

## **TRANSFORMING MULTIDISCIPLINARY TEAM MEETINGS (MDTMs)**

### **Introduction**

The main purpose for the introduction of Multidisciplinary Meetings in the late 1990s early 2000s was to increase evidence-based practice and to stop individuals from treating patients outside accepted standards. The role of MDTMs has developed over time into one of a treatment decision-making body for key points along the patient journey.

In recent years clinicians and particularly those involved in diagnostic services, have found that Multidisciplinary Meetings are causing consider pressures within the system as the number of patients that are expected to be discussed has increased. This has been highlighted in a number of reports and there is evidence that the time available to discuss individual patients is short.

Patients need to be discussed by professionals whose expertise is most relevant to their clinical situation; this is not always the Multidisciplinary Team (MDT) but may be other professionals within the same discipline.

The time allocated for MDTMs has become as serious challenge due to an increasing number of patients who are 'required' to be discussed.

There are considerable capacity issues in relation to the number of radiologists and pathologists in England and current MDTM practices present additional challenges to these specialties.

The doctor-patient one to one relationship in relation to management decisions is starting to be eroded. Clinicians need to have the responsibility for these decisions returned to them. They must be given permission to make decisions with their patients without necessarily having to seek approval from the MDTM.

Quality of care is best assured by regular audit of individual and team performance. Regular audit of compliance to algorithms, outcome and experience must be mandatory and used to benchmark and monitor the success of any MDTM operational processes.

The Cancer Transformation Board and Department of Health have asked Professor Martin Gore to lead a project whose aim is to transform the working of cancer Multidisciplinary Meetings to make them more effective in the light of increasing demands on the service.

The plan is for the reforms to be within the framework set by the recommendations set out in 'Meeting Patients' Needs: improving the effectiveness of multidisciplinary team meetings in cancer services' by Cancer Research UK (January 2017).

### **Aim of MDTM reform**

MTMs to operate more effectively in relation to:

- time
- human resource
- data collection
- decision making
- audit and bench marking to facilitate improvements in outcomes

## **Principles of the new transformed MDTMs**

1. Only patients requiring true multidisciplinary input are to be discussed
2. Patients on predetermined agreed algorithms will be recorded and not discussed
3. The time all members of the MDT in general and radiologists and pathologists in particular, spend on MDTMs is to be reduced

## **MDTM functioning**

1. The MDTM is the forum for a clinician to seek *multi-disciplinary/professional* advice and input about patient management including investigation, treatment, follow up, ethical and social matters, comorbidities and practical problems
2. The MDTM must not be used as an 'x-ray meeting' or 'pathology meeting'; images and histopathology are *not* 'to be reviewed' at MDTMs. Separate or sequential meetings must be set aside for such activity
3. Accountability for any intervention remains with the clinician responsible for that intervention
4. MDTM decisions are guidance for the responsible treating clinician
5. Each MDTM will have 2 lists: the first would contain the names of patients who do not require discussion because all their data has been reviewed and is available. These patients will be placed on a pre-agreed, recognised treatment algorithm/pathway. The second list consists of patients who require discussion multi-disciplinary/professional discussion.
6. Patients who are not discussed but who are recorded at the MDTM will have their data, treatment and outcome regularly audited for compliance to mandatory dataset collection requirements (local and national).
7. Regular audit will evaluate the acceptability of individual clinician practice in relation to standards of care as determined by MDTM protocols and national guidance.
8. The length of MDTMs should have clear limits.
9. The time radiologists and pathologists spend in and preparing for, MDTMs must be regularly reviewed. All members of the MDT should engage in ways of reducing the pressure on colleagues in imaging and pathology.
10. Changes in working practice within Departments of Imaging and Pathology need to be explored including making use of resources in a network not simply within an individual Trust, digital pathology, remote reporting etc.
11. **MDTM processes should be part of a Trust's cancer data collection systems**

## **Data and Audit**

1. Audit of MDT outcomes and MDTM processes and data will be central to the assurance of standards and mandatory.

2. Audits will be frequent and repetitive in subject matter; frequent data collection lessens the burden reporting as it is less burdensome to collate data for a quarter than a 12-month period. Repeating audits will allow real time assessment of improvements or deteriorations in performance and outcomes within MDTs.

3. Some audit subjects will be compulsory because they will facilitate learning between Alliances, Cancer Centres/Units and MDTs within the same Cancer Centre/Unit.

4. It will necessary to make sure that the processes adopted by and the data generated from the transformed MDTMs are aligned to the requirements of the newly formed Data Coordination Board which has replaced the Standardisation Committee for Care Information at NHS Digital.

5. There is a clear need to transform cancer surgical coding. The new MDTMs will not do this but the systems adopted and data collected will inform future debates on the developments of new systems or the creation of sub-categories within the current systems such as SNOWMED or OPCS.

#### **Advantages of the reformed working arrangements for MDTMs**

1. Improve patient outcomes by making audit easier and bench marking automatic and potentially in real time.

2. Improved effectiveness of the time all members of the MDT in general and radiologists and pathologists in particular, spend on MDTMs.

2. Clarification of individual clinician responsibility.

3. Clarity of standards of care across England.

4. Improved data collection.

**Martin Gore**  
**August 2017**