NHS
Greater Manchester
Cancer Alliance

Greater Manchester Cancer MDT Reform Project

Project Evaluation Report

Document Title	Multi-Disciplinary Team Reform Project
Version:	3.0
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1.0 Executive summary

- The following project has shown the importance of MDT reform within cancer pathways to streamline patient pathways, increase workforce efficiency and align with current National guidance around MDT best practice
- Despite the impact of Covid-19 throughout the lifespan of this project, reform objectives have been achieved within cancer pathways along with cross-cutting workstreams to achieve reform on a system wide level
- Co-produced patient resources have been developed in response to patient feedback. An Infographic and animation have been developed to increase accessibility and translated into Urdu
- A patient impact statement has been successfully implemented to formalise how the patient voice is captured
- New standards of care pathways have been developed and piloted within pre-MDT triage meetings
- Standardised referral routes into MDT meetings have been established to streamline referrals and ensure a minimum data set is available to inform good quality discussions
- A successful MDT Reform Summit was held and attended by 80 stakeholders, which showcased the outcomes of the project and raised awareness of reform within cancer services; 95% of respondents (n=21) said the GM MDT Standards and MDT toolkit would be useful in the future to support MDT reform
- The GM Cancer Alliance supports this work and further initiation of MDT reform with dedicated resources and examples of best practice. Regional agreement and buy in for the new GM MDT Standards and an accompanying toolkit will support sustainability of ongoing reform
- MDT Leadership Coaching Programme was successfully piloted across 3 sites and 88% of attendees would recommend the training to others
- Since project end, reform has continued across several pathways and is now embedded in the work of the Cancer Pathway Boards

2.0 Introduction

This report summarises progress achieved through the Greater Manchester MDT Reform Project and next steps to ensure reform continues to be a priority area for Greater Manchester (GM) cancer services.

2.1 National and local context

Multidisciplinary team meetings (MDTMs) were introduced in the late 1990s and early 2000s. Their purpose was to increase evidence-based practice and prevent implementation of treatments outside of accepted standards. MDTMs are considered the gold standard for cancer patient management and mandated by the National Cancer Plan in 2000; with the pledge all patients with cancer have their care reviewed by a quorate multidisciplinary team.

An MDTM typically comprises of a variety of healthcare professionals involved in treating and caring for patients, including, Clinicians, Physicians, Oncologists, Surgeons, Nurses, Diagnosticians, AHPs, and MDT Coordinators. MDTMs usually occur on a weekly basis to discuss individual patient cases and make treatment recommendations.

Health services have changed significantly since the introduction of MDTMs in 1995. These meetings have come under increasing pressure due to:

- Significant increases in caseload
- A change in case-mix including: a high number of patients with comorbidities due to an ageing population, and an increasing number of complex treatment options
- This increase in numbers/complexity of cases to be discussed has not been matched by any increase in time set aside for the MDT
- Some MDTMs are poorly attended by members due to competing clinical pressures. There are also issues relating to consistent, reliable information technology, data collection and infrastructure such as videoconferencing
- The necessary information regarding the patient and their clinical diagnosis/diagnostic results is not always available to the MDT resulting in a delay in decision-making
- MDTMs require adequate preparation, effective, inclusive chairing proactively involving all MDT members to ensure appropriate discussion of the case, and the ability of the chair to encapsulate the discussion into a clear outcome
- There is evidence that there is a wide variation in MDT leadership, which can impact on the efficiency and inclusivity of MDTMs

3.0 Project Background & Methodologies

3.1 Project background

Several key papers have been published in recent years providing a strong case for change to the original MDT meeting model, these include Martin Gore's 2017 report on 'Transforming Multidisciplinary Teams', CRUK's 2017 report on 'Improving the effectiveness of MDT meetings in Cancer Services', and most recently in January 2020 the NHSE/I report on 'Streamlining Multidisciplinary Team Meetings'.

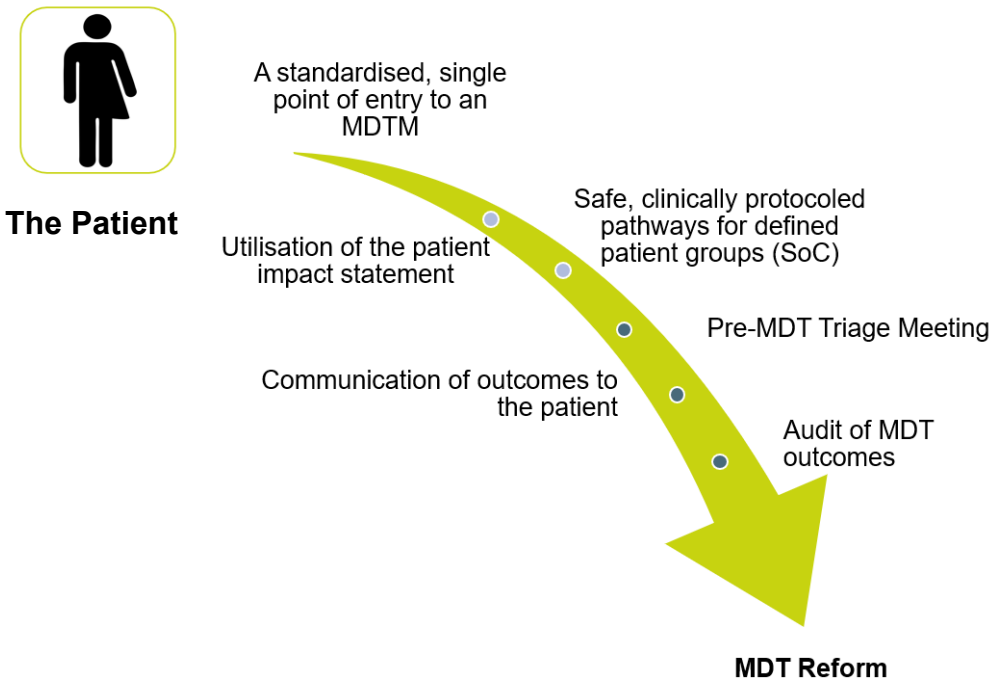
Despite this evidence, reform has been variable and slow in GM, however, the COVID-19 pandemic enabled rapid changes to occur. To capitalise on these changes the Alliance focused resources into a project team and dedicated Clinical Lead to support MDT Reform across all cancer pathways, commencing in June 2020. The Clinical Lead and project team worked closely with pathway Clinical Lead's and healthcare professionals to ensure that reform is part of the pathway's long-term objectives to deliver the following benefits:

- Improving the effectiveness of cancer MDTM's across GM and East Cheshire (EC), ensuring streamlined processes and standards of care pathways are developed and implemented to make the best use of clinical time and resources
- Improving patient outcomes through robust auditing processes
- Improved effectiveness of the time all members of the MDT, in particular Radiologists and Pathologists, spend on MDTs
- Improved data collection
- Specialism attendance will be assured, allowing for comprehensive discussion and decision making, including access and suitability for clinical trials

3.2 Methodologies

The overall approach to the project was pathway specific as each cancer pathway works differently across the network and was at different stages of reform. A baseline mapping exercise and anonymous qualitative survey was conducted to understand the cancer MDT landscape across all Trusts and to identify specific pain points. This data included information such as frequency of MDTMs, a breakdown of local, sectorised and centralised formats, active participation, the method of communicating the MDT outcome to patients, referral routes, plus many more variables.

The data collated helped to identify the following opportunities for change:



The survey received 258 respondents across all cancer pathways and highlighted areas of improvement from the MDT members' perspective. This alongside the quantitative results were presented to pathway boards.

Please find the full report here: MDT-Survey-Results-ALL.pdf (gmcancer.org.uk)

The project team chose to approach reform in two waves as shown below. Wave 1 pathways had expressed an interest in exploring reform or were already making progress / had plans in place. Learning and progress made with wave 1 pathways could then be shared with the second wave of pathways (some of which had

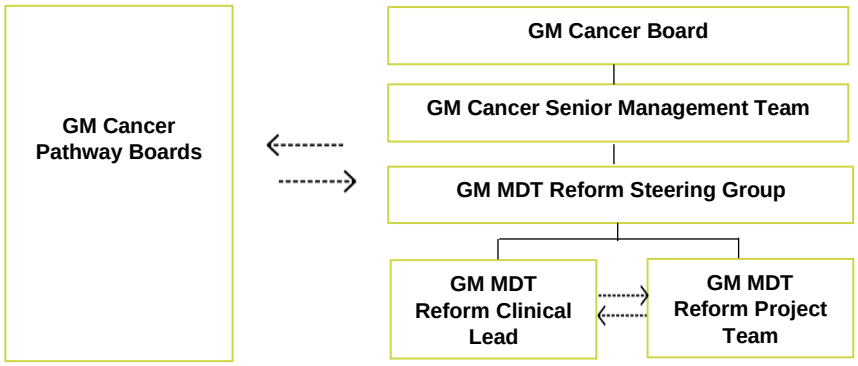
progressed reform previously and therefore were not considered a priority e.g. Lung and haematology):

Wave 1	Wave 2
Breast	Urology
Acute Oncology	Skin
Oesophageal (OG)	SPC
Sarcoma	Lung
Head and neck - Thyroid	Colorectal
Hepato Pancreatico Biliary (HPB)	Brain and CNS
Gynaecology	Haematology

Once the baseline data was presented to the relevant board, an MDT Lead / point of contact was nominated in addition to requesting members to join task and finish group where possible. A further meeting was arranged with the Clinical Lead / Pathway Board Director to identify objectives to be achieved within the agreed timeframe. The task and finish groups were then established to drive forward delivery of the objectives.

A steering group was established to provide project oversight and agree outcome measures to assess impact and to support the sustainability of reform.

Below is the governance and reporting structure implemented for the lifespan of this project.



Progress was relatively slow for wave 1 pathways due to the pandemic and added pressures on the workforce, so the approach was adapted for wave 2 pathways with the project team reduced the number of objectives for wave 2 pathways, focusing in the main on delivering NHSE streamlining guidance as this would have the greatest impact. Other additional objectives would be piloted on a smaller scale rather than across all trusts.

To ensure completed objectives were implemented into each pathway, sign off was required by the pathway board to provide the project with a robust governance process and ensuring effective communication and engagement.

Below is a high-level view of the approach taken with each cancer pathway to achieve identified areas of reform.

Keeping patients at the heart of the reform project was critical to its success. The project team engaged with the GM Cancer User Involvement community at project initiation and it became very clear how important and anxiety-inducing the MDT process is for patients. It also became clear how little patients knew about the functionality of an MDTM and how critical communication is to minimise the impact on mental health. This became a core objective of the project and the project team worked with user involvement representatives throughout the project.

The steering group and each task and finish group had a user involvement representative as a core member.

4.0 Delivering Measured Outcomes

The user involvement representatives suggested several resources to compliment this work and to ensure the patient remains central to any reform, these are presented below.

4.1 Patient Resources

To publicise the project and engage the right stakeholders, a short video was created to encapsulate “hearts and minds” and the importance of MDT reform for patients. Click the video below or visit the website to view this resource.

The project team worked with our user involvement community to co-produce a patient infographic and animation to help empower and improve patient’s understanding of MDTs. Click on the videos below:

All resources are also available to download via the GM Cancer Alliance website.

4.2 Snapshot of objectives by cancer pathway

The below table displays agreed objectives achieved or in progress by each cancer pathway across GM.

The following subsections detail the approach taken to achieve each objective with an example of best practice from a cancer pathway. Please note that Acute Oncology and Breast were two of the first pathways to be established and so allowed for timely data collection to show initial impact on the changes made. These pathways feature as examples of best practice given the pilot outcomes and supporting quantitative data.

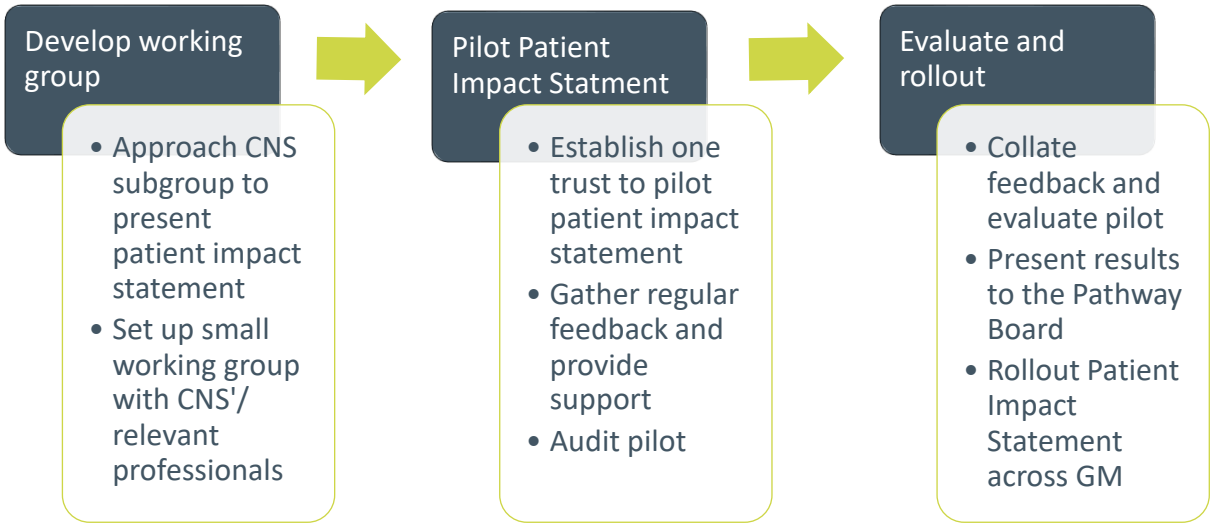
Pathways	Standardised Referral Form	Standards of Care	Pre-MDT Triage	Patient Impact Statement	Communication of outcomes to the patient	Cross-cutting activity
Acute oncology	✓			✓	✓	Auditing capabilities Review of the CUP MDT model
Breast	✓	✓	✓	✓	✓	
Sarcoma						
OG	✓	✓	✓		✓	
Thyroid			✓			
HPB				✓		
Gynae	✓					
Lung	✓	✓		✓		MDT lung charter
Urology				✓		
Skin		✓				
SPC				✓		
Colorectal	✓					
Haematology				✓		
Brain and CNS						

4.3 Capturing the patient voice

Principle: ***The patient impact statement should be utilised to inform MDT discussions where possible***

Patient impact statement was developed as part of the gynaecology pathway MDT reform work; co-produced with service users. It formalises how patient's wishes are considered during MDT meetings.

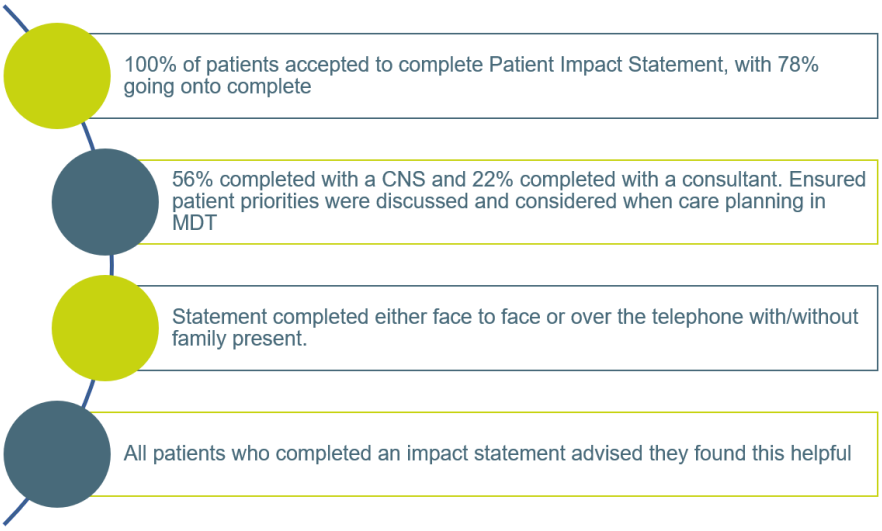
This is being rolled out across all pathways and the statement supports the patient in being part of their care planning process, reflecting what is important to them to bring their voice into the MDTM.



Example of best practice: Acute Oncology

The Acute Oncology pathway was the first to adopt the patient impact statement into MDT meetings. The task and finish group saw the value in a process to reflect patient wishes and priorities in the MDT meeting to aid teams with early planning stages.

This resource was piloted initially at Wythenshawe and Leighton and then implemented within all Trusts. An implementation audit was conducted, and results were as below.



The task and finish group reflected the benefit of offering the patient impact statement in conjunction with a Holistic Needs Assessment. When auditing the implementation of the patient impact statement, the need for the resource was reflected in 39% of patients referred had psycho-social needs that required consideration.

The Acute Oncology Pathway Board will now take ownership of sustaining utilisation of the patient impact statement.

Download the 'Patient Impact Statement' template here: [Patient-impact-Statement-Template.pdf (gmcancer.org.uk)]

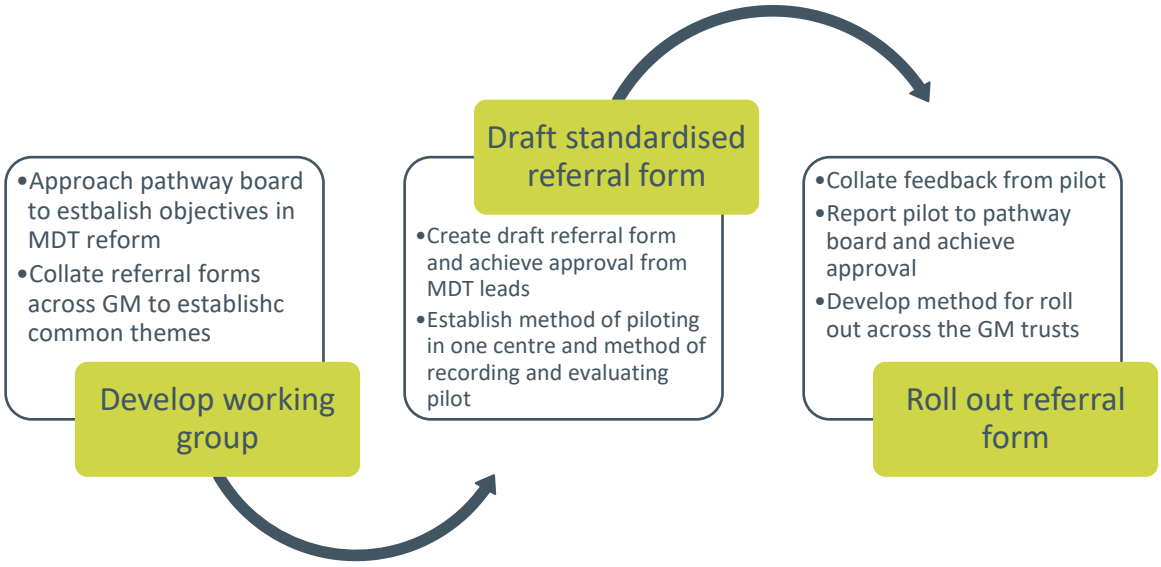
4.4 A standardised, single point of entry to an MDT meeting

Principle: *Ensuring the minimum dataset required for safe MDTM discussion and decision making through a standardised proforma*

Standardising referral forms to include a minimum data set needed for an informed MDT discussion aids with efficiency within the MDT. Each tumour group has different requirements but there are some commonalities such as patient co-morbidities, WHO performance, investigations that require review and psychosocial needs.

The baseline mapping exercise highlighted that most, if not all, pathways were not using a standardised approach to referring patients into MDTMs. Where referral forms existed, variation was identified. The process below was adopted to

standardised the referral route into the acute oncology, breast and lung pathways.



Example of best practice: Acute Oncology Pathway

Prior to reform, the Cancer of Unknown Primary (CUP) MDTM within the acute oncology pathway lacked standardisation with varied methods of referral including proformas, email, letters, and verbal referrals. Working with a dedicated MDT reform lead and an established task and finish group, the project team collated the existing referral forms across GM to define the essential information required to inform an effective patient discussion.

As part of the minimum data set, task & finish group members felt it important to include whether the patient had been offered a Holistic Needs Assessment and Patient Impact Statement to ensure holistic patient care is provided. Also included on the form was a section indicating whether the patient was aware of a suspected cancer diagnosis. This information allowed the team to plan further investigations and communication sensitively and appropriately.

This resource was implemented within the Acute Oncology pathway for a 6-week period initially and an implementation audit was conducted. Referring teams included: ward teams, A&E, General Medicine, Colorectal & Upper GI, MSCC Co-ordinator, a GP and a Christie Consultant. 83% of the patients referred were appropriate for discussion at the CUP/MUO MDT. 77% of the patients referred were aware of a suspected cancer/diagnosis and 39% of patients referred had psycho-social needs that required consideration.

Following the initial implementation, the standardised referral form was approved by the Acute Oncology Pathway Board for continued use and Trusts uploaded the revised version to IT platforms as appropriate.

The Acute Oncology Pathway Board will now take ownership of sustaining the reformed referral process.

View examples of standardised referral forms produced here:

MUO-CUP-.pdf (gmcancer.org.uk)

Lung-Condensed-version.pdf (gmcancer.org.uk)

4.5 Standards of care pathways

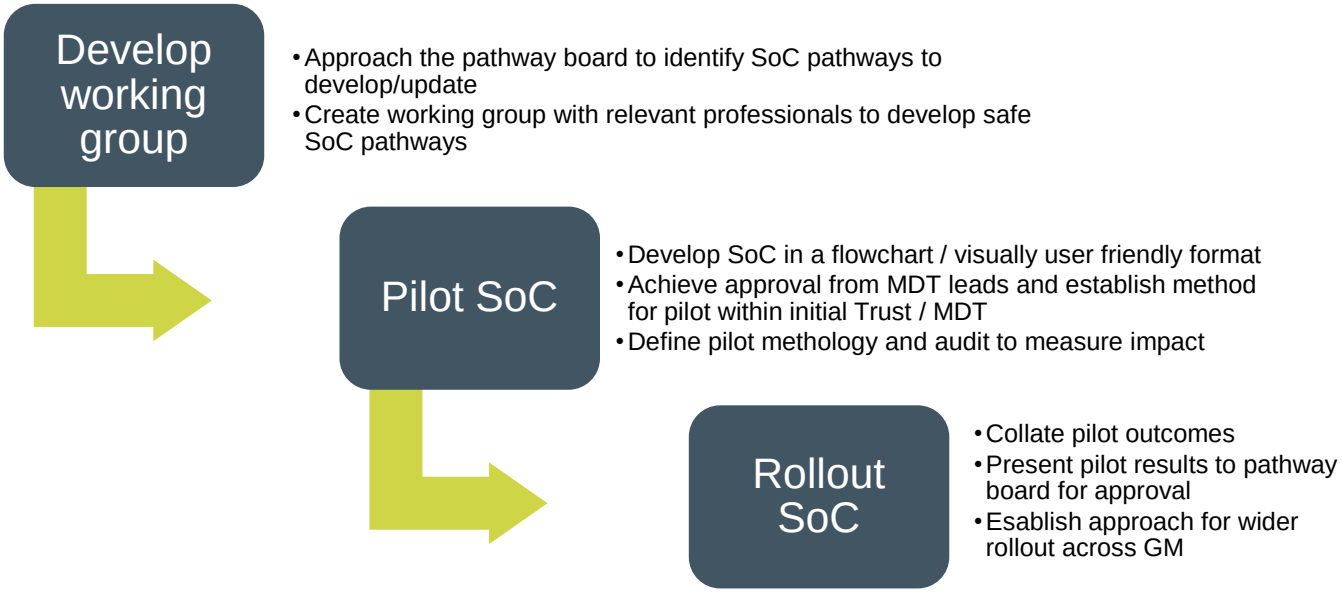
Principle: ***Safe, clinically protocoled pathways for defined patient groups should be agreed at a National/Regional level***

Standards of care (SoC) can be used within tumour sites with well-established pre-defined treatment pathways, where there is clear consensus and where a patient may not require a full discussion. SoC can be used in a pre-triage meeting where effective care planning can take place without the need for discussion within the main MDT.

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

As seen with other cancer pathways, there was variability between each tumour group with some pathways already having developed SoC, although often not in use, and other pathways with no standards developed.

Below is the process the project team followed to work with pathways to support the development or improvement of SoC.

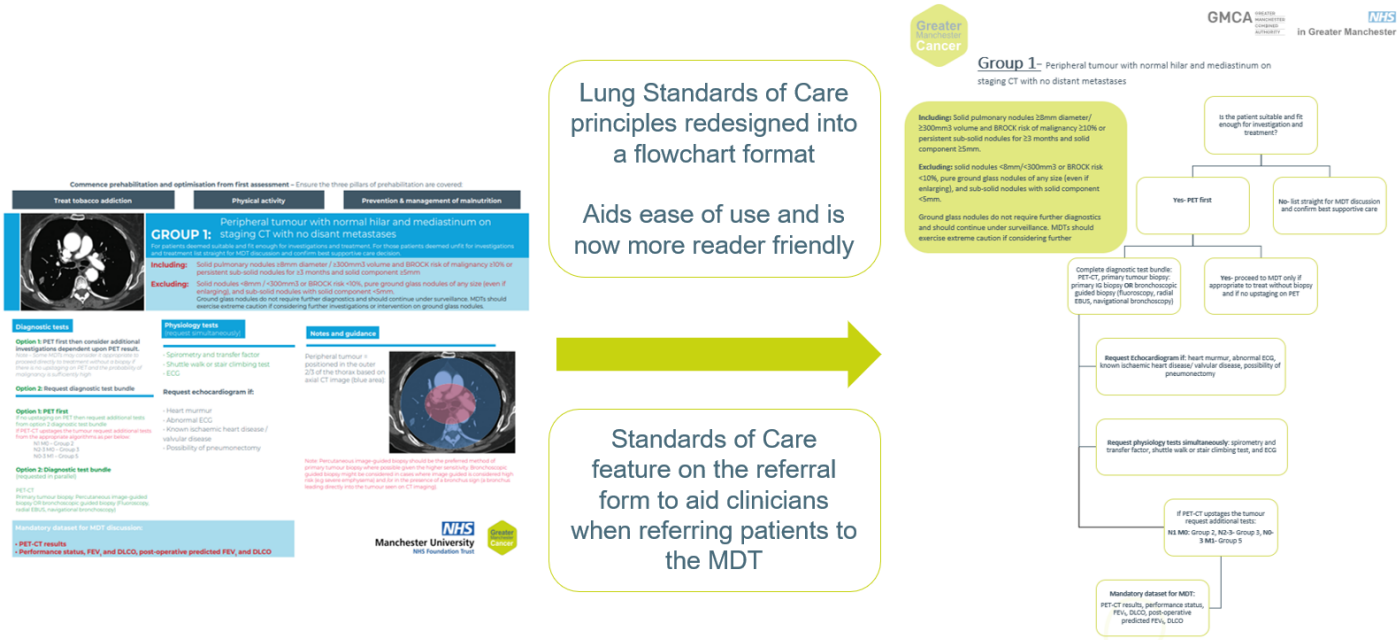


Example of best practice: Lung Pathway

Working with a dedicated MDT Reform Lead for the lung pathway, an objective identified was to update the existing Standards of Care (SoC) already developed and cited in the pathway's Standards Operating Procedure (SOP Primary Lung Cancer 2020). Feedback suggested that the SoC pathways were not user friendly and complicated to group patients into, and therefore had not been fully implemented across GM. To improve useability and enhance the protocolisation of patient cases, the SoC were developed into a flowchart format.

The updated SoC pathways were then embedded within the standardised referral form, which allows the referring clinician to outline if a patient meets the agreed criteria in order to be placed on a SOC pathway, therefore streamlining the referral process and reducing the number of patients needing full discussion.

Both the standardised referral form and SoC were approved by the dedicated MDT reform lead and presented to the Lung Pathway Board where the board will now take ownership of facilitating system wide implementation.



View further examples of Standards of Care Protocols on the website: [MDT Reform - Greater Manchester Cancer (gmcancer.org.uk)]

4.6 Pre-MDT Triage Meetings

Pre-Triage meetings support MDT reform to effectively streamline MDT meetings by way of reducing the number of cases requiring formal MDT discussion. The pathway board agrees who should be involved in the pre-triage meeting, which could be a single clinician or a small, focussed group of suitable clinicians, meeting together with an MDT coordinator in advance of the MDT. This meeting is to determine those cases that are to be listed for formal discussion, those who are not yet ready for formal discussion and those cases suitable for management by protocolisation using SoC pathways.

Outcomes from a pre-MDT triage meeting should be clearly and efficiently communicated to all MDT members and any actions should have a responsible healthcare professional identified and documented. Below is the process by which the project team took to work with pathways to support the development of pre-MDT triage meetings.

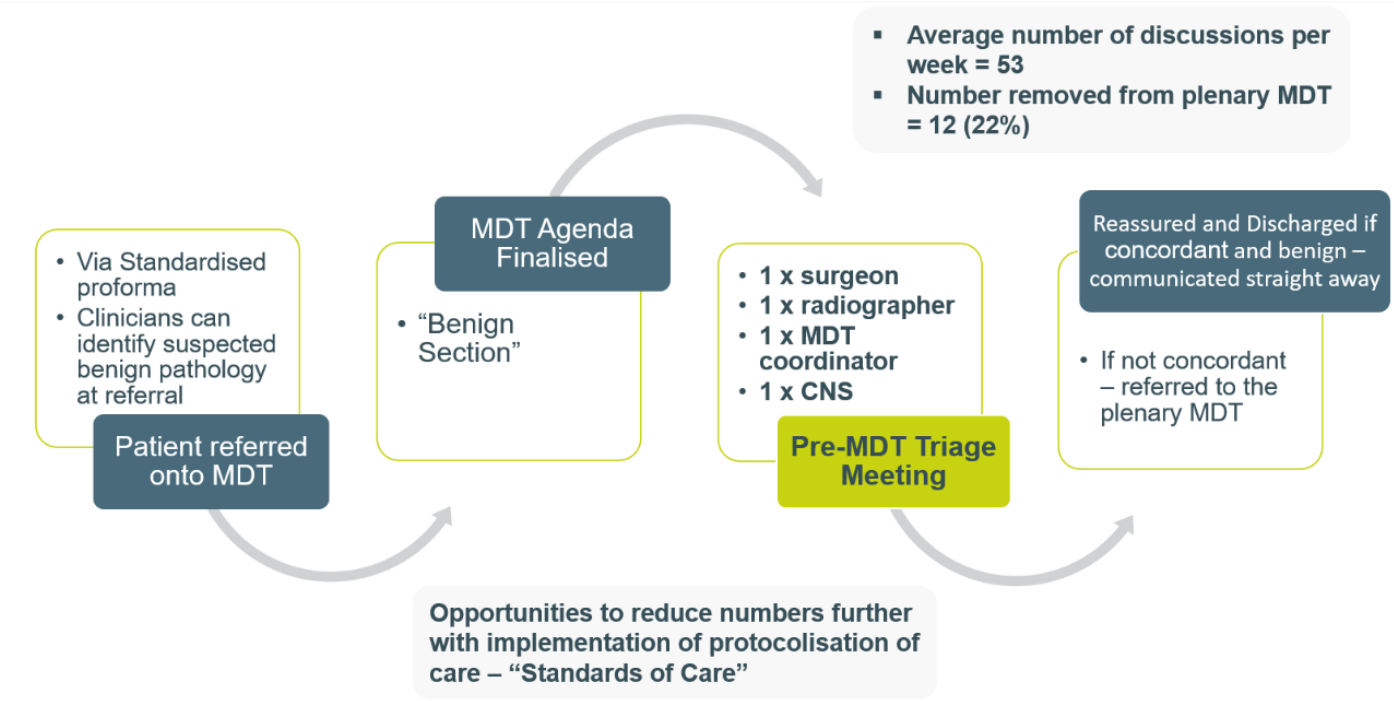
Identify Appropriate Pathways	Develop remit of pre-MDT Triage	Pilot pre-MDT Triage
☐ Project team identified pathways with well-established pre-defined treatment pathways, where a patient may not require a full discussion	☐ Establish an MDT Lead / small working group for pathway to define patient groups with clear treatment pathways or benign disease, and do not require a full discussion ☐ Establish membership and remit of a pre-MDT triage meeting where effective care planning can take place and streamline the number of patients requiring a full MDT discussion ☐ Achieve approval from MDT leads and establish method for pilot within initial Trust / MDT	☐ Define pilot methology and audit to measure impact ☐ Collate pilot outcomes ☐ Present pilot results to pathway board for approval ☐ Esablish approach for wider rollout across GM

Example of best practice: Breast

The established breast task and finish group identified an opportunity to utilise a pre-MDT triage process to streamline MDT working. With increasing referrals and a lengthy MDT, the pre-MDT triage offered a process whereby patient cases are reviewed for suitability prior to the MDT meeting to streamline patient pathways and increase workforce efficiency. In the first instance, the focus of the pre-MDT triage was to identify patients suspected of benign disease who do not require a full MDT discussion and can be removed from the MDT agenda. Following confirmed benign diagnosis by the reporting Pathologist, a small triage group including a Surgeon, Radiographer, MDT Co-ordinator, and a CNS meet prior to the MDT to remove benign patients and agree the outcome.

The pre-MDT triage process was trialled at North Manchester and presented to the Breast Pathway Board.

It is anticipated that larger numbers of patients could be removed at other Trusts, for example, the screening units such as Wythenshawe. The board will now take ownership of facilitating wider roll out to additional Trusts along with incorporating standards of care pathways into the triage process.



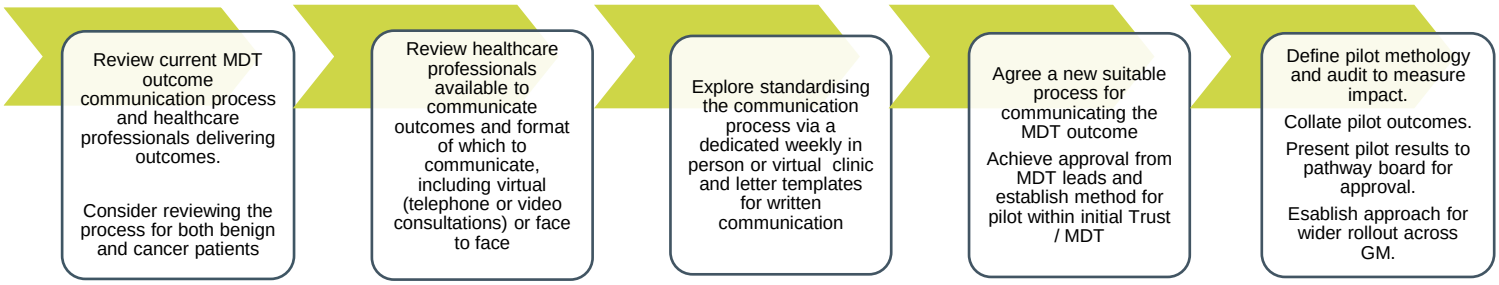
See the pre-MDT triage process adopted by the OG Pathway here: [OG-Pathway.pdf (gmcancer.org.uk)]

4.7 Communication of outcomes to the patient

Principle: ***Responsibility of the communication of outcomes to the patient should be made clear on the MDT outcome***

Standardised outcome communication reduces the time patients wait to be informed of the MDT outcome. As outlined earlier, this was the most important objective for improving patient experience and reducing anxiety. Baseline data suggested communication of outcomes could take up to 2 weeks post MDT for some pathways, which significantly impacts on patient's mental health. The project team worked with clinicians and proposed the ambitious yet achievable aim of communication of the MDT management plan to the patient within 2 working days where possible and a focus on re-thinking team working practices to achieve this, which could include telephone clinics led by CNS' rather than waiting for a letter or clinic appointment.

Below is the process the project team took to support pathways to reform the MDT outcome communication process. The patient impact statement also formalises patient's communication preferences.



Example of best practice: Breast Pathway

Working with the established breast task and finish group, an identified objective for reform was the communication of the MDT outcome to patients, particularly for patients with benign disease. The process prior to reform meant that patients were waiting extended periods to be informed of the outcome with communication performed by various team members in a variety of different ways. The task and finish group worked to restructure this process and establish a dedicated telephone clinic to effectively communicate the MDT outcome to benign patients. Having Advanced Nursing Practice (ANPs) taken on this role has alleviated workload from Surgeons and Consultants who can then support patients with a diagnosis of cancer.

PREVIOUS PRACTICE

- Surgeons / CNS' / Consultants took on all active cases as capacity allowed
- 63% of benign patients received a letter within a mean time of 14 working days

FOLLOWING REFORM

- ANPs take on all benign cases and radiology take on all screening cases
- Benight patients receive the outcome within 24 hours of MDT discussion via a pre-arranged telephone call
- More effective use of the workforce
- Improved auditing functions to collate data and evidence workload and capacity of nursing workforce

This reformed communication process and outcomes of the pilot at Bolton and North Manchester were presented to the Breast Pathway Board where the board will now take ownership of facilitating wider roll out to additional Trusts.

Visit the website for more information: MDT Reform - Greater Manchester Cancer (gmcancer.org.uk)

4.8 Audit of MDT Outcomes and an opportunity for learning and reflection

Principle: *Continuous improvement through the audit of 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 (including capturing patient's wishes), the quality of the discussion, and the effectiveness of working as a multidisciplinary team. 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, along with a twice-yearly review of mortality and learning from complex cases. Any discrepancy may inform team learning and reflection with a focus on reviewing any mortalities and specific complex cases. New national or regional guidelines should be highlighted to the team and any local guidance updated accordingly to support this auditing process.

Example of best practice: Acute Oncology

During the lifespan of the Acute Oncology task & finish group, the CUP auditing processes at Bolton and Wigan were highlighted as areas of good practice with evidence of an annual review to audit the quality of the service and to prove to the Trust that the MDT is well functioning. This audit demonstrated the importance of capturing the workload of the acute oncology workforce, as not all patients referred to the MDT are accepted, but advice and support is given in timely fashion. It is an opportunity to audit the mutual working between departments and to showcase patient advocacy and empowerment of the nursing workforce.

Find audit templates on the website: MDT Reform - Greater Manchester Cancer (gmcancer.org.uk)

5.0 Cross Cutting Workstreams

5.1 GM MDT Leadership Coaching Programme

MDT chairs are responsible for effective leadership, managing discussions to ensure inclusive contributions to treatment decisions and holistic patient care, and guide discussions to highlight any relevant clinical trials to offer to the patient. The need for effective, standardised MDT Chair training was highlighted in the anonymous survey conducted at baseline. Out of the 258 responses received, only 31% advised MDTs are well organised and structured meetings, with adequate preparation beforehand and only 21% advised MDTs include collaborative, respectful and efficient discussions.

To address variation and support standardisation across all cancer MDTs a comprehensive MDT Leadership Coaching Programme has been developed in collaboration with the Organisational Development Team at Manchester Foundation Trust (MFT) for all MDT Chairs and Leads. The training was piloted across three GM Trusts, led by trust Organisational Development leads. To maximise capacity training was not site specific and open to workforce across different sites. In total 21 delegates attended from 6 Trusts. Delegates mainly consisted of Consultants, however, there was 1 x Lead Nurse, 1 x Fellow, 1 x Specialty Doctor, and 1 x Deputy Performance Manager. Of those who attended 81% completed the feedback survey:

- 88% rated the training as good or excellent
- 88% stated that they would recommend this training course, particularly benefiting from the content, delivery, and interactive nature of the coaching
- 76% of delegates agreed or strongly agreed that the coaching covered the right elements of leadership, at the right level for them
- When asked, ‘What did you learn that will influence your practice/patient care?’, common themes included, importance of being an enthusiastic and diplomatic lead with clear expectations, useful tips to manage situations and increase inclusive participation along with considering the variation of behaviour that comes with an MDT meeting.

5.2 GM System Wide IT MDT platform

One of the key enablers for reform identified through the anonymous survey was the need for a single MDT platform for all tumour groups across all of GM to aid meeting preparation and discussion. This project offered an opportunity to start conversations with Chief Informatic Officers across GM, and to explore a system wide procurement exercise to fulfil this objective.

6.0 Supporting further MDT Reform

6.1 Sustainability

Due to clinical pressures and competing priorities impacting on progressing reform through pathway boards, the project team increased engagement with Lead Cancer Clinicians across GM to discuss how best to enable reform to progress and continue beyond the lifespan of the project. It was agreed to develop Regional MDT Meeting Standards to outline what principles should be central to cancer MDT working across the region.

The GM MDT Standards were developed by the project Clinical Lead and ratified by the MDT Reform Steering Group, Trust Cancer Clinical Leads and the Alliance Senior Management Team. They consist of 10 principles which align to the objectives achieved in the project and to national guidance.

The GM MDT Standards can be downloaded here - V2.1-GM-MDT-Standards-April-23.pdf (gmcancer.org.uk)

To support the implementation of the standards, an interactive MDT Reform Toolkit has been produced with examples of best clinical practice to provide pathways with effective methodologies to achieve reform. The toolkit format and content were ratified at a one-off workshop attended by Clinicians, Cancer Clinical Leads, Lead Cancer Nurses, CNS' and MDT Co-ordinators.

Find the supporting toolkit here - MDT Toolkit (gmcancer.org.uk)

To ensure sustainability of reform, the project team have worked with the Trust Cancer Triumvirates to explore ways of embedding the GM MDT Standards within their Trust annual auditing processes and MDT Reform now forms part of each Pathway Boards' work programme.

6.2 MDT Reform Summit

To close the MDT Reform Project and to launch the standards, toolkit and patient resources, the project team hosted an MDT Reform Summit. This was also a good opportunity to showcase project outcomes and demonstrate opportunities for change management within MDT meetings and sustain further MDT reform.

The summit was a half day, virtual event and broken down into the following topic areas:

- Introduction to MDT reform
- Launch of Co-produced patient resources
- Launch of GM MDT Standards

- Pathway Board Spotlight – Acute Oncology, Breast, Lung
- Launch of MDT Reform Toolkit
- MDT Leadership Training Programme

The summit was attended by 80 healthcare professionals from across the NW. To assess the impact of the summit, a survey was sent out to all attendees which attracted 22 responses.

Survey results are detailed below:

- 86% of respondents (n=19) were aware of MDT reform prior to the summit and 50% of respondents (n=11) had attempted MDT reform within their own MDTs
  95% of respondents (n=21) advised it was useful to learn about MDT reform in other cancer pathways

- When asked what the best part of the event was, 64% of respondents (n=14) said the GM MDT Standards and 40% of respondents (n=9) said the MDT reform toolkit
  95% of respondents (n=21) said the GM MDT Standards and MDT toolkit would be useful in the future to support MDT reform

- On average, respondents rated the summit as 7 out of 10. When we asked respondents, what their valuable feedback was on the event, common themes were:

Summit Feedback	**Areas for Improvement**	**Summit Take Away**
Very beneficial to see the outcomes of this work and how they work in practice. With highlighting area of good practice and food for thought as to how these can be implemented into local practice	A face to face event to facilitate better interaction in the session and networking opportunities	Restructuring the MDT to benefit service process e.g. pre-MDT triage and streamlining
The speakers were very engaging and seemed to be very passionate about their work. The on24 platform worked brilliantly and the whole event was put together seamlessly.	Additional Pathway Board Spotlight speakers from the same pathway, but different Trusts, to demonstrate further examples of reform	The patient impact statement was brilliant, and it absolutely makes a difference to the MDT
Useful event to gain insight into MDT reform, and in particular hearing patient representative	Increased presence of other key roles such as Managers and MDT co-ordinators who	GM MDT Standards will increase confidence to vocalise if the MDT is not meeting the standards

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feedback on involvement with the process was very eye opening	will be key to embedding changes around MDT	
Details of the patient resources and patient impact statement very clear and how to best use these without overwhelming patients	Time devoted to discussing / reviewing potential IT solutions to MDT working. For example,	Good communication with colleagues from different specialities including Radiologists, Oncologists, Surgeons and Nurses are important for good patient management

7.0 Discussion

The aim of this MDT Reform Project was to align MDT working with current National guidance around MDT best practice, by highlighting the importance of MDT reform within cancer pathways to streamline patient pathways and increase workforce efficiency through new ways of working.

Covid-19 has impacted the delivery of this project with challenges faced around engagement, capacity of clinicians, and the varying degrees of priority MDT reform has held across pathway boards over the lifespan of the project.

Both approaches to the project methodologies had their merit and challenges. Wave 1 pathways underwent the establishment of a task and finish group dedicated to the development and delivery of identified objectives. In contrast, the approach for wave 2 pathways was taken to pilot and implement developed objectives into one local or sector MDT to measure the impact and functionality of the reform in the first instance. Despite the approach for wave 1 pathways being more resource intensive, this was needed to gain awareness and buy in for reform against previous resistance, which enabled wave 2 pathways to progress more quickly. A recommendation for other alliances is to consider both approaches and align with delivery timescales.

The MDT reform summit showcased the outcomes of the project along with raising the awareness of reform within cancer services. Using this event to launch the GM MDT standards and accompanying toolkit, patient resources and dedicated webpage supports sustainability of the achieved outcomes and initiation of further reform.

The GM Cancer Alliance supports the sustainability and further initiation of MDT reform with ownership of outcomes by the Pathway Boards and at a Trust level.

The following subsections detail the project challenges, successes, lessons learned and recommendations for cancer pathways, Trusts and Cancer Alliances supporting MDT reform.

7.1 Challenges

- The impact of Covid-19 created time delays within the project, particularly during the Omicron variant (Nov 21 – Jan 22) during which time the cancellation of non-urgent activity slowed predicted progress
- Variance in the way each Trust operates across GM so a 'one size fits all' approach was not appropriate requiring subjective methodologies to the project
- Time of significant flux of change in GM with reconfiguration of services and Trusts leading to new working relationships and collaborations, which impacted on being able to progress reform
- Engagement was challenging throughout, with MDT reform not always being prioritised by Pathway Boards within their programme of work due to numerous competing priorities
- Approach with wave 1 pathways to establish a pathway specific task and finish group was an effective methodology however too time consuming to continue for the lifespan of the project
- Resistance to change in some instances with reference to a need for change in job planning and job descriptions to enable any reform work to take place which fall outside the control of the project team
- Having one Clinical Lead working across the whole network and across all cancer pathways was too ambitious and on 1 PA per week
- Ongoing workforce issues presented a challenge for achieving some objectives due to depleted teams
- Difficulties to recruit to the project team; Band 7 1.0 WTE Project Manager vacancy never recruited to
- Conducting a large-scale mapping exercise to collate baseline data during the peak of the pandemic was a challenge.

7.2 Successes

- Pathways that engaged with the reform project facilitated time efficient progress, particularly where a dedicated MDT Reform Lead was present. Successful collaborative working with Clinical Leads, Pathway Board Managers, and subject matter experts influenced reform.
- Recruiting a dedicated MDT Reform Clinical Lead provided the project with the required focus and influence to progress effectively
- The GM MDT Steering Group provided a robust governance process to adhere to project timelines, escalate risks to delivery and establish the appropriate direction of travel for the project amid the impact of Covid-19

- The aims outlined in the voxpop have been delivered through co-production with service users to change hearts and minds and address the importance of MDT reform
- Regional agreement and buy in for the new GM MDT Standards and toolkit to support sustainability of ongoing reform
- Buy-in from Cancer Clinical Leads across GM to support the implementation of the GM standards and to hold cancer pathways accountable at a Trust level
- The involvement of service user representatives within the project has demonstrated the value of collaborative working to develop co-produced patient resources and kept the patient at the heart of the project
- Successful MDT reform summit attended by 80 stakeholders, which showcased the outcomes of the project and raised awareness of reform within cancer services.
- Project aims delivered in certain cancer specific MDTMs utilising appropriate project methodology; pilots undertaken to support objective outcomes and influence change management
- Positive meetings with other Cancer Alliances to share MDT reform best practice and lessons learned.

7.3 Lessons Learned and Recommendations

- Involve Cancer Clinical Leads right from initiation.
- Realistic timeframes, taking into account implementation science principles
- Summit feedback demonstrated the appetite for an in-person event. The confirmed number of attendees could not justify an in-person event at the time of arranging. However, a different approach to publicising the event such as earlier communication will be reflected upon
- National working group to drive this change on a national level
- Steering group membership – ensuring more senior representatives to enable change at a trust level
- Dedicated project resource, the project team and Clinical lead all had other competing projects / clinical work impacting on capacity to dedicate to reform
- Recruit pathway specific Clinical Leaders to the project team to support the MDT Reform Clinical Lead; workload demands of the project challenging to manage on 1 PA per week
- MDT Reform across all GM Cancer Pathways was an ambitious target given the subjective, tailored approach required to address each pathway and patient demographic.

8.0 Next steps

Since project close in March 2022, clinical teams across GM have continued to reform practices within their MDTMs; here are some examples below:

1) Colorectal Nurse led telephone clinic at Stockport *(principle 5)*:

- **Output**: telephone clinic to inform patients of the outcome 1 working day after the MDT meeting, with a focus on patients with post-operative histology or require further investigations. This was introduced in response to lack of clinic capacity meaning patients were experiencing long waiting times for outcome MDT outcome. During this call, the nurse discusses the outcome, actions any bookings for further tests/appointments, completes a patient impact statement to inform further care planning and dictates a letter to the GP and other healthcare professionals involved in the patients care.

- **Impact:** Since initiation in July 2022, 31 patients have been called through the clinic, saving 31 clinic slots and generating income for the Surgical Business Department. This new way of working is achieving the GM Cancer communication of outcomes principle along with the integration of the patient impact statement.

2) OG Pre-MDT Triage Meeting at NCA *(principle 4)*:

- **Output:** this was developed towards the end of project and has since been successfully implemented and embedded. This triage process has a focus on non-surgical, gastrointestinal patients.

- **Impact**: delivered a reduction in patient numbers at the main MDT meeting, removing patients on follow up/surveillance, allowing the main MDT to have a strong focus on patient cases which may require interventional procedure. Audit is imminent.

3) Patient Impact Statement within the One-Stop Lung Cancer Clinic at Wythenshawe *(principle 2):*

- **Output:** Newly established One-stop Lung Cancer Clinic at Wythenshawe Hospital for patients diagnosed with lung cancer suitable for curative intent treatment has integrated completion of the patient impact statement within this accelerated treatment pathway.

4) MSD MDT Reform Implementation Project at the NCA: MSD has funded a part time project manager to work with one organisation in Greater Manchester on behalf of the Cancer Alliance to:

- Embed the MDT standards within their quality assurance process for every tumour group.

- Work with the NCA to embed the patient impact statement *(principle 2)* and communication of MDT outcome within 1 working day *(principle 7)* across all.

  Learning will be shared across all organisations, with Stockport and MFT already expressing an interest.

5) Standards of care *(principle 3)* embedded in all Pathway Board work programmes: which will include an auditing process to measure the impact.

6) MDT Training Programmes:

- **MDTM Leadership Coaching Programme *(principle 9)*** achieved CPD accreditation and has been piloted and evaluated (see section 5.1). Discussions are ongoing regarding sustainability with a view to embed the programme within existing Trust leadership training offers. Tameside and Stockport have expressed an interest in incorporating into their 'Aspire' development programme as an MDT Leadership section. MFT and Bolton are in discussions with the Senior Executive Team regarding future rollout and anticipate the pilot evaluation will provide positive influence. NCA will pilot the programme during 23/24. Wigan and The Christie did not take part in the pilot.

- **MDT coordinator training –** programme has been coproduced with MDT Coordinators and Senior Managers and will be CPD accredited and piloted in 23/24. Please find the module here: MDT - Cancer performance and your role - Greater Manchester Cancer Academy (gmcanceracademy.org.uk)

9.0 Conclusion

Despite challenges, this project has initiated reform across numerous pathways and demonstrated the potential for what can be achieved within cancer pathways on a system wide level. Delivering MDT reform and new ways of MDT working supports a future proofing approach to cancer patient management and GM Cancer service recovery plans. One of the major successes within this project is reducing resistance to change and the consideration of standards of care pathways for patients. The project team has witnessed this change in mindset over the course of the project, which is evident by the continued reform that has taken place since project end, and although there is much work to be done, this project has opened the door for reform to continue and given the tools to support this.

10.0 References

CRUK. (2017). *Improving the effectiveness of multidisciplinary team meetings in cancer services.* [online] Available at: Guides: How to reference a Website in Harvard style – Cite This For Me [Accessed date 25th January 2022].

Milburn, A. (2000). *The NHS Cancer Plan*. London: NHS, p. 3-15. [online] Available at: NHSCancerPlan.pdf (thh.nhs.uk) [Accessed date 25th January 2022].

Gore, M. (2017). *Transforming multidisciplinary team meetings (MDTMs).* England: NHS, p. 1-3. [online] Accessed at: Transforming-MDTM-Martin-Gore-August-2017.pdf (england.nhs.uk) [Accessed date 25th January 2022].

NHSE/I. (2019). *Streamlining multi-disciplinary team meetings.* England: NHS, p1-19. [online] Accessed at: Streamlining (england.nhs.uk) [Accessed date 25th January 2022].

sop-gm-lung-cancer-referrals-final-version-nov-2020.pdf.