	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 (i.e. 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.			

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Post MDT meeting/co-ordination of services

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
3.4.1.	Processes are in place: • for communicating MDT recommendations to patients, GPs and clinical teams within locally agreed timeframes e.g. 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 e.g. Within cancer waits standards where applicable.			

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

4. Patient Centered Clinical Decision-Making

Who to discuss?

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
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 i.e. 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 (e.g. from a local to a specialist MDT).			
4.1.3	There is local agreement about if/when patients with			

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	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.			

Patient-centered care

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
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			

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	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.			

Clinical Decision-Making Process

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
4.3.1	A locally agreed minimum dataset of information is provided at the meeting i.e. 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			

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	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 coordinator/ 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 (e.g. via holistic needs assessment).			

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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-centered (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			

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	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 / NIECR / CAPPS (based on NHS Data Dictionary definitions) and MDTs should link up to the source of these data rather than create separate data capture processes.			

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5. Team Governance

Organisational support

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
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).			

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Data collection, analysis and audit of outcomes

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
5.2.1.	Data collection resource (i.e. 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 (e.g. 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 analyzed 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.			

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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.			

Clinical governance

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
5.3.1	Data collection resource (i.e. the ability to capture relevant information in a timely manner etc) is available to the MDT.			
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.			

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	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:			

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	• 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 Clinical Reference Group (CRG) 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			

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	other national tools as they become available – results of the assessment are acted on by the MDT or employing organisation.			

Appendix 4- Minimum Data Set Form for MDM. This is the standardised data that must be submitted by all

Tumour Site MDM Registration Form

Referrals to the ? MDM must fulfil the following criteria:

1. **Y**our local MDT Co-Ordinator should be notified of the referral to enable them to transfer the patient on CaPPS for discussion.
2. Referral form is mandatory for all new MDM discussions
3. Referrals to MDT must be made by a Consultant.
4. A clear question for the MDT to discuss must be stated on the referral form **and** investigations that need discussed
5. ECOG status is mandatory for all referrals.

Patient Name Click here to enter text.
DOB: Click or tap here to enter text.
HCN Click here to enter text.
Date of Referral Click here to enter a date.
Local CNS informed **YES☐ NO☐**

Referring Clinician Click or tap here to enter text.
Referring Trust Choose an item.
Patient Aware of Diagnosis **YES☐ NO☐**
Copy of MDM Report to Click or tap here to enter text.

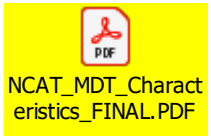
Co Morbidities:
COPD ☐ Diabetes ☐ Dementia ☐ IHD ☐ CHF Renal Disease ☐ Hypertension ☐ CVD ☐ PVD ☐
Other Malignancy ☐ Click or tap here to enter text. Other Condition ☐ Click or tap here to enter text.
Blood thinning medication YES ☐ please list detail Click or tap here to enter text.
NO ☐
Performance Status Choose an item.

For discussion of:
OGD/Path ☐ Date: Click or tap to enter a date. **Findings:** Click or tap here to enter text.
CT ☐ Date: Click or tap to enter a date. **Requested - Await date prior to MDM discussion ☐**
PET ☐ Date: Click or tap to enter a date. **Requested - Await date prior to MDM discussion ☐**

E-mail to: [redacted]
MDM Chair: **MDM Co-Ordinator: (SHSCT MDT Co-Ordinator)**
MDM Cut off: (Date & Time) **MDM: (Date & Time)**
Videoconference:

Received from Maria O'Kane on 02/09/22. Annotated by Urology Services Inquiry

Appendix 5- This is the Cancer Action Teams guidance for Effective MDT



NHS

National Cancer Action Team

The Characteristics of an Effective Multidisciplinary Team (MDT)

February 2010

Contents

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 [redacted]

NHS

National Cancer Action Team

Appendix 6- This is the results from the baseline assessment of all tumour site MDTS

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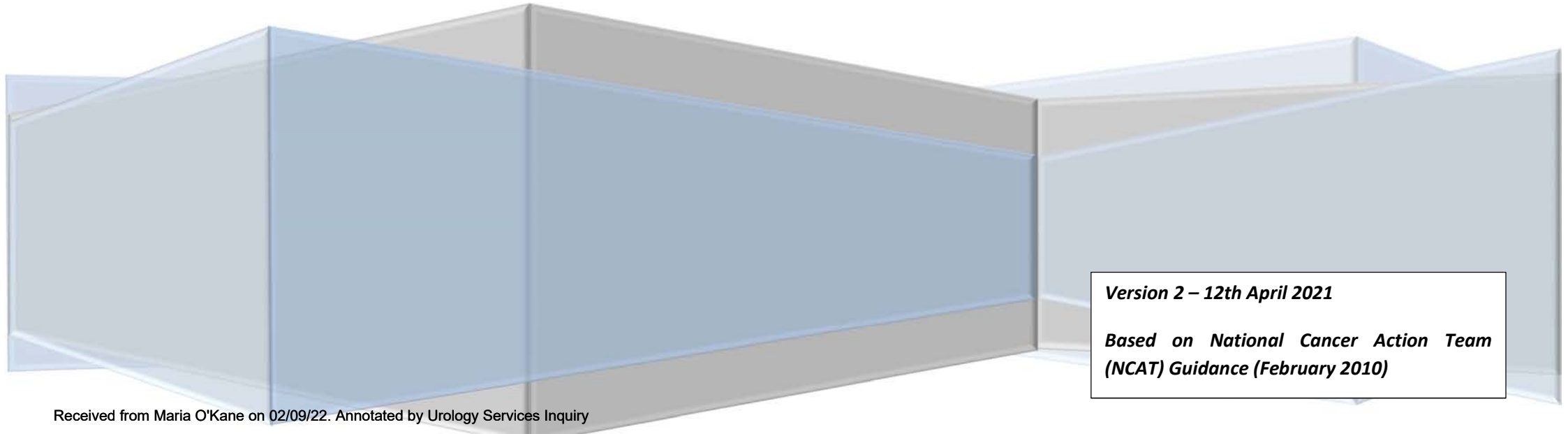
Characteristics of an Effective Multidisciplinary Team (MDT)

Self Assessment and Feedback Questionnaire

Overview of results



Version 2 – 12th April 2021

Based on National Cancer Action Team (NCAT) Guidance (February 2010)

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1. The Multidisciplinary Team

KEY: Yellow – partially **Blue – Not in place**

Membership

No.	Effective MDT Characteristic	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
1.1.1	All relevant professions/disciplines – core & extended members - are represented in the team in line with the Manual of Cancer Services.	P Issue re. cover for radiology and oncology at the MDT	F	P	F	F	F	F	P
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.	F	F	F	F	F	F	F	F
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.	P Cover for radiology & oncology	F	P	F	F	F	F	P

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1.1.4	Members have the level of expertise and specialization Prequired by the MDT in qPuestion – where there are no relFevant peer review measures or Paccreditation for these roles the issue of clinical competence is for the relevant professional body or the Trust to determine.	F	F	F	F	F	F	F	F

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Attendance

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
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.	P Spec palliative CNS attends MDT when is able but has no protected time to prepare and attend	P No preparation time included	P	P	P	F	P	F
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.	F	F	P	F	P	F	P	F
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.	F	F	P	F	F	F	F	F
1.2.4	The chair is responsible for	F	F	F	F	P	F	F	F

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	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.	P Attendance is recorded by MDT Co-coordinator, sign in/out is not used as some members video-link	F	F	F	P	F	P	F
1.2.6	Extended members and non-members attend for the cases that are relevant to them.	F	NIP MDT protocol for referral to the Breast MDT is not fully implemented	P	F	F	F	F	NIP
1.2.7	Anyone observing MDT meetings should be introduced to team members and their details included on the attendance list.	P Medical student attendees are not	F	F	P	P	F	F	F

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		recorded							

Leadership

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
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	F	F	F	F	F	F	F	F
1.3.2.	The MDT chair is responsible for the organisation and the running of the MDT meetings.	F	F	F	F	F	F	F	F
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.	F	F	F	F	F	F	F	F
1.3.4.	The chair: • prepares and/or agrees the agenda with the MDT coordinator;	F	F	P	F	F	F	F	F

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	• ensures the meeting is quorate and takes action if not; • ensures all relevant cases are discussed and prioritized as necessary; • ensures all relevant team members are included in discussions; • ensures discussions are focused and relevant; • ensures good communications/a pro-discussion environment; • promotes evidence-based and patient-centered 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								

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	going to take any resulting actions post meeting and that this is minuted.								
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 e.g. 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.	F	P Pre-COVID, there were regular 2 weekly meetings with Senior Managers to discuss / highlight areas of concern. These need to be re-established.	F	P	F	F	P	F

Team working & culture

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
1.4.1.	Each MDT member has clearly defined roles and	F	P Prep time for MDT not	P	P	P	F	P	F

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	responsibilities within the team which they have signed up to and which are included in their job plans.		included						
1.4.2.	The team has agreed what is acceptable team behavior/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.	F	NIP Develop a memorandum of understanding in relation to MDT etiquette Maybe consider a 360 questionnaire to audit / measure?	F	F	F	F	F	F
1.4.3.	MDT members play a role in sharing learning and best practice with peers.	F	F	F	F	F	F	F	F

Personal development & training

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
1.5.1.	Team members recognise the need for continued learning and individual	F	F	F	F	F	F	F	F

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	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.	Not in place Suggestion: Set up a bi-annual meeting of MDT leads to share learning and experiences	P Need to provide opportunity for MDT Leads to sit-in on other MDT meetings to review practice / share learning and support opportunity for developing	NIP	F	F	F	F	F
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; • advanced	F	P Suggestion: Bespoke course for MDT's – mandatory training for	F	P	P	F	F	F

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	communication skills including listening, presenting and, where relevant, writing; • time management; • confidence & assertiveness; • use of IT equipment e.g. video-conferencing; • knowledge of anatomy, oncology, radiology & pathology (for members not expert in these areas).		new appointees for MDT core members, including CNS's and other specialities						
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).	F	F	P	F	F	F	F	F

2. Infrastructure for Meetings

Physical environment of meeting venue

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
2.1.1.	There is a dedicated MDT room in a suitable (quiet) location with sound proofing if	F	F	P	F	F	P	P	F

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	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.	F	P The venue space is too small for full attendance in the room	P	P	NIP	P	F	F

Technology & equipment (availability & use)

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
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 relevant IT systems;	F	√ X √ √	F	P	F	F	P	F

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	• 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	F	P There was a change of video-conferencing provider by the trust which was not communicated to MDTs	F	F	P	F	P	F

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	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.	F	F	F	F	P	F	P	F

3. Meeting Organisation & Logistics

Scheduling of MDT meetings

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
3.1.1.	MDT meetings take place regularly (as set out in Manual of	F	F	F	F	F	F	F	F

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	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.	F	F	F	F	F	F	F	F

Preparation prior to MDT meetings

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
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	F	F	F	F	F	F	F	F

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	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..	F	F	P	F	F	F	NIP	F
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 Fcases – the structure of the agenda allows, for example, the pathologist to leave if all cases requiring their input have been discussed.	P This could be improved by implementing protocolised pathways for more straight forward cases which just need to be registered and signed off by the MDT Chair.	F	P	F	F	F	F	F

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		The other more complex cases would be listed for discussion.							
3.2.4.	The structured agenda/patient list is circulated prior to the meeting if members agree this would be useful.	F	F	F	F	F	F	F	F
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	P Use of a MDT proforma would help to ensure a minimum dataset is completed for each patient being presented – reviewed by chair re. which goes to protocol and what requires discussion	F	P	F	F	F	P	F

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	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.	Not in place Use of a MDT proforma would help to ensure a minimum dataset is completed for each patient being presented	F	NIP	F	F	F	P	F

Organisation/administration during MDT meetings

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
3.3.1.	It is clear who wants to discuss a particular patient and why they are being discussed.	P Use of MDT proforma would help to improve this	P Sometimes patients are listed and it is not clear	P	F	F	F	F	F

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			why they are being discussed Use of MDT proforma would help to improve this						
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.	P Improve listing of patients by indicating which aspects need to be reviewed e.g. pathology, radiology	F	P	F	P	F	F	F

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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.	F	F	F	F	F	F	P	F
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.	P CAPPs system is an electronic database which is used to collect data on patients and document MDT decisions. Investigation plans and treatment recommendations are formulated	F	F	F	F	F	F	F

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		during the meeting and recorded in narrative format by the MDT Co-ordinator. .							
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 (i.e. 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	Not in place Further discussion/work required to explore how to streamline process.	F	F	F	F	F	F	F

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	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.	F	P Mobile phones are not turned off	F	F	F	F	P	P
3.3.7.	There is effective chairing and co-ordination throughout the meeting.	F	F	F	F	F	F	F	F

Post MDT meeting/co-ordination of services

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
3.4.1.	Processes are in place: • for communicating MDT recommendations to patients, GPs and clinical teams within locally agreed timeframes e.g. patient clinics on the same or next day as MDT meetings where feasible; • for ensuring that patients' information needs are assessed	P Some of the consultant clinics take place the week after the MDT	P F F	P F F NIP	F	F	P F F	P	P

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	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 e.g. Within cancer waits standards where applicable.	NIP NIP F F Patients are tracked from diagnosis up until the 1st definitive treatment (31 day & 62 day pathways).	NIP F Re-discussed if there is a change F F F	NIP F P			F NIP F F	NIP	
3.4.2.	Relevant items from cancer datasets are completed (if this has	F	F	F	F	F	F	F	F

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	not been done in real time at the meeting).								

4. Patient Centered Clinical Decision-Making

Who to discuss?

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
4.1.1.	There are local mechanisms in place to identify all patients where discussion at MDT is needed.	Not sure? Red flag referrals from GPs and other consultants are triaged and depending on outcome are put on 31 day and 62 day pathways which are tracked.	F	F	NIP	F	F	F	F
4.1.2	There are referral criteria in place so it is clear when to send a case to the MDT for consideration i.e. clarity on: • which patients should be discussed by the MDT; • the clinical questions	F	P Some patients are added and at times it is not clear what the question is – a MDT proforma would help to standardize	F	F	F	F	F	F

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	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 (e.g. from a local to a specialist MDT).		this						
4.1.3	There is local agreement about if/when patients with advanced/recurrent disease should be discussed at MDT meetings.	P	P Metastatic patients are not always brought back to the MDT and is based on the consultant's decision	F	F	F	F	F	F
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	NIP	F	F	N/A	F	F	F	F

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	local determination.								

Patient-centered care

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
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.	F	F	F	F	F	F	F	F
4.2.2	A patient's views/preferences/holistic needs are presented by someone who has met the patient whenever possible.	F	F	F	F	F	F	P	F
4.2.3	A named individual at the MDT has responsibility for identifying a key worker for the patient.	NIP Key worker not identified at the MDT meeting – this may happen afterwards	F	NIP	F	F	F	NIP	P
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	F	F	F	F	F	F	NIP	F

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	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.	F	F	F	F	F	F	F	F

Clinical Decision-Making Process

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
4.3.1	A locally agreed minimum dataset of information is provided at the meeting i.e. 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	NIP An MDT Proforma would help with this	P Not all of the information is provided (e.g. co-morbidities)- an MDT Proforma would help with this	NIP	F	P	F	F	F

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	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.	F	F	F	F	F	F	F	F
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 coordinator/ research nurse attends MDT	P Patients who are referred to the Specialist MDT will have access to clinical trials as they are usually regional trials	P The MDT does have access to relevant trials though the Clinical Trial nurse does not attend MDT meeting	P	P	NIP	F	P	F

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	meetings where feasible.								
4.3.4.	Standard treatment protocols are in place and used whenever appropriate	F	Nip There is individual case discussion. The MDT does not use treatment protocols.	F	F	F	F	F	F
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.	F	F	F	F	F	F	F	F
4.3.6	A patient's psychosocial and supportive & palliative care issues are always considered (e.g. via holistic needs assessment).	F	F	F	F	F	F	F	F
4.3.7	A patient's views, preferences and needs inform the decision-making process when relevant/possible	F	F	F	F	F	F	F	F
4.3.8	The clinical–decision making process results in clear recommendations	F	F	F	F	F	F	F	F

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	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-centered (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.	F	F	F	F	F	F	F	F
4.3.10	Where a recommendation cannot be made because of incomplete data or where new data becomes	F	F	F	F	F	F	F	F

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	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.	F	P This is not minuted but each consultant is responsible for review/sign off on CAPPS for their own patients	F	P	F	F	F	F
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 / NIECR / CAPPS (based on NHS Data Dictionary	P Not sure if ethnicity is collected?	P ethnicity is not collected – this would be important particularly in relation to impact on appointment time if interpreters are required	P	P	P	P	P	P

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	definitions) and MDTs should link up to the source of these data rather than create separate data capture processes.								

5. Team Governance

Organisational support

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
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	F P Issues with cover for Radiology and Oncology Need more	F P Room space does not accommodate all members present in	F P	F P	F P	F P	F P	F P

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	out in this document).	resource for audit and tracking	room -Issues with V/C and sound at times -Need more resource for audit						
5.1.2.	Trusts consider their MDTs' annual assessments and act on issues of concern (see 5.3.10).	NIP	P The screening part of the Breast service is reviewed annually by the Trust SMT but not the full service	F	P	F	F	NIP	F

Data collection, analysis and audit of outcomes

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
5.2.1.	Data collection resource (i.e. the ability to capture relevant information in a timely manner etc) is available to the MDT.	P Histology, stage and grade are captured Radiological info	P Data collection resource is limited and would require	F	P	F	F	F	F

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		All treatment options captured – free text is used to generate an outcome	further resourcing in terms of staff and setting up an independent database for research / audit purposes						
5.2.2.	Key information that directly affects treatment decisions (e.g. staging, performance status and co-morbidity) is collected by the MDT.	P Performance & co-morbidity is recorded in the free text box, there is no structured data fields to capture this	P Staging is recorded, co-morbidities may be recorded if it is something significant, performance status is not recorded	P	F	P	F	P	P
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.	P CAPPs datasets are populated after MDT Under current legislation regarding the use of secondary data, the	F	P	F	F	P	P	F

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		MDT is not able to provide data for national datasets							
5.2.4.	Data collected during MDT meetings (including social demographic data extracted from PAS) is analyzed and fed back to MDTs to support learning.	NIP This is not currently happening and would require further resource to support this. It would support the MDT with forward planning, and provide assurance in relation to meeting standards / guidelines by providing a systematic review of MDT activity		NIP	P	P	NIP	NIP	P
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.	P Limited audits due to lack of resource available to support	P Limited audits due to lack of resource available to support	P	P	P	F	F	F
5.2.6.	MDTs consider and act on clinical outcomes data as they become available eg. through peer review, NCIN	NIP Clinical outcomes data not	F	P	F	F	F	F	F

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	clinical reference groups etc.	available through peer review							
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.	P CPES & local surveys don't ask specific questions on MDT working	P As per urology	NIP	P	F	F	P	F

Clinical governance

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
5.3.1	Data collection resource (i.e. the ability to capture relevant information in a timely manner etc) is available to the MDT.	P Very limited due to lack of support available	NIP As per urology	P	P	F	F	F	F
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;	F	P ? not sure Perhaps needs to be	F	F	F	F	F	F

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	• communications post meetings eg. To patients, GPs and other clinical colleagues.		a policy for this – usually agreed & disseminated through CRG for surgery but unsure of process for other modalities						
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.	NIP There is a Trust Cancer Service User Group who have acted as a readers panel in relation to the MDT patient information leaflet. This group is currently being re-established and the terms of reference reviewed. There is scope to explore how the group can support the development of the MDT.							
5.3.4	MDT policies, guidelines and protocols are reviewed at least annually	F	F	F	F	P	F	P	P
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	NIP will required dedicated support in relation to ongoing audit of MDT outcomes. Reinforces importance of role of CNS at clinics.	NIP Needs to be considered but will required dedicated support in relation to ongoing audit of MDT outcomes	P F	P F	P		NIP F	F

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	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.	Department of Health Patient Safety regulations does not overlap with cancer services							
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.	NIP Needs to be considered but will required dedicated support to ensure regular auditing	NIP Needs to be considered but will required dedicated support in relation to ongoing audit of MDT outcomes	NIP	P NIP	NIP	NIP	NIP	NIP
5.3.7	The MDT shares good practice and discusses local problem areas with MDTs within its own trust/Network.	P There is no formal mechanism locally for MDTs to do this but	P At network level, there is an opportunity through the regional	P	P	F	F	F	F

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		should be considered.	Clinical Reference Group to share good practice and highlight areas of concern						
5.3.8	The MDT has representation on the Clinical Reference Group (CRG) for its cancer site and that representative attends the meetings or sends a deputy.	F	F	F	F	F	F	F	F
5.3.9	Significant discrepancies in pathology, radiology or clinical findings between local and specialist MDTs should be recorded and be subject to audit.	NIP Discrepancies may be recorded but are not audited	NIP There is no specialist Breast MDT unlike some of the other tumour sites e.g. Gynae	P	P	P	F	F	P
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.	NIP Needs to be considered but will required dedicated support	P MDT has completed an audit to review the age stratified management of women with breast cancer in the	NIP	NIP	NIP	F	F	F

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			trust compared to the National audit The Screening service has implemented programmes to promote uptake of screening in particular groups of people.						
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.	P The MDT was peer reviewed in September 2015 and submitted self-assessments in 2016 and 2017	F	P	F	F	F	F	P

Appendix 7- Draft MDT Principals Document

Draft MDT Principles Document.xlsx

Area	Principle	Quality Indicator	Evident	Yes/No/Na	Additional info
1. Operational	1.1 All relevant professions/disciplines (core & extended members) are represented in the team in line with the Manual of Cancer Services >95% of the time with cover. Their role should be added to their Job Plan with dedicated time for preparation & attendance at MDT	Quoracy	Annual report		
	1.2 MDM Etiquette: The team has agreed what is acceptable team behavior/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 Mobile phones should be turned off or on silent during MDM discussions. If calls need to be taken the core member should leave the room	MDM etiquette agreed	Operational Policy		
	1.3 The MDT will meet at the regular agreed times. All MDT members should make every effort to be punctual. The chair is responsible for ensuring the meeting is paced appropriately and the meeting length is not excessive.	Annual Audit	Audit		
	1.4 The role of MDT chair and deputy should be supported through regular appraisal at least every 12 months. The position of MDT Lead will be supported by a defined role specification and the time required to effectively chair, including preparation time, should be recognised in job plans.	Job description and job plan allowance in place	Operational Policy		
	1.5 The MDT co-ordinator is recognised as a core member of the team. Each MDT should have adequate MDT co-ordinator support to ensure smooth preparation, running and communication of the MDT, including cross-cutting specialties where necessary. MDT coordinators should be supported to fulfil their role with clear line management, training and development.	There is a dedicated MDT co-ordinator who is provided with adequate training and support along with cross cover when needed	Operational Policy		
	1.6 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. Extended members/non-members attend for cases relevant to them.	Quoracy	Annual Report		
	1.7 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.	Use off PPI engagement	Annual reports		
	1.8 The MDT chair will be made aware of any absences (and cover arrangements) and/or new attendees in advance, and introduce them at the start of the meeting. Anyone observing MDT meetings should be introduced to team members and their details included on the attendance list. The observor should sign a confidentiality agreement form.	There is advance notice to MDT chair	Operational Policy		
	1.9 The MDT is the forum for clinicians with differing areas of expertise to input into the management of patients with cancer, and will include investigation, treatment, follow up, ethical and social matters, comorbidities and practical problems. Each MDT should agree a policy for discussion of newly suspected/confirmed and recurrent malignancies. Processes should be 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. There is information on when to refer patient to local and regional MDMs.	There is a weekly or fortnightly MDT. Details in operational Policy	Operational Policy		
	1.10 For some tumour sites, certain subgroups of patients now follow very well-established treatment protocols. 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'. Patients on predetermined agreed algorithms will be recorded and not discussed by the full MDT. Decision making for patients put on a protocolised pathway should be regularly reviewed.	Standards of Care pathways	Operational Policy		
	1.11 The Trust will ensure appropriate IT support for audio-visual teleconferencing equipment, able to respond to issues during meetings if required. A dedicated and appropriate meeting room should be available which has access to other essential technology and software for example access to projected digital images.	Audit	Annual Audit		
		There is a dedicated meeting room equipped with appropriate technology. Audiovisual and teleconferencing equipment working well with technical support available	Escalation protocol if issues		

2. Communication	**2.1 MDM recommendations are only as good as information they are based on. A communication protocol should be in place for all MDMs to cover aspects such as Pre/During MDM. If there are concerns that key data is missing this should be documented. The Minimum dataset must include** **- Clinical summary to include co-mobrbities, psycholosocal and specialist palliative care needs along with patient preferences where known** **- Question to MDM** **- Person responsible** **- Summary of the record** **Post MDM** **- Informing GP/referring clinician** **- Filing of MDM record** **- Communication to core/non core members** **- Referrals/Actions from MDM** **- MDM sign off** **- Discrepancies noted and audited** **2.2 The Chair should ensure a clear plan is in place for communication with the patient. The decision of the MDT should be recorded on CaPPs in real time in full view of the MDM with person responsible for action listed where appropriate. The MDM outcome should be communicated to the relevant professionals (e.g. referring MDT, GP, CNS) to enable early discussion and management ideally on the same day and within 1 working day**	**Annual Audit against MDT communication protocol & number of cases deferred with reason**	**Annual Audit**		
	2.3 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-centered (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.**	**Audit**	**Audit**		
	2.4 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 last minute due to clinical urgency.	**Detailed in operational policy and agreed by team**	**Operational Policy**		
	2.5 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.	**Detailed in operational policy and agreed by team**	**Operational Policy**		
	2.6 There are processes in place: **• 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 another provider);** **• to track patients through the system to ensure that any tests, appointments, treatments are carried out in a timely manner e.g. Within cancer waits standards where applicable.**	**MDM outcomes audit, ITT protocol, tracking of NEW cancer patients to First treament tretament**	**Audit**		
	2.7 The MDT should be patient centred in its approach ensuring that wherever possible someone who has met the patient and can express their views, wishes and needs is in attendance.	**Patient preferences are discussed at MDT where appropriate**	**Annual Audit**		
	2.8 The MDT/Service has responsibility for identifying a key worker for the patient.	**Patient experience survey**	**Annual survey**		
	2.9The MDT has responsibility for ensuring all clinically appropriate treatment options for a patient even those they cannot offier/provide locally are considered and that the patients information needs have been (or will be) assessed and addressed.				
	2.10 Patient experience surveys include questions relevant to MDT working and action is taken by MDTs to implement improvements needed in response to patient feedback.				
	2.11 Every patient discussed should be considered for appropriate/available clinical trials, and this should be recorded.	**Annual Audit**	**Annual Audit**		
	2.12 Patients are aware of the MDT, it's purpose, membership, when it meets and that their case is being/has been discussed and are given the outcome within a locally agreed timeframe. A leaflet about the MDM working is provided to patients.	**Website/Patient Information**	**Operational Policy**		
	2.13 Each MDT should have a patient information leaflet on the MDT and permanent record of consultation given out to them by the CNS, this is one of the peer review standards.	**Patient Information**	**Operational Policy**		
	2.14 A clinician can bring the case of a private patient to the MDT for discussion provided there is time on the agenda and the appropriate reimbursement arrangements are completed				

	When patients are referred into an MDT the specific MDT referral form should be completed, and any relevant imaging made available for the scheduled discussion. When a patient's care is being transferred into the NHS, the imaging should be uploaded onto the relevant imaging viewer (eg: PACS). In addition, a letter of referral should be generated from the Independent Sector for the NHS records. Pathology reports should be included in the referral and samples should be sent to the MDT pathologist(s) on request. This process should be facilitated by the private medical practitioner. It is not the responsibility of the MDT chair or co-ordinator to organise transfer of images, pathology or clinical information into the MDT.	Annual Audit against MDT communication protocol	Audit		

3. Governance/Audit/Research	**3.1 MDT decisions are guidance for the responsible treating clinician. Accountability for any intervention remains with the clinician responsible for that intervention.**	**MDM outcomes audit**	**Quarterly audit**		
	3.2 Clear governance arrangements should be in place to ensure that patients, relatives, medical and nursing staff in primary, secondary and tertiary care are all clear who is responsible for taking forward MDT action.	**Audit against MDT communication protocol**	**Audit**		
	3.3 MDT members are encouraged to raise any concerns about the functioning of the MDT with the MDT chair. The MDT should agree a process for regularly monitoring and reviewing the functioning of the MDT and undertake continuous improvement activities and identify if there are any areas of training required.	**Annual MDM improvement Survey/Business meeting**	**Annual report/Survey**		
	3.4 Audit of MDT outcomes, processes and data will be central to the assurance of quality and results will be communicated with all core members of the MDMs and discussed at annual business meetings. Agreed audits include: **1. MDM communication (Referral proformas, communication with GPs and filing of MDM outcomes)** **2. MDM outcomes**	**Audit**	**Audit**		
	3.5 Each service area supporting the MDM should ensure they have oversight and ownership of mortality and morbidity data to ensure all adverse outcomes can be discussed by the relevant professional group and learned from. All core members attend Trust M&M and ensure cancer patients are discussed. If required a selection of learning from M&M can be presented for educational purposes at the annual/bi annual business meetings.	**Clear mortality and morbidity review in place**	**Operational Policy**		
	3.6 The implementation and outcomes of protocolised approaches should be audited and reviewed by the full MDT in an operational meeting. Patients who are not discussed but who are recorded at the MDT will have their data, treatment and outcome regularly audited for compliance to mandatory dataset collection requirements.	**Audit**	**Annual report**		
	3.7 Peer support and external scrutiny of MDT processes, functioning and outcomes are welcomed by all MDTs and NICaN Clinical Reference Groups (CRGs). The review should take place against peer review standards as set out in the manual of cancer standards. MDT members work in partnership with other peers to offer reciprocal peer support. Nominated members who attend the CRG should routinely feed back to the MDT	**CRG attendance**	**Annual report**		
	3.8 MDTs should be a part of a formal governance framework within the Southern Trust. Members of the MDT should ensure that they are aware of this governance framework and those relevant policies and procedures are followed by the MDT. The Clinical Lead should be responsible for raising issues through this governance process on behalf of the MDT however all members of the team should take responsibility for raising issues.	**Clear governance processes, policies and procedures in place**	**Operational Policy**		
	3.7 There is organisational (employer) support for MDT meetings and MDT membership demonstrated via: **· Recognition that MDTs are 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)**	**Adequate funding/resources and facilities**	**Annual report - quoarcy - Cancer Improvement plan**		
	3.8 Trusts consider their MDT's annual reports via discussion of these at annual business meetings and act on issues of concern. Please confirm date of last meeting	**Annual/Bi-annual business meetings**	**Minutes/Cancer Improvement Plans**		
	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.				
	3.9 MDT policies, guidelines and protocols are reviewed at least annually. All annual reports, operational policies, cancer improvement plans are discussed at annual business meetings and signed off by all core members of the team.				

Appendix 8- This is the most recent feedback (2018)

CPES Report – SHSCT

451 patients (total sample 3217) from SHSCT

77 respondents were treated for urological cancer (17% of total sample)

Highest scores:

Q1.Saw GP once/twice before being told had to go to hospital ***(NI-74%, ST-82%)***

Q2.Patient thought they were seen as soon as possible ***(NI-86%; ST – 87%)***

Q6.Staff gave complete explanation of purpose of test ***(NI-84%; ST – 86%)***

Q7.Staff explained completely what would be done during test ***(NI-88%; ST – 89%)***

Q14.Patient given written info about type of cancer they had ***(NI-48%; ST – 54%)***

Q17.Possible side effects explained in understandable way ***(NI-75%; ST – 77%)***

Q22.Patient finds it easy to contact CNS ***(NI – 82%; ST – 88%)***

Q24.Get understandable answers to imp questions all/most of time ***(NI-89%;ST-90%)***

Q28.Patient has seen info about cancer research in hospital ***(NI-79%; ST-90%)***

Q37.Patient had confidence & trust in all Drs treating them ***(NI-86%; ST-90%)***

Q38.Drs didn't talk in front of patient as if they were not there ***(NI-80%; ST-86%)***

Q52.Given clear written info about what should/should not do post-discharge ***(NI-78%; ST – 84%)***

Q54.Family given all info needed to help care at home ***(NI-59%; ST-68%)***

Q61.Dr had right notes & documentation with them ***(NI-97%; ST-98%)***

Q69.Patient's rating of care excellent / very good ***(NI-90%; ST-90%)***

Lower scores:

Q8.Given easy to understand written information about test ***(NI-88%; ST-83%)***

Q11.Patient told they could bring a friend when first told they had cancer ***(NI-76%; ST-71%)***

Q15.Patient given a choice of different types of treatment ***(NI-81%; ST-67%)***

Q18.Patient given written information about side effects ***(NI-64%; ST-61%)***

Q20.Patients definitely involved in decisions about care and treatment ***(NI-75%; ST-71%)***

Q21.Patient given the name of the CNS in charge of their care ***(NI-53%; ST-48%)***

Q25.Hospital staff gave info about support groups **(NI-67%; ST – 47%)**, Q26. impact cancer could have on work/education **(NI-60%; ST-55%),** Q27. info on getting financial help **(NI-41%; ST-33%)**

Q29.Taking part in research discussed with patient ***(NI-9%; ST-1%)***

Q36.Got understandable answers to important questions all/most of time ***(NI-74%; ST-72%)***

Q39.Patients family def had opportunity to talk to doctor ***(NI-58%; ST – 56%)***

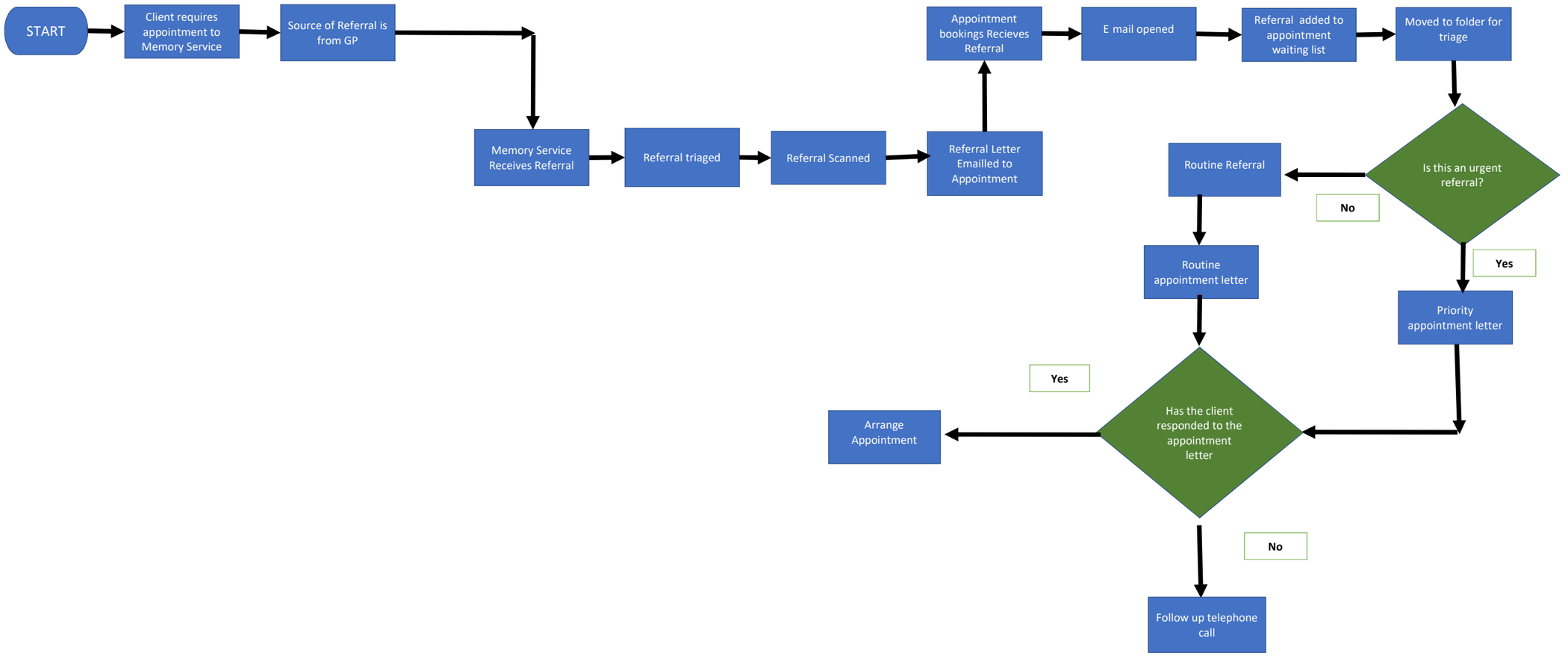
Q49.Patient was able to discuss worries or fears with staff during visits ***(NI-69%; ST-67%)***

Q59.Hospital staff definitely gave patient enough emotional support ***(NI-75%; ST-71%)***

Q67.Patient offered written assessment and care plan ***(NI-11%; ST-9%)***

Q68.Patient did not feel that they were treated as a 'set of cancer symptoms' ***(NI-84%; ST-78%)***

Memory Service Clinic Appointment



Received from Maria O'Kane on 02/09/22. Annotated by Urology Services Inquiry

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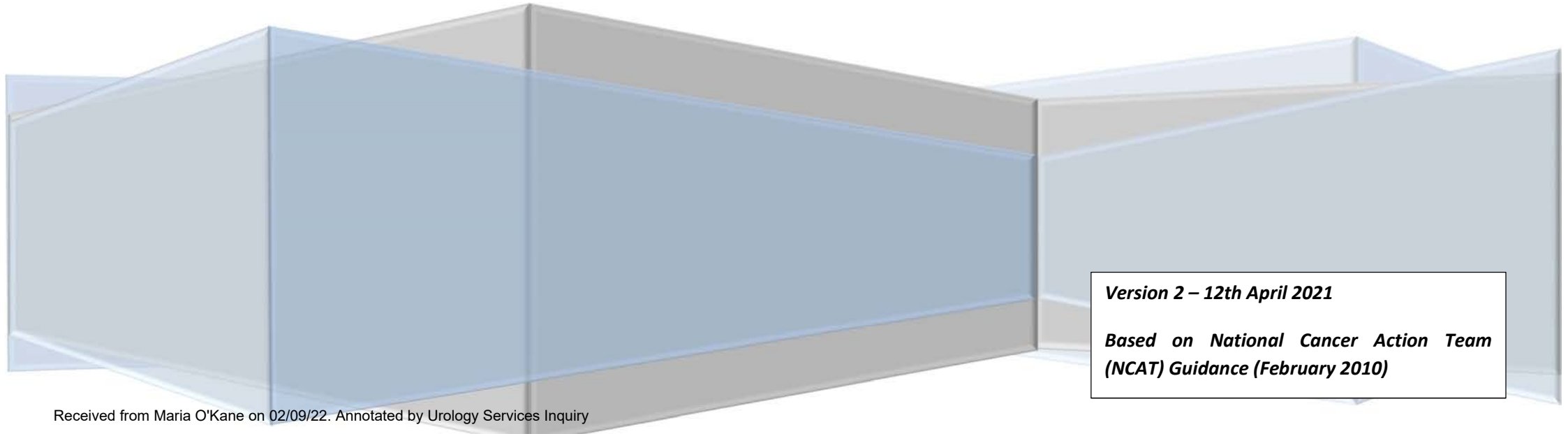
Characteristics of an Effective Multidisciplinary Team (MDT)

Self Assessment and Feedback Questionnaire



Version 2 – 12th April 2021

Based on National Cancer Action Team (NCAT) Guidance (February 2010)

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1. The Multidisciplinary Team

Membership

No.	Effective MDT Characteristic	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
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 specialization 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.			

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Attendance

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
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			

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	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.			

Leadership

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
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			
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			

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	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 coordinator; • ensures the meeting is quorate and takes action if not; • ensures all relevant cases are discussed and prioritized as necessary; • ensures all relevant team members are included in discussions; • ensures discussions are focused and relevant; • ensures good communications/a pro-discussion environment; • promotes evidence-based and patient-centered 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			

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	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.			
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 e.g. 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.			

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Team working & culture

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
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 behavior/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.			

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Personal development & training

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
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; • advanced communication skills including listening, presenting and, where relevant, writing; • time management;			

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	• confidence & assertiveness; • use of IT equipment e.g. 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

Physical environment of meeting venue

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
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.			

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Technology & equipment (availability & use)

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
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 relevant IT systems; • 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.			

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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.			

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3. Meeting Organisation & Logistics

Scheduling of MDT meetings

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
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.			

Preparation prior to MDT meetings

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
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			

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	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-			

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	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.			

Organisation/administration during MDT meetings

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
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			

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	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			

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	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 (i.e. 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.			

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Post MDT meeting/co-ordination of services

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
3.4.1.	Processes are in place: • for communicating MDT recommendations to patients, GPs and clinical teams within locally agreed timeframes e.g. 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 e.g. Within cancer waits standards where applicable.			

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

4. Patient Centered Clinical Decision-Making

Who to discuss?

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
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 i.e. 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 (e.g. from a local to a specialist MDT).			
4.1.3	There is local agreement about if/when patients with			

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	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.			

Patient-centered care

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
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			

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	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.			

Clinical Decision-Making Process

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
4.3.1	A locally agreed minimum dataset of information is provided at the meeting i.e. 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			

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	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 coordinator/ 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 (e.g. via holistic needs assessment).			

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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-centered (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			

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	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 / NIECR / CAPPS (based on NHS Data Dictionary definitions) and MDTs should link up to the source of these data rather than create separate data capture processes.			

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5. Team Governance

Organisational support

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
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).			

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Data collection, analysis and audit of outcomes

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
5.2.1.	Data collection resource (i.e. 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 (e.g. 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 analyzed 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.			

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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.			

Clinical governance

No.	Statement	Embedded (Fully, Partially, Not in Place)	Evidence	Comments / Action Required to Improve?
5.3.1	Data collection resource (i.e. the ability to capture relevant information in a timely manner etc) is available to the MDT.			
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.			

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	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:			

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	• 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 Clinical Reference Group (CRG) 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			

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	other national tools as they become available – results of the assessment are acted on by the MDT or employing organisation.			

Tumour Site MDM Registration Form

Referrals to the ? MDM must fulfil the following criteria:

1. **Y**our local MDT Co-Ordinator should be notified of the referral to enable them to transfer the patient on CaPPS for discussion.
2. Referral form is mandatory for all new MDM discussions
3. Referrals to MDT must be made by a Consultant.
4. A clear question for the MDT to discuss must be stated on the referral form **and** investigations that need discussed
5. ECOG status is mandatory for all referrals.

Patient Name Click here to enter text.
DOB: Click or tap here to enter text.
HCN Click here to enter text.
Date of Referral Click here to enter a date.
Local CNS informed **YES☐ NO☐**

Referring Clinician Click or tap here to enter text.
Referring Trust Choose an item.
Patient Aware of Diagnosis **YES☐ NO☐**
Copy of MDM Report to Click or tap here to enter text.

Co Morbidities:
COPD ☐ Diabetes ☐ Dementia ☐ IHD ☐ CHF Renal Disease ☐ Hypertension ☐ CVD ☐ PVD ☐
Other Malignancy ☐ Click or tap here to enter text. Other Condition ☐ Click or tap here to enter text.
Blood thinning medication YES ☐ please list detail Click or tap here to enter text.
NO ☐
Performance Status Choose an item.

For discussion of:
OGD/Path ☐ Date: Click or tap to enter a date. **Findings:** Click or tap here to enter text.
CT ☐ Date: Click or tap to enter a date. **Requested - Await date prior to MDM discussion ☐**
PET ☐ Date: Click or tap to enter a date. **Requested - Await date prior to MDM discussion ☐**

E-mail to: [redacted]t
MDM Chair: **MDM Co-Ordinator: (SHSCT MDT Co-Ordinator)**
MDM Cut off: (Date & Time) **MDM: (Date & Time)**
Videoconference:

Received from Maria O'Kane on 02/09/22. Annotated by Urology Services Inquiry

NHS

National Cancer Action Team

The Characteristics of an Effective Multidisciplinary Team (MDT)

February 2010

Contents

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 [redacted]

Personal information redacted by USI

NHS

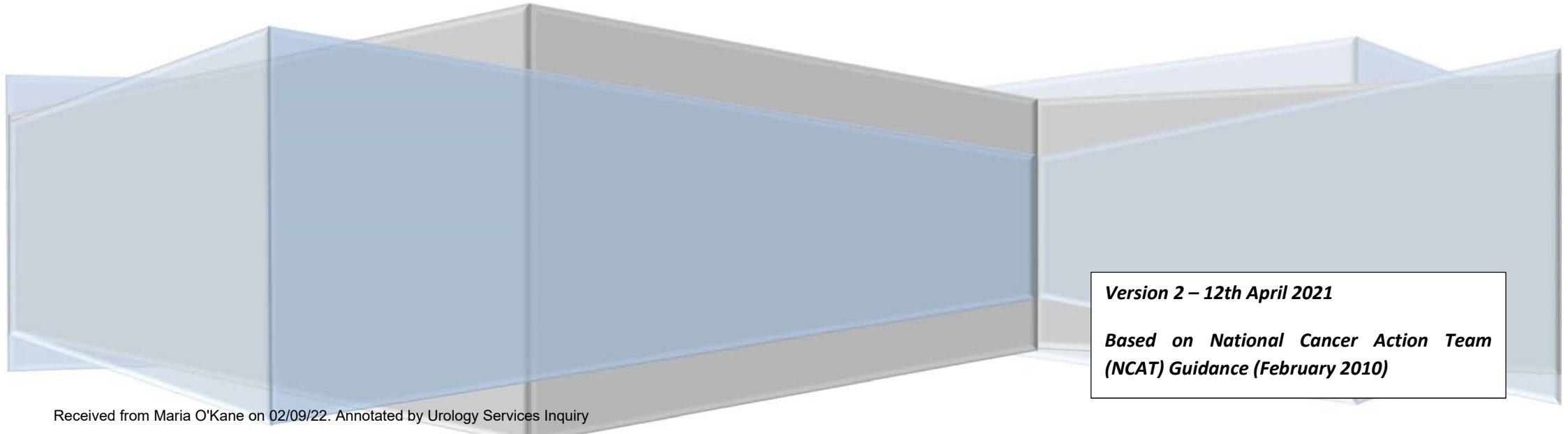
National Cancer Action Team

Southern Health and Social Care Trust

Characteristics of an Effective Multidisciplinary Team (MDT)

Self Assessment and Feedback Questionnaire

Overview of results



Version 2 – 12th April 2021

Based on National Cancer Action Team (NCAT) Guidance (February 2010)

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1. The Multidisciplinary Team

KEY: Yellow – partially **Blue – Not in place**

Membership

No.	Effective MDT Characteristic	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
1.1.1	All relevant professions/disciplines – core & extended members - are represented in the team in line with the Manual of Cancer Services.	P Issue re. cover for radiology and oncology at the MDT	F	P	F	F	F	F	P
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.	F	F	F	F	F	F	F	F
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.	P Cover for radiology & oncology	F	P	F	F	F	F	P

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1.1.4	Members have the level of expertise and specialization Prequired by the MDT in qPuestion – where there are no relFevant peer review measures or Paccreditation for these roles the issue of clinical competence is for the relevant professional body or the Trust to determine.	F	F	F	F	F	F	F	F

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Attendance

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
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.	P Spec palliative CNS attends MDT when is able but has no protected time to prepare and attend	P No preparation time included	P	P	P	F	P	F
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.	F	F	P	F	P	F	P	F
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.	F	F	P	F	F	F	F	F
1.2.4	The chair is responsible for	F	F	F	F	P	F	F	F

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	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.	P Attendance is recorded by MDT Co-coordinator, sign in/out is not used as some members video-link	F	F	F	P	F	P	F
1.2.6	Extended members and non-members attend for the cases that are relevant to them.	F	NIP MDT protocol for referral to the Breast MDT is not fully implemented	P	F	F	F	F	NIP
1.2.7	Anyone observing MDT meetings should be introduced to team members and their details included on the attendance list.	P Medical student attendees are not	F	F	P	P	F	F	F

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		recorded							

Leadership

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
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	F	F	F	F	F	F	F	F
1.3.2.	The MDT chair is responsible for the organisation and the running of the MDT meetings.	F	F	F	F	F	F	F	F
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.	F	F	F	F	F	F	F	F
1.3.4.	The chair: • prepares and/or agrees the agenda with the MDT coordinator;	F	F	P	F	F	F	F	F

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	• ensures the meeting is quorate and takes action if not; • ensures all relevant cases are discussed and prioritized as necessary; • ensures all relevant team members are included in discussions; • ensures discussions are focused and relevant; • ensures good communications/a pro-discussion environment; • promotes evidence-based and patient-centered 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								

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	going to take any resulting actions post meeting and that this is minuted.								
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 e.g. 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.	F	P Pre-COVID, there were regular 2 weekly meetings with Senior Managers to discuss / highlight areas of concern. These need to be re-established.	F	P	F	F	P	F

Team working & culture

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
1.4.1.	Each MDT member has clearly defined roles and	F	P Prep time for MDT not	P	P	P	F	P	F

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	responsibilities within the team which they have signed up to and which are included in their job plans.		included						
1.4.2.	The team has agreed what is acceptable team behavior/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.	F	NIP Develop a memorandum of understanding in relation to MDT etiquette Maybe consider a 360 questionnaire to audit / measure?	F	F	F	F	F	F
1.4.3.	MDT members play a role in sharing learning and best practice with peers.	F	F	F	F	F	F	F	F

Personal development & training

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
1.5.1.	Team members recognise the need for continued learning and individual	F	F	F	F	F	F	F	F

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	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.	Not in place Suggestion: Set up a bi-annual meeting of MDT leads to share learning and experiences	P Need to provide opportunity for MDT Leads to sit-in on other MDT meetings to review practice / share learning and support opportunity for developing	NIP	F	F	F	F	F
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; • advanced	F	P Suggestion: Bespoke course for MDT's – mandatory training for	F	P	P	F	F	F

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	communication skills including listening, presenting and, where relevant, writing; • time management; • confidence & assertiveness; • use of IT equipment e.g. video-conferencing; • knowledge of anatomy, oncology, radiology & pathology (for members not expert in these areas).		new appointees for MDT core members, including CNS's and other specialities						
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).	F	F	P	F	F	F	F	F

2. Infrastructure for Meetings

Physical environment of meeting venue

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
2.1.1.	There is a dedicated MDT room in a suitable (quiet) location with sound proofing if	F	F	P	F	F	P	P	F

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	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.	F	P The venue space is too small for full attendance in the room	P	P	NIP	P	F	F

Technology & equipment (availability & use)

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
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 relevant IT systems;	F	√ X √ √	F	P	F	F	P	F

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	• 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	F	P There was a change of video-conferencing provider by the trust which was not communicated to MDTs	F	F	P	F	P	F

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	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.	F	F	F	F	P	F	P	F

3. Meeting Organisation & Logistics

Scheduling of MDT meetings

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
3.1.1.	MDT meetings take place regularly (as set out in Manual of	F	F	F	F	F	F	F	F

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	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.	F	F	F	F	F	F	F	F

Preparation prior to MDT meetings

No.	Statement	Urology	Breast	Gynae	Lung	LGI	UGI	Skin	Thyroid
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	F	F	F	F	F	F	F	F

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	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..	F	F	P	F	F	F	NIP	F
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 Fcases – the structure of the agenda allows, for example, the pathologist to leave if all cases requiring their input have been discussed.	P This could be improved by implementing protocolised pathways for more straight forward cases which just need to be registered and signed off by the MDT Chair.	F	P	F	F	F	F	F

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		The other more complex cases would be listed for discussion.							
3.2.4.	The structured agenda/patient list is circulated prior to the meeting if members agree this would be useful.	F	F	F	F	F	F	F	F
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	P Use of a MDT proforma would help to ensure a minimum dataset is completed for each patient being presented – reviewed by chair re. which goes to protocol and what requires discussion	F	P	F	F	F	P	F