

# MEETING PATIENTS' NEEDS

## IMPROVING THE EFFECTIVENESS OF MULTIDISCIPLINARY TEAM MEETINGS IN CANCER SERVICES



CANCER  
RESEARCH  
UK

# EXECUTIVE SUMMARY

Around 357,000 people in the UK were diagnosed with cancer in 2014.<sup>1</sup>

This figure is expected to increase: by 2035 the number of diagnoses each year could reach 500,000<sup>2</sup>. Survival has also increased; Cancer Research UK aims to reach 3 in 4 people surviving cancer for 10 years or more by 2034.

To ensure that this ambition is realised, effective cancer services in the UK are key.

Central to the UK's cancer services are multidisciplinary teams – MDTs. An MDT is made up of a variety of health professionals involved in treating and caring for patients, such as surgeons, clinicians, nurses and diagnosticians. Each week, the MDT meets to discuss individual patients' cases and make treatment recommendations.

MDT working is considered the gold standard for cancer patient management<sup>3</sup>, bringing continuity of care and reducing variation in access to treatment – and ultimately improving outcomes for patients. However, the health service has changed significantly since their introduction in 1995.

There is now a timely opportunity to review MDTs and consider new ways of working. Although the challenges in each of the four nations are not identical, there is a common theme: a dramatic increase in demand, with only minor increases in capacity. For example, the cancer strategy for England contained recommendations to streamline MDT working.<sup>4</sup>

The number of patients to be discussed in MDT meetings has grown significantly, as has the complexity of patients; due to an ageing population and the growing number of treatment options available.

However, the way that MDT meetings are organised has not adapted to cope with this



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increased demand. This has meant that MDT meetings are lasting for several hours, with only a few minutes available to discuss each patient. As a result, these discussions often only involve a few people, and often do not include information such as the patient's preferences, comorbidities or whether the patient is suitable for a clinical trial.

This strain has also impacted how well the MDT can reflect on their decisions, improve their processes and learn.

To reflect the changing nature of cancer care and the increased demand for services, there is a need to refresh the format of MDT meetings to make them work more effectively. Recognising this, Cancer Research UK commissioned 2020 Delivery to undertake this project.

We do not in any way propose removing or diluting MDT working, or to return to the pre-1990s era of patient care being solely managed by one clinician.

We aimed instead to suggest streamlining MDT meetings and improve the quality of discussions, especially for the more complex patients who would benefit the most from

the input of the full MDT.

Throughout this research we were struck by the willingness of MDT members to be involved, to share their experiences and to improve their meetings so that they worked better for patients – with an unprecedented 2,300 responses to our first survey and over 1,250 in our second. Our fieldwork covered 624 patient discussions, across 24 MDT meetings in 10 clinical sites.

Solutions will not be the same for every MDT, or every specialty. However, in several areas there is a need for updated guidance developed on a national level.

This research should therefore be the start of further, in-depth work to implement these recommendations.

## **THERE IS NOT ENOUGH TIME TO DISCUSS THE MORE COMPLEX PATIENTS**

The mean length of the 624 patient discussions observed in this study was 3.2 minutes, and over half of MDT discussions were less than two minutes long. Meetings could last up to five hours.

It is difficult to imagine that this method of working produces the same quality of discussion for all patients, or that there is always enough time for full discussion of patients with particularly complex cases.

For many tumour sites, certain subgroups of

patients now follow very well-established treatment protocols. 74 per cent of MDT members responding to our second survey agreed with the statement that some patients could be streamlined, or reviewed outside of the full MDT meeting. This already happens in some MDTs, but to date there has been no clear national guidance on how this should be managed.

Establishing a 'triage' process to identify patients that should follow these protocolised pathways would reduce the number of discussions happening in the full MDT meeting, allowing more time to discuss the more complex patients.

## **RECOMMENDATIONS**

**Recommendation 1: The UK's health services should work with NICE<sup>i</sup> and SIGN<sup>ii</sup> to identify where a protocolised treatment pathway could be applied and develop a set of treatment recommendations for each of these, to be implemented across the UK. Every Cancer Alliance or devolved cancer network should develop their own approach based on these central recommendations. These treatment protocols should be reviewed regularly.**

**2. MDTs for tumour types for which a protocolised approach has been developed should agree and document their approach to administering protocols. This could include a 'pre-MDT triage meeting'. The implementation and outcomes of these**

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<sup>i</sup> National Institute for Health and Care Excellence

<sup>ii</sup> Scottish Intercollegiate Guidelines Network

**protocols should be audited and reviewed by the full MDT in an operational meeting.**

## **CURRENT MDT MEETING ATTENDANCE IS NOT OPTIMAL**

The growing demands placed on MDTs has a significant impact on MDT members' workloads, who must spend increasing amounts of time preparing for or attending MDT meetings. This is particularly true for pathologists and radiologists.

Workforce challenges are wider than MDT working however; the National Audit Office has said that there is a 50,000 shortfall in clinical staff in England alone.<sup>5</sup>

The 24 meetings observed in this study had between 7 and 27 in attendance, with an average of 14. However, the mean number of people contributing to each discussion was only three – with discussions involving just one or two people not uncommon.

In some meetings everyone spoke at some point, whereas in others it was always the same few people.

In contrast to this observation, other MDT meetings were unable to finalise any treatment recommendation because certain individuals were not present. This was mostly a result of a wider staff shortages.

Attendance guidelines are most strict in England, where MDT attendees are required to attend 66 per cent of meetings. This target is often difficult to reach, meaning

that many MDTs fall foul of national assessments and there are delays in patient care.

Amending such guidelines to focusing instead on individual specialty cover within a meeting would strike the right balance. This would ensure that the right specialties are represented so as to ensure that discussions can progress, without requiring an unnecessarily large group.

MDT members were very supportive of this, with 80 per cent supporting a move to requiring specialty cover.<sup>iii</sup> When staff are mandated to attend MDTs, adequate time must be allocated in their job plans for preparation and attendance.

## **RECOMMENDATION**

**3. National requirements for individual minimum attendance should be reviewed and amended where necessary, with an emphasis on ensuring all required specialties are present at a meeting. NHS England should run a series of pilots to determine optimal percentage attendance requirements. The success of these pilots should be evaluated and national guidance changed as appropriate.**

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<sup>iii</sup> Responses to our second survey of MDT members.

## THE RIGHT INFORMATION IS OFTEN NOT USED TO INFORM DISCUSSIONS

An MDT's treatment recommendation is only as good as the information it takes into account.

MDT discussions must include all relevant information about a patient, so that the patient is given the most appropriate recommendation and can go onto achieve the best outcome possible.

In seven per cent of discussions observed, decisions were deferred due to either missing information (usually diagnostic imaging results) or missing core MDT members.

When information was missing, a treatment recommendation could not be made and so they were deferred for discussion at the following meeting, a week later – introducing an unnecessary seven-day delay, which is distressing for the patient and can lengthen their wait to start vital treatment.

We also found that only 14 per cent of discussions included information that did not relate specifically to their tumour, for example the patient's preference, known comorbidities or psychosocial status.

Although many expected this to be the role

of the clinical nurse specialists, in over 75 per cent of meetings there was no verbal contribution from nurses at all in discussions.<sup>iv</sup>

Only 25 per cent of the patients we surveyed were satisfied with the amount of information they were able to contribute to the MDT meeting.<sup>v</sup>

This has a demonstrable impact on patient experience, as well as on clinical care: research has found that between 10 and 15 per cent of MDT recommendations are not implemented, the patient preferring more conservative treatment, since the discussion had not considered information such as their comorbidities or their preferences.<sup>6,7</sup>

Clinical trial recruitment can also be facilitated via MDTs; however we know that there is considerable variation across the UK in how many patients are spoken to about research opportunities.

Disappointingly, only eight of the 624 MDT discussions observed mentioned clinical trials at all.

One way of ensuring that all relevant information is considered by the MDT would be to implement a standardised proforma, which would be completed by the clinician referring the patient to the MDT.

54 per cent of MDT members already use some form of proforma, but this is not consistent and there is no national guidance

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<sup>iv</sup> See Appendix 1 for full methodology.

<sup>v</sup> See Appendix 4 for text of patient survey.

on content. 81 per cent of MDT members felt that using a proforma would have a beneficial impact on meeting efficiency.

## RECOMMENDATION

**4. The UK's health services should lead the development of national proforma templates, to be refined by MDTs. MDTs should require incoming cases and referrals to have a completed proforma with all information ready before discussion at a meeting.**

The proforma could include:

- Patient demographics;
- Diagnostic information
- Patient fitness and co-morbidities, history of previous malignancies;
- Results from a Holistic Needs Assessment (if available);
- The patient's preferences (if known);
- The rationale for requiring MDT discussion;
- Whether there were known treatment protocols for the specific tumour type;
- Whether the patient is suitable for any current clinical trials.

**The MDT should have the power to bypass this requirement in exceptional circumstances.**

## MDTS ARE UNABLE TO FULFIL THEIR SECONDARY ROLES

As well as making treatment

recommendations, the MDT plays several other roles: facilitating data validation, ensuring consistency in decision-making, educating team members and managing the pathways of the patients within their care.

Discussion amongst steering group members, and responses to our surveys, indicate concern that current pressures have limited these aspects of MDT working.

Since their introduction, the MDT has played a vital role in ensuring timely and accurate data validation. This has been hugely important for auditing services and facilitating information flows to national cancer registries.

However, we found the extent to which this happened highly variable. The best example seen in our observations was when information was directly added by an oncologist, and was projected on a screen for the whole MDT to view. Real time data entry reduces errors and provides an immediate opportunity to validate and clarify information.

As a central tenet of cancer services, it is important that MDTs review their own performance and that a culture of continuous improvement is fostered. Less than half (48 per cent) of MDT members felt their MDT has a process in place that is sufficient for improving their effectiveness.

The suggestion of holding a regular 'operational' meeting, either quarterly or biannually, was supported by 67 per cent of respondents to our second survey.

## RECOMMENDATIONS

**5. MDTs should use a database or proforma to enable documentation of recommendations in real time. Ideally this should be projected so that it is visible to team members; if this is not possible there should be a named clinical individual responsible for ensuring the information is accurate. Hospital Trusts and boards should ensure that MDTs are given sufficient resource to do this.**

**6. Each MDT should ensure that they have a mortality and morbidity process to ensure all adverse outcomes can be discussed by the whole MDT and learned from, rather than discussed in silos. The primary time for this to take place should be a quarterly or biannual operational meeting. Time for quarterly operational meetings should be included in attendees' job plans. There should be oversight from national MDT assessment programmes.**

**[www.cancerresearchuk.org/mdts-research](http://www.cancerresearchuk.org/mdts-research)**

For more information, or for a copy of the full report, please contact [policydepartment@cancer.org.uk](mailto:policydepartment@cancer.org.uk)

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<sup>1</sup> Cancer Research UK (2016) *Cancer Statistics for the UK*  
[www.cancerresearchuk.org/health-professional/cancer-statistics](http://www.cancerresearchuk.org/health-professional/cancer-statistics) (Accessed December 2016).

<sup>2</sup> Smittenaar, C.R., Petersen, K.A., Stewart, K. and Moitt, N. "Cancer incidence and mortality projections in the UK until 2035". *British Journal of Cancer*, 2016. 115, p1147-1155. <http://go.nature.com/2fxmfdb> (Accessed November 2016)

<sup>3</sup> Independent Cancer Taskforce. 2015. *Achieving World-Class Cancer Outcomes: A Strategy for England 2015-2020*. London: Independent Cancer Taskforce.  
<http://bit.ly/1dwf5W> (Accessed November 2016)

<sup>4</sup> Independent Cancer Taskforce. 2015. *Achieving World-Class Cancer Outcomes: A Strategy for England 2015-2020*. London: Independent Cancer Taskforce.  
<http://bit.ly/1dwf5W> (Accessed November 2016)

<sup>5</sup> National Audit Office, 2016. *Managing the supply of NHS clinical staff in England*.  
<http://bit.ly/2fjEdCh> (Accessed November 2016)

<sup>6</sup> Blazeby, J.M. et al (2006), Analysis of clinical decision-making in multidisciplinary cancer teams. *Ann Oncol* 17: pp.457-60. <http://bit.ly/2gcZ2yz> (Accessed November 2016)

<sup>7</sup> Wood, J.J. et al (2008), An evaluation of treatment decisions at a colorectal cancer multidisciplinary team. *Colorectal Dis.* 10: pp.769-72. <http://bit.ly/2fjHHEK> (Accessed November 2016)

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