ABS ASSOCIATION OF BREAST SURGERY

BSBR BRITISH SOCIETY OF BREAST RADIOLOGY

ASSOCIATION OF BREAST PATHOLOGY

UKBCG

Improving the Efficiency of Breast Multidisciplinary Team Meetings:

A Toolkit for Breast Services

Appendix 1: Cancer Research UK Report (2017): Meeting the patient's needs: improving the effectiveness of the multidisciplinary meetings in cancer services

Key findings

MDT working is considered the gold standard for cancer patient management[1] bringing continuity of care and reducing variation in access to treatment – and ultimately improving outcomes for patients. However, the UK's health services have 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.

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 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 pre1990s 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.

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.

Appendix 1:

Recommendations:

There is not enough time to discuss the more complex patients

RECOMMENDATION 1:

The UKs health services should work with NICE and SIGN 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.

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

Current MDT meeting attendance is not optimal

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.

The right information is often not used to inform in discussions

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.

MDTs are unable to fulfil their secondary roles: in data validation, audit and education

RECOMMENDATION 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.

RECOMMENDATION 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.

References:

1. Independent Cancer Taskforce. Achieving World-Class Cancer Outcomes: A Strategy for England 2015-2020. London: Independent Cancer Taskforce 2015.