

# Multidisciplinary team meetings

Guidance notes on multidisciplinary team meetings to discuss those identified with frailty in the community

October 2019

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# Introduction

## Frailty

Frailty is the manifestation of ageing that is associated with poor outcomes. A person with frailty can experience serious adverse consequences following even a relatively minor illness. Its impact can be very significant in terms of consequent disability or admission to a nursing home. Timely identification of frailty, and targeting with appropriate evidence-based interventions, can help to reduce the likelihood of progression of frailty or poor outcomes and support the long-term management of people's health and wellbeing.

To coordinate interventions that support people identified with frailty, a multidisciplinary team (MDT) approach could be used to ensure timely, holistic individualised care and to agree a plan of action based on intended outcomes for the patient.

However you identify people with frailty, this guide provides suggestions on how an MDT case review meeting could be organised.

## Benefits of an MDT approach

Integrated care requires professionals and practitioners from across different sectors to work together around the needs of people, their families and their communities.

An MDT case review meeting provides an opportunity for a structured conversation about a person who has complex issues, involving a range of practitioners.

Each practitioner brings their knowledge about the person and / or their area of specialist knowledge, to inform and jointly create an action plan.

MDT case review meetings work best when they are well structured, with a clear agenda, membership, roles and responsibilities. Each MDT case review meeting is often different in order to suit the people involved (both those attending and those being discussed). This guidance document provides general suggestions to maximise the value of MDT case review meetings ([1](#), [2](#)).

# Structure of MDT case review meetings

## Suggested Membership

The membership of the multidisciplinary team can be varied and will depend on the context. It is worth thinking ‘who can help’ and inviting as wide a membership as possible. It may be that the team starts small and builds momentum. And of course there is no one size fits all. A high performing team is probably more important than ticking all the boxes. Teams that work well together are those where each member is clear on their roles and responsibilities and where there are clear goals and a supportive environment that allows people to raise concerns safely.

Membership of your team could include:

Practice GPs	Links Workers	Voluntary Sector
Practice Nurses	Pharmacy	Dietitian
District Nurses	Carers Support	Housing
Rehab Team	Social Care Workers	Community Mental Health Team

## Suggested Frequency

It is suggested that MDT case review meetings are scheduled in advance to take place once a month, and ideally be face-to-face meetings where possible ([2](#), [3](#)). Meeting more often is not discouraged but can be hard to sustain. Teams that meet too infrequently will spend a lot of time re-orienting themselves to each other and the processes and may not build traction.

## Identify people to discuss

The purpose of the MDT case review meeting is to discuss those who are considered at risk or who have experienced a change in their situation.

It is therefore important to agree how people will be identified for discussion at your MDT case review meeting. This could include using the e-Frailty Index (eFI) to identify those people whose level of frailty has escalated in recent months. See [appendix A](#) for further details on using the eFI.

Having a process for identifying people for discussion in advance of each MDT can ensure consistency of approach and make the most of the time that professionals have together.

# You may wish to include

## Suggested MDT roles and responsibilities ([2](#), [3](#))

Admin support	<ul style="list-style-type: none"><li>• Receive referrals prior to meeting;</li><li>• send out meeting invites and chase up non-attenders;</li><li>• take notes at meeting and record decisions made.</li><li>• arrange secure storage of notes;</li><li>• keep a record of who attends each MDT case review meeting, who is discussed, all actions agreed by whom and when.</li></ul>
Chair	<ul style="list-style-type: none"><li>• May be clinical or non-clinical MDT member as best fits your context;</li><li>• ask each person to introduce themselves and their role per meeting;</li><li>• ensure the meeting runs to time, yet allows for structured, open discussions and safe challenge;</li><li>• relay any relevant information to the wider team;</li><li>• ensure that any actions given to absent team members are conveyed to them in a timely and clear manner;</li><li>• summarise decisions and ensure they are recorded accurately.</li></ul>
Attendees	<ul style="list-style-type: none"><li>• Refer appropriate people for discussion;</li><li>• attend meetings prepared with the relevant information;</li><li>• participate in discussions actively and constructively;</li><li>• share information and support team members;</li><li>• maintain a person-centred, not organisational, focus;</li><li>• carry out agreed tasks within agreed timeframes;</li><li>• be aware that health and social care is a language of its own, avoid using acronyms and medicalised language, without explanation, plain English is always best.</li></ul>

- Key worker for each case
- Contact the person discussed following the MDT to facilitate further assessment and interventions based on the case review;
  - subsequent discussions with the person to generate a personal frailty and falls plan – documented in line with local procedures and standards, ensuring that the outcomes are shared through the GP summary;
  - responsible for feeding back at subsequent MDT case review meetings.

Note: This role should be agreed on a person by person basis and assigned to the most relevant person at during the MDT case review meeting.

*It may be helpful to create a Memorandum of Understanding to ensure that the different cultures, approaches and resources of each service are treated with dignity and respect.*

## Evaluating your MDT

It may be beneficial to decide how to assess the usefulness of the MDT approach and the impact this has on people with frailty.

This could involve creating a measurement plan and method of evaluation (for example, case review at 6 and 12 months, interventions by type and admissions to hospital).

## Suggested Agenda

Standing items may be introduced to the agenda to support the sharing of information. These may include:

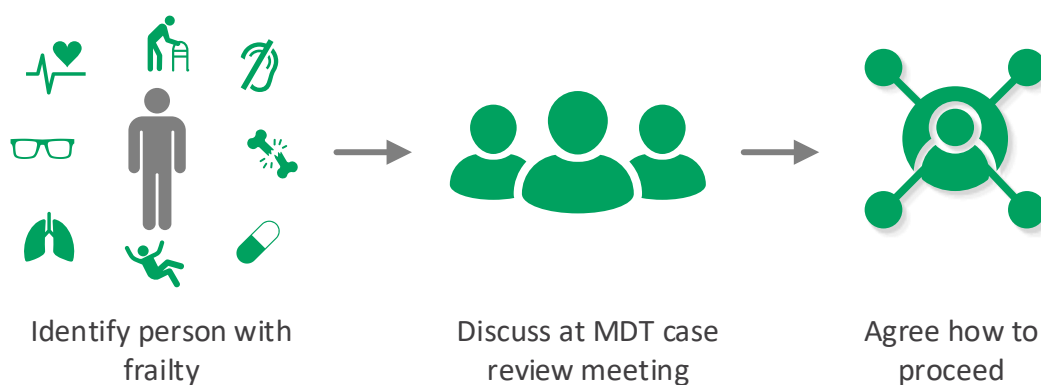
- Welcome and introductions;
- people who have been identified with frailty;
- options for supporting each person and agree individual plan;
- people recently discharged from hospital;
- people with recent Scottish Ambulance Service attendance;
- an update on previous case reviews;
- summary of agreed decisions.

## Suggested responses

As part of the MDT case review meeting the MDT members should agree how to proceed for each person discussed.

For example, the MDT members may want to agree a standard response to people identified with frailty, which ensures both consistency of care and flexibility to adapt to the person's individual needs. An example of a standard response could be to complete the following five key interventions (Frailty 5) for each person discussed:

1. Identify a Key worker who is best placed for each person identified.
2. Conduct a frailty and falls assessment with person identified using the [ihub guide](#) and pursue any relevant outcomes of this.
3. Discuss 'What matters to you?', explore their care wishes and Anticipatory Care Plan (ACP) and upload their ACP to eKIS.
4. Offer carer support and assessment if appropriate.
5. Code for frailty on EMIS or VISION GP system.



# Appendix A – Using the eFI

## What is the e Frailty Index (eFI)?

The [e-Frailty Index](#) (eFI) is a clinically validated tool that can identify people with frailty on a population basis using routinely collected primary care data. The eFI, which uses a cumulative deficit model for frailty, was developed in England using GP data and was validated against a population of over 900,000 people aged 65 years and over.

As individuals interact with GP practices, their records accumulate a list of read codes and community prescriptions. The eFI uses a subset of these read codes to interpret any number of up to 36 potential deficits. The number of deficits that an individual is considered to have is then divided by the total (36) to produce a score.

The score determines whether a person is considered:

- Fit (a score below 0.12)
- Mildly frail (0.12 to 0.24)
- Moderately frail (0.24 to 0.36) or
- Severely frail (0.36 and above).

These categories align with the [Rockwood Clinical Frailty scale](#).

This can be calculated for an individual or for a whole GP practice population.

## Why use the eFI?

Evidence shows that timely identification of frailty followed by appropriate evidence-based interventions, can help to reduce the likelihood of progression of frailty and support the long-term management of people's health and wellbeing.

Unlike other tools that use a person's interactions with services to produce a service perspective of risk, the eFI uses personal information to assess the condition of an individual. This increases the likelihood of identifying people with frailty before they experience a crisis or interact with unplanned services.

## Why use the eFI through SPIRE?

The benefit of using the eFI through SPIRE is that it includes additional reports which enable practices to identify 'high priority' people who have experienced significant change in their frailty risk over a six-month period. The eFI that is available through GP systems such as Vision and EMIS do not include the ability to identify people based on their changing condition. The definitions of change in the Scottish eFI were developed with GP practices following feedback that being presented with total frailty numbers produced too great a list to consider and act on.

Another benefit is that the eFI on SPIRE has been adapted to Scottish coding practices. Following small scale testing in Scotland it was recognised that not all codes were being

picked up. An independent group of GPs from the Scottish Clinical Information Management in Practice reviewed, added and tailored these codes for the Scottish context. As a result, the frailty scores are more thorough, taking into account variation in coding across Scotland. As a result you may notice different results than if you used Vision or EMIS alone

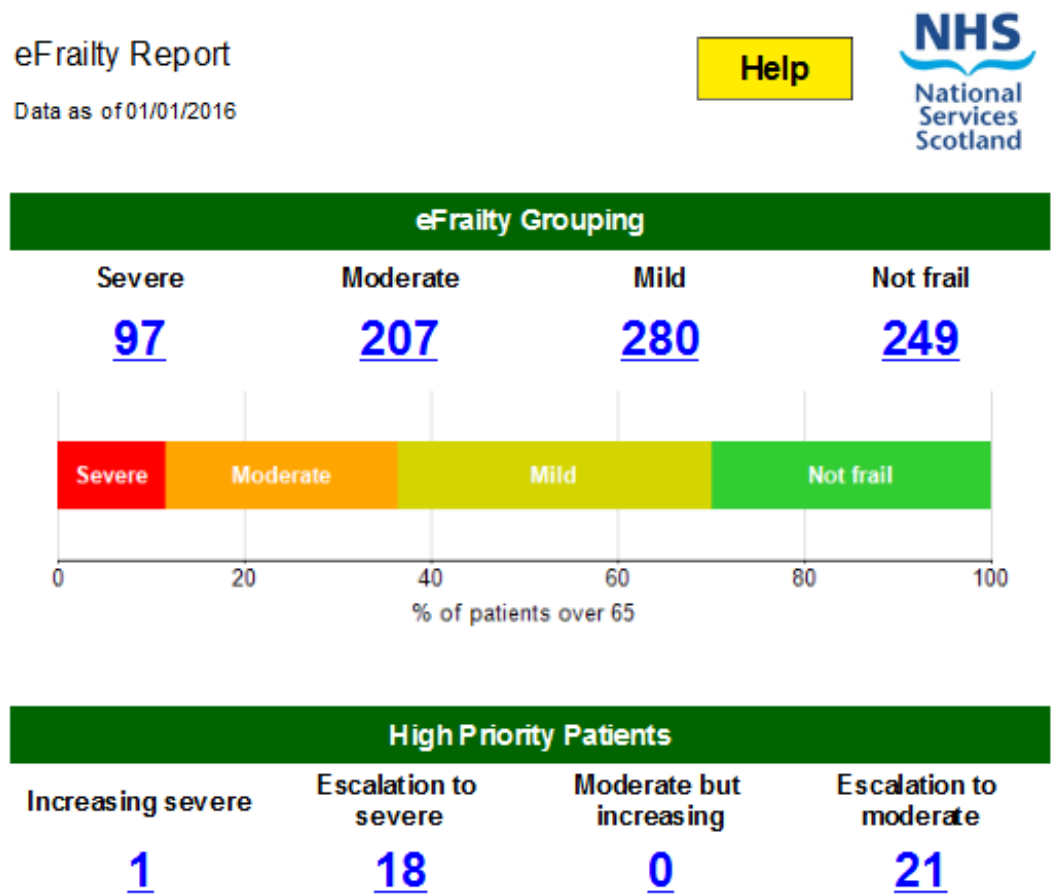
## What will my report show?

The eFI will present a dashboard with options to view your population living with frailty. Those identified are separated into 4 categories: Fit, Mild, Moderate or Severely frail. The dashboard further provides reports on your high priority individuals that have experienced significant change in their level of frailty. The high priority groups include people who:

- escalate to being moderately frail;
- are moderately frail and have experienced significant change; and
- escalate to being severely frail.

Teams can then access individual level data on each patient, allowing health and social care partnerships to make the best use of existing resource in the community by targeting their services to the individuals most at risk.

This is the GP dashboard:



Clicking on the blue numbers provides a list of individuals in each category. As an example, this is a list of individual people who have moved from moderate frailty to severe frailty over the last six months:

#### eFrailty Report

Patient list: Escalation to severe

Data as of 01/01/2016

18 records found

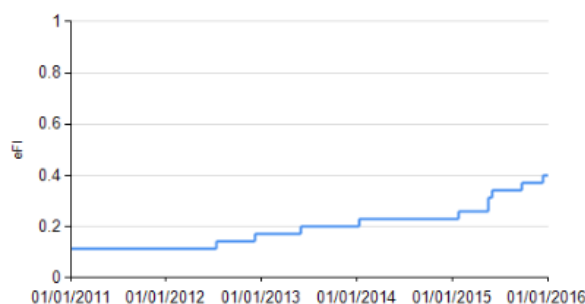
[Help](#)
[Back](#)


CHI Number	Clinical System ID	Surname	Forenames	Age	Gender	Frailty group	Current eFI	Priority group	Change last 6 months
<a href="#">7770005056</a>	ClinicalSystem ID_5056	Sumame_5056	Forenames_5056	76	M	Severe	0.40	Escalation to severe	0.06
<a href="#">7770009965</a>	ClinicalSystem ID_9965	Sumame_9965	Forenames_9965	67	F	Severe	0.40	Escalation to severe	0.06
<a href="#">7770001060</a>	ClinicalSystem ID_1060	Sumame_1060	Forenames_1060	65	M	Severe	0.37	Escalation to severe	0.03
<a href="#">7770001223</a>	ClinicalSystem ID_1223	Sumame_1223	Forenames_1223	68	M	Severe	0.37	Escalation to severe	0.09
<a href="#">7770001824</a>	ClinicalSystem ID_1824	Sumame_1824	Forenames_1824	71	M	Severe	0.37	Escalation to severe	0.06
<a href="#">7770003540</a>	ClinicalSystem ID_3540	Sumame_3540	Forenames_3540	81	M	Severe	0.37	Escalation to severe	0.03
<a href="#">7770005906</a>	ClinicalSystem ID_5906	Sumame_5906	Forenames_5906	77	M	Severe	0.37	Escalation to severe	0.03
<a href="#">7770006842</a>	ClinicalSystem ID_6842	Sumame_6842	Forenames_6842	78	F	Severe	0.37	Escalation to severe	0.03
<a href="#">7770006846</a>	ClinicalSystem ID_6846	Sumame_6846	Forenames_6846	77	F	Severe	0.37	Escalation to severe	0.03
<a href="#">7770008154</a>	ClinicalSystem ID_8154	Sumame_8154	Forenames_8154	83	F	Severe	0.37	Escalation to severe	0.03
<a href="#">7770008189</a>	ClinicalSystem ID_8189	Sumame_8189	Forenames_8189	78	M	Severe	0.37	Escalation to severe	0.03

Selecting a person's CHI number will open an individual person report. For example, the below record shows an individual person's report with the deficits, when they first applied to the individual and a chart to show increase in frailty score over time.

#### eFrailty Report

Data as of 01/01/2016

[Help](#)
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Date	e FI	Deficit
26/05/1992	0.028571	Hypotension/Syncope
26/02/2002	0.057142	Osteoporosis
28/11/2002	0.085714	Ischaemic Heart Disease (CHD)
10/03/2004	0.114285	Hypertension
13/07/2012	0.142857	Fragility Fracture
07/12/2012	0.171428	Respiratory Disease
30/05/2013	0.200000	Arthritis
09/01/2014	0.228571	Housebound
26/01/2015	0.257142	Visual Impairment
21/05/2015	0.314285	Dizziness Falls
03/06/2015	0.342857	Urinary system disease
24/09/2015	0.371428	Foot Problems
17/12/2015	0.400000	Anaemia and haematinic deficiency Deficit

## Suggested Interventions

Patients triggering severe frailty scores on the eFI may be most appropriate for an ACP, a medication review and a diagnostic code of 'Frailty' in their notes.

Patients in the moderate category, or those whose condition has changed most dramatically, may be in need of more responsive and anticipatory support. This support could include a comprehensive geriatric assessment and potentially reablement, medication reviews, carers assessments or referral on to specialty services.

# References

1. Social Care Institute for Excellence. Delivering integrated care: the role of the multidisciplinary team. 2018 [cited; Available from: <https://www.scie.org.uk/integrated-health-social-care/measuring-progress/role-multidisciplinary-team>].
2. Kernow Clinical Commissioning Group. Multi-Disciplinary Team (MDT) meetings: A simple guide. 2014 [cited; Available from: [www.cornwall-link.co.uk/wp-content/uploads/2014/11/MDT-meeting-guidance-final.docx](http://www.cornwall-link.co.uk/wp-content/uploads/2014/11/MDT-meeting-guidance-final.docx)].
3. Dorset Clinical Commissioning Group. Dorset Frailty Toolkit v1. 2017 [cited; Available from: <https://www.clahrc-wessex.nihr.ac.uk/img/casestudies/Tool%20Kits%20JN20857.pdf>].

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