

# Multi Disciplinary Team Coordinators Conference

## ‘Focus on the Challenges Ahead’

### 10<sup>th</sup> March 2009



**6<sup>th</sup> Annual MDT Coordinators Conference – Welcome from Professor Mike Richards, National Cancer Director** We are now one year on from the publication of the Cancer Reform Strategy. It has been a busy and productive first year with all stakeholders defining their requirements and establishing work programmes to take the Strategy forward.

I would like to draw specific attention to a few areas which I think will have a major impact on the workings of the multidisciplinary team in the foreseeable future. We all know that due to our ageing population the incidence of cancer will continue to rise, with a prediction that incidence is set to increase by around a third between 2001 and 2020. This translates into an increase from about 224,000 per annum in 2001 to about 300,000 by 2020. From an MDT perspective this will require each MDT to have the correct infrastructure and capacity to meet this additional demand.

As is now widely known, cancer survival rates in the UK tend to be poorer than those in other western European countries. Our poor survival rates can largely be attributed to patients being diagnosed with more advanced disease than their counterparts in other countries. This is likely to be due to low public awareness of cancer symptoms in the UK leading to late presentation when symptoms arise and, in some cases, to late onward referral from primary care. To address this, we launched the National Awareness and Early Detection Initiative (NAEDI) in November last year. This initiative is co-chaired by myself and Harpal Kumar, the CEO of CR-UK, and its role is to co-ordinate and provide support to activities that promote the earlier diagnosis of cancer. There is still a lot we do not know about how to solve these problems and there is great demand for both action and research in this area. To that end we have established the following 8 work streams:

- A review of the evidence base on links between early diagnosis and survival
- Measuring awareness of cancer symptoms through regular surveys
- Interventions to promote early presentation, focusing on evaluation and dissemination
- Interventions to reduce delays in primary care
- International benchmarking against countries with better outcomes
- Prospective research to identify and fill gaps in the knowledge base
- Key messages which use language consistently and effectively
- Ensuring appropriate access to and usage of diagnostic tests

As this initiative moves forward we are likely to see increased referral rates into secondary care, and again this will have an impact on all the MDTs with which you work. So coupled together with the increase in incidence predicted, the roles of the MDT Coordinator, Patient Trackers and Navigators will continue to be key to the success of the MDTs.

Linked to this I am delighted to let you know of two other work areas focussing on MDTs. Firstly, the National Cancer Action Team is establishing a project to define the characteristics that make a high-performing MDT.

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The focus to date has been on getting the MDTs in place – there are now over 1500 cancer MDTs around the country. However, we now need to look at how these MDTs are working and what we can do to support them. A questionnaire that will be circulated to all MDTs is the first step in that process. This questionnaire will provide important information to identify what makes an MDT work well and what support MDTs need. It will be followed by a series of workshops to discuss the findings and consider potential ways forward. A programme of action to support MDTs over the next few years will then be launched. I encourage all of you to complete this questionnaire, as your opinions are important to the way the MDTs of the future are implemented.

Secondly, I know there is also a very active steering group looking at the training requirements of all those involved in the collection of data for improving cancer outcomes, on your behalf. The steering group has representation from the MDT Taskforce, the UK Association of Cancer Registries, Cancer Networks, and is being chaired by the National Cancer Intelligence Network. Initially this group will be conducting a review of both the requirements for training courses and how they can be integrated into the everyday working lives of staff groups such as yourselves. I look forward to seeing the results from both of these projects as they evolve over the next year or so.

Unfortunately, I am unable to be with you at this year's MDT Coordinators Conference, but I know you have a very interesting and diverse agenda and wish you all a very successful and informative conference.

**A Network Perspective from Ben Thomas, Director, SWSH Cancer Network** During my five years as director of the Surrey, West Sussex and Hampshire Network, the constituent members; patients and carers, acute trusts, the cancer centre, hospices and primary trusts supported by the network team have made significant progress in a number of areas. Cancer waiting times have been achieved, and are being sustained; patients diagnosed with cancer now have the benefit of an MDT discussion and have a much greater say in how, when and where they are treated. Services are now based around specialist teams and services, and all those affected by cancer are having an increased and important influence in how services are planned, developed and delivered.

The Cancer Reform Strategy published in December 2007 presents all of us involved in cancer care with new challenges and opportunities over the next five years. In taking up this challenge Network teams must continue to demonstrate leadership, challenge the status quo, and use their new roles as agents for commissioners to ensure that primary care trusts have all the necessary information to allow them to commission evidence based services which are compliant with NICE Improving Outcomes Guidance, delivered within an agreed quality assured and clinical governance framework and provide patients with optimum treatment, support and care.

Whilst supporting patient choice and introducing new providers into the healthcare market, PCTs must work in conjunction with networks to ensure new entrants work to agreed policies and protocols and can be accredited using IOGs and the Peer Review process.

Cancer networks are well placed to ensure that new services are developed around patients and their needs along agreed pathways of care, with services delivered close to home where this is clinically appropriate and cost effective. This way of working can often be threatening for acute providers who have to service the running costs of large buildings and staff delivering care in a secondary care environment.

The introduction of HRG4 and the unbundling of tariffs will provide commissioners with the opportunity of facilitating change by moving funding around the system. All providers, therefore, need to consider how they can work together more effectively across networks in delivering integrated care. Putting patients first should not be a simple mantra that is rolled out from time to time but should be at the core of how we think about caring for and treating patients and their families in the future.

The incidence of cancer is rising as we all get older, more people are living longer because of improved treatments, better diagnostic techniques are being developed and the knowledge of cancer amongst the scientific community is increasing rapidly. New drugs and other treatment modalities are increasing patient expectations with some cancers now viewed as chronic diseases. All this is great news but it comes with huge increases in treatment costs and an even greater need to ensure that treatment is evidence based, and that treatment options are clearly communicated to allow patients to make informed choices.

One of the keys to taking forward much of this work is access to reliable and timely information. The recent launch of the Cancer Commissioning Toolkit is an important step forward, but clinical coding and other data collection needs significant investment if we are to maintain the momentum and achieve the new standards and initiatives set out in the Cancer Reform strategy between now and 2012.

The role of the MDT coordinator is important in this area and the development of this role in terms of both case and data management must be encouraged. Finally and most importantly we need to continue to invest in staff and equipment so that we have an experienced and flexible workforce to underpin the delivery of the new strategy.



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**Making a Difference Together**  
"As the Cancer MDT Coordinators Taskforce, we provide a national voice to inform, support and motivate fellow coordinators, to bring professional recognition to the role and contribute to improving the patient pathway."



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Post Vacant

Post Vacant



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N07	Humber and Yorkshire Coast	TBC
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N11	Pan Birmingham	Diane Wilkes
N12	Arden	Patricia Hewitt
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N14	Derby-Burton	Patricia Hewitt
N15	Leicestershire, Northamptonshire and Rutland	Patricia Hewitt
N20	Mount Vernon	Serena Hodges
N21	West London	Serena Hodges
N22	North London	Lynne Newbury
N23	North East London	Lynne Newbury
N24	South East London	Suzanne Jenkins
N25	South West London	Suzanne Jenkins
N26	Peninsula	Kay Pollard
N27	Dorset	Kay Pollard
N28	Avon, Somerset and Wiltshire	Serena Hodges
N29	3 Counties	Suzanne Jenkins
N30	Thames Valley	Juanita Asumds
N31	Central South Coast	Serena Hodges
N32	Surrey West Sussex & Hampshire	Juanita Asumds
N33	Sussex	Juanita Asumds
N34	Kent and Medway	Juanita Asumds
N35	Greater Midlands	Diane Wilkes
N36	North of England	TBC
N37	Anglia	TBC
N38	Essex	Juanita Asumds
	Northern Ireland	Margaret Fleming
	North Wales	Sue Hughes
	South West Wales	Lynne Newbury
	South East Wales	Suzanne Jenkins
	Scotland 1	Michael Hogg
	Scotland 2	Michael Hogg
	Scotland 3	Michael Hogg





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## MDT Taskforce Conference Newsletter – Cancer Reform Strategy, MDTs & Cancer Registries

The Cancer Reform Strategy (CRS) identified better and more timely information as a key deliverable within the NHS for England; and the newly launched National Cancer Intelligence Network (NCIN) will take the lead in key areas concerned with all elements of the data pathway, from collection, through to linkage and information delivery.

The NCIN is an umbrella organisation which will bring together all the relevant stakeholders involved in the cancer information pathway from data collection through to data analysis. This naturally includes individual trusts, its constituent MDTs, Cancer Networks, PCTs, the UK Association of Cancer Registries (UKACR), the National Cancer Services Analysis Team (NatCanSAT), the National Clinical Audit Support Programme (NCASP), Royal Colleges, and the National Cancer Research Institute (NCRI), to name a few.

The case for better data collection is strong. Not only will it support more effective commissioning but also timelier clinical audit and outcome information will allow us to tell much sooner if we are going in the right direction and policies are beginning to work.

To realise the potential of the NCIN the collection of robust, timely and accurate data on all patients diagnosed and treated for cancer is key. The challenge therefore is to ensure that the collection of cancer data are embedded within routine patient management and hospital processes and not considered as a separate requirement, with data being recorded once for multiple purposes, along the whole patient pathway. In addition to standard hospital systems (PAS, pathology, radiology, etc), the multidisciplinary team is seen as having an important role in collecting specific relevant items of information for all cancer patients under their care (especially those data items not held elsewhere) and for making this available to the national repository via cancer registries, national audits, cancer waits, commissioning datasets, etc.

Allied with the publication of the CRS, the NHS National Contract for Acute Services required all NHS Trusts in England to be transmitting the cancer registration dataset in an electronic format by 2011, and other specific datasets as they are approved for required collection e.g. Going Further on Cancer Waits, radiotherapy and chemotherapy. Within these initiatives, particular focus has been placed on the collection of specific information which will give a greater understanding of risk adjusted clinical outcomes, such as stage and co-morbidity.

The role of the MDT Coordinator, Patient Tracker, Pathway Navigator and other similar roles within Trusts are a key staff group, crucial to the success of the NCIN. Such staffs are at the front line of data collection and it is important that everyone involved has access to good training & support. To meet the requirements of the CRS, all the Cancer Registries in England are working closely with their Cancer Networks and MDTs to ensure that all trusts are able to transfer the cancer registration dataset electronically by 2011.

Different registries have taken different approaches but they are all focused on facilitating both the collection of data at the MDT, and the subsequent electronic transfer of these data directly to the local registry. One registry has already identified that by receiving electronic data directly from their local MDTs, rather than no data, or data in paper format, the timeliness of cancer registration has already improved by 6 months. Working closely together with MDT staff we are optimistic that these significant benefits can be replicated across England.



Di Riley,  
Associate Director - Clinical Outcomes Programme



Chris Carrigan,  
Head of National Cancer Intelligence Network Coordinating Team

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### 10<sup>th</sup> March 2009, Thistle Hotel, Bristol

## Programme

09:00	Registration & Refreshment	
10:00	Welcome Plenary	<i>The Wessex Suite</i> Serena Hodges
10:10	The Impact the National Awareness and Early Detection Initiative may have on MDTs	Sara Hiom, Director of Health Information, Cancer Research UK
10:40	What happens to Target Data submitted by Trusts	Dr Jane Hanson, Programme Co-ordinator. The Cancer Services Co-ordinating Group, Wales
11:00	Workshops ( <i>Refreshments available in Workshop rooms</i> ) 1 Children & Young Persons Cancers - Dr Meriel Jenney, Paediatric Specialist, Cardiff & Vale 2 Hepatobiliary Cancers – Mr Simon Bramhall Consultant Surgeon, Pan Birmingham 3 Neurology Cancers - Charlotte Attwood, Clinical Nurse Specialist, Cardiff & Vale	
12:00	Workshops ( <i>Refreshments available in Workshop rooms</i> ) 1 Children & Young Persons Cancers - Dr Meriel Jenney, Paediatric Specialist, Cardiff & Vale 2 Hepatobiliary Cancers – Mr Simon Bramhall Consultant Surgeon, Pan Birmingham 3 Neurology - Charlotte Attwood, Clinical Nurse Specialist, Cardiff & Vale	
13:00	Lunch	<i>The Wessex Suite</i>
13:45	Target Data: Its wider use, performance, submission	<i>The Wessex Suite</i> Di Riley Associate Director, Clinical Outcomes National Cancer Intelligence Network & National Cancer Action Team
14:15	Histopathology – Group session	<i>The Wessex Suite</i> Dr Susan Andrew, Consultant Hisopathologist, Bangor, North Wales
15:00	Break	
15.10	A Patients Perspective	John Pattison, Clinical Nurse Specialist for Haematology, South Tyneside
16.00	A Patients Perspective	Lynn Faulds Wood, Taskforce President
16:20	Closing Plenary	Juanita Asumda
16:30	Close & Finish	