NHS
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Cancer Alliance

Greater Manchester Cancer MDT Meeting Standards

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Introduction

Multidisciplinary Team Meetings (MDTMs) are a well-established aspect of cancer care and have been regarded as gold standard practice since the Calman-Hine report of 1995[1] and the NHS National Cancer Plan in 2000[2]. They are a setting where clinicians can discuss individual cases and formulate individualised patient care plans based on best practice evidence and standards.

Over the past 25 years, there has been little change to the format of MDTMs despite significant changes in cancer care. With the move towards fewer specialist cancer centres with higher case volume, there has been a significant increase in the number of patients discussed at MDTMs. That, coupled with increasing treatment options, more clinical trials, a more complex case mix and an ageing demographic has led to an increased challenge to deliver an effective and succinct MDTM. This results in limited opportunity for clinical teams to have meaningful discussion of more complex cases.

In England some aspects of multidisciplinary team (MDT) working, such as MDT membership and whether protocols for referral and treatment are in place, are assessed through the Quality Surveillance Programme (formally known as the National Cancer Peer Review programme). Critical to the delivery of effective MDTMs however are many other aspects of team-working that are not easily translated into measurable standards but can impact significantly on decision making and quality of care. These include the quality of leadership of the MDT, team dynamics, and the effectiveness of communication between MDT members along with the sharing of contemporaneous relevant information to ensure all options for each patient are considered. Poor quality discussion in MDTMs, particularly those which fail to consider all relevant individualised patient-focussed information, may result in recommendations that are not in the patient's best interest and/or may cause delays in patient treatment[3].

Workforce issues in disciplines that are vital to the delivery of MDT care have magnified the issues with MDTMs, namely radiology, pathology and oncology. Efforts should be made to utilise these limited resources more effectively and efficiently for the benefit of clinicians and patients. Currently mandated cancer clinician attendance levels and a blanket approach to include all cancer cases to MDTMs means there is significant clinician time committed to MDTMs.

A need for significant change to cancer MDT working was first highlighted nationally in 2015 by an Independent Cancer Taskforce[4] then supported by Cancer Research UK in 2017[5] and confirmed by NHS Improvement in 2020[6]. It is agreed that by improving communication and documentation between team members and adopting a more streamlined approach to MDTMs, there is significant potential to release clinician time. This time could then be repurposed elsewhere in patient care. Rationalisation of clinician attendance in combination with pre-MDT triage, careful protocolisation of care for select patient groups and MDT Chair and membership training should improve the quality of discussions taking place for more complex cases and streamline the treatment pathways of other cancer patients.

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The Greater Manchester MDT Reform Project Group has outlined within this document what principles should be central to Cancer MDT working across the Region. The accompanying MDT toolkit gives examples of good practice across Greater Manchester and is a document designed to encourage shared, peer-peer learning. Trust Cancer Leadership teams should be mindful that these principles may require significant changes to clinician job plans as well as the identification of further funded administrative support. Barriers to these changes should be identified and Trust Cancer Leadership Teams should ensure that MDT teams are enabled and supported to introduce the changes need to streamline MDT working, patient pathways and care.

Principles of MDT Meeting Reform

1. There should be a standardised, single point of entry to an MDTM

- A minimum dataset is required for safe MDTM discussion and decision making. The use of a standardised pro-forma that collates this information prior to the meeting should be mandatory so that safe discussion can occur even without the presence of the referring clinician. MDT Coordinators should be empowered to be able to insist on the use of the agreed pro-forma prior to listing a patient on the MDT agenda.

- The minimum dataset will vary dependent on tumour site however most will need to include patient demographics, WHO co-morbidity status and the Rockwood frailty score. The clinical question for the MDT should be clear and any imaging or pathology specimen numbers and dates should be outlined. Any individual holistic needs identified that will impact on treatment choices should be highlighted on the pro-forma to inform MDT discussion.

2. The Greater Manchester developed patient impact statement resource should be utilised to inform MDTM discussions where possible

- Cancer teams have always been aware that the voice of the patient should be central to all MDT discussions, yet this can be unintentionally lost if teams are faced with pressure of time and suboptimal support.

- GM Cancer advocates that all MDTs should work towards ensuring that the patients' individual wants, and needs are placed central to treatment decision making wherever possible and the use of the GM developed patient impact statement resource will help facilitate this.

- This resource will have a different role in different patient pathways and will be relevant for use at different points in a cancer treatment pathway but its importance to patients should be remembered by clinical teams.

3. Safe, clinically protocoled pathways for defined patient groups should be agreed at a national/regional level

- A Standard of Care (SoC) is a point in the pathway of patient management where there is recognised national or regional guideline on the intervention(s) that should be made available to the patient. SoCs should focus on those points in the pathway where there is clear clinical consensus on the treatment or care that a patient should receive.

- SoCs should be reviewed and agreed upon by Cancer Pathway boards at least once every two years or when there is a change to best practice in national or international guidance.

4. Pre-MDT triage meeting

- A Pre-MDT Triage Meeting is an effective way of reducing the number of cases requiring formal MDTM discussion. A single or a small focussed group of suitable clinicians may meet together with an MDT co-ordinator in advance of the MDTM to determine those cases that are to be listed for formal discussion, those who are not yet ready for formal discussion (for example, investigations are unavailable for review or patients need further investigations organising prior to a treatment decision) and those cases suitable for management by protocolisation (SoCs).

- Effective pre-MDT triage means that the number of MDT discussions for each patient is rationalised and patient pathways are more efficient.

- Outcomes from a pre-MDT triage meeting should be clearly communicated to the whole MDT team efficiently and any actions should have a responsible healthcare professional identified and documented.

- Patients should be stratified to either patient on a SoC (no discussion) or Patient requires discussion. All patients should all remain accounted for through inclusion on the MDTM list.

- Regular audit of patient cases not discussed at the main MDT and their outcomes should be undertaken.

5. Responsibility of the communication of outcomes to the patient should be made clear on the MDT outcome

- The person responsible for each MDT action and the person responsible for communicating the outcome to each individual patient should be highlighted in the MDT outcomes.

- Communication with patients may be virtual (telephone or video consultations) or face to face. Where possible patients should be offered the choice of consultation type prior to the MDT, which can be recorded in the patient impact statement.

- Communication of the MDT management plan to the patient should be achieved within 2 working days where possible. Teams should consider how working practices may be altered to ensure patients are informed as soon as possible, in the way in which the patient prefers. Teams should carefully consider whether the person delivering the news has to be a specific clinician or healthcare professional.

- Please consider informing the patient's GP regarding outcomes of the MDT discussion.

6. Audit of MDT Documented Treatment Plan Outcomes compared to Actual Patient Outcomes

- MDT decisions do not always match the outcome of the patient. The concordance of the two outcomes is a measure of the accuracy of the information provided to the MDT and the quality of the discussion and the team-working skills. Teams should ensure that there is evidence of an annual "snap-shot" audit of MDT management outcomes compared to the actual outcomes of the patient discussed. Any discrepancy may inform team learning and reflection.

- Recording of stage at diagnosis as per National standard.

7. MDTM attendance and quoracy requirements

- The national requirement is now for individual scheduled treatment planning MDTMs to be quorate on 95% or more occasions. **There is no longer a requirement for a minimum attendance by individual members[6].** This gives teams more flexibility with the number of clinicians who need to be present at each meeting and means that clinical expertise can be streamlined and utilised in other parts of patient care. This should enable each individual MDT to re-organise their clinical time to develop the changes outlined above. Core membership is different for each tumour group but is outlined and regularly updated in UK cancer guidance.

8. Communication of outcomes of the MDT discussion to the referring clinician should be performed within one working day

- The MDT coordinator should ensure outcomes from pre-MDT triage and MDT discussions are distributed to all referring clinicians within 1 working day of the main MDT meeting.

9. MDT Chair Leadership Training and team working skills

- GM Cancer recognises that there is an opportunity to offer a training scheme for all MDT chairs to improve and hone their chairing skills. There is a regional aim to work towards a standardised job description for all MDTM chairs.

- Remote MDTMs can be a useful tool in modern practice but can also lead to some team members contributing to discussion less often than they would if the meeting were face to face. A “cameras on” policy can be helpful to manage these complexities and MDT chair training should include some specific approaches to these unique remote meeting challenges.

- The importance of effective leadership and chairing cannot be over-estimated. Chairs should ensure they manage discussions to ensure all team members are able to contribute to treatment decisions and that the holistic needs of the patient are considered.

- Where possible the MDT Chair should guide discussions to highlight any relevant clinical trials to offer to the patient.

- Other team members may benefit from opportunities for peer-peer learning on how to present cases effectively and succinctly to allow a fully informed yet efficient MDTM discussion. Such learning should be encouraged and facilitated by Trusts.

10. Biannual Learning and reflection

- Teams should ensure quarterly reflection on any mortalities as well as any learning from specific complex cases

- Any new national or regional guidelines should be highlighted to the team and any local guidance updated accordingly

- MDTs should ensure an audit of outcomes a minimum of twice a year for patients on SoC pathways and highlight where patients have been managed inappropriately on one of these pathways and investigate how this can be avoided in the future.

References

1. A policy framework for commissioning cancer services: A report by the Expert Advisory Group on Cancer to the Chief Medical Officers of England and Wales (The Calman-Hine Report) April 1995
2. The NHS Cancer plan: a plan for investment, a plan for reform. Department of Health, September 2000
3. Goolam-Hoosen T, Metcalfe C, Cameron A, et al. Waiting times for cancer treatment: the impact of multidisciplinary team meetings. Behaviour & Information Technology 2004; 30: 467-471.
4. Independent Cancer Taskforce. 2015 Achieving World-Class Cancer Outcomes: A Strategy for England 2015-2020.
5. Meeting patients' needs improving the effectiveness of multidisciplinary team meetings in cancer services CRUK 2017.
6. Streamlining MDTM Meetings – Guidance for cancer alliances. NHS England and NHS Improvement 2020.