The Characteristics of an Effective Multidisciplinary Team (MDT)

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Foreword by the National Cancer Director

Before the early 1990s only a relatively small proportion of cancer patients benefited from their care being managed by a MDT of cancer specialists. Such teams had existed for decades for some cancers in some hospitals but this was the exception not the rule. Before MDTs were established:

- diagnostic assessments were often made, and cancer treatments often delivered, by generalists without the necessary knowledge and skills related to a specific cancer;
- staff were often working in isolation – there was little direct discussion between physicians, surgeons, radiologists, pathologists and oncologists about the clinical, radiological and pathological features of individual cases and as a result, some factors relevant to decision making were being missed and in some cases patients were not being considered for treatments such as radiotherapy and chemotherapy when these might have been beneficial;
- information was not being collated, making audit virtually impossible and hampering the onward flow of data to cancer registries;
- communication with patients was often poor - they received little written information or support – as was communication between primary, secondary and tertiary care.

Cancer MDTs were established to overcome these and other challenges and there are now around 1500 in England. There is a widespread perception that MDT working has brought benefits to patients and that decision making has improved.

While we have rightly focused on getting MDTs in place over recent years we now need to turn our attention to how these MDTs are working.

Over 2000 MDT members responded to a survey in early 2009 to give us their views on what makes an MDT effective. We have built on their views and those of stakeholders who have attended workshops and meetings to produce a set of characteristics that define how an effective MDT would work.

I would encourage you to:

- look at these characteristics and see how your MDT(s) compares with them;
- initiate discussions within your MDT(s) and Trust(s) about what actions might need to be taken locally to bring MDTs in line with these characteristics.

These characteristics will form the framework for a broader programme of work which is being led by the National Cancer Action Team to support MDT development during 2010. I hope you find them useful.

Professor Sir Mike Richards
National Cancer Director

The Characteristics of an Effective MDT

Aim

This document sets out the characteristics of an effective MDT as identified by the responses of over 2000 MDT members to a survey in early 2009 about MDT working. It also takes into account additional views expressed at 6 workshops held in May 2009 plus a variety of ad hoc meetings with stakeholders. These characteristics will form the foundation on which the National Cancer Action Team's (NCAT) MDT development work programme will build. They may evolve over time.

Introduction

The NHS Cancer Plan confirmed that *'the care of all patients with cancer should be formally reviewed by a specialist team'*. It went on to note that this would help ensure that *'all patients have the benefit of the range of expert advice needed for high quality care.'*

MDTs need to bring together staff with the necessary knowledge, skills and experience to ensure high quality diagnosis, treatment and care – core and extended team membership for different tumour MDTs is set out in the Manual for Cancer Services, 2004. The MDT meeting is about considering the patient as a whole not just about treating the cancer. To support this, an MDT should take account of the patient's views, preferences and circumstances wherever possible when considering their advice on the care that is most appropriate for the patient's condition.

An MDT makes recommendations rather than decisions. These recommendations can only be as good as the information available to the MDT at the meeting. The final decision on the way forward needs to be made by the patient in discussion with their clinician. MDTs should be alerted if there are significant changes to their recommendations and the reason for this so they have the opportunity to review and learn from these cases.

The initial focus of the MDT is a patient's primary treatment. It is for organisations to decide locally if/how patient cases should be re-considered (taking into account any relevant recommendations by NICE) beyond this point.

Effective MDT working should result in:

- treatment and care being considered by professionals with specialist knowledge and skills in the relevant aspects of that cancer type;
- patients being offered the opportunity to be entered into high quality and relevant clinical trials;
- patients being assessed and offered the level of information and support they need to cope with their condition;
- continuity of care, even when different aspects of care are delivered by different individuals or providers;
- good communication between primary, secondary and tertiary care;
- good data collection, both for the benefit of the individual patient and for the purposes of audit and research;
- improved equality of outcomes as a result of better understanding and awareness of patients' characteristics and through reflective practice;
- adherence to national and local clinical guidelines;
- promotion of good working relationships between staff, thereby enhancing their job satisfaction and quality of life;
- opportunities for education/professional development of team members (implicitly through the inclusion of junior team members and explicitly when meetings are used to devise and agree new protocols and ways of working);
- optimisation of resources – effective MDT working should result in more efficient use of time which should contribute to more efficient use of NHS resources more generally.

These outcomes are expected to be more likely in MDTs exhibiting the characteristics set out in this document.

The characteristics do not address the wider issue of MDT costs – this will be part of a separate work stream.

Categorisation of MDT Characteristics

The characteristics of an effective MDT fall into a number of categories and sub-categories as set out below:

1.   The Team

1.1.   Membership

1.2.   Attendance

1.3.   Leadership

1.4.   Team working & culture

1.5.   Personal development & training

2.   Infrastructure for Meetings

2.1.   Physical environment of meeting venue

2.2.   Technology & equipment (availability & use)

3.   Meeting Organisation & Logistics

3.1.   Scheduling of MDT meetings

3.2.   Preparation prior to MDT meetings

3.3.   Organisation/administration during MDT meetings

3.4.   Post MDT meeting /co-ordination of service

4.   Patient-Centred Clinical Decision-Making

4.1.   Who to discuss?

4.2.   Patient-centred care

4.3.   Clinical decision-making process

5.   Team Governance

5.1.   Organisational Support

5.2.   Data collection, analysis and audit of outcomes

5.3.   Clinical governance

The characteristics of an effective MDT based around these categories are set out in this document.

1. The team

1.1. Membership

1.1.1. All relevant professions/disciplines – core & extended members - are represented in the team in line with the Manual of Cancer Services.

1.1.2. The MDT co-ordinator is recognised as a core member of the team – they sit where they can hear and see everything.

1.1.3. Cross cover/deputies with authority to support recommendations are in place to cover planned (and where possible unplanned) absences - advanced notice is given of core member absence so that this cover (or alternative management) can be organised if possible.

1.1.4. Members have the level of expertise and specialisation required by the MDT in question – where there are no relevant peer review measures or accreditation for these roles the issue of clinical competence is for the relevant professional body or the Trust to determine.

1.2. Attendance

1.2.1. MDT members (core and extended) have dedicated time included in their job plans to prepare for, travel to (if necessary) and attend MDT meetings – the amount of time is negotiated locally to reflect their workload and varies according to discipline and cancer type.

1.2.2. Core members are present for the discussion of all cases where their input is needed – it is for the chair to decide (in consultation with others as he/she sees fit) whether there is adequate representation at a single meeting to make safe recommendations about any/all patients and the action to take if not.

1.2.3. Every effort should be made to ensure that a clinician who has met the patient whose case is being discussed is present at the meeting.

1.2.4. The chair is responsible for raising concerns about non-attendance of particular members (or their deputies) and escalating these concerns if regular non-attendance is impacting on the quality of MDT working/recommendations. Frequent non-attendance is addressed during appraisal processes & job plan reviews.

1.2.5. A register of attendance is maintained – members signing in and out (with times) supports assessment of attendance.

1.2.6. Extended members and non members attend for the cases that are relevant to them.

1.2.7. Anyone observing MDT meetings should be introduced to team members and their details included on the attendance list.

1.3. Leadership

1.3.1. There is an identified leader/chair of the MDT and a deputy to cover when necessary – the leader and the chair do not have to be the same person.

Chair

1.3.2. The MDT chair is responsible for the organisation and the running of the MDT meetings.

1.3.3. The chair has skills in the following areas:

- meeting management;
- listening & communication;
- interpersonal relations;
- managing disruptive personalities & conflict;
- negotiations;
- facilitating effective consensual clinical decision-making;
- time-management.

1.3.4. The chair:

- prepares and/or agrees the agenda with the MDT co-ordinator;
- ensures the meeting is quorate and takes action if not;
- ensures all relevant cases are discussed and prioritised as necessary;
- ensures all relevant team members are included in discussions;
- ensures discussions are focussed and relevant;
- ensures good communications/a pro-discussion environment;
- promotes evidence-based and patient-centred recommendations and ensures that eligibility for relevant clinical trial recruitment is considered;
- ensures the current patient discussion and treatment/care plan recommendations are complete before the next patient discussion starts;
- ensures relevant demographic and clinical data items are recorded;
- ensures recommendations are clearly summarised, recorded and fed back to the patient, GP and clinical team within a locally agreed timeframe;
- ensures that it is clear who is going to take any resulting actions post meeting and that this is minuted.

Leader

1.3.5. The MDT leader (who may also be the chair) has a broader remit not confined to the MDT meetings. They are responsible for:

- issues of governance eg. setting clear objectives/purpose for the team/what is expected of members etc;
- ensuring that others in the organisation have an understanding of the role of the MDT and why it is important in cancer care;
- negotiating locally for funding/resources needed for the MDT to be effective;
- escalating issues of concern that may impact on safety of MDT recommendations etc.

1.4. Team working & culture

1.4.1. Each MDT member has clearly defined roles and responsibilities within the team which they have signed up to and which are included in their job plans.

1.4.2. The team has agreed what is acceptable team behaviour/etiquette including:

- mutual respect & trust between team members;
- an equal voice for all members - different opinions valued;
- resolution of conflict between team members;
- encouragement of constructive discussion/debate;
- absence of personal agendas;
- ability to request and provide clarification if anything is unclear.

1.4.3. MDT members play a role in sharing learning and best practice with peers.

1.5. Personal development & training

1.5.1. Team members recognise the need for continued learning and individual members are supported to gain the necessary knowledge and skills for their roles and responsibilities within the MDT and for their respective professional role – support is available from the team, the organisation and nationally as appropriate and members take up relevant CPD opportunities.

1.5.2. There are networking opportunities to share learning and experiences with other MDTs in the same Trust and potentially in other Trusts in the Network or beyond.

1.5.3. There is access to training opportunities as required to support an individual's role in the MDT in areas such as:

- leadership skills;
- chairing skills;
- communication skills including listening, presenting and, where relevant, writing;
- time management;
- confidence & assertiveness;
- use of IT equipment eg. video-conferencing;
- knowledge of anatomy, oncology, radiology & pathology (for members not expert in these areas).

1.5.4. There is a teaching & training role for MDTs both within the team itself (eg. bringing patient cases back) and beyond (eg. for clinicians in training).

2. Infrastructure for Meetings

2.1. Physical environment of meeting venue

2.1.1. There is a dedicated MDT room in a suitable (quiet) location with sound proofing if necessary to ensure confidential discussions.

2.1.2. The room is environmentally appropriate in size and layout ie. all team members have a seat and are able to see and hear each other and view all presented data (eg. diagnostics) within and across hospital trusts.

2.2. Technology & equipment (availability & use)

2.2.1. Rooms where MDT meetings take place have:

- access to equipment for projecting and viewing radiology images including retrospective images;
- facilities for projecting and viewing specimen biopsies/resections and accessing retrospective pathology reports;
- connection to PACS;
- access to a database or proforma to enable documentation of recommendations in real-time;
- projection facilities so members can view and validate the recommendations being recorded;
- facilities (when needed) to see and speak to members who are off site (eg. video-conferencing) and share all information that will be viewed (eg. images and reports) with them.

2.2.2. There is commitment/buy-in from all sites to provide technology and equipment (including video-conferencing) that is good quality and reliable, up to at least a minimum network wide specification, which takes into account issues such as:

- standards of data transfer;
- image quality;
- bandwidth - speed for loading images, time delay for discussions;
- inter-hospital compatibility / cross-site co-ordination etc.

This specification is kept under review and updated in light of technological advances.

2.2.3. There is technical support for MDT meetings so that assistance can be provided in a timely fashion (ie. during the meetings) if there are problems with any IT systems or video-conferencing links during the meeting – the quality of MDT decision making can be seriously affected when equipment fails.

3. Meeting Organisation & Logistics

3.1. Scheduling of MDT meetings

3.1.1. MDT meetings take place regularly (as set out in Manual of Cancer Services).

3.1.2. MDT meetings are held during core hours where possible - ('core hours' are defined locally and included in staff job plans) and are set up so as not to clash with related clinics that core members need to attend – such clinics follow MDT meetings where feasible.

3.2. Preparation prior to MDT meetings

3.2.1. Processes are in place to ensure that all patients diagnosed with a primary cancer have their case considered by the relevant MDT and it is clear when patient cases can be taken back to MDTs including when discussion of patients with metastatic disease/recurrence should take place.

3.2.2. There is a locally agreed cut-off time for inclusion of a case on the MDT list/agenda and team members abide by these deadlines – there is flexibility for cases that may need to be added at the last minute due to clinical urgency.

3.2.3. Cases are organised on the agenda in a way that is logical for the tumour area being considered and sufficient time is given to more complex cases – the structure of the agenda allows, for example, the pathologist to leave if all cases requiring their input have been discussed.

3.2.4. The structured agenda/patient list is circulated prior to the meeting if members agree this would be useful.

3.2.5. A locally agreed minimum dataset of information about patients to be discussed should be collated and summarised prior to MDT meetings wherever possible – this should include diagnostic information (pathology and radiology), clinical information (including co-morbidities, psychosocial and specialist palliative care needs) and patient history, views and preferences where known. It is important that any data items collected locally that are in existing national datasets or are within the NHS Data Dictionary are in line with these data definitions and codes when collected.

3.2.6. Members know what information from the locally agreed minimum dataset of information they will be expected to present on each patient so that they can prepare and be ready to share this information (or have delegated this to another member if they cannot attend) prior to and/or at the meeting.

3.3. Organisation/administration during MDT meetings

3.3.1. It is clear who wants to discuss a particular patient and why they are being discussed.

3.3.2. A locally agreed minimum dataset of information is presented on each patient including diagnostic information (pathology and radiology), clinical information (including co-morbidities, psychosocial and specialist palliative care needs) and patient history, views and preferences – the focus is on what the team need to hear to make appropriate recommendations on the patient in question. It may not, for example, be necessary to show/discuss the pathological or radiological findings in all cases.

3.3.3. There is access to all relevant information at the meeting including patient notes, test results/images/samples (past and present) and appointment dates (or a proforma /summary record with the necessary information) along with access to PAS, radiology & pathology systems etc – relevant past material should be reviewed prior to the meeting if it is not accessible during the meeting.

3.3.4. Electronic databases are used to capture recommendations during the meeting (including the rationale for the decision and any uncertainties or disagreements about the recommendations) – a standard pro-forma is used where such a database is not available.

3.3.5. Core data items are collected during the meeting and cancer datasets completed in real time (where feasible) – training may be required to ensure accurate recording of real-time information to minimise the impact on (ie slowing down) the MDT discussion. Some MDTs will wish to collect as much of the core data items before the meeting to save time – the function of the MDT is then to check these are correct. It is important that any data items collected locally that are in existing national datasets or are within the NHS Data Dictionary are in line with these data definitions and codes when collected.

3.3.6. Mobile phones are off or on silent during the meeting and if phone calls have to be taken during the meeting the person taking the call leaves the room.

3.3.7. There is effective chairing and co-ordination throughout the meeting.

3.4. Post MDT meeting/co-ordination of services

3.4.1. Processes are in place:

- for communicating MDT recommendations to patients, GPs and clinical teams within locally agreed timeframes eg. patient clinics on the same or next day as MDT meetings where feasible;
- for ensuring that patients' information needs are assessed and met;
- to ensure actions agreed at the meeting are implemented;
- to ensure the MDT is notified of significant changes made to their recommended treatment/care plan;
- to manage referral of patient cases between MDTs (including to MDTs in a different Provider);
- to track patients through the system to ensure that any tests, appointments, treatments are carried out in a timely manner eg. within cancer waits standards where applicable.

3.4.2. Relevant items from cancer datasets are completed (if this has not been done in real time at the meeting).

4. Patient Centred Clinical Decision-Making

4.1. Who to discuss?

4.1.1. There are local mechanisms in place to identify all patients where discussion at MDT is needed.

4.1.2. There are referral criteria in place so it is clear when to send a case to the MDT for consideration ie: clarity on:

- which patients should be discussed by the MDT;
- the clinical questions that need to be addressed by the MDT;
- what information has to be available for the MDT discussion to be productive;
- when to refer a patient on to another MDT (eg from a local to a specialist MDT).

4.1.3. There is local agreement about if/when patients with advanced/recurrent disease should be discussed at MDT meetings.

4.1.4. A clinician can bring the case of a private patient to the MDT for discussion provided there is time on the agenda - any reimbursement arrangements are for local determination.

4.2. Patient-centred care

4.2.1. Patients are aware of the MDT, its purpose, membership, when it meets and that their case is being/has been discussed and are given the outcome within a locally agreed timeframe.

4.2.2. A patient's views/preferences/holistic needs are presented by someone who has met the patient whenever possible.

4.2.3. A named individual at the MDT has responsibility for identifying a key worker for the patient.

4.2.4. A named individual at the MDT has responsibility for ensuring that the patient's information needs have been (or will be) assessed and addressed.

4.2.5. Patients are given information consistent with their wishes, on their cancer, their diagnosis and treatment options including therapies which may be available by referral to other MDTs, sufficient to make a well informed choice/decision on their treatment and care.

4.3.   Clinical Decision-Making Process

4.3.1.   A locally agreed minimum dataset of information is provided at the meeting ie the information the MDT needs to make informed recommendations including diagnostic information (pathology and radiology), clinical information (including co-morbidities, psychosocial and specialist palliative care needs) and patient history, views and preferences. It is important that any data items collected locally that are in existing national datasets or are within the NHS Data Dictionary are in line with these data definitions and codes when collected.

4.3.2.   MDTs consider all clinically appropriate treatment options for a patient even those they cannot offer/provide locally.

4.3.3.   MDTs have access to a list of all current and relevant clinical trials (including eligibility criteria) particularly those in the NCRN portfolio and consider patients' suitability for appropriate clinical trials as part of the decision-making process - the relevant trial co-ordinator/research nurse attends MDT meetings where feasible.

4.3.4.   Standard treatment protocols are in place and used whenever appropriate.

4.3.5.   A patient's demographic profile and co-morbidities are always considered - age does not in itself act as a barrier to active treatment.

4.3.6.   A patient's psychosocial and supportive & palliative care issues are always considered (eg. via holistic needs assessment).

4.3.7.   A patient's views, preferences and needs inform the decision-making process when relevant/possible.

4.3.8.   The clinical–decision making process results in clear recommendations on the treatment/care plan resulting from the meeting. These recommendations are:

- evidence-based (eg. in line with NICE and/or cancer network guidelines);
- patient-centred (in line with patient views & preferences when known and taking into account co-morbidities);
- in line with standard treatment protocols unless there is a good reason against this, which should then be documented.

4.3.9.   MDT recommendations are only as good as the information they are based on – if there are concerns that key data is missing this should be documented.

4.3.10. Where a recommendation cannot be made because of incomplete data or where new data becomes available at a later stage it should be possible to bring the patient case back to the MDT for further discussion.

4.3.11. It is clear who will communicate the MDT recommendation(s) to the patient, GP and clinical team, how and by when and this is minuted.

4.3.12. MDTs collect social demographic data (on age, ethnicity and gender as a minimum) and consider that data periodically to reflect on equality of access to active treatments and to other aspects of treatment, care and experience – Information relating to these issues will/should be on PAS (based on NHS Data Dictionary definitions) and MDTs should link up to the source of these data on PAS rather than create separate data capture processes.

5. Team Governance

5.1. Organisational support

5.1.1. There is organisational (employer) support for MDT meetings and MDT membership demonstrated via:

- recognition that MDTs are the accepted model by which to deliver safe and high quality cancer care;
- adequate funding/resources in terms of people, time, equipment and facilities for MDT meetings to operate effectively (as set out in this document).

5.1.2. Trusts consider their MDTs' annual assessments and act on issues of concern (see 5.3.10).

5.2. Data collection, analysis and audit of outcomes

5.2.1. Data collection resource (ie. the ability to capture relevant information in a timely manner etc) is available to the MDT.

5.2.2. Key information that directly affects treatment decisions (eg. staging, performance status and co-morbidity) is collected by the MDT.

5.2.3. Mandated national datasets are populated prior to or during MDT meetings where possible and appropriate – if this is not possible this takes place shortly after the meetings.

5.2.4. Data collected during MDT meetings (including social demographic data extracted from PAS) is analysed and fed back to MDTs to support learning.

5.2.5. The MDT takes part in internal and external audits of processes and outcomes and reviews audit data (eg. to confirm that treatment recommendations match current best practice and to consider trial recruitment) taking action to change practice etc where necessary.

5.2.6. MDTs consider and act on clinical outcomes data as they become available eg. through peer review, NCIN clinical reference groups etc.

5.2.7. Patient experience surveys include questions relevant to MDT working and action is taken by MDTs to implement improvements needed in response to patient feedback.

5.3. Clinical governance

5.3.1. The purpose of the MDT and its expected outputs are clearly defined locally.

5.3.2. There are agreed policies, guidelines or protocols for:

- how the MDT operates;
- who the core and extended members are;
- the roles of members;
- how members should work together;
- how changes in clinical practice are to be managed;
- communications post meetings eg. to patients, GPs and other clinical colleagues.

5.3.3. User Partnership Groups are given the opportunity to advise on the development of MDT policy and practice – they are given feedback in response to their advice including actions taken in response to their recommendations.

5.3.4. MDT policies, guidelines and protocols are reviewed at least annually.

5.3.5. There are mechanisms in place to:

- record the MDT recommendation(s) versus the actual treatment given and to alert the MDT if their treatment recommendation(s) are not adopted and the reason for this – the MDT has regular opportunities to review and act on learning from such cases;
- ensure that the MDT is alerted to serious treatment complications and adverse or unexpected events/death in treatment - the MDT has regular opportunities to review and act on learning from such cases.

5.3.6. There are strategies in place to monitor:

- the proportion of patients discussed without sufficient information to make recommendations/ take action at that meeting;
- the proportion of patients offered and/or receiving information recommended by the MDT.

5.3.7. The MDT shares good practice and discusses local problem areas with MDTs within its own trust/Network.

5.3.8. The MDT has representation on the Network Site Specific Group (NSSG) for its cancer site and that representative attends the meetings or sends a deputy.

5.3.9. Significant discrepancies in pathology, radiology or clinical findings between local and specialist MDTs should be recorded and be subject to audit.

5.3.10. MDTs reflect, at least annually, on equality issues, for example, that there is equality of access to active treatments and other aspects of treatment, care and experience for all patients.

5.3.11. The MDT assesses (at least annually) its own effectiveness/performance and where possible benchmarks itself against similar MDTs making use of cancer peer review processes and other national tools as they become available – results of the assessment are acted on by the MDT or employing organisation.

Next Steps

The characteristics of an effective MDT set out in this document provide the framework for a broader work programme which is being led by the National Cancer Action Team. This work programme includes:

• liaising with the National Peer Review Team to see if any peer review measures can be refined, or added to, to help MDTs assess themselves against some of these characteristics;

• piloting approaches with MDTs to 'self assessment & feedback' in areas that are less suitable for peer review such as team working and leadership;

• identifying development /support needs of MDTs based on pilot work and seeking to address these needs;

• considering how a DVD could be used to, for example, demonstrate the impact on MDT working of different working practices and behaviours;

• developing a toolkit to share local practice associated with the characteristics of an effective MDT;

• liaising with the National Clinical Intelligence Network (NCIN) about data that it is feasible for MDTs to collect, what MDT system specifications might look like and how outcome data can be fed back to, and used by, MDTs.

More information

If you wish to see the results of the survey on which the characteristics are largely based you can find them at **www.ncin.org.uk/mdt**

If you have any queries about the MDT development programme or are interested in being involved please contact **cheryl.cavanagh@gstt.nhs.uk**