The role of the MDT to address frailty across Primary Care Networks

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The Multidisciplinary Approach to Addressing Frailty

- Government Policy to provide health and social care
  - Health and Social Care Act 2012
  - Five Year Forward View 2014 – New Models of Care (MCPs)
  - Long term plan 2018
- Long Term Plan
  - Use of MDT linking social care, mental health and primary care
  - Easy access to care close to home
  - Good communication and collaboration across organizational boundaries
  - Reduction in multiple assessments and duplication of resource
  - Education and Upskilling of teams
  - Early identification of frailty to ensure timely interventions

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Encompass: Multispeciality Community Provider

- 180K patient population across Canterbury and Coastal CCG
- Community Hub Operating Centres (CHOCs) or MDTs
- Key features
  - Regular face to face meetings – enabling trust, collaboration and efficiency with co-operative decision making
  - Team consistency
  - Inter-organizational representation and 'buy-in'
  - Relationship/partnership building
  - Administrative support crucial
  - Investment into IT and workforce
  - Clear definition of roles
  - Local leadership at both organizational level and local level

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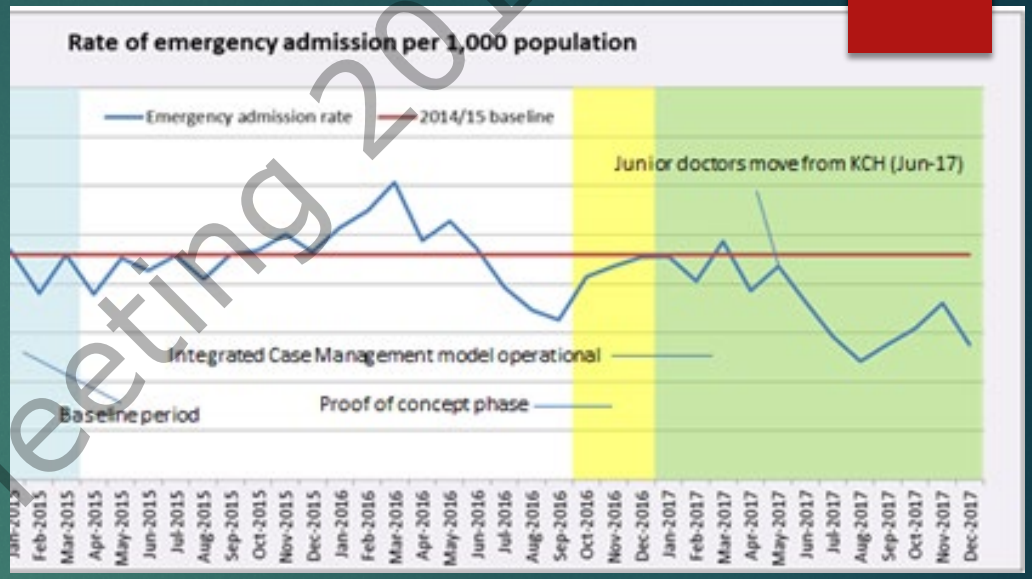
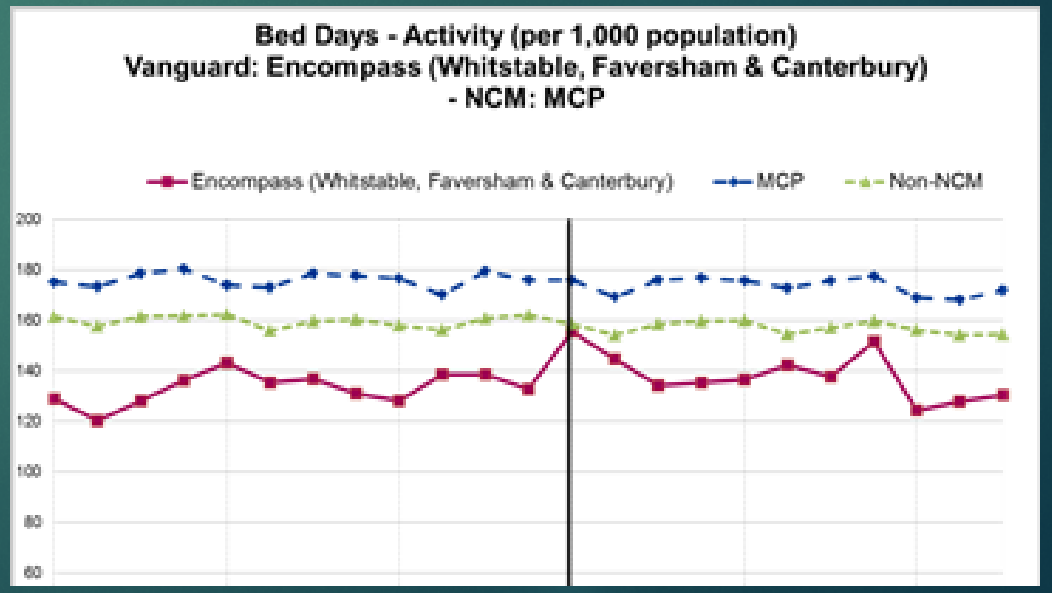
Evidence to support MDT frailty approach approach

- 1747 service users were analysed across 18m period (October 2016-March 2018)
- 1.7% reduction in emergency admissions
- 0.8% reduction in bed days
- Cohort of 100 service users who had a more developed MDT approach
- 22% reduction in emergency admissions over 1 year period (April 2017-March 2018)
- 4% reduction in bed days





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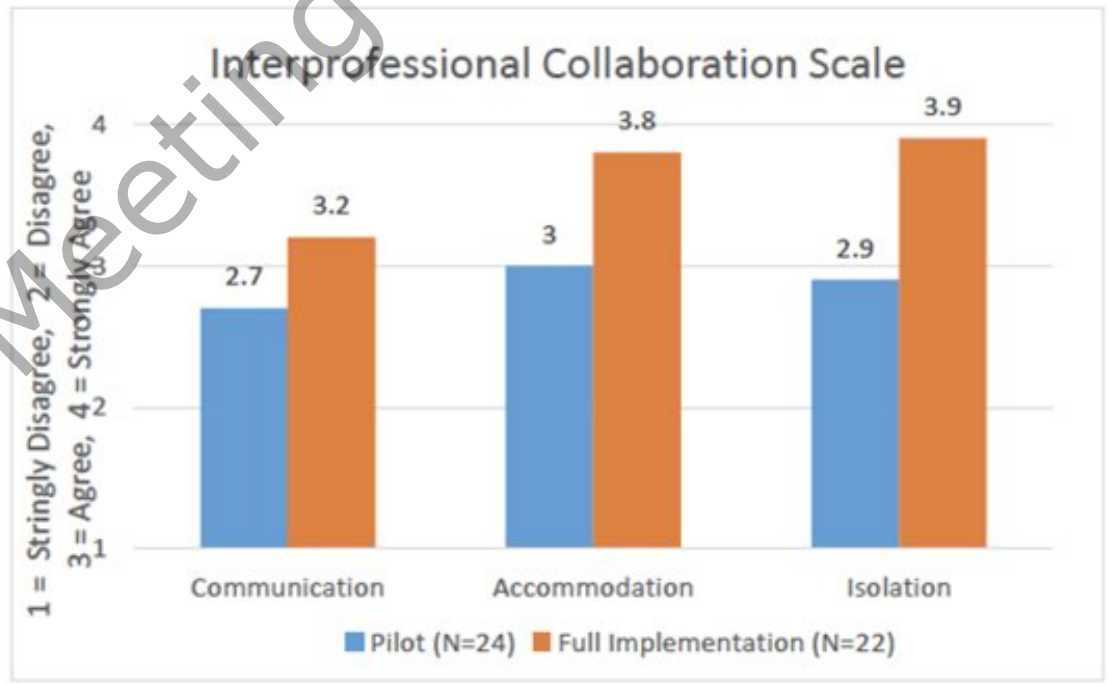
Evidence to support MDT frailty approach

- Qualitative evidence from **staff**:
  - Marked improvement in how patient care was managed
  - Better communication and information flow across teams
  - Reduced duplication
  - Improved access for patients to services



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Evidence to support MDT frailty approach

- Qualitative evidence from **service users**:
  - Majority experienced better person-centre care (PC3EQ)
  - Better communication and information flow between service users and professionals
  - There was better access to the services and resources available in the health, social and voluntary sectors

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Core MDT members

- Administrator
- AgeUK personal independence coordinator/dementia specialist
- Community nurses
- Frailty practitioner +/- consultant geriatrician
- GP
- Health and social care coordinator
- Intermediate care practitioner
- Mental health practitioner
- Pharmacist +/- pharmacy technician
- Social services representative

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Additional MDT members

- Community Warden
- Hospice practitioner
- Kent Fire and Rescue
- Vulnerable adult police community special officer

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Link with secondary care

- Patient tracker list
- In-reach
- Out-reach
- Discharge
- Referral into MDT

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Role of Clinical Pharmacist

- Extended role – clinical pharmacist advice +/- prescriber/deprescriber
- Medicines management assessments
- Advanced Care Planning
- DNACPR discussions
- Functional assessment referrals
- Mini-memory assessments
- Measuring Postural Blood Pressure and AF screening
- Completing other components of Comprehensive Geriatric Assessment (CGA) and identifying gaps which need to be completed to bring back to MDT

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Case Study

- Husband (Bob) and wife (Mary) referred to HUB by GP, with concerns about safety at home and ability to manage medicines

- Pharmacist visited as an urgent home visit; due to lack of local support from family and high risk medicine (warfarin)

	Bob	Mary
PMH	Parkinson's (new diagnosis) | MI | Hypertension | anxiety | gastritis	AF | Hypothyroidism | Peripheral oedema
Medicines	Amlodipine 10mg OM Omeprazole 20mg OM Sinemet Plus QDS Clopidogrel 75mg OM Laxido sachets BD	Bisoprolol 5mg OM Levothyroxine 50microg OM Warfarin – as INR Digoxin 125microg OM Bumetanide 1mg OM

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Comprehensive Geriatric Assessment

	Bob	Mary
Pain	No issues identified	No issues identified
Continence	No issues	No issues identified
Sensory impairment	**Poor eyesight even with glasses**	No issues identified
Musculoskeletal problems	**New Parkinson's diagnosis, tremor and rigidity, 2 recent falls**	No issues identified
Nutritional	**Reports is struggling to manage nutritional needs**	**Bob and daughter report that Mary doesn't eat regularly, Mary reports no issues**
Skin assessment	Mobile – no issues identified	Mobile – no issues identified
Mood	Long term anxiety, but no new changes	No issues identified
Cognitive impairment	**Complains of short-term memory issues (which he described as intermittent) 6CIT = 3/28 - reports of "fuzzy head"**	**Poor cognition – no insight (6CIT = 21/28)**
Functional abilities	**Struggling to manage ADLs, feels mobility poorer than previous**	**Bob and daughter report that Mary not managing to wash or dress well, Mary reports no issues**
Living environment	Have cleaner, no issues identified	
Social support networks	**Would like to be involved in groups, but doesn't feel physically able**	Doesn't want to join any groups, happy at home with her cat!

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Interventions

	Bob	Mary
Sensory impairment	Referral to at-home optician via daughter	-
MSK problems	**Referral to ICT for falls assessment**	-
Nutritional	Referral to AGEUK for Meals on wheels – both gained weight	
Cognitive impairment	**?ADR of co-careldopa – discussion with Parkinson's nurse, dose cut in half – no change in functional ability, memory symptoms improved greatly**	**Referral to memory team – did not consent to this, but after assessment did not have capacity to decline – diagnosed with Alzheimer's**
Functional abilities	Referral to intermediate care team, referral to social services for care needs assessment; self-funded care package initiated. Also Bob's functional abilities improved after sinemet ↓	
Social support networks	**Referred to Men's shed, which he loved and after dose of Sinemet reduced was able to interact**	Doesn't want to interact with any groups
Other	Started pharmacy-filled medicines compliance aid (MCA) Swapped omeprazole to H2 agonist (interaction) DNACPR and Advanced Care Planning	Started self-filled MCA to monitor concordance – then started pharmacy-filled MCA Changed to DOAC as INR variable **Increased bisoprolol to 10mg OM so normocardic (once concordance improved)** Stopped bumetanide – no peripheral oedema DNACPR and Advanced Care Planning

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Recognising Challenges

- Resource and capacity
- Working together
- Collaboration across primary care – forming PCNs
- Cross organisational working
- Communication and IT

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Reflection: How can we improve?

- Ensure a strong chair
- Feedback to referrers to ensure high quality referrals (SBARs) into the HUB
- Empower all members of the MDT to contribute to discussion
- Time efficiency
- Prioritise discussions
- Summarise discussions
- Better patient communication and collaborative care plan development
- ‘No decision about me without me’

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The future

- Link with care-home working
- IT development – care flow and communication tools
- Discharge communication – via CGA template?
- Prioritisation strategies
- Population mapping and its use to identify patient populations to target
- Virtual HUB

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Thanks for listening – Questions?

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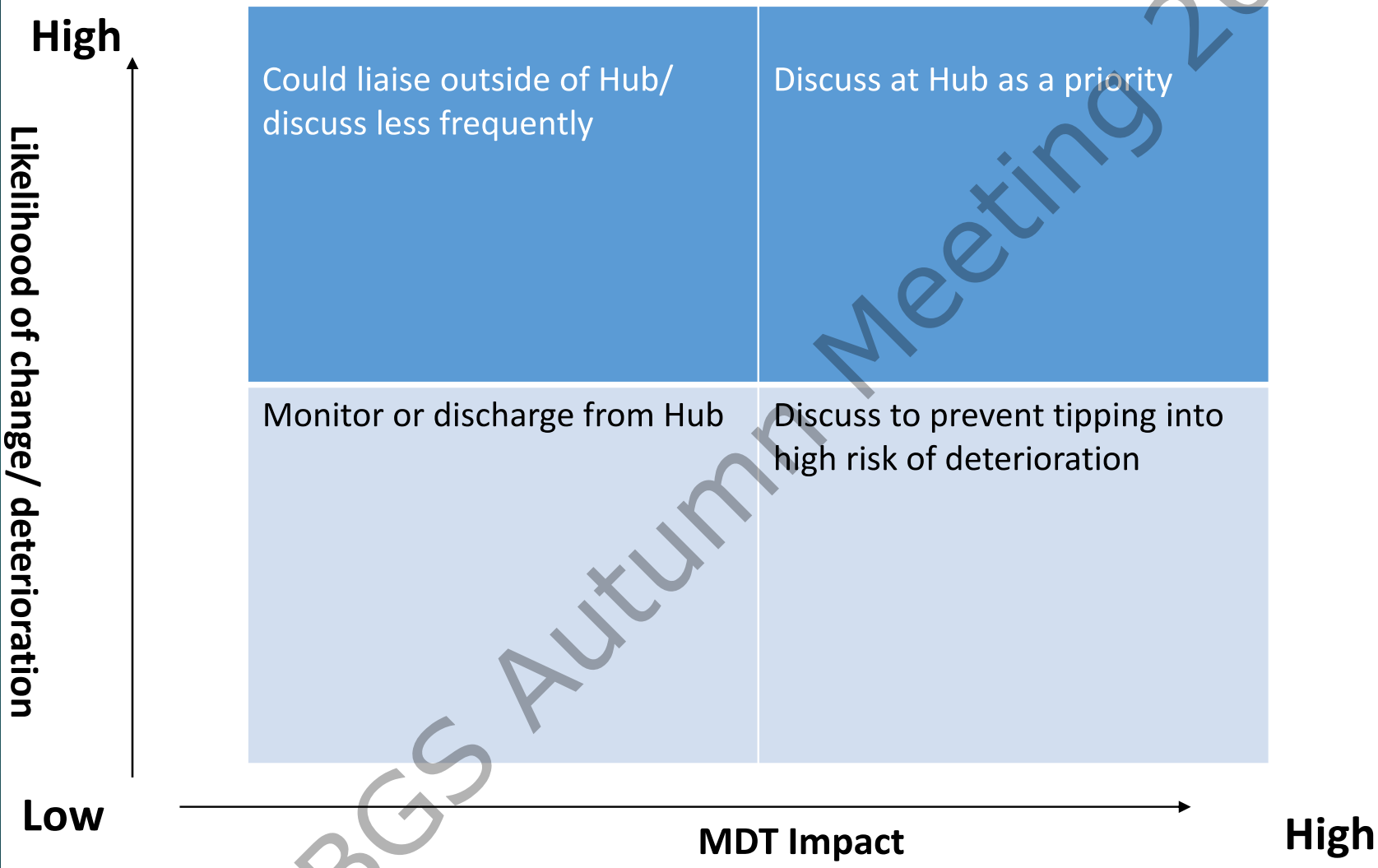
Hub Discussion Matrix



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