all times to all agreed key parties (in/out of hours GP, social care, emergency and urgent care services, secondary care). NHS England, in

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		and outcome principles would be: All involved workforce (who may need to be specifically identified and resourced) must be suitably trained to support personalised care and support planning and encourage self management. A common language set must be used within the process to ensure reproducibility and avoid ambiguity at the point of key decision making (for example decisions to escalate, withdraw or substantially alter care delivery objectives; It should achieve key identified positive person centred outcomes (optimised involvement in key decision making, improved experience of care, achievement of personalised care	adoption and spread will be encouraged. These approaches are central to the delivery of chapter 2 of the 5YFV. http://www.nesta.org.uk/project/realising-value Evidence (www.phbe.org.uk) shows that personal health budgets increase peoples quality of life and enable them to manage their LTCs so reducing their reliance on reactive unplanned care such as hospital admissions. People receiving NHS Continuing Healthcare (who often have multimorbidity) have the right to have a personal health budget and others who could benefit from them should have the option of them.		partnership with The Coalition for Collaborative Care, has published a handbook which provides information on care and support, which is available at:http://www.england.nhs.uk/resources/resources-for-ccgs/out-frwrk/dom-2/ltc-care/ Where appropriate the person (for example if they receive NHS Continuing Healthcare) should have the option of a personal health budget. Data on numbers of PHBs included in IAF dashboard.

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		delivery) It should achieve key identified positive system outcomes (optimised use of key resources (urgent and emergency care, primary care)			
33	Parkinson's UK	More discussion around advanced care planning	As Parkinson's is a condition which is always degenerative, it is vital that people with Parkinson's and other comorbidities have health and social care services which increase in-step with their needs. Research conducted by Sheffield Hallam University on behalf of Parkinson's UK found that people with the condition were often unaware of social care and the associated psychological and mental health support services that it can offer, and in many cases only accessed care at 'crisis point' – when their independence was at significant risk. The research therefore recommended an 'anticipatory' approach to social care planning,	The Parkinson's UK audit (2015) highlighted anticipatory care planning is something that needs to improve. In the audit, of those people with Parkinson's who had signs of advanced symptoms (such as dementia, increasing frailty, impaired swallowing, nursing home level of care) discussions about end of life care issues and advice about lasting power of attorney was recorded in only around 28% and 26% of cases, respectively. https://www.parkinsons.org.uk/sites/default/files/audit2015_patientandcarerreport.pdf Numerous sources including Palliative care and end-of-life planning in Parkinson's disease by J Neural Transm and The conceptual framework of palliative care applied to advanced Parkinson's disease Parkinsonism and Related Disorders by Ghoche R (2012) show that people with neurological conditions including Parkinson's are much less likely to have	Resources: Thinking about advanced Parkinson's https://www.parkinsons.org.uk/news/28-october-2014/new-advanced-parkinsons-booklet-available Resource: Arranging the right end of life care: https://www.parkinsons.org.uk/content/arranging-right-end-life-care Harrison N, Cavers D, Campbell C, Murray SA. (2012) Are UK primary care teams formally identifying patients for palliative care before they die? Br J Gen Pract. 62(598):e344-52.

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			with support that escalates in-step with a person's growing care needs. An anticipatory approach to care planning which recognises that people with degenerative neurological conditions are likely to have increasing needs for psychological support as their condition progresses can therefore reduce hospital and GP visits and better support individuals to manage their own mental health and maintain their independence for longer. Furthermore, many of the mental and physical symptoms of Parkinson's can mean people will be unable to express their end of life wishes as the condition becomes more advanced. As many people with Parkinson's live with multimorbidities, they may have several more complicating factors which prevent them from expressing their wishes. This quality standard must reflect the importance of people with multimorbidities being given	opportunities to take part in advance care planning, or to receive specialist palliative care and end-of-life support than people with other long term conditions such as cancer.	Royal College of Physicians, National Council for Palliative Care, British Society of Rehabilitation Medicine.(2008) Long-term neurological conditions: management at the interface between neurology, rehabilitation and palliative care. Concise Guidance to Good Practice series, No 10. London: RCP, 2008 Walker RW (2013) Palliative care and end-of-life planning in Parkinson's disease J Neural Transm 2013 120:635–638 Richfield EW, Jones EJS and Alty JE (2013) Palliative care for Parkinson's disease: A summary of the evidence and future directions Palliat Med 2013 27: 805 Ghoche R (2012) The conceptual framework of

ID	Stakeholder	Suggested key area for quality improvement	Why is this important?	Why is this a key area for quality improvement?	Supporting information
			timely information and advice by professionals about advanced care planning. Palliative care requirements should be considered in all phases of the condition.		palliative care applied to advanced Parkinson's disease Parkinsonism and Related Disorders 18 S2eS5 Parkinson's Disease Society (2005). Just invisible: a summary. Parkinson's UK Tod, Angela Mary et al. "Good-Quality Social Care For People With Parkinson's Disease: A Qualitative Study". BMJ Open 6.2 (2016) available at: http://bmjopen.bmj.com/content/6/2/e006813.full?keytype=ref&ijkey=CuaBWbzDxtyfN3z
34	Royal College of General Practitioners	A standard national collaborative care and support plan for people with multimorbidities There needs to be coordinated, holistic patient-centred reviews with identification and	The move away from a disease-centric model of care towards a patient-centred system raises many challenges for those working in primary and secondary care to deliver structured, integrated and collaborative care. A standard national collaborative	At present there are many disease specific care plans. A standard national advance care plan (ACP), which follows a set format will mean patients, carers and health care professionals can recognise and interpret it swiftly. Multiple guidelines need to be formulated into a single care plan. Health care	Morgan MAJ, Coates MJ, Dunbar JA. Using care plans to better manage multimorbidity. AMJ 2015;8(6): 208–215 http://dx.doi.org/10.4066/AMJ.2015.2377 Heslop, P, Blair, PS,

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		documentation of the patient's priorities and quality of life issues. Training in communication skills, care planning and personal goal-setting for all health and social care professionals to develop the right skills and competences among the workforce needs to be prioritised.	care and support plan will help doctors to deliver care that is focused on helping the patient achieve their aims rather than on disease-related, clinical objectives. A single patient record that is coded (like in general practice) and used in specialist/community and primary care settings will also avoid duplication of tests/information and enhance continuity. This measure will reduce the burden on patients and their family of telling their story multiple times. It will also reassure patients and families that they are getting best possible care from professionals that know about them, their conditions and their care preferences.	professionals (HCP) will need to use clinical judgement to determine which targets should be followed. Patient priorities need to be determined and SMART goals developed and written into the care plan to assist HCPs to make appropriate clinical decisions. This requires that HCPs be trained in effective goal-setting and problem solving. Quality of life and patient-centred goals and care preferences need to be reviewed and updated in the next appointment and the care plan updated. The care plan should automatically timetable recall visits to ensure ongoing continuity of chronic disease management and family experience of high quality, patient-centred care. The care plan should assist with case-management tasks by documenting referrals to other healthcare specialists, acting as a communication tool between the healthcare teams, and allowing referrals to be monitored over time. The care plan should contain automatic	Fleming, P, Hoghton, M, Marriott, A, and Russ, L. The Confidential Inquiry into premature deaths of people with intellectual disabilities in the UK: a population-based study. Lancet. 2013; (published online Dec 11.)http://dx.doi.org/10.1016/S0140-6736(13)62026-7. Boyd, K., and Murray, S.A. (2010) 'Recognising and managing key transitions in end of life care', British Medical Journal, 341:c4863. Department of Health (2008) National End of Life Care Strategy: promoting high quality care for adults at the end of their life. Available at: https://www.gov.uk/government/publications/end-of-life-care-strategy-promoting-high-quality-care-for-adults-at-the-end-

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				prompts so that all recommended checks are performed and data entered into the clinic's medical records.	of-their-life Lung Managing multi-morbidity in practice... what lessons can be learnt from the care he care of people with COPD and co-morbidities? 2013 RCGP and NHS Improvement. www.rcgp.org.uk/clinical-and-research/clinical-resources/~/media/Files/CIRC/RCGP-COPD-Multi-Morbidities-April-2013.ashx Barclay, S., Froggatt, K., Crang, C., Mathie, E., Handley, M., Iliffe, S., Manthorpe, J., Gage, H., Goodman, C. (2014) 'Living in uncertain times: trajectories to death in residential care homes', British Journal of General Practice, 64(626), pp. e576-583. DOI: 10.3399/bjgp14X681397.
Management plan – Reviewing the management plan					
35	NHS England	Review: The assessment and care plan should be	Frailty is a progressive long term condition in its own right: once	Identifying and managing frailty proactively with recurrent review gives the best	

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		reviewed as determined necessary or required by the person (or those important to them) and as a minimum every 12 months.	identified and diagnosed the commencement of interventions to reduce risk and impact of unplanned deterioration should be commended and reviewed regularly to ensure that tailored care planning remains relevant and effective for the individual. In one large scale longitudinal study the number of frailty trajectories differed according to age. Within each age group, those in the highest frailty trajectory had greater healthcare use and worse survival. Frailty trajectories may offer a way to target aging individuals at high risk of hospitalization or death for therapeutic or preventive interventions. http://onlinelibrary.wiley.com/doi/10.1111/jgs.13944/full	opportunity we have to address the association between advancing frailty and impaired quality of life: see for example: http://research-information.bristol.ac.uk/files/66253616/art_3A10.1007_2Fs11136_015_1213_2.pdf	
36	NHS England	Technology: The PCSP must be consistently documented across the system to be available (subject to permissions) at all times to all agreed key parties (in/out of			Using the enhanced summary care record helps to provide healthcare professionals treating patients in different care settings with fast access to key clinical

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		hours GP, social care, emergency and urgent care services, secondary care). As a minimum the patient should be offered the option of "switching on" the enhanced summary care record Wearable apps and other digital technology to support self care			information (which automatically includes frailty) and support safer, more effective and efficient care. http://systems.hscic.gov.uk/scr
37	Royal College of General Practitioners	Patients are provided with systematic follow up after a collaborative care and support planning consultation. It is important to find ways to measure continuity of care in general practice effectively to ensure standards are maintained. The measures should be 'real time' and be able to be bolted on to the GP medical records systems.	This provides people and their carers and family with the opportunity to consider what is working or isn't, if more support is needed, if new goals need to be agreed. There is a fear that a move towards delivering general practice at scale could jeopardise continuity of care. It is also possible that measures to improve access to care will prioritise timeliness of care to the detriment of quality and continuity. This may result in poorer quality of care for patients with multimorbidity.	Due to capacity and lack of time this part of the process can be forgotten. It is also important that this is a continuous process and people receive the necessary support to enable them to continue to address the issues that are important to them, to ensure ongoing health and wellbeing and to identify any deterioration early, thereby preventing an unplanned admission and improving patient experience and satisfaction.	

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38	Royal College of General Practitioners	Continuity of care Patients with multimorbidity are proactively invited for a collaborative care and support planning consultation at least annually or more frequently as the level of complexity increases.	Taking a proactive approach to the care of people with multimorbidity will help to prevent the development of new conditions as well as slow the deterioration of pre-existing conditions. Care has traditionally been reactive and thus has failed to prevent deterioration. People with multimorbidity have complex needs which are best met by developing a long-term relationship with their GP and practice nurses who, over time, can become familiar with their priorities. This will support optimal continuity and co-coordination of care for patients with complex care needs.	Robust call and recall systems for patients with multimorbidity to have a collaborative care and support planning consultation, rather than a single disease specific review, need to be introduced. This should incorporate a systematic overview of the process by MDTs. This means patients are less likely to be lost to follow up and so are more likely to receive all care components required to deliver all quality standards. This in turn will prevent deterioration, reduce admission, improve self-resilience and improve patient experience. This measure will reduce the burden on patients and their family of telling their story multiple times. It will also reassure patients and families that they are getting best possible care from professionals that know about them, their conditions and their care preferences.	
39	Royal College of General Practitioners	A standard national collaborative care and support plan for people with multimorbidities There needs to be coordinated, holistic patient-centred reviews with identification and documentation of the	The move away from a disease-centric model of care towards a patient-centred system raises many challenges for those working in primary and secondary care to deliver structured, integrated and collaborative care. A standard national collaborative care and support plan will help	At present there are many disease specific care plans. A standard national advance care plan (ACP), which follows a set format will mean patients, carers and health care professionals can recognise and interpret it swiftly. Multiple guidelines need to be formulated into a single care plan. Health care professionals (HCP) will need to use clinical	Morgan MAJ, Coates MJ, Dunbar JA. Using care plans to better manage multimorbidity. AMJ 2015;8(6): 208–215 http://dx.doi.org/10.4066/AMJ.2015.2377 Heslop, P, Blair, PS, Fleming, P, Hoghton, M,

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		patient's priorities and quality of life issues. Training in communication skills, care planning and personal goal-setting for all health and social care professionals to develop the right skills and competences among the workforce needs to be prioritised.	doctors to deliver care that is focused on helping the patient achieve their aims rather than on disease-related, clinical objectives. A single patient record that is coded (like in general practice) and used in specialist/community and primary care settings will also avoid duplication of tests/information and enhance continuity. This measure will reduce the burden on patients and their family of telling their story multiple times. It will also reassure patients and families that they are getting best possible care from professionals that know about them, their conditions and their care preferences.	judgement to determine which targets should be followed. Patient priorities need to be determined and SMART goals developed and written into the care plan to assist HCPs to make appropriate clinical decisions. This requires that HCPs be trained in effective goal-setting and problem solving. Quality of life and patient-centred goals and care preferences need to be reviewed and updated in the next appointment and the care plan updated. The care plan should automatically timetable recall visits to ensure ongoing continuity of chronic disease management and family experience of high quality, patient-centred care. The care plan should assist with case-management tasks by documenting referrals to other healthcare specialists, acting as a communication tool between the healthcare teams, and allowing referrals to be monitored over time. The care plan should contain automatic prompts so that all recommended checks	Marriott, A, and Russ, L. The Confidential Inquiry into premature deaths of people with intellectual disabilities in the UK: a population-based study. Lancet. 2013; (published online Dec 11.)http://dx.doi.org/10.1016/S0140-6736(13)62026-7. Boyd, K., and Murray, S.A. (2010) 'Recognising and managing key transitions in end of life care', British Medical Journal, 341:c4863. Department of Health (2008) National End of Life Care Strategy: promoting high quality care for adults at the end of their life. Available at: https://www.gov.uk/government/publications/end-of-life-care-strategy-promoting-high-quality-care-for-adults-at-the-end-of-their-life

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				are performed and data entered into the clinic's medical records.	Lung Managing multi-morbidity in practice... what lessons can be learnt from the care he care of people with COPD and co-morbidities? 2013 RCGP and NHS Improvement. www.rcgp.org.uk/clinical-and-research/clinical-resources/~/media/Files/CIRC/RCGP-COPD-Multi-Morbidities-April-2013.ashx Barclay, S., Froggatt, K., Crang, C., Mathie, E., Handley, M., Iliffe, S., Manthorpe, J., Gage, H., Goodman, C. (2014) 'Living in uncertain times: trajectories to death in residential care homes', British Journal of General Practice, 64(626), pp. e576-583. DOI: 10.3399/bjgp14X681397.
40	Royal College of General Practitioners	Ensuring roll out, training and implementation of electronic record sharing such as Summary care	A single patient record that is coded (like in general practice) and used in specialist/community and primary care settings will	At present training in solution-based approaches to care and motivational interviewing are not part of the core undergraduate or postgraduate training for	Royal College of General Practitioners. (2015). Stepping forward. www.rcgp.org.uk/~/media/

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		records, Extended summary care records, Electronic Palliative Care Co-ordination Systems (EPaCCS) and integrated inter-hospital clinical systems. Clinicians receive training in a solution-based approach to care and motivational interviewing.	avoid duplication of tests/information and enhance continuity. In order to deliver person-centred care that enables people with multimorbidity to identify what is important to them, clinicians need to develop new skill sets which support people in this process. Health coaching, motivational interviewing and solution-based approaches to care can enable these effective conversations to happen.	HCPs looking after people with multimorbidity. This training needs to be introduced to help support patients to take a more active, partnership role in their care.	Files/CIRC/Quality-Improvement/RCGP-Stepping-Forward-2016.ashx Year of care partnerships. Care planning http://www.yearofcare.co.uk/care-planning NHS England. Enhancing the quality of life for people living with long term conditions – The House of Care https://www.england.nhs.uk/house-of-care/
41	SCM4	Implementation of management plans for those identified in primary care	This is really the cornerstone of the guideline.	Unlike existing care plans, this is about communication and discussing goals, what's important, etc. This is key to improving patient experience.	
Additional areas					
42	Royal College of Nursing	Involving communities more in supporting better health outcomes particularly mental health	As above	As above	UK Government Healthy Lives Healthy People initiative
Additional areas – Self-management					
43	Older People's Advocacy Alliance	The offer and provision of independent peer advocacy support will	There is evidence that both one-to-one and group interventions, with advocates to help support	Public Health England and UCL Institute of Health Equity found that qualitative evidence suggests that independent	Please see Public Health England & UCL Institute of Equity report: "Local action

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	(OPAAL) UK	help improve and mitigate the effect of limited health literacy in older adults.	and speak up for older people, appear to have the potential to help older people to cope better with long-term conditions and their effects, access appropriate services and help, and to empower them to take greater control of their health.	advocacy is having a positive impact on older people's critical and interactive health literacy, from helping them to understand their illness to voicing concerns, exploring health options and claiming benefits.	on health inequalities Improving health literacy to reduce health inequalities" Practice resource: September 2015 https://www.gov.uk/government/publications/local-action-on-health-inequalities-improving-health-literacy Please also see Cancer, Older People and Advocacy programme blog about cancer and co-morbidities: https://opaalcopa.org.uk/2016/03/16/coping-with-more-than-cancer/
44	Older People's Advocacy Alliance (OPAAL) UK	The offer of appropriate independent peer advocacy support to older people with multi-morbidities who are also carers, especially those caring for people with dementia.	Evidence indicates that carers are at risk of depression and dementia themselves through lack of stimulation. Existing multi-morbidities will be adversely affected by either/both of these additional conditions.	A study explored the change in social support of carers and people with dementia compared with a healthy older population. It was found that carers of people with dementia experience loss of social support four times greater than the healthy older population. These findings suggest that carers and people with dementia are suffering from the effects of a lack of social support far more pronounced than in the general older population. Isolation and increased negative interactions might speed up deterioration associated with dementia,	Please see Social Isolation Resulting from Stigma in Dementia by Brigitta Schwartz 2010

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				and also put carers at risk of depression and dementia through lack of stimulation." The provision of independent peer advocacy support will open up opportunities for a major reduction in isolation and thereby improved health outcomes.	
45	Parkinson's UK	Self-management	It's vital that people with multimorbidities feel in control of their conditions and able to treat them confidently. Self management is a key way to treat Parkinson's and other long term conditions. It enables the person with Parkinson's to manage their own condition. People who have attended the self management programme developed by Parkinson's UK (Path through Parkinson's) have told us that after attending the course they feel: armed with information and knowledge more confident, positive, in control and able to move forward less alone as a result of meeting others Participants also say they gain: greater self-awareness and	Not everyone with multimorbidities is signposted to a self management programme to better help them understand and treat their condition. We also know from our Get It On Time campaign that people with Parkinson's are often unable to take their medication when in hospital. This can result in the patient with Parkinson's, and often other long term conditions, experiencing a decrease in their health and often staying in hospital longer than was first necessary. A positive approach to care requires hospitals and care homes to support people with Parkinson's to take their own medication, and have self administration policies in place when this is not the case. However many hospitals do not have these policies in place.	Parkinson's UK self management programme https://www.parkinsons.org.uk/content/self-management-programme-path-through-parkinsons and https://www.parkinsons.org.uk/content/self-management-programme-more-information and https://www.parkinsons.org.uk/content/self-management-programme-path-through-parkinsons

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			insight a personal action plan for doing specific things such as exercise, hobbies and therapeutic activities improved speech as a result of talking in the group We believe the quality standard should urge professionals to promote self-management programmes to empower people living with the condition to take an active role in managing their wellbeing with support from professionals. The standard should also signpost to general self-management resources as well as condition specific information.		
46	Royal College of Nursing	Supported Self-Management	People need to be supported to understand their disease/s better. They also should have access to structured education or support to understand their disease better with professionals who understand how to do this.	People feeling that they have some understanding and control over their daily lives with a good understanding of their disease often need lees support from professionals and keep well longer	http://www.kingsfund.org.uk/projects/gp-commissioning/ten-priorities-for-commissioners/self-management https://www.england.nhs.uk/ourwork/patient-participation/self-care/
Additional areas – carer assessment					

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47	Royal College of General Practitioners	Carers needs assessment Where someone with multimorbidity has support from a carer, his or her needs should also be considered. There are challenges in implementing comprehensive carer assessment and support. Information to patients and carers.	Many people with multimorbidity, especially those with frailty, will be supported by carers who in turn may also have multimorbidity. Information must be provided to people and carers with LTCs in ways that are understandable and enable people to make rational decisions on interventions, including carers who are responsible for a prisoner or detainee with complex needs Carer details are not recorded in healthcare clinical systems and there are commonly no consistent means of documenting their needs as separate from patients. Health care systems often do not afford opportunity for regular carer contact, assessment and follow-up.	Carers physical or mental health is at risk of getting worse when providing care for someone with multimorbidity. This could cause severe outcomes including their ability to look after any children they have responsibilities for; the provision of care to any other person; financial difficulties and hardship; maintenance of their home in a fit and proper state; eating properly and maintaining proper nutrition; maintaining and developing relationships with family and friends; participation in any education, training, work or volunteering; time for social activities, hobbies etc.	Summary Report on GP practice journeys towards improved carer identification and support. RCGP /www.rcgp.org.uk/~/media/EFE191B727514B66909FEED20FF23E1F.ashx Grande, Gunn Eli, et al. "Assessing the impact of a Carer Support Needs Assessment Tool (CSNAT) intervention in palliative home care: a stepped wedge cluster trial." BMJ supportive & palliative care (2015): bmjspcare-2014.
48	Royal College of Nursing	Carer support	Carers play a vital role in helping people with multi morbidities to live well this applies to formal and informal carers including the care home sector and they need to be supported to provide this care.		References listed above, are also relevant for this quality area for improvement.
Additional areas - Training					

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49	NHS England	Workforce: This process should be conducted through an identified and consistent, suitably trained work force. [All involved workforce (who may need to be specifically identified and resourced) must be suitably trained to support personalised care and support planning]	There is growing evidence for an increased demand on both skilled and unskilled workforce created by an expanding population of older people living with frailty- see for example: http://onlinelibrary.wiley.com/doi/10.1111/1468-0009.12199/full http://ageing.oxfordjournals.org/content/45/1/48.short http://www.andjrnl.org/article/S2212-2672(16)30776-6/abstract http://www.ncmedicaljournal.com/content/77/2/102.short http://www.tandfonline.com/doi/abs/10.1080/07481187.2015.1081542?journalCode=udst20 http://ptjournal.apta.org/content/96/1/71.short http://ageing.oxfordjournals.org/content/45/5/577.short http://onlinelibrary.wiley.com/doi/10.1111/1467-8500.12204/full		NHS England has commissioned HEE and Skills for care to identify skills and competencies of a person and community centred workforce- including the informal workforce. This resource will be published by February 2017.

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			https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/535187/gs-16-10-future-of-an-ageing-population.pdf		
50	Royal College of General Practitioners	Training of all health care professionals in recognising the prognostic indicators for approaching end of life in multimorbidity particulary in old age, people with dementia and people with a learning disability is also necessary. Advance care planning needs to be part of the collaborative care and support plan.	There are significant societal and professional barriers to recognising and acknowledging approaching end of life and then having the necessary difficult conversations needed for good advance care planning. ACP is particularly important in the care of patients with dementia and their family. Prioritisation of the specific end of life care challenges for people with dementia and their families is needed. Recognition of the difficulties around prognosis of this condition and challenges of assessments and decision-making is also necessary.	Earlier ACP conversations soon after diagnosis of dementia offer a window of opportunity to discuss and record patients preferences for their future care anticipating future loss of capacity. There is poor understanding of the very high mortality of patients with dementia admitted to hospital with pneumonia or fractured femurs. A much more supportive and palliative approach to care for these patients in hospital needs to be adopted.	Barclay, S., and Maher, J. (2010) 'Having the difficult conversations about end of life care', British Medical Journal, 341:c4862 GSF (2011) The GSF Prognostic Indicator Guidance. Available at: http://www.goldstandardsframework.org.uk/cd-content/uploads/files/General%20Files/Prognostic%20Indicator%20Guidance%20October%202011.pdf Nuffield Council on BioEthics (2009) Dementia: Ethical issues. Executive summary and recommendations. Available at: http://nuffieldbioethics.org/wp-

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					content/uploads/2014/07/Dementia-Executive-Summary1.pdf World Health Organisation (2012). Dementia, a public health priority. Available at: http://www.who.int/mental_health/publications/dementia_report_2012/en/ Sampson, L., Harrison-Dening, K., Greenish, W., Mandal, U., Holman, A., and Jones, L. (2009) End of life care for people with dementia. Available at: https://www.mariecurie.org.uk/globalassets/media/documents/commissioning-our-services/past-initiatives/end-of-life-care-and-dementia/end-of-life-project-report.pdf Crowther, J., Wilson, K.C.M., Horton, S. and Lloyd-Williams. M. (2013) 'Palliative care for dementia – time to think

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					again?' Quarterly Journal of Medicine, 106, pp. 491-494.
51	Royal College of Nursing	Staff educated to provide coaching techniques to support behaviour change and self-management	The use of coaching is well understood in enabling people to take more responsibility for their health and wellbeing	Local communities play a key role in supporting better health outcomes and are crucial in providing a range of support and activities within the local area for people with multi morbidities	https://www.eoeleadership.nhs.uk/Health_Coaching_Training_Programmes http://www.betterconversation.co.uk/
Additional area – Integrated personalised commissioning (IPC)					
52	NHS England	Additional developmental areas of emergent practice: Integrated Personalised Commissioning IPC Health Literacy/ The information standard. Single Point of Access		IPC is beginning to achieve success in joining up health and social care provision around the needs of an individual at a local level. It is focused on those with the highest levels of need, including those with multimorbidity.	The IPC emerging framework published in May (https://www.england.nhs.uk/commissioning/ipc) provides a blueprint for national rollout of the programme and increasingly IPC is being seen as a quality model for delivering personalised care and support. The MCP and PACS emerging framework signalled the requirement for all MCPs and PACS to adopt the IPC model for supporting people with long term conditions.

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					There is further information on the web pages here https://www.england.nhs.uk/tis/
Additional areas – Comprehensive Geriatric Assessment					
53	Royal College of Physicians of Edinburgh	Comprehensive assessment of all frail inpatients over age 75 whatever specialty they are admitted under	Comprehensive Geriatric Assessment (CGA) involves a holistic, multidimensional, interdisciplinary assessment of an individual by a number of specialists of many disciplines in older people's health and has been demonstrated to be associated with improved outcomes in a variety of settings.	Extensive research has shown that CGA in hospital increases independence (individuals are more likely to go home after this process compared to standard medical care) and reduces mortality. A recent Cochrane review showed that those who underwent CGA on a ward had a 30% higher chance (OR 1.31 CI 1.15 – 1.49) of being alive and being in their own home at 6 months.	British Geriatrics Society- Fit for Frailty http://www.bgs.org.uk/campaigns/fff/fff_full.pdf British Geriatrics Society - Comprehensive Geriatric Assessment (CGA) http://www.bgs.org.uk/index.php/cga-managing Improving the identification and management of frailty Healthcare Improvement Scotland 2014 http://www.jitscotland.org.uk/wp-content/uploads/2014/11/Frailty-report.pdf http://www.knowledge.scot.nhs.uk/improvingcareforolderpeople/think-frailty.aspx
54	SCM4	Use of CGA for	The guideline uses actual	I am not aware of any existing evidence	Guideline recs on CGA,

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		appropriate geriatric patients in secondary care	evidence to indicate that the use of CGA appropriately	about how widespread is the use of CGA, and the guideline found evidence of improvement in outcomes in certain situations	and the evidence used
Additional area – Shared Decision Making					
55	NHS England	Additional developmental areas of emergent practice: Shared Decision Making		The drive to embed shared decision making into everyday clinical practice gained significant momentum in 2015, when a pivotal ruling by the UK Supreme Court (Montgomery v Lanarkshire Health Board) pronounced that the process of gaining consent for any procedure which interferes with' bodily integrity' should be informed by the principles and practice if shared decision making. Consent should only be gained when patients have shared a decision informed by what is known about the risks, benefits and consequences of all reasonable options. NHS England believes information that is clear, accurate, evidence-based, up-to-date and easy to use enables people, patients and communities to become better informed and more involved in their health and care.	NHS England is working with NICE and a coalition of national partners in building a Shared Decision Making Collaborative to embed into the everyday work of the NHS. An action plan has been developed.
56	Royal College of Anaesthetists	Elective Surgical Care: Early Risk Stratification and Collaborative/Shared Decision Making	Patients with multi-morbidities may not gain the expected benefit from interventions, including surgical procedures, and may be more susceptible to harm from	Please consider including "Perioperative Medicine: the path to better surgical care (RCoA, 2015) in section 3.2 Key development sources (Key policy documents, reports and national audits):	A number of studies have shown that premorbid conditions affect surgical outcome including anaemia, diabetes and

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			interventions. As a consequence the balance of benefit and harm may, in some cases, be in favour of not undertaking an intervention. High quality collaborative decision-making is critical to well-informed patient decisions in such cases.	http://www.rcoa.ac.uk/periopmed/vision-document	frailty. Musallam KM, Tamim HM, Richards T, Spahn DR, Rosendaal FR, Habbal A, Khreiss M, Dahdaleh FS, Khavandi K, Sfeir PM, Soweid A. Preoperative anaemia and postoperative outcomes in non-cardiac surgery: a retrospective cohort study. The Lancet. 2011 Oct 21;378(9800):1396-407. Frisch A, Chandra P, Smiley D, Peng L, Rizzo M, Gatcliffe C, Hudson M, Mendoza J, Johnson R, Lin E, Umpierrez GE. Prevalence and clinical outcome of hyperglycemia in the perioperative period in noncardiac surgery. Diabetes care. 2010 Aug 1;33(8):1783-8. Partridge JS, Harari D, Dhesi JK. Frailty in the older surgical patient: a review. Age and ageing.

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					2012 Mar 1;41(2):142-7.
57	Royal College of General Practitioners	Patients are provided with information related to their health in advance of a care and support planning consultation. Patients are provided with either a paper or electronic record of their agreed care planning discussion and the goals developed.	It is recognised that patients are more likely to take an active role in their own self care if they are provided with consistent information and are supported to think about what help they need to address what is important to them in advance of their consultation. Having a record of agreed goals can help people to refer back to the discussion that took place during the collaborative care and support planning consultation and so will help people to take action.	Patients are more likely to carry out the changes that they have identified as being important. This in turn will improve health and wellbeing, ability to self-care and quality of life. This can reduce service utilization and improve patient experience. Care plans are often written in the language of the health and care professional rather in the individual's own words. People are more likely to have ownership over actions they have written themselves and so are more likely to complete these actions. This in turn will improve activation, self-care, patient experience and satisfaction and reduced health service utilisation.	
Additional areas – Surgical Care					
58	Royal College of Anaesthetists	Elective Surgical Care: Prehabilitation	Patients with comorbidities are more likely to suffer complications and death following surgery. Exercise training, nutrition support, smoking and alcohol cessation interventions can all improve these clinical outcomes.	Please consider including "Perioperative Medicine: the path to better surgical care (RCoA, 2015) in section 3.2 Key development sources (Key policy documents, reports and national audits): http://www.rcoa.ac.uk/periopmed/vision-document	Gillis C, Li C, Lee L, Awasthi R, Augustin B, Gamsa A, et al. Prehabilitation versus rehabilitation: a randomized control trial in patients undergoing colorectal resection for cancer. Anesthesiology. 2014;121(5):937-47. O'Doherty AF, West M,

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					Jack S, Grocott MP. Preoperative aerobic exercise training in elective intra-cavity surgery: a systematic review. Br J Anaesth. 2013;110(5):679-89 Tønnesen H, Nielsen PR, Lauritzen JB, Møller AM. Smoking and alcohol intervention before surgery: evidence for best practice. British Journal of Anaesthesia. 2009;102:297-306. Sørensen LT, Jørgensen T, Kirkeby LT, Skovdal J, Vennits B, Wille-Jørgensen P. Smoking and alcohol abuse are major risk factors for anastomotic leakage in colorectal surgery. The British Journal of Surgery. 1999;86:927-31.
59	Royal College of Anaesthetists	Elective Surgical Care: Preoperative Comorbidity Clinics	Patients with comorbidities are more likely to suffer complications and death following surgery.	Please consider including “Perioperative Medicine: the path to better surgical care (RCoA, 2015) in section 3.2 Key development sources (Key policy	Guinn NR, Guercio JR, Hopkins TJ, Grimsley A, Kurian DJ, Jimenez MI, Bolognesi MP, Schroeder

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			Improved comorbidity management can be achieved in dedicated (often virtual) preoperative clinics.	documents, reports and national audits): http://www.rcoa.ac.uk/periopmed/vision-document	R, Aronson S; Duke Perioperative Enhancement Team (POET). How do we develop and implement a preoperative anemia clinic designed to improve perioperative outcomes and reduce cost? Transfusion. 2016 Feb;56(2):297-303
Additional areas – Access to services					
60	Public Health England	Unmet need	Evidence from experts by experience and practitioners tell us that people with co-occurring conditions are often unable to access the care they need. This may be particularly true of those who are not mentally unwell enough to meet the thresholds for mental health services yet are also excluded from lower threshold mental health services. At the most severe end of the mental health spectrum, it is common to hear of people being excluded from adult mental health services because of co-occurring alcohol/drug use	The Home Affairs Select Committee report on mental health and policing found that people in crisis, even those being taken to a place of safety, are withheld vital support because of alcohol and drug use being applied as an exclusion criteria (House of Commons Home Affairs Committee Report (2015) Policing and Mental Health. HC202. London: The Stationery Office Limited). A MEAM coalition's report (Voices from the Frontline: Listening to people with multiple needs and those who support them (MEAM Coalition, 2015) describes a persistent failure of services to work collaboratively to support people with multiple and complex needs, and the inadequacy of a support system which "treats people based on what it considers to be their primary need, be that	

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				mental ill-health, dependence on drugs and alcohol, homelessness or offending." Drugscope's 'State of the Sector' report for 2014/2015 surveyed 189 drug treatment services in England and found that 22% of respondents indicating that access to mental health services had deteriorated over the 12 months to September 2014. The Care Quality Commission's review of mental health crisis care 'Right here, right now' found that far too many people in crisis have poor experiences due to service responses that "fail to meet their needs and lack basic respect, warmth and compassion". 'The Bradley Report five years on (Centre for Mental Health on behalf of the Bradley Commission (2014) The Bradley Report five years on – an independent review of progress to date and priorities for future development) noted that substance misuse services and mental health services in adult prisons continued to work separately and that a model of integrated working needed to be developed in prisons which recognised the multiplicity of need typical in this population.	
61	Royal College of Psychiatrists	Multi-morbidity in individuals with learning disabilities	Reports such as CIPOLD and Mencap's Death by Indifference show that adults with a mild-moderate learning disability have	It is a legislated requirement for health services to make so-called reasonable adjustments for people with a disability – to facilitate access to services and effective	1. NHS England reducing premature mortality in people with learning disabilities: effective

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		Treatment of physical and mental co-morbidity in adults with a mild-moderate learning disability. Current pathways show great variation in inclusion of reasonable adjustments to mainstream services, including liaison psychiatry.	high levels of physical morbidity including obesity, type 2 diabetes, heart disease, and so on. They are less likely to use health services and they have appalling life expectancy (women 20 years lower than national average). They also have high rates of other mental health problems including mood disorders, that impair self-management.	use of those services. Such adjustments are in fact rarely made by mainstream services. Although GPs keep a learning disability register and it is used to plan annual health checks, the registers include only about ¼ of the target population (usually with a more severe learning disability), only about half these are called for a health check, and when co-morbidity is found there are few services to which the GP can refer given that most LD services see almost nobody with a mild LD and don't usually have liaison-type skills in the team. Liaison psychiatry services almost never make reasonable adjustments and in a recent National survey almost none had links with local learning disability teams, although many hospitals now have an LD liaison nurse attached.	interventions and reasonable adjustments. Publications Gateway Ref 01412 2. Heslop P et al The confidential inquiry into premature deaths of people with intellectual disabilities in the UK: a population study Lancet 2014; 383; 889-95 3. Emerson et al The physical health of British adults with intellectual disability Int J equity Health 2016: 15;11 4. McVilly et all Diabetes in people with an intellectual disability: prevalence incidence and impact Diabetic medicine 2014: 31; 897-904
Additional areas - Outcomes					
62	Royal College of Psychiatrists	Multi-morbidity and use of unscheduled care Although increased use of healthcare is recognised for those with multi-morbidity, emergency and	Multi-morbidity is associated with an increased likelihood of using unscheduled care (Townsend et al 2008), with each additional LTC increasing the risk of use of unscheduled care by 38%.	Approximately half of all costs for people with LTCs is spent on unscheduled care, some of which may be potentially avoidable. Several factors have been identified as being important drivers of use of unscheduled care in people with LTCs including, severity of physical illness, multi-morbidity, prior use of health care,	King's Fund (2012) reported on the association of long term conditions and mental health morbidity, noting the combination increased costs, impaired physical outcomes and was very

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		unscheduled care assessments often fail to identify underlying reasons for presentation and will focus on the presenting problem only. This is especially the case for mental health co-morbidity since even the new care models tend to focus on integration of primary and secondary physical health services rather than also including primary and secondary care mental health expertise in physical disorders as is provided by Liaison Psychiatry Services.		depression and unrecognised somatoform disorder (severe medically unexplained symptom disorder). The role of each of these should be addressed in the context of multi-morbidity and use of unscheduled care.	common. 1. Townsend A, Wyke S, Hunt K. Frequent consulting and multiple morbidity: a qualitative comparison of 'high' and 'low' consulters of GPs. Family Practice. 2008;25:168–175 2. Chris Naylor, Michael Parsonage, David McDaid, Martin Knapp, Matt Fossey, Amy Galea (2012). Long-term conditions and mental health: the cost of co-morbidities. Kings Fund.
63	SCM4	Patient satisfaction	Part of the impetus in this guideline is treatment burden and other elements of patient satisfaction and QoL. It would be good to measure those. Can't think how, though, without heavy burden on Gps.		